Pharmacy Update

The formulary changes below meet requirements set by the State of Michigan and the Common Formulary Workgroup. Blue Cross Complete is a member of Michigan Managed Care Common Formulary Workgroup.

Please Note: Changes established by the Common Formulary Workgroup may not be posted immediately. Please allow time for documents to be updated and posted. New information will be posted as soon as possible.

Medication Name	Preferred Drug List Update*	Effective Date
ALBUTEROL HFA 90 MCG INHALER	Moved PDL Preferred and removed PA requirement	8/1/2025
ALHEMO 60 MG/1.5 ML PEN ALHEMO 150 MG/1.5 ML PEN ALHEMO 300 MG/3 ML PEN	Added to formulary as carved-out	8/1/2025
ALYFTREK 4-20-50 MG TABLET ALYFTREK 10-50-125 MG TABLET	Added to formulary as carved-out	8/1/2025
ANORO ELLIPTA 62.5-25 MCG INH	Added brand preferred over generic	8/1/2025
AVMAPKI-FAKZYNJA CO-PACK	Added to formulary as carved-out	8/1/2025
BRILINTA 90 MG TABLET	Added brand preferred over generic	8/1/2025
CIPRO 250 MG TABLET CIPRO 500 MG TABLET	Updated QL max quantity of 56 per claim	8/1/2025
CIPROFLOXACIN HCL 250 MG TAB CIPROFLOXACIN HCL 500 MG TAB CIPROFLOXACIN HCL 750 MG TAB	Updated QL max quantity of 56 per claim	8/1/2025
CRESEMBA 74.5 MG CAPULSE CRESEMBA 186 MG CAPSULE	Added AL min. of 6 years old	8/1/2025
DABIGATRAN ETEXILATE 75 MG CAP DABIGATRAN ETEXILATE 110 MG CAP DABIGATRAN ETEXILATE 150 MG CAP	Moved to PDL Preferred and removed PA requirement *Generic for Pradaxa*	8/1/2025
DEXAMETHASONE 6 DAY 1.5 MG TAB DEXAMETHASONE 10 DAY 1.5 MG TAB DEXAMETHASONE 13 DAY 1.5 MG TAB	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	8/1/2025
DIAZOXIDE 50 MG/ML ORAL SUSP	Added PDL Maintenance	8/1/2025

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Medication Name	Preferred Drug List Update*	Effective Date
DIFICID 40 MG/ML SUSPENSION	Moved to PDL Non-Preferred	8/1/2025
DOLOBID 375 MG TABLET	Added to formulary as PDL Non-Preferred with PA required	8/1/2025
ECONAZOLE NITRATE 1% CREAM	Moved to PDL Preferred and removed PA requirement	8/1/2025
FERRIC CITRATE 210 MG TABLET	Added to formulary as PDL Non-Preferred with PA required and PDL Maintenance	8/1/2025
FLAVOXATE HCL 100 MG TABLET	Added PDL Maintenance	8/1/2025
FLUCONAZOLE 150 MG TABLET	Updated QL max quantity of 4 per claim	8/1/2025
GNP VITAMIN E 1,000 UNIT SFGL	Removed coverage	8/1/2025
HUMALOG MIX 75-25 KWIKPEN	Moved to PDL Non-Preferred with PA required and no longer brand preferred over generic	8/1/2025
INSULIN ASPART 100 UNIT/ML CRT	Moved to PDL Preferred and removed PA requirement	8/1/2025
INSULIN LISPRO MIX 75-25 KWKPN	Moved to PDL Preferred and removed PA requirement	8/1/2025
JANUVIA 25 MG TABLET JANUVIA 50 MG TABLET JANUVIA 100 MG TABLET	Added PA requirement	8/1/2025
JYNARQUE 15 MG TABLET JYNARQUE 15 MG-15 MG TABLET JYNARQUE 30 MG TABLET JYNARQUE 30 MG-15 MG TABLET JYNARQUE 45 MG-15 MG TABLET JYNARQUE 60 MG-30 MG TABLET JYNARQUE 90 MG-30 MG TABLET	Removed coverage	8/1/2025
LEVOFLOXACIN 0.5% EYE DROP	Added to formulary as PDL Non-Preferred with PA required	8/1/2025
LEVOFLOXACIN 250 MG TABLET LEVOFLOXACIN 500 MG TABLET	Updated QL max quantity of 28 per claim	8/1/2025
LEVOFLOXACIN 750 MG TABLET	Updated QL max quantity of 14 per claim	8/1/2025

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LIQREV 10 MG/ML ORAL SUSP	Added PDL Maintenance	8/1/2025
LUTRATE DEPOT 22.5 MG VIAL	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	8/1/2025
MAGNESIUM OXIDE 400 MG TABLET	Added to formulary covered for CSHCS members	8/1/2025
MOXIFLOXACIN HCL 400 MG TABLET	Updated QL max quantity of 21 per claim	8/1/2025
NALOXONE 0.4 MG/ML VIAL NALOXONE 2 MG/2 ML SYRINGE NALOXONE 4 MG/10 ML VIAL NALOXONE HCL 4 MG NASAL SPRAY	Removed QL	8/1/2025
NARCAN 4 MG NASAL SPRAY	Removed QL	8/1/2025
NOVOLOG PENFILL 100 UNIT/ML	Moved to PDL Non-Preferred with PA required and no longer brand preferred over generic	8/1/2025
PAXLOVID 300-100 MG DOSE PACK PAXLOVID 300/150-100 MG (SEVERE) PAXLOVID 150-100 MG DOSE PACK	Added to formulary as PDL Preferred	8/1/2025
PHENTERMINE-TOPIR ER 3.75-23 MG PHENTERMINE-TOPIR ER 7.5-46 MG PHENTERMINE-TOPIR ER 11.25-69 PHENTERMINE-TOPIR ER 15-92 MG	Added to formulary as PDL Preferred with PA required and AL min. of 12 years old	8/1/2025
PRADAXA 75 MG CAPSULE PRADAXA 150 MG CAPSULE PRADAXA 110 MG CAPSULE	Moved to PDL non-Preferred with PA required and no longer brand over generic preferred	8/1/2025
QC ENEMA READY USE QC ENEMA READY USE TWIN PAK	Added to formulary and covered for CSHCS members	8/1/2025
REXTOVY 4 MG NASAL SPRAY	Removed QL	8/1/2025
ROMVIMZA 14 MG CAPSULE ROMVIMZA 20 MG CAPSULE ROMVIMZA 30 MG CAPSULE	Added to formulary as carved-out	8/1/2025
SIKLOS 100 MG TABLET SIKLOS 1,000 MG TABLET	Removed AL and added Specialty	8/1/2025
SIMLANDI(CF) AI 80 MG/0.8 ML	Added as PDL Non-Preferred with PA required with AL in	8/1/2025

