Sentara Health Plans Pharmacy Changes

Effective: April 1, 2024

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

<table>
<tr><td colspan="2">DRUG NAME: Abrilada™ (adalimumab-afzb) pen/syringe, all strengths</td><td>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 4 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 moderate-to-severe ulcerative colitis in adults</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (CED), Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Quantity Limit</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td colspan="3">QUANTITY LIMIT:
(COMMERCIAL): 2 syringes/pens per 28 days
(MEDICAID): 2 syringes/pens per 28 days
(MEDICARE): N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL): Humira® pen/syringe, Cyltezo® (adalimumab-adbm), Hyrimoz® (adalimumab-adaz); (MEDICAID): Humira® pen/syringe; (MEDICARE): Humira® pen/syringe, Cyltezo® (adalimumab-adbm), Hyrimoz® (adalimumab-adaz)</td></tr>
</table>

Sentara Health Plans Pharmacy Changes

Effective: April 1, 2024

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

<table>
<tr><td colspan="2">DRUG NAME: adalimumab-adbm (CF) pen/syringe, all strengths</td><td>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 hidradenitis suppurativa in adult patients and treatment of non-infectious intermediate, posterior, and panuveitis in adult patients</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (CED), Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Non-Formulary</td><td>Quantity Limit</td></tr>
<tr><td>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Quantity Limit</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td colspan="3">QUANTITY LIMIT:
(COMMERCIAL): 2 syringes/pens per 28 days
(MEDICAID): 2 syringes/pens per 28 days
(MEDICARE): N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL): Humira® pen/syringe, Cyltezo® (adalimumab-adbm), Hyrimoz® (adalimumab-adaz); (MEDICAID): Humira® pen/syringe; (MEDICARE): Humira® pen/syringe, Cyltezo® (adalimumab-adbm), Hyrimoz® (adalimumab-adaz)</td></tr>
</table>

DRUG NAME: Airsupra™(albuterol/budesonide) Inhalation Aerosol		**INDICATION:** To be used for as needed treatment or prevention of bronchoconstriction and to reduce the risk of exacerbations in patients ≥18 years of age with asthma
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), Age- Edit ≤ 17 years of age
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Ventolin® HFA, Breyna ™; (MEDICAID): Proair ® HFA, Venolin® HFA, Symbicort®; (MEDICARE): albuterol sulfate HFA, fluticasone-salmeterol Diskus, Dulera ®		

DRUG NAME: Akeega™ (abiraterone acetate/niraparib tosylate) tablets, all strengths		**INDICATION:** For the treatment of deleterious or suspected deleterious BRCA-mutated (BRCAm) metastatic castration-resistant prostate cancer (mCRPC) (in combination with prednisone) 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: • 500-50 mg: 2 tablets per day • 500-100 mg: 2 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Aphexda™ (motixafortide) 62 mg as a lyophilized powder in a single-dose vial for reconstitution for SC injection		**INDICATION:** For mobilization of hematopoietic stem cells to the peripheral blood (in combination with granulocyte colony–stimulating factor [filgrastim]) for collection and subsequent autologous transplantation in patients with multiple myeloma
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: Brand Oxycontin® (oxycodone) extended-release tablets, all strengths		**INDICATION:** For the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate in adults and opioid-tolerant pediatric patients ≥11 years of age who are already receiving and tolerating a minimum daily opioid dose of at least 20 mg oxycodone orally or its equivalent
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 2	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 2	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Tier 3 - all other strengths; Tier 5 - 80 mg	Prior Authorization, Quantity Limit
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): fentanyl 12, 25, 50, 75 & 100 mcg patches & morphine sulfate ER tablets		

DRUG NAME: Brand Spiriva HandiHaler (tiotropium bromide) 18 mcg capsules		**INDICATION:** For the maintenance treatment of bronchospasm associated with chronic obstructive pulmonary disease (COPD), including chronic bronchitis and emphysema; reduction of COPD exacerbations
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Spiriva® Respimat®, Incruse Ellipta; (MEDICARE): Spiriva® Respimat®, Incruse Ellipta		

