Optima Health Pharmacy Changes

Effective: July 1, 2023

(For plans with pharmacy benefits administered by Optima Health)

DRUG NAME: Chemet® (succimer) capsules 100 mg		**INDICATION:** For the treatment of lead poisoning in children with blood lead levels >45 mcg/dL
REASON FOR CHANGE: Change Drug Tier and Add Age Edit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 03	Prior Authorization (Age-Edit = ≥ 18)
STANDARD FORMULARY	Tier 03	Prior Authorization (Age-Edit = ≥ 18)
EXCHANGE FORMULARY	Tier 03	Prior Authorization (Age-Edit = ≥ 18)
FAMIS FORMULARY	Formulary	Prior Authorization (Age-Edit = ≥ 18)
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	Prior Authorization (Age-Edit = ≥ 18)
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	Prior Authorization (Age-Edit = ≥ 18)
MEDICARE FORMULARY	Tier 03	Prior Authorization
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** • COMMERCIAL: Yes • MEDICAID: Yes • MEDICARE: Yes; Limited
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Fylnetra™ (pegfilgrastim-pbbk) 6 mg/0.6 mL prefilled syringe		**INDICATION:** Used to decrease the incidence of infection (as manifested by febrile neutropenia), in patients with nonmyeloid malignancies receiving myelosuppressive cancer chemotherapy associated with a clinically significant incidence of febrile neutropenia
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization
STANDARD FORMULARY	Specialty	Prior Authorization
EXCHANGE FORMULARY	Specialty	Prior Authorization
FAMIS FORMULARY	Formulary	Prior Authorization
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (MEDICARE): Zarxio *require prior authorization*		

Optima Health Pharmacy Changes

Effective: July 1, 2023

(For plans with pharmacy benefits administered by Optima Health)

DRUG NAME: Auvelity™ (dextromethorphan and bupropion) 45-105 mg ER tablets		**INDICATION:** For the treatment of unipolar major depressive disorder in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 03	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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty	Quantity Limit
QUANTITY LIMIT: 2 tablets per day		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (COMMERCIAL): bupropion IR/SR/XL, sertraline, venlafaxine; (MEDICAID): bupropion IR, SR &XL, desvenlafaxine ER tab (generic for Pristiq®), mirtazapine ODT/tab trazodone tab, venlafaxine IR tab & ER cap		

DRUG NAME: Rolvedon™ (eflapegrastim-xnst) 13.2 mg/0.6 mL prefilled syringe for SQ administration		**INDICATION:** Used to decrease the incidence of infection, as manifested by febrile neutropenia, in adults with nonmyeloid malignancies receiving myelosuppressive anticancer drugs associated with clinically significant incidence of febrile neutropenia
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization
STANDARD FORMULARY	Specialty	Prior Authorization
EXCHANGE FORMULARY	Specialty	Prior Authorization
FAMIS FORMULARY	Formulary	Prior Authorization
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (MEDICARE): Udenyca & Ziextenzo *both require prior authorization*		

DRUG NAME: Relyvrio™ (sodium phenylbutyrate and taurursodiol) 3-1 gm powder pack for oral suspension		**INDICATION:** For the treatment of adults with amyotrophic lateral sclerosis
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization, Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 2 packets per day • MEDICAID: 2 packets per day • MEDICARE: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (MEDICARE): riluzole 50 mg tablets & Radicava ORS suspension *both require prior authorization*		

DRUG NAME: Furoscix® (furosemide 80 mg/10 mL) cartridge kit: single-dose prefilled cartridge for use only with co-packaged single-use, On-Body Infusor		**INDICATION:** For the treatment of congestion due to fluid overload in adult patients with New York Heart Association (NYHA) Class II and Class III chronic heart failure
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 03	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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 2 kits per fill • MEDICAID: 2 kits per fill • MEDICARE: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: furosemide tablets		

Optima Health Pharmacy Changes

Effective: July 1, 2023

(For plans with pharmacy benefits administered by Optima Health)

<table>
<tr><td colspan="2">DRUG NAME: Xelstrym™ (dextroamphetamine) transdermal patch, all strengths</td><td>INDICATION: For the treatment of attention deficit hyperactivity disorder (ADHD) in adults and children 6 years and older</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 03</td><td>Prior Authorization (Age-Edit = ≥ 19), Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (Age-Edit = ≥ 19), Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (Age-Edit = ≥ 19), Quantity Limit</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (Age-Edit = ≥ 19), Quantity Limit</td></tr>
<tr><td>OHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Prior Authorization (Age-Edit = ≥ 18), Quantity Limit</td></tr>
<tr><td>VPHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Prior Authorization (Age-Edit = ≥ 18), Quantity Limit</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td colspan="2">QUANTITY LIMIT:
• COMMERCIAL: 1 patch per day
• MEDICAID: 1 patch per day
• MEDICARE: N/A</td><td>TRANSITION OF CARE: Yes; Limited</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL): amphetamine-dextroamphetamine IR/XR, Vyvanse capsules/chewable tablets, dextroamphetamine IR/ER; (MEDICAID): Adderall XR, amphetamine salts combo (generic for Adderall IR) dextroamphetamine (generic for Dexedrine), Vyvanse cap/chewable tab (lisdexamfetamine); (MEDICARE): dextroamphetamine IR tablets/ER capsules</td></tr>
</table>

Optima Health Pharmacy Changes

Effective: July 1, 2023

(For plans with pharmacy benefits administered by Optima Health)

DRUG NAME: Stimufend® (pegfilgrastim-fpgk) 6 mg/0.6 mL prefilled syringe		**INDICATION:** Used to decrease the incidence of infection (as manifested by febrile neutropenia), in patients with nonmyeloid malignancies receiving myelosuppressive cancer chemotherapy associated with a clinically significant incidence of febrile neutropenia
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization
STANDARD FORMULARY	Specialty	Prior Authorization
EXCHANGE FORMULARY	Specialty	Prior Authorization
FAMIS FORMULARY	Formulary	Prior Authorization
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (MEDICARE): Zarxio *require prior authorization*		