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	accordance with PA criteria as Specialty	
SITAGLIPTIN-METFORM ER 50-500 SITAGLIPTIN-METFOR ER 50-1,000 SITAGLIPTIN-METFO ER 100-1,000	Added to formulary as PDL Non-Preferred with PA required and PDL Maintenance *Generic Zituvimet XR*	8/1/2025
STEQEYMA 45 MG/0.5 ML SYRINGE STEQEYMA 90 MG/ML SYRINGE STEQEYMA 130 MG/26 ML VIAL	Added to formulary as PDL Non-Preferred with PA required, QL in accordance with PA criteria as Specialty	8/1/2025
TADLIQ 20 MG/5 ML SUSPENSION	Added PDL Maintenance	8/1/2025
TAPERFEX 6 DAY 1.5 MG TBALET	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	8/1/2025
TAZAROTENE 0.05% CREAM	Added as PDL Non-Preferred with PA required with AL in accordance with PA criteria as Specialty	8/1/2025
TICAGRELOR 60 MG TABLET	Added to formulary as PDL Non-Preferred with PA required and PDL Maintenance *Generic for Brilinta*	8/1/2025
TOLVAPTAN 15 MG TABLET TOLVAPTAN 15 MG-15 MG TABLET TOLVAPTAN 30 MG TABLET TOLVAPTAN 30 MG-15 MG TABLET TOLVAPTAN 45 MG-15 MG TABLET TOLVAPTAN 60 MG-30 MG TABLET TOLVAPTAN 90 MG-30 MG TABLET	Added to formulary as covered with PA required, AL min. 18 years old, QL of 2 per day and as Specialty *Generic for Jynarque*	8/1/2025
UMECLIDINIUM-VILANTERO 62.5-25	Added to formulary as PDL Non-Preferred covered with PA required with QL of 3 inhalers per 90 days and PDL Maintenance *Generic for Anoro Ellipta*	8/1/2025
VELTASSA 1 GM POWDER PACKET	Added to formulary as PDL Non-Preferred covered with PA required and PDL Maintenance	8/1/2025

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Medication Name	Preferred Drug List Update*	Effective Date
VITAMIN D3 50 MCG CAPSULE	Added to formulary as covered for CSHCS members	8/1/2025
VITAMIN D3 50 MCG TABLET	Covered for CSHCS members *only*	8/1/2025
VITAMIN E 450 MG SOFTGEL	Added to formulary as covered	8/1/2025
VTAMA 1% CREAM	Added QL of 60 grams per 30 days	8/1/2025
XIFAXAN 550 MG TABLET	Added QL 3 per day	8/1/2025
XOFLUZA 40 MG TABLET XOFLUZA 80 MG TABLET	Moved to PDL Non-Preferred with PA required	8/1/2025
XROMI 100 MG/ML SOLUTION	Added to formulary with QL up to 102-day supply	8/1/2025
YESINTEK 45 MG/0.5 ML SYRINGE YESINTEK 45 MG/0.5 ML VIAL YESINTEK 90 MG/ML SYRINGE YESINTEK 130 MG/26 ML VIAL	Added to formulary as PDL Non-Preferred with PA requires, QL edits vary in accordance with PA criteria and as a Specialty drug	8/1/2025
BISOPROLOL FUMARATE 2.5 MG TAB	Added to new strength as PDL Preferred and PDL Maintenance	6/1/2025
ADALIMUMAB-ADAZ(CF) 10 MG/0.1 ML	Added to formulary as PDL Non-Preferred with AL, PA required, QL and as a Specialty	5/1/2025
AZOPT 1% EYE DROPS	Moved to PDL Non-Preferred with PA required *brand over generic no longer applies*	5/1/2025
BISOPROLOL FUMARATE 5 MG TAB BISOPROLOL FUMARATE 10 MG TAB	Moved to PDL Preferred	5/1/2025
BRINZOLAMIDE 1% EYE DROPS	Moved to PDL Preferred **generic for Azopt 1% Eye Drops*	5/1/2025
BYSTOLIC 2.5 MG TABLET BYSTOLIC 5 MG TABLET BYSTOLIC 10 MG TABLET BYSTOLIC 20 MG TABLET	Moved to PDL Non-Preferred with PA required	5/1/2025
CARVEDILOL ER 10 MG CAPSULE CARVEDILOL ER 20 MG CAPSULE CARVEDILOL ER 40 MG CAPSULE CARVEDILOL ER 80 MG CAPSULE	Moved to PDL Non-Preferred with PA required Grandfathering allowed for	5/1/2025

