AvMed Pharmacy Changes

Effective: April 1, 2026

(For plans with pharmacy benefits administered by AvMed

DRUG NAME: adalimumab-ryvk (CF) 80 mg 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 (4- TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
OPEN FORMULARY (5-TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Non-Formulary	Quantity Limit
QUANTITY LIMIT: 2 injections per 28 days		
FORMULARY ALTERNATIVES: SELF FUNDED COMMERCIAL GROUPS – Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Yuflyma (adalimumab-aaty); **FULLY INSURED COMMERCIAL GROUPS/HIX/SG 2026** – Simlandi (adalimumab-ryvk) and adalimumab-adbm		

AvMed Pharmacy Changes

Effective: April 1, 2026

(For plans with pharmacy benefits administered by AvMed

DRUG NAME: Avtozma® (tocilizumab-anoh) single-dose vials for intravenous use, all strengths		**INDICATION:** Biosimilar to Actemra® indicated for the 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; Patients 2 years of age and older with active systemic juvenile idiopathic arthritis; Adults and pediatric patients 2 years of age and older with chimeric antigen receptor (CAR) T cell-induced severe or life-threatening cytokine release syndrome, and; Hospitalized adult patients with coronavirus disease 2019 (COVID-19) who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Medical Benefit	Prior Authorization
OPEN FORMULARY (5-TIER)	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY (4-TIER)	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY (5-TIER)	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

AvMed Pharmacy Changes

Effective: April 1, 2026

(For plans with pharmacy benefits administered by AvMed

DRUG NAME: Beizray (albumin solubilized docetaxel injection) 80 & 160 mg kit, for intravenous use		**INDICATION:** For the treatment of - Breast Cancer (BC): single agent for locally advanced or metastatic BC after chemotherapy failure; and with doxorubicin and cyclophosphamide as adjuvant treatment of operable node-positive BC; Non-small Cell Lung Cancer (NSCLC): single agent for locally advanced or metastatic NSCLC after platinum therapy failure; and with cisplatin for unresectable, locally advanced or metastatic untreated NSCLC; Castration-Resistant Prostate Cancer (CRPC): with prednisone in metastatic castration-resistant prostate cancer; Gastric Adenocarcinoma (GC): with cisplatin and fluorouracil for untreated, advanced GC, including the gastroesophageal junction; Squamous Cell Carcinoma of the Head and Neck (SCCHN): with cisplatin and fluorouracil for induction treatment of locally advanced SCCHN
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Medical Benefit	N/A
OPEN FORMULARY (5-TIER)	Medical Benefit	N/A
STANDARD FORMULARY	Medical Benefit	N/A
EXCHANGE FORMULARY (4-TIER)	Medical Benefit	N/A
EXCHANGE FORMULARY (5-TIER)	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

AvMed Pharmacy Changes

Effective: April 1, 2026

(For plans with pharmacy benefits administered by AvMed

DRUG NAME: Blujepa (gepotidacin) 750 mg tablets		**INDICATION:** For the treatment of female adult and pediatric patients 12 years of age and older weighing at least 40 kilograms (kg) with uncomplicated urinary tract infections (uUTI) caused by the following susceptible microorganisms: Escherichia coli, Klebsiella pneumoniae, Citrobacter freundii complex, Staphylococcus saprophyticus, and Enterococcus faecalis
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Tier 3	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Tier 4	Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Non-Formulary	Quantity Limit
QUANTITY LIMIT: 20 tablets per 30 days		
FORMULARY ALTERNATIVES: generic nitrofurantoin capsules, cephalexin capsules, trimethoprim-sulfamethoxazole tablets		

DRUG NAME: Brekiya® (dihydroergotamine mesylate) 1 mg/mL single-dose auto-injector for subcutaneous use		**INDICATION:** For the acute treatment of migraine with or without aura and the acute treatment of cluster headaches in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
OPEN FORMULARY (5-TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Non-Formulary	Quantity Limit
QUANTITY LIMIT: 24 mL per 28 days		
FORMULARY ALTERNATIVES: dihydroergotamine 1 mg/mL ampule, dihydroergotamine 4 mg/mL nasal spray *both require prior authorization*		