DRUG NAME: Byooviz® (ranibizumab-nuna) intravitreal solution for injection		**INDICATION:** For the treatment of patients with: Neovascular (Wet) Age-Related Macular Degeneration (AMD), Macular Edema Following Retinal Vein Occlusion (RVO) & Myopic Choroidal Neovascularization (mCNV)
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Cimerli™ (ranibizumab-eqrn) intravitreal solution for injection		**INDICATION:** For the treatment of neovascular (wet) age-related macular degeneration (AMD), macular edema following retinal vein occlusion (RVO), diabetic macular edema (DME), diabetic retinopathy (DR), and myopic choroidal neovascularization (mCNV)
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Tzield™ (teplizumab-mzwv) injection for IV use		**INDICATION:** Used to delay the onset of Stage 3 type 1 diabetes (T1D) in adults and pediatric patients aged 8 years and older with Stage 2 T1D
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Terlivaz® (terlipressin lyophilized powder for injection for IV administration)		**INDICATION:** Used to improve kidney function in adults with hepatorenal syndrome with rapid reduction in kidney function
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit – Inpatient Only	N/A
STANDARD FORMULARY	Medical Benefit – Inpatient Only	N/A
EXCHANGE FORMULARY	Medical Benefit – Inpatient Only	N/A
FAMIS FORMULARY	Medical Benefit – Inpatient Only	N/A
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit – Inpatient Only	N/A
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit – Inpatient Only	N/A
MEDICARE FORMULARY	Medical Benefit – Inpatient Only	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Hemgenix® (etranacogene dezaparvovec-drlb) IV suspension, all strengths		**INDICATION:** For the treatment of hemophilia B (congenital factor IX deficiency) in adults who currently use factor IX prophylaxis therapy, or have current or historical life-threatening hemorrhage, or have repeated, serious spontaneous bleeding episodes
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Elahere™ (mirvetuximab soravtansine-gynx) injection 100 mg		**INDICATION:** For the treatment of adult patients with folate receptor-alpha (FRα) positive, platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer, who have received one to three prior systemic treatment regimens
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Lunsumio™ (mosunetuzumab-axgb) PF solution in SDV for IV infusion, all strengths		**INDICATION:** For the treatment of adult patients with relapsed or refractory follicular lymphoma (FL) after two or more lines of systemic therapy
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Rezlidhia™ (olutasidenib) 150 mg capsules		**INDICATION:** For the treatment of relapsed or refractory acute myeloid leukemia in adults with a susceptible isocitrate dehydrogenase-1 (IDH1) mutation as detected by an approved test
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization, Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 2 capsules per day		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Krazati™ (adagrasib) 200 mg tablets		**INDICATION:** For the treatment of KRAS G12C-mutated locally advanced or metastatic non–small cell lung cancer (NSCLC), as determined by an approved test, in adults who have received at least 1 prior systemic therapy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization, Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 6 tablets per day		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Olumiant® (baricitinib) 4 mg tablets		**INDICATION:** For the treatment of severe alopecia areata in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Excluded Benefit	N/A
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Excluded Benefit	N/A
MEDICARE FORMULARY	Excluded Benefit	N/A
QUANTITY LIMIT: • COMMERCIAL: 1 packet per day • MEDICAID: N/A • MEDICARE: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Noxafil® PowderMix Pak (posaconazole) for delayed-release oral suspension, 300 mg		**INDICATION:** For the prophylaxis of invasive Aspergillus and Candida infections in patients who are at high risk of developing these infections due to being severely immunocompromised (e.g., hematopoietic stem cell transplant with graft-versus-host disease, hematologic malignancy with prolonged neutropenia due to chemotherapy)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 03	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 03	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 03	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 1 packet per day • MEDICAID: N/A • MEDICARE: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (MEDICAID): fluconazole tab/susp, griseofulvin susp, nystatin tab/susp , terbinafine tab; (MEDICARE): Posaconazole 100 mg delayed-release tablets *requires prior authorization*		

DRUG NAME: Relexxii® (methylphenidate) ER osmotic tablets 45 mg & 63 mg		**INDICATION:** For the treatment of attention-deficit/hyperactivity disorder (ADHD)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Non-Formulary	Prior Authorization (CED), Prior Authorization (Age-Edit = ≥ 19), Quantity Limit
STANDARD FORMULARY	Non-Formulary	Prior Authorization (Age-Edit = ≥ 19), Quantity Limit
EXCHANGE FORMULARY	Non-Formulary	Prior Authorization (Age-Edit = ≥ 19), Quantity Limit
FAMIS FORMULARY	Non-Formulary	Prior Authorization (Age-Edit = ≥ 19), Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria), Prior Authorization (Age-Edit = ≥ 18), Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria), Prior Authorization (Age-Edit = ≥ 18), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 1 tablet per day • MEDICAID: 1 tablet per day • MEDICARE: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (COMMERCIAL): methylphenidate HCL tablet osmotic release (OSM 18mg, 27mg, 36mg, 54mg, 72mg; (MEDICAID): Brand Concerta; (MEDICARE): methylphenidate ER capsules/tablets		

DRUG NAME: Ermeza™ (levothyroxine) 150 mcg/5 mL solution		**INDICATION:** For use in in adult and pediatric patients, including neonates as a replacement therapy in primary (thyroidal), secondary (pituitary), and tertiary (hypothalamic) congenital or acquired hypothyroidism; As an adjunct to surgery and radioiodine therapy in the management of thyrotropin dependent well-differentiated thyroid cancer
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	N/A
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: levothyroxine tablets		

