Sentara Health Plans Pharmacy Changes

Effective: July 1, 2024

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

<table>
<tr><td colspan="2">DRUG NAME: adalimumab-aacf (CF) pen 40 mg</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 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</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 28 days
MEDICAID: 2 syringes/ pens per 28 days
MEDICARE: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]; (MEDICAID): Humira pen/syringe (Abbvie mfg only); (MEDICARE): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]</td></tr>
</table>

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DRUG NAME: Adzynma (ADAMTS13, recombinant-krhn)		**INDICATION:** For prophylactic or on demand enzyme replacement therapy (ERT) in adult and pediatric patients with congenital thrombotic thrombocytopenic purpura (cTTP)
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: Agamree® (vamorolone) 40 mg/mL oral suspension		**INDICATION:** For the treatment of Duchenne muscular dystrophy in patients ≥2 years of age
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	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 2 bottles per 26 days • MEDICAID: 2 bottles per 26 days • MEDICARE: N/A		
FORMULARY ALTERNATIVES: N/A		

Sentara Health Plans Pharmacy Changes

Effective: July 1, 2024

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

DRUG NAME: Altuviiio™ [antihemophilic factor (recombinant), Fc-VWF-XTEN fusion protein-ehtl] 750-unit vial		**INDICATION:** For use in adults and children with hemophilia A (congenital factor VIII deficiency) for: Routine prophylaxis to reduce the frequency of bleeding episodes; On-demand treatment & control of bleeding episodes; Perioperative management of bleeding
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	N/A
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Amjevita™ (adalimumab-atto) CF, all strengths & formulations		**INDICATION:** The first U.S. biosimilar to Humira 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: • COMMERCIAL: 0.4 mL (2 syringes) per 28 days • MEDICAID: 0.4 mL (2 syringes) per 28 days • MEDICARE: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]; (MEDICAID): Humira pen/syringe (Abbvie mfg only); (MEDICARE): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]		

DRUG NAME: Augtyro™ 40 mg (repotrectinib) capsules		**INDICATION:** For the treatment of locally advanced or metastatic ROS1-positive non-small cell lung cancer 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: 8 capsules per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Bijuva® (estradiol and progesterone) 0.5 mg/100 mg capsules		**INDICATION:** For use in a woman with a uterus for the treatment of moderate to severe vasomotor symptoms due to menopause
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	Non-Formulary	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 1 capsule per day • MEDICAID: N/A • MEDICARE: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Prempro tablets, Premphase tablets; (MEDICARE): Prempro tablets, Premphase tablets		

DRUG NAME: Bimzelx® (bimekizumab-bkzx) 160 mg/mL subcutaneous solution prefilled syringe/auto-injector		**INDICATION:** For the treatment of moderate to severe plaque psoriasis in adult patients who are candidates for systemic therapy or phototherapy
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 injections (2 mL) per 56 days • MEDICAID: 2 injections (2 mL) per 56 days • MEDICARE: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Enbrel® Pen/Sureclick/Syringe/Vial, Humira® Pen/Syringe (Abbvie mfg only), infliximab (generic Remicade®); (MEDICARE): Cimzia®, Cyltezo®, Enbrel®, Humira® (Abbvie mfg only), Hyrimoz® (Sandoz mfg only), Otezla®, Skyrizi®, Stelara®, Taltz®		

DRUG NAME: Bosulif® (bosutinib) capsules, all strengths		**INDICATION:** For the treatment of chronic phase Philadelphia chromosome-positive (Ph+) chronic myeloid leukemia (CML) in adults and pediatric patients ≥1 year of age who are newly diagnosed or with resistance or intolerance to prior 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: • 3 capsules per day (100 mg) • 1 capsule per day (50 mg)		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Cabtreo™ (clindamycin phosphate, adapalene and benzoyl peroxide) topical gel 1.2%/0.15%/3.1%		**INDICATION:** For the treatment of acne vulgaris in adult and pediatric patients ≥12 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): adapalene 0.1 % 0.3% gel, benzoyl peroxide 5 & 10 % gel, clindamycin 1 % gel/solution; (MEDICAID): benzoyl peroxide wash/cream/gel/lotion (OTC), clindacin ETZ 1% pledget, clindamycin ph 1% solution, clindamycin Phos 1% pledget/swab, clindamycin/benzoyl peroxide (Duac®), adapalene gel OTC; (MEDICARE): clindamycin 1% gel/solution, tretinoin 0.1%, 0.025% & 0.05% gel/cream		