DRUG NAME: Breo Ellipta (fluticasone furoate and vilanterol inhalation powder) 50/25 mcg per actuation		**INDICATION:** For the maintenance treatment of asthma in patients 5 years to 11 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	N/A
STANDARD FORMULARY	Tier 2	N/A
EXCHANGE FORMULARY	Tier 2	N/A
FAMIS FORMULARY	Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Tier 3	Quantity Limit
QUANTITY LIMIT: • (COMMERCIAL): N/A • (MEDICAID): N/A • (MEDICARE): 60 actuations per 30 days		
FORMULARY ALTERNATIVES: (MEDICAID): Advair® Diskus, Advair® HFA, Dulera®, Symbicort®		

DRUG NAME: brimonidine 0.1% ophthalmic drops (generic Alphagan P)		**INDICATION:** For the reduction of elevated intraocular pressure (IOP) in patients with open-angle glaucoma or ocular hypertension
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Step-Edit
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): brimonidine 0.15% & 0.2% drops; (MEDICARE): Brand Alphagan P 0.1%		

DRUG NAME: Calsodore (calcipotriene 0.005% cream & dressing) kit		**INDICATION:** For the treatment of plaque psoriasis
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: calcipotriene 0.005% cream		

DRUG NAME: Cosentyx® (secukinumab) 125 mg/5 mL solution in a single-dose vial for IV infusion		**INDICATION:** For the treatment of psoriatic arthritis, ankylosing spondylitis, and non-radiographic axial spondyloarthritis in adult patients
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Cresemba® (isavuconazonium sulfate) 74.5 mg capsules		**INDICATION:** For the treatment of invasive aspergillosis and invasive mucormycosis in patients ≥18 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 5 capsules per day • (MEDICAID): N/A • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): voriconazole tablets, liposomal amphotericin B (*medical benefit); (MEDICAID): voriconazole tablets (*requires prior authorization), liposomal amphotericin B (*medical benefit); (MEDICARE): voriconazole tablets (*requires prior authorization)		

DRUG NAME: Entyvio® Pen (vedolizumab) 108 mg/0.68 mL solution in a single-dose prefilled pen injection for SC administration		**INDICATION:** For the treatment of moderately to severe active ulcerative colitis & moderately to severe active Crohn's disease 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	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 2 pens per 28 days • (MEDICAID): 2 pens per 28 days • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Humira® pen/syringe, infliximab (gen Remicade®), methotrexate tab/PF vial/MDV; (MEDICARE): Humira® pen/syringe, Cyltezo® (adalimumab-adbm), Hyrimoz® (adalimumab-adaz), Stelara		

DRUG NAME: Eylea® HD (aflibercept) injection, for intravitreal use		**INDICATION:** For the treatment of: Neovascular (Wet) Age-Related Macular Degeneration (nAMD), Diabetic Macular Edema (DME) and Diabetic Retinopathy (DR)
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: Generic oxycodone extended-release tablets, all strengths		**INDICATION:** For the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate in adults and opioid-tolerant pediatric patients ≥11 years of age who are already receiving and tolerating a minimum daily opioid dose of at least 20 mg oxycodone orally or its equivalent
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Brand Oxycontin (*requires prior authorization) ; (MEDICAID): fentanyl 12, 25, 50, 75 & 100 mcg patches & morphine sulfate ER tablets ; (MEDICARE): Brand Oxycontin (*requires prior authorization)		

DRUG NAME: glipizide 2.5 mg immediate-release tablets		**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: glipizide 5 & 10 mg immediate-release tablets		

DRUG NAME: Hyrimoz® (adalimumab-adaz) pen/syringe, all strengths		**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	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • (COMMERCIAL): 2 syringes/pens 28 days • (MEDICAID): 2 syringes/pens 28 days • (MEDICARE): 4 syringes/pens 28 days		
FORMULARY ALTERNATIVES: (MEDICAID): Humira® pen/syringe		