DRUG NAME: Basaglar® Tempo Pen™ (insulin glargine) injection, for subcutaneous use 100 units/mL		**INDICATION:** New insulin delivery device: Prefilled, disposable pen compatible with multiple Lilly insulins. Functions similarly to a Lilly KwikPen®
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (COMMERCIAL): Lantus, Toujeo; (MEDICAID): Basaglar Kwikpen, Lantus, Levemir; (MEDICARE): Lantus, Toujeo		

DRUG NAME: Humalog® Tempo Pen™ (insulin lispro) injection, for subcutaneous use 100 units/mL		**INDICATION:** New insulin delivery device: Prefilled, disposable pen compatible with multiple Lilly insulins. Functions similarly to a Lilly KwikPen®
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (COMMERCIAL): Humalog vial/pen, Humalog Cartridge, Humalog Kwikpen 100 unit/ml; (MEDICAID): Humalog vial/pen, Humalog Cartridge, Humalog Kwikpen 100 unit/ml; (MEDICARE): Humalog vial/kwikpen & Novolog vial/kwikpen		

DRUG NAME: Lyumjev® Tempo Pen™ (insulin lispro-aabc) injection, for subcutaneous use 100 units/mL		**INDICATION:** New insulin delivery device: Prefilled, disposable pen compatible with multiple Lilly insulins. Functions similarly to a Lilly KwikPen®
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (COMMERCIAL): Humalog vial/pen, Humalog Cartridge, Humalog Kwikpen 100 unit/ml; (MEDICAID): Humalog vial/pen, Humalog Cartridge, Humalog Kwikpen 100 unit/ml; (MEDICARE): Lyumjev vial/Kwikpen, Humalog vial/kwikpen & Novolog vial/kwikpen		

Optima Health Pharmacy Changes

Effective: July 1, 2023

(For plans with pharmacy benefits administered by Optima Health)

<table>
<tr><td colspan="2">DRUG NAME: Ozempic® (semaglutide) 2 mg/3 mL solution pen injector</td><td>INDICATION: For use as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus; risk reduction of major cardiovascular events (cardiovascular death, nonfatal myocardial infarction, nonfatal stroke) in adults with type 2 diabetes mellitus and established cardiovascular disease</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 02</td><td>Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Tier 02</td><td>Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Tier 02</td><td>Quantity Limit</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Formulary</td><td>Quantity Limit</td></tr>
<tr><td>OHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria)</td></tr>
<tr><td>VPHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria)</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Tier 03</td><td>Quantity Limit</td></tr>
<tr><td colspan="2">QUANTITY LIMIT:
• COMMERCIAL: 3 ml per 28 days
• MEDICAID: N/A
• MEDICARE: 3 ml per 28 days</td><td>TRANSITION OF CARE:
• COMMERCIAL: Yes
• MEDICAID: Yes; Limited
• MEDICARE: Yes</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (MEDICAID): Byetta® (exenatide), Trulicity™ (lixisenatide), Victoza® (liraglutide)</td></tr>
</table>

DRUG NAME: Vivimusta (bendamustine hcl) 100 mg/4 mL IV solution for injection		**INDICATION:** For the treatment of adult patients with chronic lymphocytic leukemia and for the treatment of adult patients with indolent B-cell non-Hodgkin lymphoma that has progressed during or within six months of treatment with rituximab or a rituximab-containing regimen
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	N/A
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	N/A
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Oxbryta® (voxelotor) 300 mg tablets		**INDICATION:** For the treatment of sickle cell disease in adults and pediatric patients ≥4 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	Prior Authorization (Age-Edit = ≤ 4)
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	Prior Authorization (Age-Edit = ≤ 4)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 3 tablets per day • MEDICAID: N/A • MEDICARE: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (MEDICARE): Oxbryta 500 mg tablets & 300 mg tablet for oral suspension *requires prior authorization*		

DRUG NAME: Turalio® (pexidartinib) 125 mg capsules		**INDICATION:** For the treatment of symptomatic tenosynovial giant cell tumor (TGCT) associated with severe morbidity or functional limitations and not amenable to improvement with surgery in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization, Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 4 capsules per day		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: ezetimibe-atorvastatin tablets, all strengths		**INDICATION:** Used in combination with a low-fat diet and other treatments to lower total cholesterol in adults with familial hypercholesterolemia (an inherited type of high cholesterol)
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (COMMERCIAL): ezetimibe tablets, atorvastatin tablets; (MEDICAID): atorvastatin tablets, rosuvastatin tablets, simvastatin tablets, ezetimibe tablets; (MEDICARE): ezetimibe-simvastatin tablets (generic Vytorin)		

DRUG NAME: Dexcom G7 Blood glucose sensor		**INDICATION:** An all-in-one wearable sensor that sends real-time glucose readings automatically to a compatible smart device or Dexcom receiver, with no fingersticks required
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 03	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 03	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 03	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • COMMERCIAL: 3 per 30 days • MEDICAID: N/A • MEDICARE: 3 per 30 days		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Dexcom G7 Blood glucose receiver		**INDICATION:** An all-in-one wearable sensor that sends real-time glucose readings automatically to a compatible smart device or Dexcom receiver, with no fingersticks required
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 03	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 03	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 03	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • COMMERCIAL: 1 device per lifetime • MEDICAID: N/A • MEDICARE: 1 device per 365 days		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: NexoBrid® (anacaulase-bcdb) for Topical gel		**INDICATION:** A concentrate of proteolytic enzymes indicated for removal of eschar in adults with deep partial- and full-thickness thermal burns
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit – Inpatient Only	N/A
STANDARD FORMULARY	Medical Benefit – Inpatient Only	N/A
EXCHANGE FORMULARY	Medical Benefit – Inpatient Only	N/A
FAMIS FORMULARY	Medical Benefit – Inpatient Only	N/A
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit – Inpatient Only	N/A
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit – Inpatient Only	N/A
MEDICARE FORMULARY	Medical Benefit – Inpatient Only	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Xaciato™ (clindamycin phosphate) 2% vaginal gel		**INDICATION:** For the treatment of bacterial vaginosis
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 03	N/A
STANDARD FORMULARY	Tier 03	N/A
EXCHANGE FORMULARY	Tier 03	N/A
FAMIS FORMULARY	Formulary	N/A
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** • COMMERCIAL: Yes • MEDICAID: Yes; Limited • MEDICARE: Yes; Limited
FORMULARY ALTERNATIVES: (MEDICAID): Cleocin® Ovules, Clindesse® cream, metronidazole 0.75% vaginal gel, Nuvessa™, Vandazole™ gel; (MEDICARE): clindamycin 2% vaginal cream, metronidazole 0.75% vaginal gel		