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Medication Name	Preferred Drug List Update*	Effective Date
	current utilizers through 7/31/2025	
CREXONT ER 35 MG-140 MG CAP CREXONT ER 52.5 MG-210 MG CAP CREXONT ER 70 MG-280 MG CAP CREXONT ER 87.5 MG-350 MG CAP	Added to formulary as PDL Non-Preferred with PA and AL min. 18 years old	5/1/2025
ENTRESTO SPRINKLE 6-6 MG PELLET ENTRESTO SPRINKLE 15-16 MG PELLET	Added to formulary as PDL Non-Preferred with PA required, QL 60 per 30 days and PDL Maintenance	5/1/2025
EZETIMIBE-SIMVASTATIN 10-10 MG EZETIMIBE-SIMVASTATIN 10-20 MG EZETIMIBE-SIMVASTATIN 10-40 MG EZETIMIBE-SIMVASTATIN 10-80 MG	Moved to PDL Preferred with QL 1 per day	5/1/2025
FERRIC CITRATE 210 MG TABLET	Added to formulary as PDL Non-Preferred with PA required; PDL Maintenance	5/1/2025
FLUOCINONIDE-E 0.05% CREAM	Moved to PDL Non-Preferred with PA required	5/1/2025
HEMANGEOL 4.28 MG/ML ORAL SOLUTION	Moved to PDL Preferred with AL max 1 year old	5/1/2025
JANUVIA 25 MG TABLET JANUVIA 50 MG TABLET JANUVIA 100 MG TABLET	Added PA requirement	5/1/2025
LENALIDOMIDE 2.5 MG CAPSULE LENALIDOMIDE 20 MG CAPSULE	Added to formulary as Tier 4; as specialty ***Policy Update 2022-PA-0019***	5/1/2025
MESNA 400 MG TABLET	Added to formulary as Tier 4 as Specialty; ***Policy Update 2022-PA-0019***	5/1/2025
METHOCARBAMOL 1,000 MG TABLET	Added to formulary as covered	5/1/2025
NADOLOL 20 MG TABLET NADOLOL 40 MG TABLET NADOLOL 80 MG TABLET	Moved to PDL Preferred	5/1/2025
NEFFY 1 MG/0.1 ML NASAL SPRAY	Added to formulary as PDL Non-Preferred with PA required and QL max 4 per day	5/1/2025
NORLIQVA 1 MG/ML SOLUTION	Moved to PDL Preferred with PA required and AL min. 6 years old	5/1/2025

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RESTASIS MULTIDOSE 0.05% EYE EMULSION	Moved to PDL Non-Preferred with PA required	5/1/2025
SAXENDA 18 MG/3 ML PEN	Added QL of 15 mLs per 30 days	5/1/2025
SIMLANDI(CF) AI 80 MG/0.8 ML	Added to formulary as PDL Non-Preferred with PA required, AL; Specialty	5/1/2025
TAZAROTENE 0.05% CREAM	Added to formulary as covered with PA required, AL and QL	5/1/2025
TICAGRELOR 90 MG TABLET	Added to formulary as PDL Non-Preferred with PA required and PDL Maintenance *Generic for Brilinta*	5/1/2025
TRADJENTA 5 MG TABLET	Added PA requirement	5/1/2025
TREMFYA 100 MG/ML PEN	Added to formulary as PDL Non-Preferred covered with PA required as a Specialty Drug	5/1/2025
WEGOVY 0.25 MG/0.5 ML PEN WEGOVY 0.5 MG/0.5 ML PEN WEGOVY 1 MG/0.5 ML PEN	Added QL of 2 mLs per 28 days	5/1/2025
WEGOVY 1.7 MG/0.75 ML PEN WEGOVY 2.4 MG/0.75 ML PEN	Added QL of 3 mLs per 28 days	5/1/2025
XENICAL 120 MG CAPSULE	Added QL of 90 capsules per 30 days	5/1/2025
ZEPBOUND 2.5 MG/0.5 ML PEN ZEPBOUND 5 MG/0.5 ML PEN ZEPBOUND 7.5 MG/0.5 ML PEN ZEPBOUND 10 MG/0.5 ML PEN ZEPBOUND 12.5 MG/0.5 ML PEN ZEPBOUND 15 MG/0.5 ML PEN	Added QL 2 mLs per 28 days	5/1/2025
ZEPBOUND 2.5 MG/0.5 ML VIAL ZEPBOUND 5 MG/0.5 ML VIAL ZEPBOUND 7.5 MG/0.5 ML VIAL ZEPBOUND 10 MG/0.5 ML VIAL	Added to formulary as PDL Preferred with PA required, AL min. 18 years old and QL of 2 mLs per 28 days	5/1/2025
CLOBETASOL 0.025% CREAM	Added to formulary as PDL Non-Preferred with PA required	4/1/2025

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GLUCAGON 1 MG EMERGENCY KIT *Amphastar Pharm*	Moved to PDL Non-Preferred with PA required	4/1/2025
METAXALONE 640 MG TABLET	Added to formulary as PDL Non-Preferred with PA required	4/1/2025
OMVOH 100 MG/ML SYRINGE OMVOH 300 MG DOSE – 2 PENS OMVOH 300 MG DOSE – 2 SYRINGES	Added to formulary as PDL Non-Preferred with PA required, AL min. 18 years old; Specialty	4/1/2025
RIVAROXABAN 2.5 MG TABLET	Added to formulary as PDL Non-Preferred with PA required, QL 2 tablets per day; PDL Maintenance **generic Xarelto*	4/1/2025
RYBELSUS 1.5 MG TABLET RYBELSUS 4 MG TABLET RYBELSYS 9 MG TABLET	Added to formulary as PDL Non-Preferred with PA required, QL 1 tablet per day, PDL Maintenance	4/1/2025
XARELTO 2.5 MG TABLET	Added brand preferred over generic	4/1/2025
ZEPBOUND 2.5 MG/0.5 ML VIAL ZEPBOUND 5 MG/0.5 ML VIAL ZEPBOUND 7.5 MG/0.5 ML VIAL ZEPBOUND 10 MG/0.5 ML VIAL	Added to formulary as PDL Preferred with PA required and AL min. 18 years old	4/1/2025
MERCAPTOPURINE 20 MG/ML SUSP	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	3/12/2025
ALOCRIL 2% EYE DROPS	Removed from formulary Non-rebatable	3/1/2025
CALCIUM GLUC 1,000 MG/10 ML VL	Added to formulary covered for CSHCS members only	3/1/2025
GOMEKLI 1 MG CAPSULE GOMEKLI 1 MG TABLET FOR SUSP	Added to formulary as carved out	3/1/2025
KOMBIGLYZE XR 2.5-1,000 MG TAB KOMBIGLYZE XR 5-500 MG TAB KOMBIGLYZE XR 5-1,000 MG TAB	Removed from formulary Non-rebatable	3/1/2025
MAGNESIUM OXIDE 440 MG TABLET	Added to formulary covered for CSHCS members only	3/1/2025
METFORMIN HCL 750 MG TABLET	Added to formulary as PDL Non-Preferred with PA required; PDL Maintenance	3/1/2025