DRUG NAME: Izervay™ (avacincaptad) 20 mg/mL intravitreal solution in a single-dose vial		**INDICATION:** For the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD)
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: Jesduvroq (daprodustat) tablets, all strengths		**INDICATION:** For treatment of anemia due to chronic kidney disease (CKD) in adults who have been receiving dialysis for at least 4 months
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, 2, & 4 mg: 1 tablet per day • 6 mg: 2 tablets per day • 8 mg: 3 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Kalydeco® (ivacaftor) 5.8 mg granules		**INDICATION:** For the treatment of cystic fibrosis (CF) in patients age 1 month and older who have at least one mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is responsive to ivacaftor potentiation based on clinical and/or in vitro assay data
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 packets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Kepivance (palifermin) 5.16 mg reconstituted solution for IV administration		**INDICATION:** For use to decrease the incidence and duration of severe oral mucositis associated with hematologic malignancies in patients receiving myelotoxic therapy in the setting of autologous hematopoietic stem cell support (when the preparative regimen is expected to result in mucositis ≥ grade 3 in the majority of patients)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Lantidra™ (donislecel-jujn) suspension for IV infusion		**INDICATION:** For treatment of type 1 diabetes mellitus, in conjunction with concomitant immunosuppression, in adults who are unable to approach target HbA1c because of current repeated episodes of severe hypoglycemia despite intensive diabetes management and education
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: Likmez™ (metronidazole) 500 mg/ 5 mL oral suspension		**INDICATION:** For the treatment of acute intestinal amebiasis (amebic dysentery) and extraintestinal amebiasis (liver abscess); For the treatment of anaerobic bacterial infections; For the treatment of infections caused by Trichomonas vaginalis
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: metronidazole tablets		

DRUG NAME: Lodoco® (colchicine) 0.5 mg tablets		**INDICATION:** For use to reduce the risk of myocardial infarction, stroke, coronary revascularization, and cardiovascular death in adult patients with established atherosclerotic disease or with multiple risk factors for cardiovascular disease
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 3	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 3	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Tier 4	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 1 tablet per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Mircera® (methoxy polyethylene glycol-epoetin beta)		**INDICATION:** For the treatment of anemia associated with chronic kidney disease (CKD) in adult patients on dialysis, adult patients not on dialysis, and in pediatric patients 5 to 17 years of age on hemodialysis who are converting from another erythropoiesis-stimulating agent (ESA) after their hemoglobin level was stabilized with an ESA
REASON FOR CHANGE: Add Utilization Management Requirements		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization
FAMIS FORMULARY	Formulary	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Epogen®, Retacrit™ (PFIZER mfg only); (MEDICARE): Procrit®, Retacrit™		

DRUG NAME: Motpoly XR (lacosamide) capsules, all strengths		**INDICATION:** For the treatment of partial-onset seizures in adults and in pediatric patients weighing at least 50 kg
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria),
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit

QUANTITY LIMIT:
• COMMERCIAL: 100, 150 & 200 mg – 2 capsules per day
• MEDICAID: N/A
• MEDICARE:
  • 100 mg – 4 capsules per day
  • 150 & 200 mg – 2 capsules per day		

FORMULARY ALTERNATIVES: (COMMERCIAL): lacosamide solution/tablet (*requires prior authorization); (MEDICAID): lacosamide solution/tablet		

DRUG NAME: Ojjaara (momelotinib) tablets, all strengths		**INDICATION:** For the treatment of intermediate or high-risk myelofibrosis (MF), including primary MF or secondary MF (post-polycythemia vera [PV] and post-essential thrombocythemia [ET]), in adults with anemia
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: • 100 mg: 1 tablet per day • 150 mg: 1 tablet per day • 200 mg: 1 tablet per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Opfolda™ (miglustat) 65 mg capsules		**INDICATION:** For use in combination with Pombiliti, a hydrolytic lysosomal glycogen-specific enzyme, for the treatment of adult patients with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) weighing ≥40 kg and who are not improving on their current enzyme replacement therapy (ERT)
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: 8 capsules per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Opvee® (nalmefene) nasal spray 2.7 mg		**INDICATION:** For the emergency treatment of known or suspected opioid overdose as manifested by respiratory and/or CNS depression in adults and pediatric patients ≥12 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Quantity Limit
STANDARD FORMULARY	Tier 3	Quantity Limit
EXCHANGE FORMULARY	Tier 3	Quantity Limit
FAMIS FORMULARY	Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Age-Edit ≤ 11 years of age
MEDICARE FORMULARY	Tier 4	N/A
QUANTITY LIMIT: • COMMERCIAL: 2 unit-dose nasal spray devices (1 carton) per fill • MEDICAID: N/A • MEDICARE: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Paxlovid™ (nirmatrelvir/ritonavir) tablet therapy pack, all strengths		**INDICATION:** For the treatment of mild to moderate COVID-19 in adults who are at high risk for progression to severe COVID-19, including hospitalization or death
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Quantity Limit
STANDARD FORMULARY	Tier 2	Quantity Limit
EXCHANGE FORMULARY	Tier 2	Quantity Limit
FAMIS FORMULARY	Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Quantity Limit
MEDICARE FORMULARY	Tier 3	Quantity Limit