DRUG NAME: Leuprolide Depot 22.5 mg [3-month] vial for injection		**INDICATION:** For the treatment of pediatric patients with central precocious puberty (CPP); For the management of endometriosis; For the treatment of advanced prostate cancer; For the treatment (preoperative) of anemia caused by uterine leiomyomata (fibroids)
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	Prior Authorization, Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 1 vial per 84 days • MEDICAID: 1 vial per 84 days • MEDICARE: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (MEDICARE): Lupron Depot 22.5 mg syringe kit *requires prior authorization*		

DRUG NAME: Skyrizi® (risankizumab-rzaa) 180 mg/1.2 mL single-dose prefilled cartridge for SC injection		**INDICATION:** For the treatment of moderately to severely active Crohn's disease in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Specialty	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 1.2 mL (1 cartridge) per 56 days		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (MEDICAID): Enbrel® Pen/Sureclick/Syringe/Vial, Humira® Pen/ Syringe, Inflectra®, methotrexate tab/PF vial/MDV		

DRUG NAME: Tascenso ODT™ (fingolimod) 0.5 mg		**INDICATION:** For the treatment of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in patients 10 years of age and older weighing more than 40 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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 1 tablet per day • MEDICAID: N/A • MEDICARE: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (COMMERCIAL): fingolimod 0.5 mg capsules; (MEDICAID): Avonex®, Avonex® Adm Pack, Betaseron®, Copaxone 20 mg syringe®, dimethyl fumarate and Starter Pack, Kesimpta® *requires prior authorization*; (MEDICARE): Brand or Generic Gilenya (fingolimod) 0.5 mg capsules *requires prior authorization*		

DRUG NAME: Sezaby™ (phenobarbital) powder for injection by IV infusion		**INDICATION:** For the management of generalized tonic-clonic, status epilepticus, and partial seizures; management of neonatal seizures in term and preterm infants
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	N/A
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	N/A
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Aponvie™ (aprepitant) injection		**INDICATION:** For the prevention of postoperative nausea and vomiting (PONV)
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	N/A
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	N/A
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Nuvessa™ (metronidazole) vaginal 1.3% gel		**INDICATION:** For the treatment of bacterial vaginosis
REASON FOR CHANGE: Change Drug Tier and Remove Utilization Management Requirements		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 03	N/A
STANDARD FORMULARY	Tier 03	N/A
EXCHANGE FORMULARY	Tier 03	N/A
FAMIS FORMULARY	Formulary	N/A
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	N/A
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** • COMMERCIAL: Yes • MEDICAID: Yes; Limited • MEDICARE: Yes; Limited
FORMULARY ALTERNATIVES: (MEDICARE): clindamycin 2% vaginal cream, metronidazole 0.75% vaginal gel		

DRUG NAME: Cleocin® (clindamycin) 100 mg vaginal ovules		**INDICATION:** For the treatment of bacterial vaginosis
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 03	N/A
STANDARD FORMULARY	Tier 03	N/A
EXCHANGE FORMULARY	Tier 03	N/A
FAMIS FORMULARY	Formulary	N/A
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	N/A
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** • COMMERCIAL: Yes • MEDICAID: Yes; Limited • MEDICARE: Yes; Limited
FORMULARY ALTERNATIVES: (MEDICARE): clindamycin 2% vaginal cream, metronidazole 0.75% vaginal gel		

DRUG NAME: Clindesse® (clindamycin) 2% vaginal cream		**INDICATION:** For the treatment of bacterial vaginosis
REASON FOR CHANGE: Change Drug Tier		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 03	N/A
STANDARD FORMULARY	Tier 03	N/A
EXCHANGE FORMULARY	Tier 03	N/A
FAMIS FORMULARY	Formulary	N/A
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	N/A
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** • COMMERCIAL: Yes • MEDICAID: Yes; Limited • MEDICARE: Yes; Limited
FORMULARY ALTERNATIVES: (MEDICARE): clindamycin 2% vaginal cream, metronidazole 0.75% vaginal gel		

<table>
<tr><td colspan="2">DRUG NAME: Grastek® (Timothy Grass Pollen Allergen Extract) tablet for sublingual use</td><td>INDICATION: Immunotherapy for the treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for timothy grass or cross-reactive grass pollens in patients 5 through 65 years of age</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: Change Drug Tier, Utilization Management Requirements and Quantity Limit</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Tier 03</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Tier 03</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Tier 03</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>OHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td>VPHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td colspan="2">QUANTITY LIMIT:
• COMMERCIAL: 1 tablet per day
• MEDICAID: N/A
• MEDICARE: N/A</td><td>TRANSITION OF CARE: Yes; Limited</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (MEDICAID): Oralair *requires prior authorization*; (MEDICARE): fluticasone nasal spray, montelukast tablets, azelastine nasal spray</td></tr>
</table>