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METRONIDAZOLE 125 MG TABLET	Added to formulary as PDL Non-Preferred with PA required	3/1/2025
ONGLYZA 2.5 MG TABLET ONGLYZA 5 MG TABLET	Removed from formulary Non-rebatable	3/1/2025
QC ENEMA READY TO USE QC ENEMA READY TO USE TWIN PAK	Added to formulary covered for CSHCS members only	3/1/2025
ROMVIMZA 14 MG CAPSULE ROMVIMZA 20 MG CAPSULE ROMVIMZA 30 MG CAPSULE	Added to formulary as carved out	3/1/2025
ROXYBOND 10 MG TABLET	Added to formulary as PDL Non-Preferred with PA required and QL of 90 per 30 days	3/1/2025
SIMLANDI (CF) 20 MG/0.2 ML SYRINGE SIMLANDI (CF) 40 MG/0.4 ML SYRINGE SIMLANDI (CF) 80 MG/0.8 ML SYRINGE	Added to formulary as PDL Non-Preferred with PA required, AL; Specialty	3/1/2025
STALEVO 50 MG TABLET STALEVO 75 MG TABLET STALEVO 100 MG TABLET STALEVO 125 MG TABLET STALEVO 200 MG TABLET	Removed from formulary Non-rebatable	3/1/2025
DUVYZAT 8.86 MG/ML ORAL SUSP	Added to formulary as carved out	2/1/2025
ENTRESTO 24 MG-26 MG TABLET ENTRESTO 49 MG-51 MG TABLET ENTRESTO 97 MG-103 MG TABLET	Added brand preferred over generic	2/1/2025
ESOMEPRAZOLE DR 2.5 MG PACKET ESOMEPRAZOLE DR 5 MG PACKET	Added to formulary as PDL Non-Preferred with PA required and QL of 2 packets per day **generic Nexium Packets*	2/1/2025
FLUOCINONIDE 0.05% CREAM FLUOCINONIDE 0.05% GEL FLUOCINONIDE 0.05% OINTMENT FLUOCINONIDE 0.05% SOLUTION FLUOCINONIDE 0.1% CREAM	Moved to PDL Preferred and removed PA requirement	2/1/2025
HYDROCORTISONE 2.5% SOLUTION	Added TO formulary as PDL Non-Preferred with PA required	2/1/2025
KESIMPTA 20 MG/0.4 ML PEN	Moved to PDL Preferred and removed PA requirement	2/1/2025

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LABETALOL HCL 400 MG TABLET	Added to formulary as PDL Preferred and PDL Maintenance	2/1/2025
MICONAZOLE-ZINC-PETRO 0.25-15%	Added AL max of 16 years old	2/1/2025
MORPHINE 10 MG/0.5 ML ORAL SYRINGE MORPHINE 20 MG/ML ORAL SYRINGE	Added QL of 120 mL per 30 days	2/1/2025
NEXIUM DR 2.5 MG PACKET NEXIUM DR 5 MG PACKET	Added brand preferred over generic	2/1/2025
OXYCONTIN ER 10 MG TABLET OXYCONTIN ER 15 MG TABLET OXYCONTIN ER 20 MG TABLET OXYCONTIN ER 30 MG TABLET OXYCONTIN ER 40 MG TABLET OXYCONTIN ER 60 MG TABLET OXYCONTIN ER 80 MG TABLET	Moved to PDL Preferred and removed PA requirement, individual QL remain	2/1/2025
PREDNISOLONE 15 MG/5 ML SOLN CUP	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	2/1/2025
PRUCALOPRIDE 1 MG TABLET PRUCALOPRIDE 2 MG TABLET	Added to formulary as PDL Non-Preferred with PA required **generic Motegrity*	2/1/2025
SACUBITRIL-VALSARTAN 24-26 MG TABLET SACUBITRIL-VALSARTAN 49-51 MG TABLET SACUBITRIL-VALSARTAN 97-103 MG TABLET	Added to formulary as PDL Non-Preferred with PA required, QL of 60 tablets per 30 days and PDL Maintenance **generic Entresto*	2/1/2025
SITAGLIPTIN-METFORMIN 50-500 SITAGLIPTIN-METFORMIN 50-1000	Added to formulary as PDL Non-Preferred with PA required	2/1/2025
VAFSEO 150 MG TABLET VAFSEO 300 MG TABLET	Added to formulary as PDL Non-Preferred with PA required and AL min. of 18 years old	2/1/2025
XOLREMDI 100 MG CAPSULE	Added to formulary as carved out	2/1/2025
ZEPOSIA 0.92 MG CAPSULES ZEPOSIA STARTER PACK (7-DAY) ZEPOSIA STARTER PACK (28-DAY)	Updated AL min. ≥ 18 years old	2/1/2025