AvMed Pharmacy Changes

Effective: April 1, 2026

(For plans with pharmacy benefits administered by AvMed

DRUG NAME: carbidopa-levodopa ER capsules, all strengths		**INDICATION:** For the treatment of Parkinson's disease, post-encephalitic parkinsonism, and parkinsonism that may follow carbon monoxide intoxication or manganese intoxication
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Tier 3	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Tier 4	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Non-Formulary	Quantity Limit
QUANTITY LIMIT: 10 capsules per day (all strengths)		
FORMULARY ALTERNATIVES: carbidopa-levodopa ER 25-100 & 50-200 mg tablets		

AvMed Pharmacy Changes

Effective: April 1, 2026

(For plans with pharmacy benefits administered by AvMed

DRUG NAME: Cimzia® (certolizumab pegol) 200 mg/mL syringe kit injection, for subcutaneous use		**INDICATION:** For reducing signs and symptoms of Crohn's disease and maintaining clinical response in adult patients with moderately to severely active disease who have had an inadequate response to conventional therapy; Treatment of adults with moderately to severely active rheumatoid Arthritis; Treatment of active polyarticular juvenile idiopathic arthritis (pJIA) in patients 2 years of age and older; Treatment of adult patients with active psoriatic arthritis; Treatment of adults with active ankylosing spondylitis; Treatment of adults with active non-radiographic axial spondyloarthritis with objective signs of inflammation; Treatment of adults with moderate-to-severe plaque psoriasis who are candidates for systemic therapy or phototherapy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 syringe kits per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Dawnzera™ (donidalorsen) 80 mg/0.8 mL solution in a single-dose auto-injector, for subcutaneous use		**INDICATION:** For prophylaxis to prevent attacks of hereditary angioedema (HAE) in adult and pediatric patients 12 years of age and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 0.8 mL (1 injection) per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: generic dihydroergotamine 1 mg/mL ampule		**INDICATION:** For the acute treatment of migraine with or without aura in adults
REASON FOR CHANGE: Change Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Tier 2	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Tier 2	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 2	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Tier 2	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Tier 3	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 24 mL per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Doptelet® Sprinkle (avatrombopag) 10 mg oral granules		**INDICATION:** For the treatment of thrombocytopenia in pediatric patients 1 year to less than 6 years with persistent or chronic ITP who have had an insufficient response to a previous treatment
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 capsules per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: econazole nitrate 1% foam		**INDICATION:** For the treatment of interdigital tinea pedis caused by *Trichophyton rubrum*, T*richophyton mentagrophytes*, and *Epidermophyton floccosum* in patients 12 years and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Non-Formulary	Prior Authorization (CED)
OPEN FORMULARY (5-TIER)	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY (4-TIER)	Non-Formulary	N/A
EXCHANGE FORMULARY (5-TIER)	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: ciclopirox cream, econazole cream, ketoconazole cream, nystatin cream/ointment/solution		

DRUG NAME: Eliquis® (apixaban) 0.5 mg tablets for oral suspension		**INDICATION:** For the treatment of venous thromboembolism (VTE) and reduction in the risk of recurrent VTE in pediatric patients from birth and older after at least 5 days of initial anticoagulant treatment
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
OPEN FORMULARY (5-TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Non-Formulary	Quantity Limit
QUANTITY LIMIT: • 0.5 mg: 28 count tablet carton (1 tablet per packet) = 112 tablets per 28 days • 1.5 mg: 84 count tablet carton (3 tablets per packet) = 336 tablets per 28 days • 2 mg: 112 count tablet carton (4 tablets per packet) = 448 tablets per 28 days		
FORMULARY ALTERNATIVES: Brand Eliquis® tablets		

DRUG NAME: Eliquis® Sprinkle (apixaban) 0.15 mg capsules for oral suspension		**INDICATION:** For the treatment of venous thromboembolism (VTE) and reduction in the risk of recurrent VTE in pediatric patients from birth and older after at least 5 days of initial anticoagulant treatment
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
OPEN FORMULARY (5-TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Non-Formulary	Quantity Limit
QUANTITY LIMIT: 56 capsules per 28 days		
FORMULARY ALTERNATIVES: Brand Eliquis® tablets		

DRUG NAME: Enbumyst (bumetanide) 0.5 mg/0.1 mL nasal spray		**INDICATION:** For the treatment of edema associated with congestive heart failure, hepatic and renal disease, including nephrotic syndrome in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
OPEN FORMULARY (5-TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Non-Formulary	Quantity Limit
QUANTITY LIMIT: 120 cartons per 30 days		
FORMULARY ALTERNATIVES: generic bumetanide tablets		