<table>
<tr><td colspan="2">DRUG NAME: Ragwitek® (Short Ragweed Pollen Allergen Extract) tablet for sublingual use</td><td>INDICATION: For the treatment of short ragweed pollen-induced allergic rhinitis, with or without conjunctivitis, confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for short ragweed pollen in persons 5 to 65 years of age.</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: Change Drug Tier, Add Utilization Management and Quantity Limit</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Tier 03</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Tier 03</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Tier 03</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>OHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Non-Formulary</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>VPHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Non-Formulary</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td colspan="2">QUANTITY LIMIT:
• COMMERCIAL: 1 tablet per day
• MEDICAID: 1 tablet per day
• MEDICARE: N/A</td><td>TRANSITION OF CARE: Yes; Limited</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (MEDICARE): fluticasone nasal spray, montelukast tablets, azelastine nasal spray</td></tr>
</table>

<table>
<tr><td colspan="2">DRUG NAME: Odactra™ House Dust Mite (Dermatophagoides farinae and Dermatophagoides pteronyssinus) Allergen Extract tablet for sublingual use</td><td>INDICATION: For the treatment of house dust mite (HDM)-induced allergic rhinitis, with or without conjunctivitis, confirmed by in vitro testing for IgE antibodies to Dermatophagoides farinae or D. pteronyssinus house dust mites, or skin testing to licensed house dust mite allergen extracts in adults ≤ 65 years</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: Add Utilization Management and Quantity Limit</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Tier 03</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Tier 03</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Tier 03</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>OHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Non-Formulary</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>VPHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Non-Formulary</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td colspan="2">QUANTITY LIMIT:
• COMMERCIAL: 1 tablet per day
• MEDICAID: 1 tablet per day
• MEDICARE: N/A</td><td>TRANSITION OF CARE: Yes; Limited</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (MEDICARE): fluticasone nasal spray, montelukast tablets, azelastine nasal spray</td></tr>
</table>

DRUG NAME: Oralair® (Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens Allergen Extract) tablet for sublingual use		**INDICATION:** Immunotherapy for the treatment of grass pollen-induced allergic rhinitis with or without conjunctivitis confirmed by positive skin test or in vitro testing for pollen-specific IgE antibodies for any of the 5 grass species contained in this product in patients 5 to 65 years of age
REASON FOR CHANGE: Add Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 03	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Tier 03	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Tier 03	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	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		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (MEDICARE): fluticasone nasal spray, montelukast tablets, azelastine nasal spray		

DRUG NAME: Brexafemme® (ibrexafungerp)		**INDICATION:** For the treatment of vulvovaginal candidiasis (VVC) and reduction in the incidence of recurrent VVC in adult and postmenarchal pediatric patients
REASON FOR CHANGE: Remove Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 03	Prior Authorization
STANDARD FORMULARY	Tier 03	Prior Authorization
EXCHANGE FORMULARY	Tier 03	Prior Authorization
FAMIS FORMULARY	Formulary	Prior Authorization
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (MEDICAID): fluconazole tablets/suspension; (MEDICARE): fluconazole tablets		

Optima Health Pharmacy Changes

Effective: July 1, 2023

(For plans with pharmacy benefits administered by Optima Health)

DRUG NAME: Sunlenca (lenacapavir sodium) subcutaneous solution for injection 463.5 mg/1.5 mL		**INDICATION:** For the treatment of HIV-1 infection, in combination with other antiretrovirals, in heavily treatment-experienced adults with multidrug-resistant HIV-1 infection failing their current antiretroviral regimen due to resistance, intolerance, or safety considerations
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: • COMMERCIAL: 3 mL (2 vials) per 168 days • MEDICAID: N/A • MEDICARE: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (MEDICAID): Fuzeon vial, Rukobia™ ER tab, Selzentry® tab/soln		

DRUG NAME: Sunlenca (lenacapavir sodium) subcutaneous solution for injection 463.5 mg/1.5 mL		**INDICATION:** For the treatment of HIV-1 infection, in combination with other antiretrovirals, in heavily treatment-experienced adults with multidrug-resistant HIV-1 infection failing their current antiretroviral regimen due to resistance, intolerance, or safety considerations
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Medical Benefit	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Medical Benefit	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

<table>
<tr><td colspan="2">DRUG NAME: Sunlenca (lenacapavir sodium) tablet therapy pack 300 mg</td><td>INDICATION: For the treatment of HIV-1 infection, in combination with other antiretrovirals, in heavily treatment-experienced adults with multidrug-resistant HIV-1 infection failing their current antiretroviral regimen due to resistance, intolerance, or safety considerations</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</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Specialty</td><td>Prior Authorization, Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Specialty</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>OHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria)</td></tr>
<tr><td>VPHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria)</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Specialty</td><td>N/A</td></tr>
<tr><td colspan="2">QUANTITY LIMIT:
• COMMERCIAL:
  • 4 x 300 therapy pack – 1 pack per 365 days
  • 5 x 300 therapy pack – 1 pack per 365 days
• MEDICAID: N/A
• MEDICARE: N/A</td><td>TRANSITION OF CARE: Yes; Limited</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (MEDICAID): Fuzeon vial, Rukobia™ ER tab, Selzentry® tab/soln</td></tr>
</table>

<table>
<tr><td colspan="2">DRUG NAME: Amjevita (adalimumab-atto) solution prefilled syringe, all strengths</td><td>INDICATION: The fourth biosimilar to AbbVie's Humira® (adalimumab) approved by the FDA; Shares 7 of the 10 indications for Humira for treatment of the following: Rheumatoid arthritis, juvenile idiopathic arthritis, psoriatic arthritis, ankylosing spondylitis, adult Crohn's disease, ulcerative colitis & plaque psoriasis</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>OHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Quantity Limit</td></tr>
<tr><td>VPHP COMMUNITY CARE FORMULARY (MEDICAID)</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="2">QUANTITY LIMIT:
• COMMERCIAL:
  • 40 mg/0.8 mL prefilled syringe – 2 syringes (1.6 mL) per 28 days
  • 20 mg/0.4 mL prefilled syringe – 2 syringes (0.8 mL) per 28 days
• MEDICAID:
  • 40 mg/0.8 mL prefilled syringe – 2 syringes (1.6 mL) per 28 days
  • 20 mg/0.4 mL prefilled syringe – 2 syringes (0.8 mL) per 28 days
• MEDICARE: N/A</td><td>TRANSITION OF CARE: Yes; Limited</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL): Brand Humira; (MEDICAID): Brand Humira</td></tr>
</table>