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ZITUVIMET 50-500 MG TABLET ZITUVIMET 50-1000 MG TABLET ZITUVIMET XR 50-500 MG TABLET ZITUVIMET XR 50-1000 MG TBALET ZITUVIMET XR 100-1000 MG TABLET	Added to formulary as PDL Non-Preferred covered with PA	2/1/2025
CAPEX SHAMPOO	Added to formulary as PDL Non-Preferred with PA required	1/1/2025
BREO ELLIPTA 50-25 MCG INHALETR	Added AL max of 11 years old	1/1/2025
BUDESONIDE 0.25 MG/2 ML SUSP BUDESONIDE 0.5 MG/2 ML SUSP BUDESONIDE 1 MG/2 ML SUSP	Added AL max of 8 years old and QL of 2 respules per day	12/1/2024
PULMICORT 0.25 MG/2 ML RESPULES PULMICORT 0.5 MG/2 ML RESPULES PULMIOCRT 1 MG/2 ML RESPULES	Added AL max of 8 years old and QL of 2 respules per day	12/1/2024
ADALIMUMAB-RYVK(CF) AI 40 MG	Added to formulary as PDL Non-Preferred specialty with PA required	11/1/2024
AMCINONIDE 0.1% CREAM	Added to formulary as PDL Non-Preferred with PA required	11/1/2024
ARNUITY ELLIPTA 50 MCG INH	Moved to PDL Preferred with AL max 11 years old	11/1/2024
DULERA 50 MCG-5 MCG INHALER	Added AL max of 11 years old	11/1/2024
ENDARI 5 GRAM POWDER PACKET	Removed from formulary use generic L-Glutamine 5 gram Powder Packet	11/1/2024
EVEROLIMUS 2 MG TAB FOR SUSP EVEROLIMUS 3 MG TAB FOR SUSP EVEROLIMUS 5 MG TAB FOR SUSP	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	11/1/2024
GLUCAGON 1 MG EMERGENCY PEN	Moved to PDL Non-Preferred with PA required	11/1/2024
INVOKAMET 50-500 MG TABLET INVOKAMET 50-1,000 MG TABLET INVOKAMET 150-500 MG TABLET INVOKAMET 150-1,000 MG TABLET	Moved to PDL Non-Preferred with PA required. Grandfathering allowed for current utilizers through 2/28/2025	11/1/2024
INVOKANA 100 MG TABLET INVOKANA 300 MG TABLET	Moved to PDL Non-Preferred with PA required. Grandfathering allowed for	11/1/2024

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Medication Name	Preferred Drug List Update*	Effective Date
	current utilizers through 2/28/2025	
KIPROFEN 25 MG CAPSULE	Added to formulary as PDL Non-Preferred with PA required	11/1/2024
L-GLUTAMINE 5 GRAM POWDER PKT	Added to formulary as covered with PA required AL min. of 5 years old with QL 180packets per 30 days *Generic for Endari*	11/1/2024
LINZESS 72 MCG CAPSULE LINZESS 145 MCG CAPSULE LINZESS 290 MCG CAPSULE	Added AL min. of 6 years old and QL of 1 capsule per day	11/1/2024
LOFEXIDINE 0.18 MG TABLET	Added to formulary as Tier 4; ***Policy Update 2022-PA-0019***	11/1/2024
LOKELMA 5 GRAM POWDER PACKET LOKELMA 10 GRAM POWDER PACKET	Moved to PDL Preferred no PA required	11/1/2024
LOMAIRA 8 MG TABLET	Updated AL to 17 years old	11/1/2024
METFORMIN HCL 625 MG TABLET	Moved to PDL Non-Preferred with PA required	11/1/2024
NGENLA PEN 24 MG/1.2 ML NGENLA PEN 60 MG/1.2 ML	Added AL max of 16 years old	11/1/2024
NOXAFIL 300 MG POWDERMIX SUSP	Added AL max of 17 years old	11/1/2024
OPSYNVI 10-20 MG TABLET OPSYNVI 10-40 MG TABLET	Added to formulary as Non-Preferred with PA required, AL min. of 18 years old and QL of 1 tablet per day	11/1/2024
OTEZLA 10-20 MG STARTER 28 DAY OTEZLA 20 MG TABLET	Added to formulary as PDL Non-Preferred Specialty with PA required	11/1/2024
OZEMPIC 0.25-0.5 MG/DOSE PEN OZEMPIC 1 MG/DOSE PEN (4 MG/3 ML) OZEMPIC 2 MG/DOSE PEN (8 MG/3 ML)	Moved to PDL Preferred with PA required with QL of 3 per 28 days and PDL Maintenance	11/1/2024
PENTASA 250 MG CAPSULE PENTASA 500 MG CAPSULE	Moved to PDL Preferred and removed PA requirement	11/1/2024
PHOSLYRA 667 MG/5 ML SOLUTION	Added back to formulary as PDL non-Preferred with PA required	11/1/2024

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Medication Name	Preferred Drug List Update*	Effective Date
PRADAXA 110 CAPSULE	Added *Brand over Generic* logic	11/1/2024
PROLATE 5-300 MG TABLET PROLATE 7.5-300 MG TABLET PROLATE 10-300 MG TABLET	Moved to PDL Non-Preferred with PA required and QL	11/1/2024
PROLATE 10 MG-300 MG/5 ML SOLN	Moved to PDL Non-Preferred with PA required and QL	11/1/2024
PROTONIX DR 20 MG TABLET PROTONIX DR 40 MG TABLET	Moved to PDL Non-Preferred with PA required and QL of 2 tablets per day	11/1/2024
SIMLANDI(CF) AI 40 MG/0.4 ML	Added to formulary as PDL Non-Preferred as Specialty with PA required and QL	11/1/2024
SKYTROFA 3 MG CARTRIDGE SKYTROFA 3.6 MG CARTRIDGE SKYTROFA 4.3 MG CARTRIDGE SKYTROFA 5.2 MG CARTRIDGE SKYTROFA 6.3 MG CARTRIDGE SKYTROFA 7.6 MG CARTRIDGE SKYTROFA 9.1 MG CARTRIDGE SKYTROFA 11 MG CARTRIDGE SKYTROFA 13.3 MG CARTRIDGE	Added AL max 16 years old	11/1/2024
SODIUM PHOSPHATE 15 MMOL/5 ML SODIUM PHOSPHATE 45 MMOL/15 ML SODIUM PHOSPHATE 150 MMOL/50 ML	Added to formulary covered for CSHCS members only	11/1/2024
SUMATRIPTAN 5 MG NASAL SPRAY SUMATRIPTAN 20 MG NASAL SPRAY	Moved to PDL Preferred with QL of 6 per claim	11/1/2024
SYNJARDY XR 5-1,000 MG TABLET SYNJARDY XR 10-1,000 MG TABLET SYNJARDY XR 12.5-1,000 MG TABLET SYNJARDY XR 25-1,000 MG TABLET	Moved to PDL Preferred and removed PA requirement	11/1/2024
TACROLIMUS 0.1% OINTMENT	Moved to PDL Preferred with AL of 16 years old, QL of 30 grams per 30 days and removed PA requirement	11/1/2024
TACROLIMUS 0.03% OINTMENT	Moved to PDL Preferred with AL min of 2 years old, QL of 30 grams per 30 days and removed PA requirement	11/1/2024
TALTZ 20 MG/0.25 ML SYRINGE TALTZ 40 MG/0.5 ML SYRINGE	Added to formulary as Specialty PDL Non-Preferred with PA required	11/1/2024