DRUG NAME: Calsodore (calcipotriene 0.005% cream, dimethicone 5% 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: Casgevy™ (exagamglogene autotemcel)		**INDICATION:** For the treatment of sickle cell disease (SCD) in patients 12 years and older with recurrent vaso-occlusive crises (VOCs)
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: Combogesic® IV (acetaminophen/ibuprofen)		**INDICATION:** For use in adults where an intravenous (IV) route of administration is considered clinically necessary for the relief of mild to moderate pain or the management of moderate to severe pain as an adjunct to opioid analgesics
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	N/A
STANDARD FORMULARY	Medical Benefit	N/A
EXCHANGE FORMULARY	Medical Benefit	N/A
FAMIS FORMULARY	Medical Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	N/A
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Coxanto (oxaprozin) 300 mg capsules		**INDICATION:** For relief of the signs and symptoms of osteoarthritis (OA), rheumatoid arthritis (RA), and juvenile rheumatoid arthritis (JRA)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 4 capsules per day • MEDICAID:4 capsules per day • MEDICARE: N/A		
FORMULARY ALTERNATIVES: oxaprozin 600 mg tablets		

DRUG NAME: dapagliflozin tablets, all strengths		**INDICATION:** For use to reduce the risk of sustained eGFR decline, end-stage kidney disease, cardiovascular death, and hospitalization for heart failure in adults with chronic kidney disease at risk of progression; As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus; risk reduction of hospitalization for heart failure in adults with type 2 diabetes mellitus and established cardiovascular disease or multiple cardiovascular risk factors; For risk reduction of cardiovascular mortality, hospitalization for heart failure, and urgent heart failure visit in adults with heart failure
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED); Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 1 tablet per day (5 & 10 mg tablets) • (MEDICAID): N/A • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: Farxiga®		

DRUG NAME: dapagliflozin-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), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A

QUANTITY LIMIT:
• (COMMERCIAL):
  • 2 tablets per day (5-1000 mg tablets)
  • 1 tablet per day (10-1000 mg tablets
• (MEDICAID): N/A
• (MEDICARE): N/A		

FORMULARY ALTERNATIVES: Xigduo® XR		

DRUG NAME: Darunavir propylene tablets, all strengths		**INDICATION:** For the treatment of HIV-1 infection, coadministered with ritonavir and other antiretroviral agents, in adults and pediatric patients 3 years and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	N/A
STANDARD FORMULARY	Specialty (Tier 4)	N/A
EXCHANGE FORMULARY	Specialty (Tier 4)	N/A
FAMIS FORMULARY	Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): darunavir ethanolate tablets; (MEDICAID) Prezista® tablet/suspension		

DRUG NAME: DefenCath™ (taurolidine and heparin) single-dose vial		**INDICATION:** A catheter lock solution (CLS) to reduce catheter-related bloodstream infections in adult patients with kidney failure who are receiving chronic hemodialysis (HD) through a central venous catheter (CVC)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	N/A
STANDARD FORMULARY	Medical Benefit	N/A
EXCHANGE FORMULARY	Medical Benefit	N/A
FAMIS FORMULARY	Medical Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	N/A
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: deflazacort tablets (generic Emflaza), all strengths		**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	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
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: EmReal (lidocaine/prilocaine) 2.5%-2.5% cream kit		**INDICATION:** A topical anesthetic for use on normal intact skin to provide local analgesia
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: lidocaine/prilocaine 2.5%-2.5% cream		

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 (Abbvie mfg only), infliximab (gen Remicade®); (MEDICARE): Humira® pen/syringe (Abbvie mfg only), Cyltezo® (adalimumab-adbm), Hyrimoz® (adalimumab-adaz) [Sandoz mfg only], Stelara®		

DRUG NAME: Fabhalta® (iptacopan) capsules		**INDICATION:** For the treatment of paroxysmal nocturnal hemoglobinuria (PNH) 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 capsules per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: fluticasone propionate diskus, all strengths		**INDICATION:** For the maintenance treatment of asthma as prophylactic therapy in patients aged 4 years and older
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	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): Arnuity Ellipta, QVAR Redhihaler; (MEDICARE): Arnuity Ellipta, QVAR Redhihaler		