DRUG NAME: Amjevita (adalimumab-atto) solution auto-injector 40/0.8 mL		**INDICATION:** The fourth biosimilar to AbbVie's Humira® (adalimumab) approved by the FDA; Shares 7 of the 10 indications for Humira for treatment of the following: Rheumatoid arthritis, juvenile idiopathic arthritis, psoriatic arthritis, ankylosing spondylitis, adult Crohn's disease, ulcerative colitis & plaque psoriasis
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 2 pens (1.6 mL) per 28 days • MEDICAID: 2 pens (1.6 mL) per 28 days • MEDICARE: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (COMMERCIAL): Brand Humira; (MEDICAID): Brand Humira		

DRUG NAME: Rebyota (fecal microbiota, live-jslm) rectal suspension 150 mL		**INDICATION:** For the prevention of recurrence of C. difficile infection (CDI) in patients ≥18 years of age following antibiotic treatment of recurrent CDI
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Briumvi (ublituximab-xiiy) solution for IV infusion 150 mg/6 mL		**INDICATION:** For the treatment of relapsing forms of multiple sclerosis, including clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Medical Benefit	Prior Authorization
STANDARD FORMULARY	Medical Benefit	Prior Authorization
EXCHANGE FORMULARY	Medical Benefit	Prior Authorization
FAMIS FORMULARY	Medical Benefit	Prior Authorization
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Leqembi (lecanemab-irmb) IV solution, all strengths		**INDICATION:** For the treatment of Alzheimer disease; to be initiated in patients with mild cognitive impairment or mild dementia stage of disease, with confirmed presence of amyloid beta pathology prior to treatment initiation
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Medical Benefit	Prior Authorization
MEDICARE FORMULARY	Medical Benefit	Prior Authorization
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Jaypirca (pirtobrutinib) tablets, all strengths		**INDICATION:** For the treatment of relapsed or refractory mantle cell lymphoma (MCL) after at least two lines of systemic therapy, including a Bruton tyrosine kinase (BTK) inhibitor, in adults
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization, Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • 100 mg – 2 tablets per day • 50 mg tablet – 1 tablet per day		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Orserdu (elacestrant HCl) tablets, all strengths		**INDICATION:** For the treatment of estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative, ESR1-mutated advanced or metastatic breast cancer in postmenopausal patients or adult males with disease progression following at least 1 line of endocrine therapy
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization, Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • 345 mg – 1 tablet per day • 86 mg – 3 tablets per day		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: N/A		

<table>
<tr><td colspan="2">DRUG NAME: Vegzelma® (bevacizumab-adcd) IV solution for infusion 100 mg/4 mL</td><td>INDICATION: Celltrion’s third oncology biosimilar Avastin to receive approval from the U.S. FDA indicated for the treatment of patients with metastatic colorectal cancer (mCRC); recurrent or metastatic non-squamous non-small cell lung cancer (nsNSCLC); recurrent glioblastoma (GBM); metastatic renal cell carcinoma (mRCC); persistent, recurrent, or metastatic cervical cancer (CC); epithelial ovarian, fallopian tube, or primary peritoneal cancer</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>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>OHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>VPHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Medical Benefit</td><td>Prior Authorization</td></tr>
<tr><td colspan="2">QUANTITY LIMIT: N/A</td><td>TRANSITION OF CARE: No</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: N/A</td></tr>
</table>

DRUG NAME: Vibrant – transient device for constipation oral - capsules		**INDICATION:** An FDA-cleared, drug-free treatment proven to promote more complete spontaneous bowel movements
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Excluded Benefit – Medical Device	N/A
STANDARD FORMULARY	Excluded Benefit – Medical Device	N/A
EXCHANGE FORMULARY	Excluded Benefit – Medical Device	N/A
FAMIS FORMULARY	Excluded Benefit – Medical Device	N/A
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Excluded Benefit – Medical Device	N/A
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Excluded Benefit – Medical Device	N/A
MEDICARE FORMULARY	Excluded Benefit – Medical Device	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Vibrant – transient device for constipation oral – starter kit		**INDICATION:** An FDA-cleared, drug-free treatment proven to promote more complete spontaneous bowel movements
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Excluded Benefit – Medical Device	N/A
STANDARD FORMULARY	Excluded Benefit – Medical Device	N/A
EXCHANGE FORMULARY	Excluded Benefit – Medical Device	N/A
FAMIS FORMULARY	Excluded Benefit – Medical Device	N/A
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Excluded Benefit – Medical Device	N/A
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Excluded Benefit – Medical Device	N/A
MEDICARE FORMULARY	Excluded Benefit – Medical Device	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** No
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Tezspire (Tezepelumab-ekko) subcutaneous solution auto-injector 210 mg/1.91 mL		**INDICATION:** For add-on maintenance treatment of severe asthma in adult and pediatric patients ≥12 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization, Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 1.91 mL (1 syringe) per 28 days • MEDICAID: 1.91 mL (1 syringe) per 28 days • MEDICARE: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (MEDICARE): Dupixent, Fasenra & Nucala *all require prior authorization*		

DRUG NAME: Takhzyro® (lanadelumab-flyo) solution prefilled syringe 150 mg/mL		**INDICATION:** For the prevention of attacks of hereditary angioedema (HAE) in adults and pediatric patients ≥2 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 1 mL per 28 days • MEDICAID: 1 mL per 28 days • MEDICARE: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (MEDICAID): Berinert® & Cinryze™; (MEDICARE): Cinryze™		