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Medication Name	Preferred Drug List Update*	Effective Date
TAVABOROLE 5% TOPICAL SOLUTION	Added AL max of 6 years old	11/1/2024
TIMOPTIC 0.25% OCUDOSE DROP	Added to formulary as PDL Non-Preferred with PA required	11/1/2024
TYENNE 162 MG/0.9 ML AUTOINJECT TYENNE 162 MG/0.9 ML SYRINGE	Added to formulary as PDL Non-Preferred Specialty with PA required and AL	11/1/2024
VELTASSA 8.4 GM POWDER PACKET VELTASSA 16.8 GM POWDER PACKET VELTASSA 25.2 GM POWDER PACKET	Moved to PDL Non-Preferred with PA required	11/1/2024
VORANIGO 10 MG TABLET VORANIGO 40 MG TABLET	Added to formulary as Tier 4; Policy Update 2022-PA-0019	11/1/2024
WINREVAIR 45 MG ONE-VIAL KIT WINREVAIR 45 MG TWO-VIAL KIT WINREVAIR 60 MG ONE-VIAL KIT WINREVAIR 60 MG TWO-VIAL KIT	Added to formulary as PDL Non-Preferred Specialty with PA required and PDL Maintenance	11/1/2024
WIXELA 100-50 INHUB WIXELA 250-50 INHUB WIXELA 500-50 INHUB	Moved to PDL Non-Preferred with PA required and QL 180 per 90 days and PDL Maintenance	11/1/2024
ZYMFENTRA 120 MG/ML PEN KIT ZYMFENTRA 120 MG/ML SYRINGE KIT	Added to formulary as PDL Non-Preferred Specialty with PA required and AL min. 18 years old	11/1/2024
PALFORZIA INITIAL DOSE PACK PALFORZIA 3 MG (LEVEL 1) PALFORZIA 6 MG (LEVEL 2) PALFORZIA 12 MG (LEVEL 3) PALFORZIA 20 MG (LEVEL 4) PALFORZIA 40 MG (LEVEL 5) PALFORZIA 80 MG (LEVEL 6) PALFORZIA 120 MG (LEVEL 7) PALFORZIA 160 MG (LEVEL 8) PALFORZIA 200 MG (LEVEL 9) PALFORZIA 240 MG (LEVEL 10) PALFORZIA 300 MG (LEVEL 11) PALFORZIA 300 MG (MAINTENANCE)	Updated AL min. to 1 years old with AL max 17 years old	10/1/2024
ACYCLOVIR 5% CREAM	Moved to Tier 1 and PDL Maintenance Generic for Zovirax 5% Cream	8/1/2024

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Medication Name	Preferred Drug List Update*	Effective Date
ADIPEX-P 37.5 MG CAPSULE ADIPEX-P 37.5 MG TABLET	Updated AL min. to ≥ 17 years old	8/1/2024
ADVAIR 100-50 DISKUS ADVAIR 250-50 DISKUS ADVAIR 500-50 DISKUS	Added to formulary as Tier 1 with QL of 3 inhalers per 90 days and PDL Maintenance	8/1/2024
ADVAIR HFA 45-21 MCG INHALER ADVAIR HFA 115-21 MCG INHALER ADVAIR HFA 230-21 MCG INHALER	Added to formulary as Tier 1 with QL of 3 inhalers per 90 days and PDL Maintenance	8/1/2024
AMITIZA 8 MCG CAPSULE AMITIZA 24 MCG CAPSULES	Moved to PDL Non-Preferred with PA required, AL min. ≥ 18 years old and QL of 2 capsules per day ***Brand over generic no longer applies***	8/1/2024
APREPITANT 40 MG CAPSULE APREPITANT 80 MG CAPSULE APREPITANT 120 MG CAPSULE	Moved to PDL Preferred with AL min. ≥ 12 years old and QL max of 1 per claim	8/1/2024
ARNUITY ELLIPTA 100 MCG INH ARNUITY ELLIPTA 200 MCH INH	Moved to Tier 1 and removed from PDL Maintenance	8/1/2024
CABTREO 1.2%-0.15%-3.15% GEL	Added to formulary under Tier 3 with PA required	8/1/2024
EMEND 80 MG CAPSULE	Moved to PDL Non-Preferred ***Brand over generic no longer applies***	8/1/2024
FESOTERODINE ER 4 MG TABLET FESOTERODINE ER 8 MG TABLET	Moved to PDL Preferred and removed PA requirement **generic Toviaz ER*	8/1/2024
FIRVANQ 25 MG/ML SOLUTION FIRVANQ 50 MG/ML SOLUTION	Moved to Tier 3 with PA required ***Brand over generic no longer applies***	8/1/2024
FLUTICASONE-SALMETEROL 100-50 FLUTICASONE-SALMETEROL 250-50 FLUTICASONE-SALMETEROL 500-50	Moved to Tier 3 with PA required with QL of 180 per 90 days and PDL Maintenance	8/1/2024
FLUTICASONE-SALMETEROL 45-21 FLUTICASONE-SALMETEROL 115-21 FLUTICASONE-SALMETEROL 230-21	Moved to Tier 3 with PA required with QL of 3 inhalers per 90 days and PDL Maintenance	8/1/2024
LIALDA DR 1.2 GM TABLET	Moved to PDL Non-Preferred with PA required	8/1/2024