DRUG NAME: Freestyle Libre 3 reader		**INDICATION:** A small sensor-based system that provide real-time glucose readings day and night, without fingersticks
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 3	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 3	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Part B - Pharmacy	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • COMMERCIAL: 1 reader per lifetime • MEDICAID: 1 reader per lifetime • MEDICARE: 1 reader per 365 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Fruzaqla™ (fruquintinib) capsules, all strengths		**INDICATION:** For the treatment of metastatic colorectal cancer in adults who have been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, and an anti-EGFR therapy (if RAS wild type and medically appropriate)
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: • 5 mg- 21 capsules per 28 days • 1 mg- 84 capsules per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Hemlibra (emicizumab-kxwh) 300 mg/2 mL vial & 12 mg/0.4 mL vial		**INDICATION:** Routine prophylaxis to prevent or reduce the frequency of bleeding episodes in patients with hemophilia A (congenital factor VIII deficiency) with or without factor VIII inhibitors
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	Formulary	N/A
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Inpefa® (sotagliflozin) 200 mg tablets		**INDICATION:** Used to reduce the risk of cardiovascular (CV) death, hospitalization for heart failure, and urgent heart failure visit in adults
REASON FOR CHANGE: Change Quantity Limit		
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), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 1 tablet per day • MEDICAID: 1 tablet per day • MEDICARE: N/A		
FORMULARY ALTERNATIVES: Farxiga®, Jardiance®		

DRUG NAME: Inpefa® (sotagliflozin) 400 mg tablets		**INDICATION:** Used to reduce the risk of cardiovascular (CV) death, hospitalization for heart failure, and urgent heart failure visit in adults
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), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 1 tablet per day • MEDICAID: 1 tablet per day • MEDICARE: N/A		
FORMULARY ALTERNATIVES: Farxiga®, Jardiance®		

DRUG NAME: insulin glargine Max SoloStar U300 pen		**INDICATION:** For use to improve glycemic control in adults and pediatric patients 6 years and older with diabetes mellitus
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Prior Authorization
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) Lantus, Toujeo; (MEDICAID): insulin glargine pen and vial, Lantus Solostar & vial, Levemir pen/vial; (MEDICAIRE): Lantus, Toujeo		

DRUG NAME: Iwilfin™ (eflornithine) tablets, 192 mg		**INDICATION:** For the treatment of metastatic colorectal cancer in adults who have been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-VEGF therapy, and an anti-EGFR therapy (if RAS wild type and medically appropriate)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 8 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Ixchiq® (chikungunya vaccine, live) injection		**INDICATION:** For the prevention of disease caused by chikungunya virus (CHIKV) in individuals 18 years of age and older who are at increased risk of exposure to CHIKV
REASON FOR CHANGE: New 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	Medical Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	N/A
MEDICARE FORMULARY	Tier 3	N/A
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: Change Drug Tier		
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: Jylamvo® (methotrexate) 2 mg/mL oral solution		**INDICATION:** For the treatment of adults with acute lymphoblastic leukemia (ALL) as part of a combination chemotherapy maintenance regimen; For the treatment of adults with mycosis fungoides; For the treatment of adults with relapsed or refractory non-Hodgkin lymphoma as part of a metronomic combination regimen; For the treatment of adults with rheumatoid arthritis; For the treatment of adults with severe psoriasis
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED)
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: N/A		
FORMULARY ALTERNATIVES: methotrexate tablets/vial		

DRUG NAME: Kiprofen (Ketoprofen) 25 mg capsules		**INDICATION:** For the management of the signs and symptoms of osteoarthritis; for the management of pain; for the treatment of primary dysmenorrhea; for the management of the signs and symptoms of rheumatoid arthritis
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary Generic	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary Generic	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary Generic	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): 4 capsules per day • (MEDICAID): 4 capsules per day • (MEDICARE): N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): diclofenac sodium tablets, ibuprofen tablets; (MEDICARE): diclofenac sodium, ibuprofen cap, ibuprofen tab (OTC & Rx), meloxicam tab, naproxen tab, naproxen sodium (OTC), naproxen EC (Rx), sulindac; (MEDIARE); diclofenac sodium tablets, ibuprofen tablets		

DRUG NAME: Lidolite (lidocaine) 5% kit		**INDICATION:** This medication is used on the skin to stop itching and pain from certain skin conditions (such as scrapes, minor burns, eczema, insect bites) and to treat minor discomfort and itching caused by hemorrhoids and certain other problems of the genital/anal area (such as anal fissures, itching around the vagina/ rectum)
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: lidocaine 5% ointment		