DRUG NAME: Takhzyro® (lanadelumab-flyo) solution vial/prefilled syringe 300 mg/mL		**INDICATION:** For the prevention of attacks of hereditary angioedema (HAE) in adults and pediatric patients ≥2 years of age
REASON FOR CHANGE: Add Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria), Quantity Limit
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: • COMMERCIAL: 2 ml per 28 days • MEDICAID: 2 ml per 28 days • MEDICARE: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (MEDICAID): Berinert® & Cinryze™; (MEDICARE): Cinryze™		

DRUG NAME: Rebinyn®, coagulation factor IX (recombinant), glycopegylated for injection 3000 units – For IV infusion after reconstitution only		**INDICATION:** For the on-demand treatment and control of bleeding, perioperative management of bleeding, and routine prophylaxis to reduce the frequency of bleeding episodes in patients with factor IX deficiency (hemophilia B)
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	N/A
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	N/A
MEDICARE FORMULARY	Medical Benefit	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** • COMMERCIAL: No • MEDICAID: Yes • MEDICARE: No
FORMULARY ALTERNATIVES: N/A		

<table>
<tr><td colspan="2">DRUG NAME: Pradaxa® (dabigatran etexilate) oral pellets</td><td>INDICATION: For the treatment of unipolar major depressive disorder in adults. for the treatment of venous thromboembolic events (VTE) in pediatric patients aged 3 months to less than 12 years of age who have been treated with a parenteral anticoagulant for at least 5 days and to reduce the risk of recurrence of VTE in pediatric patients aged 3 months to less than 12 years of age who have been previously treated</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 03</td><td>Prior Authorization, 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>OHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Formulary</td><td>N/A</td></tr>
<tr><td>VPHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Formulary</td><td>N/A</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Non-Formulary</td><td>N/A</td></tr>
<tr><td colspan="2">QUANTITY LIMIT:
• COMMERCIAL:
  • 20 mg pellet packets – 1 packet per day
  • 30 mg pellet packets – 4 packets per day
  • 40 mg pellet packets – 4 packets per day
  • 50 mg pellet packets – 4 packets per day
  • 110 mg pellet packets – 4 packets per day
  • 150 mg pellet packets – 2 packets per day
• MEDICAID: N/A
• MEDICARE: N/A</td><td>TRANSITION OF CARE:
• COMMERCIAL: Yes; Limited
• MEDICAID: Yes
• MEDICARE: Yes; Limited</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL): Xarelto 1 mg/mL suspension; (MEDICARE): dabigatran 75 & 150 mg capsules</td></tr>
</table>

DRUG NAME: Clindacin (clindamycin phosphate) 1% topical foam		**INDICATION:** For the treatment of acne vulgaris
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (COMMERCIAL): clindamycin phosphate 1% solution; (MEDICAID): clindamycin phosphate 1% lotion/gel/solution/swab; (MEDICARE): clindamycin phosphate 1% lotion/gel/solution/swab		

<table>
<tr><td colspan="2">DRUG NAME: Latuda (lurasidone) tablets, all strengths</td><td>INDICATION: For the treatment of depressive episodes associated with bipolar I disorder, both as monotherapy (children ≥10 years of age, adolescents, and adults) and as an adjunct to lithium or divalproex (adults); Treatment of schizophrenia in adults and adolescents</td></tr>
<tr><td colspan="3">REASON FOR CHANGE: Change Drug Tier and Utilization Management Requirements</td></tr>
<tr><td>FORMULARY</td><td>TIER</td><td>UTILIZATION MANAGEMENT REQUIREMENTS</td></tr>
<tr><td>OPEN FORMULARY</td><td>Tier 03</td><td>Prior Authorization (Age-Edit = ≤ 17), Step-Edit, Quantity Limit</td></tr>
<tr><td>STANDARD FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (Age-Edit = ≤ 17), Quantity Limit</td></tr>
<tr><td>EXCHANGE FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (Age-Edit = ≤ 17), Quantity Limit</td></tr>
<tr><td>FAMIS FORMULARY</td><td>Non-Formulary</td><td>Prior Authorization (Age-Edit = ≤ 17), Quantity Limit</td></tr>
<tr><td>OHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Prior Authorization (Age-Edit = ≤ 17), Quantity Limit</td></tr>
<tr><td>VPHP COMMUNITY CARE FORMULARY (MEDICAID)</td><td>Non-Formulary</td><td>Prior Authorization (PDL Criteria), Prior Authorization (Age-Edit = ≤ 17), Quantity Limit</td></tr>
<tr><td>MEDICARE FORMULARY</td><td>Specialty</td><td>Quantity Limit</td></tr>
<tr><td colspan="2">QUANTITY LIMIT:
• 20 mg, 40 mg, 60 mg & 120 mg = 1 tablet per day
• 80 mg = 2 tablets per day</td><td>TRANSITION OF CARE: Yes; Limited</td></tr>
<tr><td colspan="3">FORMULARY ALTERNATIVES: (COMMERCIAL): aripiprazole, olanzapine, quetiapine, risperidone, ziprasidone; (MEDICAID): lurasidone tablets</td></tr>
</table>