QUANTITY LIMIT:
• (COMMERCIAL):
  • 150/100 mg – 40 tablets per 365 days
  • 300/100 mg – 60 tablets per 365 days
• (MEDICAID):
  • 150/100 mg – 40 tablets per 365 days
  • 300/100 mg – 60 tablets per 365 days
• (MEDICARE):
  • 150/100 mg – 20 tablets per 180 days
  • 300/100 mg – 30 tablets per 180 days		

FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Pokonza™ (potassium chloride for oral solution) 10 mEq packets		**INDICATION:** For the treatment of hypokalemia
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 1 packet per day • MEDICAID: 1 packet per day • MEDICARE: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): potassium chloride 10 mEQ ER tablet/capsule, potassium chloride 10% solution; (MEDICAID): potassium chloride 10% solution, potassium chloride 20 mEq packets; (MEDICARE): potassium chloride 10 mEQ ER tablet/capsule, potassium chloride 10% solution, potassium chloride 20 mEq packets		

DRUG NAME: Pombiliti™ (cipaglucosidase alfa-atga)		**INDICATION:** For use in combination with Opfolda, an enzyme stabilizer, for the treatment of adult patients with late-onset Pompe disease (lysosomal acid alpha-glucosidase [GAA] deficiency) weighing ≥40 kg and who are not improving on their current enzyme replacement therapy (ERT)
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: Rykindo® (risperidone) extended-release injectable suspension, all strengths		**INDICATION:** For the treatment of schizophrenia in adults and as monotherapy or as adjunctive therapy to lithium or valproate for the maintenance treatment of bipolar I disorder in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	Quantity Limit, Age-Edit ≤ 17 years of age
STANDARD FORMULARY	Tier 2	Quantity Limit, Age-Edit ≤ 17 years of age
EXCHANGE FORMULARY	Tier 2	Quantity Limit, Age-Edit ≤ 17 years of age
FAMIS FORMULARY	Formulary	Quantity Limit, Age-Edit ≤ 17 years of age.
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit, Age-Edit ≤ 17 years of age
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 25, 37.5 & 50 mg strengths – 2 vials per 28 days • MEDICAID: 25, 37.5 & 50 mg strengths – 2 vials per 28 days • MEDICARE: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Risperdal Consta®, Perseris™; (MEDICARE): Risperdal Consta®, Perseris™		

DRUG NAME: Sohonos™ (palovarotene) capsules, all strengths		**INDICATION:** For reduction in the volume of new heterotopic ossification in adults and pediatric patients (females ≥8 years of age; males ≥10 years of age) with fibrodysplasia ossificans progressiva
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, 1.5, & 10 mg capsules: 2 capsule per day • 2.5 & 5 mg capsules: 1 capsule per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: trientine 500 mg capsules		**INDICATION:** For the treatment of patients with Wilson disease who are intolerant to penicillamine
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 capsules per day		
FORMULARY ALTERNATIVES: penicillamine tablets (*requires prior authorization)		

DRUG NAME: Veopoz™ (pozelimab-bbfg) 400 mg/2 mL (200 mg/mL) single-dose vial for IV infusion or SC injection		**INDICATION:** For the treatment of CD55-deficient protein-losing enteropathy, also known as CHAPLE disease, in adult and pediatric patients ≥1 year of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		