DRUG NAME: Loqtorzi™ (toripalimab-tpzi) injection		**INDICATION:** First-line treatment (in combination with cisplatin and gemcitabine) of metastatic or with recurrent, locally advanced nasopharyngeal carcinoma (NPC) in adults; Treatment (as a single agent) of recurrent unresectable or metastatic NPC in adults with disease progression on or after a platinum-containing chemotherapy.
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: Lyfgenia™ (lovotibeglogene autotemecel) suspension for intravenous infusion		**INDICATION:** For the treatment of sickle cell disease in patients ages 12 and older who have a history of vaso-occlusive events (VOEs)
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: Ogsiveo™ (nirogacestat) 50 mg tablets		**INDICATION:** For progressing desmoid tumors in adults who require systemic treatment
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 tablets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Omeza® Collagen Matrix		**INDICATION:** For the management of wounds including partial and full-thickness wounds, pressure ulcers, venous ulcers, diabetic ulcers, chronic vascular ulcers, tunneled/undermined wounds, surgical wounds (donor sites/grafts, post-Moh's surgery, post-laser surgery, podiatric, wound dehiscence), trauma wounds (abrasions, lacerations, superficial partial thickness burns, skin tears) and draining wounds
REASON FOR CHANGE: New 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: N/A		

DRUG NAME: Omnipod 5 G6-G7 Intro Kit (generation 5)		**INDICATION:** An insulin delivery device which provides non-stop insulin delivery through a tubeless, waterproof* insulin pump called a Pod-all with no multiple daily injections
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: 1 kit per lifetime		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Omnipod 5 G6-G7 Pods (generation 5)		**INDICATION:** An insulin delivery device which provides non-stop insulin delivery through a tubeless, waterproof* insulin pump called a Pod- all with no multiple daily injections
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: 10 pods per 30 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Omvoh™ (mirikizumab-mrkz) 100 mg/mL subcutaneous solution pen-injector		**INDICATION:** For the treatment of moderately to severely active ulcerative colitis in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 2 pens- injectors (2 mL) per 28 days • MEDICAID: 2 pens- injectors (2 mL) per 28 days • MEDICARE: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Humira® pen/syringe (Abbvie mfg only), infliximab (gen Remicade®); (MEDICARE): Humira® pen/syringe (Abbvie mfg only), Cyltezo® (adalimumab-adbm), Hyrimoz® (adalimumab-adaz) [Sandoz mfg only], Stelara®		

DRUG NAME: Omvoh™ (mirikizumab-mrkz) 300 mg/15 mL vial solution for IV administration		**INDICATION:** For the treatment of moderately to severely active ulcerative colitis 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	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
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: Change Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 8 capsules per month		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Opill® (norgestrel) 0.075mg tablets		**INDICATION:** The first over-the-counter (OTC) daily oral contraceptive
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	ACA	N/A
STANDARD FORMULARY	ACA	N/A
EXCHANGE FORMULARY	ACA	N/A
FAMIS FORMULARY	Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	N/A
MEDICARE FORMULARY	Excluded Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Ozobax® DS (baclofen) 10 mg/5 mL oral solution		**INDICATION:** For the treatment of spasticity resulting from multiple sclerosis, particularly for the relief of flexor spasms and concomitant pain, clonus, and muscular rigidity
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: baclofen tablets		

DRUG NAME: Pemrydi RTU (pemetrexed) 100 mg/10 ml vial, 500 mg/50 ml vial		**INDICATION:** For use in combination with pembrolizumab and platinum chemotherapy, for the initial treatment of patients with metastatic non-squamous non-small cell lung cancer (NSCLC), with no EGFR or ALK genomic tumor aberrations; in combination with cisplatin for the initial treatment of patients with locally advanced or metastatic, non-squamous NSCLC; as a single agent for the maintenance treatment of patients with locally advanced or metastatic, non-squamous NSCLC whose disease has not progressed after four cycles of platinum-based first-line chemotherapy; as a single agent for the treatment of patients with recurrent, metastatic non-squamous, NSCLC after prior chemotherapy; in combination with cisplatin, for the initial treatment of patients with malignant pleural mesothelioma whose disease is unresectable or who are otherwise not candidates for curative surgery
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	N/A
STANDARD FORMULARY	Medical Benefit	N/A
EXCHANGE FORMULARY	Medical Benefit	N/A
FAMIS FORMULARY	Medical Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	N/A
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Penbraya™ (meningococcal groups A, B, C, W, and Y vaccine)		**INDICATION:** For active immunization to prevent invasive disease caused by Neisseria meningitidis serogroups A, B, C, W, and Y in individuals 10 through 25 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	N/A
STANDARD FORMULARY	Medical Benefit	N/A
EXCHANGE FORMULARY	Medical Benefit	N/A
FAMIS FORMULARY	Medical Benefit	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	N/A
MEDICARE FORMULARY	Tier 3	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