DRUG NAME: escitalopram 15 mg capsule		**INDICATION:** For the acute treatment of generalized anxiety disorder in adults and pediatric patients ≥7 years of age; For the acute and maintenance treatment of unipolar major depressive disorder in adults and pediatric patients ≥12 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
OPEN FORMULARY (5-TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Non-Formulary	Quantity Limit
QUANTITY LIMIT: 2 capsules per day		
FORMULARY ALTERNATIVES: generic escitalopram tablets/solution		

DRUG NAME: Exxua™ (gepirone) ER tablets & titration pack, all strengths		**INDICATION:** For the treatment of unipolar major depressive disorder in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Tier 3	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Tier 4	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Non-Formulary	Quantity Limit
QUANTITY LIMIT: • 18.2, 36.3, 54.5 & 72.6 mg tablets - 1 tablet per day • Titration pack – 32 tablets per 365 days		
FORMULARY ALTERNATIVES: citalopram tablets, escitalopram tablets, fluoxetine capsules, fluvoxamine tablets, paroxetine tablets sertraline tablets, venlafaxine IR tablets, venlafaxine ER capsules, desvenlafaxine ER tablets		

DRUG NAME: Fibryga® [fibrinogen (human)] 2-gram lyophilized powder in a single-dose vial for reconstitution, for intravenous use		**INDICATION:** Fibrinogen supplementation in bleeding pediatric and adult patients with acquired fibrinogen deficiency; For the treatment of acute bleeding episodes in pediatric and adult patients with congenital fibrinogen deficiency, including afibrinogenemia and hypofibrinogenemia
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Medical Benefit	N/A
OPEN FORMULARY (5-TIER)	Medical Benefit	N/A
STANDARD FORMULARY	Medical Benefit	N/A
EXCHANGE FORMULARY (4-TIER)	Medical Benefit	N/A
EXCHANGE FORMULARY (5-TIER)	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Inlexzo™ (gemcitabine intravesical system)		**INDICATION:** For the treatment of adult patients with Bacillus Calmette-Guérin (BCG)-unresponsive, non-muscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Medical Benefit	Prior Authorization
OPEN FORMULARY (5-TIER)	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY (4-TIER)	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY (5-TIER)	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Inluriyo™ (imlunestrant) 200 mg tablets		**INDICATION:** For the treatment of adults with ER-positive, HER2-negative, ESR1-mutated advanced or metastatic breast cancer with disease progression following at least one line of endocrine therapy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Injectafer® (ferric carboxymaltose injection) 1000 mg/20 mL single-dose vial for intravenous use		**INDICATION:** For the treatment of iron-deficiency anemia (IDA) in adults and pediatric patients ≥1 year of age with intolerance to oral iron or unsatisfactory response to oral iron; treatment of IDA in adults with nondialysis-dependent chronic kidney disease (ND-CKD); For the treatment of iron deficiency with or without anemia in adults with New York Heart Association class II or III heart failure to improve exercise capacity
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Medical Benefit	Prior Authorization
OPEN FORMULARY (5-TIER)	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY (4-TIER)	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY (5-TIER)	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Jascayd® (nerandomilast) 9 & 18 mg tablets		**INDICATION:** For the treatment of idiopathic pulmonary fibrosis in adult patients
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 tablets per day (both strengths)		
FORMULARY ALTERNATIVES: N/A		

AvMed Pharmacy Changes

Effective: April 1, 2026

(For plans with pharmacy benefits administered by AvMed

DRUG NAME: Keytruda Qlex™ (pembrolizumab and berahyaluronidase alfa-pmph) 395 mg-4,800 units/2.4 mL & 790 mg-9,600 units/4.8 mL injection, for subcutaneous use		**INDICATION:** For use in adults across most solid tumor indications for Keytruda® (pembrolizumab)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Medical Benefit	Prior Authorization
OPEN FORMULARY (5-TIER)	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY (4-TIER)	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY (5-TIER)	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Koselugo® (selumetinib) 5 mg & 7.5 mg oral granules		**INDICATION:** For the treatment of pediatric patients 1 year of age and older with neurofibromatosis type 1 (NF1) who have symptomatic, inoperable plexiform neurofibromas (PN)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • 5 mg – 20 capsules per day • 7.5 mg – 12 capsules per day		
FORMULARY ALTERNATIVES: N/A		