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	Brand over generic no longer applies	
LIRAGLUTIDE 2-PAK 18 MG/3 ML PEN	Added to formulary with PA required QL of 6 per 30 days and PDL Maintenance *Brand Victoza Preferred*	8/1/2024
LIRAGLUTIDE 3-PAK 18 MG/3 ML PEN	Added to formulary with PA required QL of 9 per 30 days and PDL Maintenance *Brand Victoza Preferred*	8/1/2024
LUBIPROSTONE 8 MCG CAPSULE LUBIPROSTONE 24 MCG CAPSULE	Added to formulary as PDL Preferred with AL min. ≥ 18 years old and QL of 2 capsules per day **generic Amitiza*	8/1/2024
MESALAMINE DR 1.2 GM TABLET	Moved to PDL Preferred	8/1/2024
NEOMYCIN-POLYMYXIN-HC EAR SUSP	Moved to Tier 1 and removed from PDL Maintenance	8/1/2024
OFLOXACIN 0.3% EAR DROPS	Moved to Tier 1 and removed from PDL Maintenance	8/1/2024
OMVOH 100 MG/ML PEN OMVOH 300 MG/15 ML VIAL	Added to formulary as Tier 3 with PA required and AL minimum of 18 years old	8/1/2024
PHENTERMINE 15 MG CAPSULE PHENTERMINE 30 MG CAPSULE PHENTERMINE 37.5 MG CAPSULE PHENTERMINE 37.5 MG TABLET	Updated AL min. to ≥ 17 years old	8/1/2024
PULMICORT 90 MCG FLEXHALER	Moved to Tier 1 with QL of 3 inhalers per 90 days and remove PA requirement and from PDL Maintenance	8/1/2024
PULMICORT 180 MCG FLEXHALER	Moved to Tier 1 with QL of 6 inhalers per 90 days and remove PA requirement and from PDL Maintenance	8/1/2024
QVAR REDIHALER 40 MCG QVAR REDIHALER 80 MCG	Moved to Tier 1 and removed from PDL Maintenance	8/1/2024
SITAGLIPTIN 25MG TABLET SITAGLIPTIN 50 MG TABLET SITAGLIPTIN 100 MG TABLET	Added to formulary as Tier 3 with PA required and PDL Maintenance	8/1/2024

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Medication Name	Preferred Drug List Update*	Effective Date
TOVIAZ ER 4 MG TABLET TOVIAZ ER 8 MG TABLET	Moved to PDL Non-Preferred with PA required ***Brand over generic no longer applies***	8/1/2024
VANCOMYCIN 25 MG/ML SOLUTION VANCOMYCIN 50 MG/M SOLUTION	Moved to Tier 1 and removed from PDL Maintenance *Generic Firvanq*	8/1/2024
VEVYE 0.1% EYE DROP	Added to formulary as Tier 3 with PA required, AL minimum of 18 years old and QL of 2 mLs per 30 days	8/1/2024
VICTOZA 2-PAK 18 MG/3 ML PEN VICOTZA 3-PAK 18 MG/3 ML PEN	Added brand preferred over generic	8/1/2024
VOQUEZNA DUAL PAK VOQUEZNA TRIPLE PAK	Added to formulary as Tier 3 with PA required	8/1/2024
XPHOZAH 20 MG TABLET XPHOZAH 30 MG TABET	Added to formulary as Tier 3 with PA required and PDL Maintenance	8/1/2024
XULANE 150-35 MCG/DAY PATCH	Removed QL	8/1/2024
ZAFEMY 150-35 MCG/DAY PATCH	Removed QL	8/1/2024
ZITUVIO 25 MG TABLET ZITUVIO 50 MG TABLET ZITUVIO 100 MG TABLET	Added to formulary as Tier 3 with PA required and PDL Maintenance	8/1/2024
ZOVIRAX 5% CREAM	Moved to Tier 3 with PA required ***Brand over generic no longer applies***	8/1/2024
ABRILADA(CF) 20 MG/0.4 ML SYRINGE ABRILADA(CF) 40 MG/0.8 ML PEN ABRILADA(CF) 40 MG/0.8 ML SYRINGE	Added to formulary as Tier 3 with PA required and AL in accordance with PA criteria	5/1/2024
AIRSUPRA 90-80 MCG INHALER	Added to formulary as Tier 3 with PA required, QL of 6 inhalers per 90 days and PDL Maintenance	5/1/2024
BIMZELX 160 MG/ML AUTOINJECTOR BIMZELX 160 MG/ML SYRINGE	Added to formulary as Tier 3 with AL ≥ 18 years old and PA required	5/1/2024