<table>
<tr><td colspan="2">DRUG NAME: Rivfloza™ (nedosiran) prefilled syringe & vial, all strengths</td><td>INDICATION: Used to lower urinary oxalate levels in children 9 years of age and older and adults with primary hyperoxaluria type 1 (PH1) and relatively preserved kidney function, e.g., estimated glomerular filtration rate (eGFR) ≥ 30 mL/min/1.73 m^2</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>Specialty (Tier 4)</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Specialty (Tier 4)</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Specialty (Tier 4)</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Formulary</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Medicare Part B</td><td>Prior Authorization</td></tr>
<tr><td colspan="3">QUANTITY LIMIT:
COMMERCIAL:
80 mg (0.5 mL) single-dose vial = 2 vials per 28 days
128 mg (0.8 mL) single-dose pre-filled syringe = 1 syringe per 28 days
160 mg (1 mL) single-dose pre-filled syringe = 1 syringe per 28 days
MEDICAID:
80 mg (0.5 mL) single-dose vial = 2 vials per 28 days
128 mg (0.8 mL) single-dose pre-filled syringe = 1 syringe per 28 days
160 mg (1 mL) single-dose pre-filled syringe = 1 syringe per 28 days
MEDICARE: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

DRUG NAME: Rivfloza™ (nedosiran) prefilled syringe & vial, all strengths		**INDICATION:** Used to lower urinary oxalate levels in children 9 years of age and older and adults with primary hyperoxaluria type 1 (PH 1) and relatively preserved kidney function, e.g., estimated glomerular filtration rate (eGFR) ≥ 30 mL/min/1.73m^2
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	Medicare Part B	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Rozlytrek® (entrectinib) 50 mg packets		**INDICATION:** For the treatment of solid tumors in adult and pediatric patients >1 month of age that have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion (as detected by an approved test) without a known acquired resistance mutation, are metastatic or where surgical resection is likely to result in severe morbidity and 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	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 12 packets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Solu-cortef® (hydrocortisone sodium succinate), all strengths		**INDICATION:** For use when oral hydrocortisone therapy is not feasible, and the strength, dosage form, and route of administration of the drug reasonably lend the preparation to the treatment of the condition, intravenous or intramuscular use is indicated for all FDA approved indications
REASON FOR CHANGE: Change Drug Tier and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Quantity Limit
STANDARD FORMULARY	Tier 3	Quantity Limit
EXCHANGE FORMULARY	Tier 3	Quantity Limit
FAMIS FORMULARY	Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 2 vials per 28 days (all strengths) • MEDICAID: 2 vials per 28 days (all strengths) • MEDICARE: N/A		
FORMULARY ALTERNATIVES: (MEDICARE): hydrocortisone tablets		

DRUG NAME: Sotyktu® (deucravacitinib), all strengths		**INDICATION:** For the treatment of moderate to severe plaque psoriasis in adults who are candidates for systemic therapy or phototherapy
REASON FOR CHANGE: Change Drug Tier		
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: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Enbrel® Pen/Sureclick/Syringe/Vial, Humira® Pen/Syringe (Abbvie mfg only), infliximab (generic Remicade®); (MEDICARE): Cimzia®, Cyltezo®, Enbrel®, Humira® (Abbvie mfg only), Hyrimoz® (Sandoz mfg only), Otezla®, Skyrizi®, Stelara®, Taltz®		

DRUG NAME: tetracycline tablets, all strengths		**INDICATION:** For use to treat a wide variety of infections of the skin, intestines, respiratory tract, urinary tract, genitals, lymph nodes, and other body systems
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: tetracycline capsules		

DRUG NAME: tramadol 25 mg tablets		**INDICATION:** For the management of pain severe enough to require an opioid analgesic and for which alternative treatments are inadequate
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Step-Edit, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Step-Edit, Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Step-Edit, Quantity Limit
FAMIS FORMULARY	Non-Formulary	Step-Edit, Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 16 tablets per day • MEDICAID: 16 tablets per day • MEDICARE: N/A		
FORMULARY ALTERNATIVES: tramadol 50 mg tablets		