AvMed Pharmacy Changes

Effective: April 1, 2026

(For plans with pharmacy benefits administered by AvMed

DRUG NAME: Krystexxa® (pegloticase) Ready-to-Use 8 mg/50 mL (0.16 mg/mL) in a single-dose vial for intravenous use		**INDICATION:** For the treatment of chronic gout in adult patients refractory to conventional therapy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Medical Benefit	Prior Authorization
OPEN FORMULARY (5-TIER)	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY (4-TIER)	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY (5-TIER)	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: lanreotide acetate 120 mg/0.5 mL extended-release SQ injection		**INDICATION:** For the long-term treatment of acromegalic patients who have had an inadequate response to or cannot be treated with surgery and/or radiotherapy; For the treatment of adult patients with unresectable, well- or moderately differentiated, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NETs) to improve progression-free survival; For the treatment of adults with carcinoid syndrome; when used, it reduces the frequency of short-acting somatostatin analog rescue therapy
REASON FOR CHANGE: Change Drug Tier, Utilization Management Requirements and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 1 injection per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Leqembi® Iqlik (lecanemab-irmb) 360 mg/1.8 mL (200 mg/mL) in a single-dose prefilled auto-injector for subcutaneous use		**INDICATION:** For the treatment of Alzheimer's disease
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 7.2 mL (4 injections) per 28 days		
FORMULARY ALTERNATIVES: N/A		

<table>
<tr><td colspan="2">DRUG NAME: octreotide injection for subcutaneous or intravenous use, all strengths (vial/ampules/syringes)</td><td>INDICATION: For use to reduce blood levels of growth hormone (GH) and insulin growth factor-1 (IGF-1; somatomedin C) in acromegaly patients who have had inadequate response to or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine mesylate at maximally tolerated doses; For the symptomatic treatment of patients with metastatic carcinoid tumors where it suppresses or inhibits the severe diarrhea and flushing episodes associated with the disease; For the treatment of profuse watery diarrhea associated with VIP-secreting tumors</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: Change Drug Tier and Utilization Management Requirements</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY (4- TIER)</td><td>Specialty (Tier 4)</td><td>Prior Authorization</td></tr>
<tr><td>OPEN FORMULARY (5-TIER)</td><td>Specialty (Tier 5)</td><td>Prior Authorization</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Specialty (Tier 4)</td><td>Prior Authorization</td></tr>
<tr><td>EXCHANGE FORMULARY (4-TIER)</td><td>Specialty (Tier 4)</td><td>Prior Authorization</td></tr>
<tr><td>EXCHANGE FORMULARY (5-TIER)</td><td>Specialty (Tier 5)</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>

DRUG NAME: Otezla XR™ (apremilast) extended-release 75 mg tablets & initiation pack		**INDICATION:** For the treatment of adults with oral ulcers associated with Behçet disease; Treatment of adults with plaque psoriasis who are candidates for phototherapy or systemic therapy; treatment of pediatric patients ≥6 years of age and ≥20 kg (immediate release) or ≥50 kg (extended release) with moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy; Treatment of adult and pediatric patients ≥6 years of age and ≥20 kg (immediate release) or ≥50 kg (extended release) with active psoriatic arthritis
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • 75 mg tablet – 1 tablet per day • Initiation Pack – 41 tablets (1 pack) per 365 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Palsonify™ (paltusotine) 20 & 30 mg tablets		**INDICATION:** For the treatment of adults with acromegaly who had an inadequate response to surgery and/or for whom surgery is not an option
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 tablets per day (both strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Papzimeos™ (zopapogene imadenovec-drba) suspension for subcutaneous injection		**INDICATION:** For the treatment of adults with recurrent respiratory papillomatosis
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Medical Benefit	Prior Authorization
OPEN FORMULARY (5-TIER)	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY (4-TIER)	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY (5-TIER)	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Phyrago™ (dasatinib) tablets, all strengths		**INDICATION:** For the treatment of newly diagnosed adults with Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in chronic phase; adults with chronic, accelerated, or myeloid or lymphoid blast phase Ph+ CML with resistance or intolerance to prior therapy including imatinib; adults with Philadelphia chromosome-positive acute lymphoblastic leukemia (Ph+ ALL) with resistance or intolerance to prior therapy; pediatric patients 1 year of age and older with Ph+ CML in chronic phase; pediatric patients 1 year of age and older with newly diagnosed Ph+ ALL in combination with chemotherapy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
OPEN FORMULARY (5-TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Non-Formulary	Quantity Limit
QUANTITY LIMIT: • 50, 70, 80, 100 & 140 mg tablets – 1 tablet per day • 20 mg – 3 tablets per day		
FORMULARY ALTERNATIVES: generic dasatinib (Sprycel®) tablets *requires prior authorization*		