DRUG NAME: lurasidone tablets, all strengths		**INDICATION:** For the treatment of depressive episodes associated with bipolar I disorder, both as monotherapy (children ≥10 years of age, adolescents, and adults) and as an adjunct to lithium or divalproex (adults); Treatment of schizophrenia in adults and adolescents
REASON FOR CHANGE: Change Drug Tier and Utilization Management Requirements		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 02	Prior Authorization (Age-Edit = ≤ 17), Step-Edit, Quantity Limit
STANDARD FORMULARY	Tier 02	Prior Authorization (Age-Edit = ≤ 17), Step-Edit, Quantity Limit
EXCHANGE FORMULARY	Tier 02	Prior Authorization (Age-Edit = ≤ 17), Step-Edit, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization (Age-Edit = ≤ 17), Step-Edit, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	Prior Authorization (Age-Edit = ≤ 17), Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	Prior Authorization (Age-Edit = ≤ 17), Quantity Limit
MEDICARE FORMULARY	Tier 04	Quantity Limit
QUANTITY LIMIT: • 20 mg, 40 mg, 60 mg & 120 mg = 1 tablet per day • 80 mg = 2 tablets per day		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: fluticasone-salmeterol HFA (Advair® HFA ABA)		**INDICATION:** For the treatment of asthma in patients ≥ 12 years of age
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 03	Prior Authorization
STANDARD FORMULARY	Non-Formulary	N/A
EXCHANGE FORMULARY	Non-Formulary	N/A
FAMIS FORMULARY	Non-Formulary	N/A
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization (PDL Criteria)
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: Brand Advair Diskus/HFA		

DRUG NAME: Erleada® (apalutamide) tablets, 240 mg		**INDICATION:** For the treatment of metastatic, castration-sensitive prostate cancer; Treatment of nonmetastatic, castration-resistant prostate cancer
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization, Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Prior Authorization, Quantity Limit
MEDICARE FORMULARY	Specialty	Prior Authorization, Quantity Limit
QUANTITY LIMIT: 1 tablet per day		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: Oxybutynin 2.5 mg tablets		**INDICATION:** For the treatment of symptoms associated with overactive bladder (e.g., urge urinary incontinence, urgency, frequency, urinary leakage, dysuria)
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
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	N/A
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	N/A
MEDICARE FORMULARY	Non-Formulary	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** • COMMERCIAL: Yes; Limited • MEDICAID: Yes • MEDICARE: Yes; Limited
FORMULARY ALTERNATIVES: (COMMERCIAL): oxybutynin 5 mg tablets, solution/syrup; (MEDICARE): oxybutynin 5 mg tablets		

DRUG NAME: Orenitram (Treprostinil) ER tablet titration kit, all strengths		**INDICATION:** For the treatment of PAH (WHO Group 1) in patients with WHO Functional Class II to III symptoms to delay disease progression and to delay disease progression and to improve exercise capacity or PAH associated with connective tissue disease
REASON FOR CHANGE: New Drug		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Specialty	Prior Authorization, Quantity Limit
STANDARD FORMULARY	Specialty	Prior Authorization, Quantity Limit
EXCHANGE FORMULARY	Specialty	Prior Authorization, Quantity Limit
FAMIS FORMULARY	Formulary	Prior Authorization, Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Non-Formulary	Quantity Limit
MEDICARE FORMULARY	Specialty	Prior Authorization, Quantity Limit
QUANTITY LIMIT: • Month 1 Kit- 168 tablets per 365 days • Month 2 Kit- 336 tablets per 365 days • Month 3 Kit- 252 tablets per 365 days		**TRANSITION OF CARE:** Yes; Limited
FORMULARY ALTERNATIVES: (MEDICAID): Ventavis®, ambrisentan (generic Letairis) 5 & 10mg, Tracleer® tab, Alyq (tadalafil), sildenafil tab/susp, tadalafil		

DRUG NAME: vancomycin capsules (Vancocin), all strengths		**INDICATION:** For the treatment of C. difficile infection (CDI) in adults and pediatric patients <18 years of age; For the treatment of enterocolitis caused by Staphylococcus aureus (including methicillin-resistant strains) in adults and pediatric patients <18 years of age
REASON FOR CHANGE: Remove Utilization Management Requirements and Remove Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 02	N/A
STANDARD FORMULARY	Tier 02	N/A
EXCHANGE FORMULARY	Tier 02	N/A
FAMIS FORMULARY	Formulary	N/A
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	N/A
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	N/A
MEDICARE FORMULARY	Tier 04	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** Yes
FORMULARY ALTERNATIVES: N/A		

Optima Health Pharmacy Changes

Effective: July 1, 2023

(For plans with pharmacy benefits administered by Optima Health)

DRUG NAME: At Home OTC COVID-19 Test Kits		**INDICATION:** Over-the-counter (OTC) diagnostic kits used to self-test at home for active COVID-19 infection
REASON FOR CHANGE: Change Drug Tier and Quantity Limit		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 01	Quantity Limit
STANDARD FORMULARY	Tier 01	Quantity Limit
EXCHANGE FORMULARY	Tier 01	Quantity Limit
FAMIS FORMULARY	Formulary	Quantity Limit
OHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	Quantity Limit
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	Formulary	Quantity Limit
MEDICARE FORMULARY	Excluded Benefit (OTC)	N/A
QUANTITY LIMIT: • COMMERCIAL: 4 total tests per member per month • MEDICAID: 8 total tests per member per month • MEDICARE: N/A		**TRANSITION OF CARE:** Yes
FORMULARY ALTERNATIVES: N/A		

DRUG NAME: ACA Breast Cancer Prevention Medications		**INDICATION:** To reduce the incidence of breast cancer in adult females at high risk for breast cancer
REASON FOR CHANGE: Update Affordable Care Act Requirements for Copay Reduction		
FORMULARY	**TIER**	**UTILIZATION MANAGEMENT REQUIREMENTS**
OPEN FORMULARY	Tier 01	N/A
STANDARD FORMULARY	Tier 01	N/A
EXCHANGE FORMULARY	Tier 01	N/A
FAMIS FORMULARY	Formulary	N/A
OHP COMMUNITY CARE FORMULARY (MEDICAID)	N/A	N/A
VPHP COMMUNITY CARE FORMULARY (MEDICAID)	N/A	N/A
MEDICARE FORMULARY	N/A	N/A
QUANTITY LIMIT: N/A		**TRANSITION OF CARE:** Yes
FORMULARY ALTERNATIVES: N/A		