DRUG NAME: Truqap™ (capivasertib) tablets, all strengths		**INDICATION:** For use in combination with fulvestrant for the treatment of adult patients with hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative, locally advanced or metastatic breast cancer with one or more PIK3CA/AKT1/PTEN-alterations as detected by an FDA-approved test following progression on at least one endocrine-based regimen in the metastatic setting or recurrence on or within 12 months of completing adjuvant 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	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty (Tier 5)	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 64 tablets per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Udenyca® Onbody™ (pegfilgrastim-cbqv) 6 mg/0.6 mL		**INDICATION:** Biosimilar to Neulasta® Onpro® (pegfilgrastim) kit
REASON FOR CHANGE: New Drug		
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
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • (COMMERCIAL): N/A • (MEDICAID): N/A • (MEDICARE): Ziextenzo® & Nyvepria® ** both require prior authorization**		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Unituxin® (dinutuximab)		**INDICATION:** For use in combination with granulocyte- macrophage colony-stimulating factor (GM-CSF), interleukin-2 (IL-2), and 13-cis-retinoic acid (RA), for the treatment of pediatric patients with high- risk neuroblastoma who achieve at least a partial response to prior first-line multiagent, multimodality therapy
REASON FOR CHANGE: Add Utilization Management Requirements		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Velsipity™ (etrasimod) 2 mg tablets		**INDICATION:** For the treatment of moderately to severely active 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	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 1 tablet per day • MEDICAID: 1 tablet per day • MEDICARE: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Humira® pen/syringe (Abbvie mfg only), infliximab (gen Remicade®); (MEDICARE): Humira® pen/syringe (Abbvie mfg only), Cyltezo® (adalimumab-adbm), Hyrimoz® (adalimumab-adaz) [Sandoz mfg only], Stelara®		

DRUG NAME: Vevye® (cyclosporine ophthalmic solution) 0.1%		**INDICATION:** For the treatment of the signs and symptoms of dry eye disease
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 4 bottles per 30 days • MEDICAID: 4 bottles per 30 days • MEDICARE: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Xiidra®, cyclosporine ophthalmic emulsion 0.05%; (MEDICAID): Restasis®, Xiidra®; (MEDICARE): Xiidra®, cyclosporine ophthalmic emulsion 0.05%		

DRUG NAME: Vigpoder™ (vigabatrin) 500 mg powder packet		**INDICATION:** For use as adjunctive therapy for adults and pediatric patients 2 years of age and older with refractory complex partial seizures who have inadequately responded to several alternative treatments and for whom the potential benefits outweigh the risk of vision loss; For use as monotherapy for pediatric patients with infantile spasms 1 month to 2 years of age for whom the potential benefits outweigh the potential risk of vision loss
REASON FOR CHANGE: New Drug		
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	Specialty (Tier 5)	Prior Authorization
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): Lamictal® ODT dose pk, lamotrigine ODT, lamotrigine tab, lamotrigine chew tab, lamotrigine XR, levetiracetam soln/tablet, levetiracetam ER, topiramate tab/sprinkle cap, zonisamide cap		

DRUG NAME: Voquezna (vonoprazan) tablets, all strengths		**INDICATION:** For the treatment of erosive esophagitis and relief of heartburn associated with erosive esophagitis in adults; For maintenance of healing of erosive esophagitis and relief of heartburn associated with erosive esophagitis in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 3	Step-Edit, Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 10 & 20 mg tablets - 1 tablets per day		
FORMULARY ALTERNATIVES: (COMMERCIAL): esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole; (MEDICAID): omeprazole RX, pantoprazole, Protonix® suspension; (MEDICARE): esomeprazole, lansoprazole, omeprazole, pantoprazole, rabeprazole		