AvMed Pharmacy Changes

Effective: April 1, 2026

(For plans with pharmacy benefits administered by AvMed

DRUG NAME: Pyquvi (deflazacort) 22.75 mg/mL oral suspension		**INDICATION:** For the treatment of Duchenne muscular dystrophy (DMD) in patients ≥2 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Rhapsido® (remibrutinib) 25 mg tablets		**INDICATION:** For the treatment of chronic spontaneous urticaria (CSU) in adult patients who remain symptomatic despite H1 antihistamine treatment
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Signifor® LAR (pasireotide) SQ injection kit, all strengths		**INDICATION:** For use in patients with acromegaly who have had an inadequate response to surgery and/or for whom surgery is not an option; For use in patients with Cushing's disease for whom pituitary surgery is not an option or has not been curative
REASON FOR CHANGE: Change Drug Tier, Utilization Management Requirements and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 1 injection per 28 days (all strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Skytrofa® (lonapegsomatropin-tcgd) 0.7, 1.4, 1.8, 2.1 & 2.5 mg cartridge for injection, for subcutaneous use		**INDICATION:** For the treatment of pediatric patients ≥1 year of age who weigh ≥11.5 kg and have growth failure due to inadequate secretion of endogenous growth hormone; replacement of endogenous growth hormone in adults with growth hormone deficiency
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 4 cartridges (1 carton) per 28 days (all strengths)		
FORMULARY ALTERNATIVES: N/A		

AvMed Pharmacy Changes

Effective: April 1, 2026

(For plans with pharmacy benefits administered by AvMed

DRUG NAME: Skytrofa® (lonapegsomatropin-tcgd) 3, 3.6, 4.3, 5.2, 6.3, 7.6, 9.1, 11 & 13.3 mg cartridge for injection, for subcutaneous use		**INDICATION:** For the treatment of pediatric patients ≥1 year of age who weigh ≥11.5 kg and have growth failure due to inadequate secretion of endogenous growth hormone; replacement of endogenous growth hormone in adults with growth hormone deficiency
REASON FOR CHANGE: Add Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • 3, 3.6, 4.3, 5.2, 6.3 & 13.3 mg cartridges = 4 cartridges (1 carton) per 28 days • 7.6, 9.1 & 11 mg cartridges = 8 cartridges (2 cartons) per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Somatuline® Depot (lanreotide) injection 60, 90 & 120 mg		**INDICATION:** For the long-term treatment of acromegalic patients who have had an inadequate response to or cannot be treated with surgery and/or radiotherapy; For the treatment of adult patients with unresectable, well- or moderately differentiated, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NETs) to improve progression-free survival; For the treatment of adults with carcinoid syndrome; when used, it reduces the frequency of short-acting somatostatin analog rescue therapy
REASON FOR CHANGE: Change Drug Tier, Utilization Management Requirements and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 1 injection per 28 days (all strengths)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Tonmya™ (cyclobenzaprine hydrochloride sublingual tablets) 2.8 mg		**INDICATION:** For the treatment of fibromyalgia in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
OPEN FORMULARY (5-TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Non-Formulary	Quantity Limit
QUANTITY LIMIT: 2 tablets per day		
FORMULARY ALTERNATIVES: generic cyclobenzaprine tablets		

<table>
<tr><td colspan="2">DRUG NAME: Tyruko® (natalizumab-sztn) 300 mg/15 mL vial</td><td>INDICATION: The first biosimilar approved for Tysabri. For use as monotherapy for the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing remitting disease, and active secondary progressive disease, in adults; For inducing and maintaining clinical response and remission in adult patients with moderately to severely active Crohn’s disease (CD) with evidence of inflammation who have had an inadequate response to, or are unable to tolerate, conventional CD therapies and inhibitors of tumor necrosis factor-alpha (TNF-α)</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 (4- TIER)</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>OPEN FORMULARY (5-TIER)</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 (4-TIER)</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>EXCHANGE FORMULARY (5-TIER)</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>