DRUG NAME: Wainua™ (eplontersen) injection for SC use, 45 mg/0.8 mL auto-injector		**INDICATION:** For the treatment of the polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty (Tier 4)	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	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 auto-injector per 28 days		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Xalkori® (crizotinib) oral pellets, all strengths		**INDICATION:** For the treatment of relapsed or refractory systemic anaplastic large cell lymphoma (ALK-positive) in pediatric patients ≥1 year of age and young adults; For the treatment of ALK-positive unresectable, recurrent, or refractory inflammatory myofibroblastic tumor in adult and pediatric patients ≥1 year of age; For the treatment of metastatic non–small cell lung cancer in patients whose tumors are ALK-positive or are ROS1-positive (as detected by an approved test)
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: • 150 mg- 6 pellets per day • 20 & 50 mg- 4 pellets per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Xolair® (omalizumab) syringe/auto-injector, all strengths	**INDICATION:** For the treatment of moderate to severe persistent asthma in adults and patients 6 years and older who have a positive skin test or in vitro reactivity to a perennial aeroallergen and whose symptoms are inadequately controlled with inhaled corticosteroids; Add-on maintenance treatment of chronic rhinosinusitis with nasal polyps in adults with inadequate response to nasal corticosteroids; Treatment of chronic spontaneous urticaria in adults and adolescents 12 years and older who remain symptomatic despite H1 antihistamine treatment

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:

- COMMERCIAL:
  - 75 mg/ 0.5 mL auto-injector: 0.5 mL per 28 days
  - 150 mg/mL auto-injector: 1 mL per 28 days
  - 300 mg/ 2 mL auto-injector: 2 mL per 28 days
  - 300 mg/ 2 mL syringe: 2 mL per 28 days
- MEDICAID:
  - 75 mg/ 0.5 mL auto-injector: 0.5 mL per 28 days
  - 150 mg/mL auto-injector: 1 mL per 28 days
  - 300 mg/ 2 mL auto-injector: 2 mL per 28 days
  - 300 mg/ 2 mL syringe: 2 mL per 28 days
- MEDICARE:
  - 75 mg/ 0.5 mL auto-injector: 1 mL (2 auto-injectors) per 28 days
  - 150 mg/mL auto-injector: 8 mL (8 auto-injectors) per 28 days
  - 300 mg/ 2 mL auto-injector: 8 mL (4 auto-injectors) per 28 days
  - 300 mg/ 2 mL syringe: 8 mL (4 syringes) per 28 days

FORMULARY ALTERNATIVES: N/A

DRUG NAME: Xphozah® (tenapanor) tablets, all strengths		**INDICATION:** For use to reduce serum phosphorus in adults with chronic kidney disease (CKD) on dialysis as add-on therapy in patients who have an inadequate response to phosphate binders or who are intolerant of any dose of phosphate binder therapy
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), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: 10, 20 & 30 mg tablets - 2 tablets per day		
FORMULARY ALTERNATIVES: calcium acetate capsules/tablets, sevelamer carbonate tablets		

DRUG NAME: Yuflyma® (adalimumab-aaty) Al 80 mg/0.8 mL – Crohn's Disease, Ulcerative Colitis or Hidradenitis Suppurativa Starter Package (3 Count)		**INDICATION:** Humira Biosimilar FDA approved to treat eight 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 and moderate-to-severe hidradenitis suppurativa in adult patients
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 3 auto-injectors (2.4 mL) per 365 days • MEDICAID: 3 auto-injectors (2.4 mL) per 365 days • MEDICARE: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]; (MEDICAID): Humira pen/syringe (Abbvie mfg only); (MEDICARE): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]		

DRUG NAME: Yuflyma® CF (adalimumab-aaty) 20 mg/0.2 mL prefilled syringe		**INDICATION:** Humira Biosimilar FDA approved to treat eight 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 and moderate-to-severe hidradenitis suppurativa in adult patients
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 2 syringes (0.4 mL) per 28 days • MEDICAID: 2 syringes (0.4 mL) per 28 days • MEDICARE: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]; (MEDICAID): Humira pen/syringe (Abbvie mfg only); (MEDICARE): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]		

DRUG NAME: Yuflyma® CF (adalimumab-aaty) 80 mg/0.8 mL auto-injector		**INDICATION:** Humira Biosimilar FDA approved to treat eight 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 and moderate-to-severe hidradenitis suppurativa in adult patients
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Quantity Limit
FAMIS FORMULARY	Non-Formulary	Quantity Limit
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 2 auto-injectors (1.6 mL) per 28 days • MEDICAID: 2 auto-injectors (1.6 mL) per 28 days • MEDICARE: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]; (MEDICAID): Humira pen/syringe (Abbvie mfg only); (MEDICARE): Humira pen/syringe (Abbvie mfg only), Cyltezo (adalimumab-adbm), Hyrimoz (adalimumab-adaz) [Sandoz mfg only]		

DRUG NAME: Zemaira®, alpha1 – proteinase inhibitor (Human) 4000 mg & 5000 mg		**INDICATION:** For the long-term augmentation and maintenance therapy in adults with severe hereditary deficiency of alpha1-antitrypsin (AAT) with clinically evident emphysema
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: Zenpep DR capsules 60,000 units		**INDICATION:** For the treatment of exocrine pancreatic insufficiency due to cystic fibrosis, or other conditions
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 2	N/A
STANDARD FORMULARY	Tier 2	N/A
EXCHANGE FORMULARY	Tier 2	N/A
FAMIS FORMULARY	Formulary	N/A
SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY	Formulary	Prior Authorization
MEDICARE FORMULARY	Tier 3	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: N/A		

<table>
<tr><td colspan="2">DRUG NAME: Zepbound™ (tirzepatide) injection, all strengths</td><td>INDICATION: For use as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adult patients with an initial BMI of ≥30 kg/m2 (obesity) or ≥27 kg/m2 (overweight) in the presence of ≥1 weight-related comorbid condition (e.g., cardiovascular disease, dyslipidemia, hypertension, obstructive sleep apnea, type 2 diabetes mellitus)</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: New Drug</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Tier 3 – Group Specific Benefit</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Tier 3 – Group Specific Benefit</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Excluded Benefit</td><td>N/A</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Excluded Benefit</td><td>N/A</td></tr>
<tr><td>SENTARA COMMUNITY PLAN (MEDICAID) FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria)</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Excluded Benefit</td><td>N/A</td></tr>
<tr><td colspan="3">QUANTITY LIMIT:
COMMERCIAL:
2.5 mg/0.5 mL = 4 auto-injectors (2 mL) per 28 days
5 mg/0.5 mL = 4 auto-injectors (2 mL) per 28 days
7.5 mg/0.5 mL = 4 auto-injectors (2 mL) per 28 days
10 mg/0.5 mL = 4 auto-injectors (2 mL) per 28 days
12.5 mg/0.5 mL = 4 auto-injectors (2 mL) per 28 days
15 mg/0.5 mL = 4 auto-injectors (2 mL) per 28 days
MEDICAID: N/A
MEDICARE: N/A</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (MEDICAID): Contrave, Orlistat, Qsymia, Saxenda SQ, Xenical, Wegovy SQ</td></tr>
</table>

DRUG NAME: Zilbrysq® (zilucoplan) 16.6 mg/0.416 mL, 23 mg/0.574 mL, or 32.4 mg/0.81 mL single-dose prefilled syringes for SC injection		**INDICATION:** For the treatment of generalized myasthenia gravis in adults who are anti-acetylcholine receptor (AChR) antibody positive
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 prefilled syringe per day		
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Zituvio™ (sitagliptan) tablets, all strengths		**INDICATION:** For use as an 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	Tier 3	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	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		
FORMULARY ALTERNATIVES: (COMMERCIAL): Januvia, Tradjenta; (MEDICAID): Januvia, Onglyza, Tradjenta; (MEDICARE): Januvia, Tradjenta		

DRUG NAME: Zoryve® (roflumilast) 0.3% foam		**INDICATION:** For the treatment of seborrheic dermatitis in adult and pediatric patients ≥ 9 years of age
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 (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 60 grams per 30 days • MEDICAID: 60 grams per 30 days • MEDICARE: N/A		
FORMULARY ALTERNATIVES: (MEDICAID): clobetasol, mometasone cream/ointment/solution, ketoconazole cream/shampoo; (MEDICARE): clobetasol, fluocinonide or mometasone cream/ointment/solution, ciclopirox shampoo/gel, ketoconazole cream/shampoo		

DRUG NAME: Zurzuvae™ (zuranolone) capsules, all strengths		**INDICATION:** For the treatment of postpartum depression 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:
• COMMERCIAL:
  • 20 mg – 28 capsules per 14 days
  • 25 mg – 28 capsules per 14 days
  • 30 mg – 14 capsules per 14 days
• MEDICAID:
  • 20 mg – 28 capsules per 14 days
  • 25 mg – 28 capsules per 14 days
  • 30 mg – 14 capsules per 14 days
• MEDICARE:
  • 20 mg – 28 capsules for 14 days
  • 25 mg – 28 capsules for 14 days
  • 30 mg – 28 capsules for 14 days		

FORMULARY ALTERNATIVES: N/A		