DRUG NAME: Tyzavan (vancomycin injection) 1 gram/200 mL bag, for intravenous use		**INDICATION:** For the treatment of the following infections in adult and pediatric patients (1 month and older) for whom appropriate dosing with this formulation can be achieved: septicemia, infective endocarditis, skin and skin structure infections, bone infections, & lower respiratory tract infections
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Medical Benefit	N/A
OPEN FORMULARY (5-TIER)	Medical Benefit	N/A
STANDARD FORMULARY	Medical Benefit	N/A
EXCHANGE FORMULARY (4-TIER)	Medical Benefit	N/A
EXCHANGE FORMULARY (5-TIER)	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Vabrinty (leuprolide acetate) 30 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 (4- TIER)	Medical Benefit	Prior Authorization
OPEN FORMULARY (5-TIER)	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY (4-TIER)	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY (5-TIER)	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Vabrinty (leuprolide acetate) 30 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 (4- TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
OPEN FORMULARY (5-TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Non-Formulary	Quantity Limit
QUANTITY LIMIT: 1 kit per 112 days		
FORMULARY ALTERNATIVES: Eligard *requires prior authorization*		

DRUG NAME: Vyscoxa™ (celecoxib) 10 mg/mL oral suspension		**INDICATION:** For use in adults for the management of the signs and symptoms of osteoarthritis, rheumatoid arthritis, and ankylosing spondylitis; in pediatric patients two years of age and older for the management of the signs and symptoms of juvenile rheumatoid arthritis
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
OPEN FORMULARY (5-TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Non-Formulary	Quantity Limit
QUANTITY LIMIT: 40 mL per day		
FORMULARY ALTERNATIVES: generic celecoxib capsules		

DRUG NAME: Wayrilz™ (rilzabrutinib) 400 mg tablets		**INDICATION:** For the treatment of adult patients with persistent or chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Yimmugo (immune globulin intravenous, human - dira), 10% liquid - 5 g in 50 mL, 10 g in 100 mL, 20 g in 200 mL		**INDICATION:** For the treatment of primary humoral immunodeficiency (PI) in patients 2 years of age or older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Medical Benefit	Prior Authorization
OPEN FORMULARY (5-TIER)	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY (4-TIER)	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY (5-TIER)	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Zanaflex 8 mg capsules		**INDICATION:** For the treatment of spasticity in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
OPEN FORMULARY (5-TIER)	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Non-Formulary	Quantity Limit
QUANTITY LIMIT: 3 capsules per day		
FORMULARY ALTERNATIVES: generic tizanidine tablets/capsules		

DRUG NAME: Zelvysia (sapropterin) 100 mg & 500 mg powder packets		**INDICATION:** For use to reduce blood phenylalanine (PHE) levels in adult and pediatric patients ≥1 month of age with hyperphenylalaninemia caused by BH4-responsive phenylketonuria in conjunction with a PHE-restricted diet
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Specialty (Tier 4)	Prior Authorization
OPEN FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization
EXCHANGE FORMULARY (4-TIER)	Specialty (Tier 4)	Prior Authorization
EXCHANGE FORMULARY (5-TIER)	Specialty (Tier 5)	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Zoryve® (roflumilast) 0.3% cream		**INDICATION:** For the treatment of plaque psoriasis, including intertriginous areas, in adult and pediatric patients ≥6 years of age
REASON FOR CHANGE: Change Drug Tier and Utilization Management Requirements		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Tier 3	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Tier 4	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 3	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Tier 3	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Tier 4	Prior Authorization, Quantity Limit
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Zoryve® (roflumilast) 0.05% cream		**INDICATION:** For the topical treatment of mild to moderate atopic dermatitis in pediatric patients 2 to 5 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Tier 3	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Tier 4	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 3	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Tier 3	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Tier 4	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 60 grams (1 tube) per 30 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Zurnai (nalmefene)1.5 mg/0.5 mL prefilled single-dose auto-injector, for intramuscular or subcutaneous use		**INDICATION:** For the emergency treatment of known or suspected opioid overdose induced by natural or synthetic opioids in adults and pediatric patients aged 12 years and older, as manifested by respiratory and/or central nervous system depression
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY (4- TIER)	Tier 3	Prior Authorization, Quantity Limit
OPEN FORMULARY (5-TIER)	Tier 4	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 3	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (4-TIER)	Tier 3	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY (5-TIER)	Tier 4	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 injections per fill		
FORMULARY ALTERNATIVES: N/A		