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BREYNA 80-4.5 MCG INHALER BREYNA 160-4.5 MCG INHALER	Added to formulary as Tier 3 with QL of 6 inhalers per 90 days and PA required	5/1/2024
BROMFENAC SOD 0.075% EYE DROP	Added to formulary as Tier 3 with PA required *equivalent to Bromsite Eye Drops*	5/1/2024
BYSTOLIC 2.5 MG TABLET BYSTOLIC 5 MG TABLET BYSTOLIC 10 MG TABLET BYSTOLIC 20 MG TABLET	Removed brand over generic logic	5/1/2024
CARVEDILOL ER 10 MG CAPSULE CARVEDILOL ER 20 MG CAPSULE CARVEDILOL ER 40 MG CAPSULE CARVEDILOL ER 80 MG CAPSULE	Moved to Tier 1 and PDL Maintenance	5/1/2024
COREG CR 10 MG CAPSULE COREG CR 20 MG CAPSULE COREG CR 40 MG CAPSULE COREG CR 80 MG CAPSULE	Moved to Tier 3 with PA required and PDL Maintenance	5/1/2024
DEFLAZACORT 6 MG TABLET DEFLAZACORT 18 MG TABLET DEFLAZACORT 30 MG TABLET DEFLAZACORT 36 MG TABLET	Added to formulary as Tier 4 Specialty Drug	5/1/2024
DOFETILIDE 125 MCG CAPSULE DOFETILIDE 250 MCG CAPSULE DOFETILIDE 500 MCG CAPSULE	Added to formulary as Tier 4 Specialty Drug	5/1/2024
ELIDEL 1% CREAM	Removed brand over generic logic, remains Tier 2 with AL ≥ 2 years old and QL 30 grams per 30 days	5/1/2024
IYUZEH 0.005% EYE DROP	Added to formulary as Tier 3 with PA required	5/1/2024
JESDUVROQ 1 MG TABLET JESDUVROQ 2 MG TABLET JESDUVROQ 4 MG TABLET JESDUVROQ 6 MG TABLET JESDUVROQ 8 MG TABLET	Added to formulary as Tier 3 with AL ≥ 18 years old and PA required	5/1/2024
JYNARQUE 15 MG TABLET JYNARQUE 15 MG-15 MG TABLET JYNARQUE 30 MG TABLET JYNARQUE 30 MG-15 MG TABLET JYNARQUE 45 MG-15 MG TABLET JYNARQUE 60 MG-30 MG TABLET JYNARQUE 90 MG-30 MG TABLET	Added to formulary as Tier 4 with AL ≥ 18 years old, QL 2 tablets per day and PA required	5/1/2024

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Medication Name	Preferred Drug List Update*	Effective Date
LIKMEZ 500 MG/5 ML SUSPENSION	Added to formulary as Tier 3 with QL 400 mLs per 10 days and PA required	5/1/2024
MOXIFLOXACIN 0.5% EYE DROPS	Moved to Tier 1 and removed PA requirement	5/1/2024
NEBIVOLOL 2.5MG TABLET NEBIVOLOL 5 MG TABLET NEBIVOLOL 10 MG TABLET NEBIVOLOL 20 MG TABLET	Moved to Tier 1 and removed PA requirement added PDL Maintenance	5/1/2024
NGENLA PEN 24 MG/1.2 ML NGENLA PEN 60 MG/1.2 ML	Added to formulary as Tier 3 Specialty Drug with PA required	5/1/2024
OLOPATADINE HCL 0.1% EYE DROPS	Rx version moved to Tier 3 with PA required. OTC generic remains Tier 1	5/1/2024
OLOPATADINE HCL 0.2% EYE DROP	Moved to Tier 3 with PA required	5/1/2024
VELSIPITY 2 MG TABLET	Added to formulary as Tier 3 Specialty Drug with AL ≥ 18 years old and PA required	5/1/2024
VIGAMOX 0.5% EYE DROPS	Moved to Tier 3 with PA required - Generic is preferred.	5/1/2024
YUFLYMA(CF) 20 MG/0.2 ML SYRINGE	Added to Tier 3 Specialty Drug with PA required and AL in accordance with PA criteria	5/1/2024
ZADITOR 0.025% (0.035%) DROPS	NDC 00065-4011-05 moved to Tier 3 with PA required for this brand, all other OTC NDCs remain Tier 1	5/1/2024
ZEPBOUND 2.5 MG/0.5 ML PEN ZEPBOUND 5 MG/0.5 ML PEN ZEPBOUND 7.5 MG/0.5 ML PEN ZEPBOUND 10 MG/0.5 ML PEN ZEPBOUND 12.5 MG/0.5 ML PEN ZEPBOUND 15 MG/0.5 ML PEN	Added to formulary as Tier 2 with PA required and AL ≥ 18 years old	5/1/2024
PIMECROLIMUS 1% CREAM	Moved to Tier 2 with PA required	4/1/2024
ADALIMUMAB-ADAZ(CF) 40 MG SYRG ADALIMUMAB-ADAZ(CF) PEN 40 MG ADALIMUMAB-FKJP(CF) 20 MG SYRG ADALIMUMAB-FKJP(CF) 40 MG SYRG	Add to formulary as Tier 3 with PA required	2/1/2024

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ADALIMUMAB-FKJP(CF) PEN 40 MG		
AJOVY 225 MG/1.5 ML AUTOINJECT AJOVY 225 MG/1.5 ML SYRINGE	Moved to Tier 2 with PA required, AL ≥ 18 years old and QL of 4.5 mL/90 days	2/1/2024
B-COMPLEX 100 INJECTION	Moved to Tier 4 coding by NDC 67457014630	2/1/2024
BEELITH TABLET	Moved to Tier 4 coding by NDC 00486113201	2/1/2024
BELBUCA 75 MCG FILM BELBUCA 150 MCG FILM BELBUCA 300 MCG FILM BELBUCA 450 MCG FILM BELBUCA 600 MCG FILM BELBUCA 750 MCG FILM BELBUCA 900 MCG FILM	MME limit no longer applies, PA required with QL of 60 per 30 days	2/1/2024
BETA-CAROTENE 7,500 MCG SFGL BETA-CAROTENE 25,00 UNIT SFGL	Moved to Tier 4 covered for CSHCS members only	2/1/2024
BUPRENORPHINE 5 MCG/HR PATCH BUPRENORPHINE 7.5 MCG/HR PATCH BUPRENORPHINE 10 MCG/HR PATCH BUPRENORPHINE 15 MCG/HR PATCH BUPRENORPHINE 20 MCG/HR PATCH	MME limit no longer applies, PA required with QL of 6 patches per 28 days	2/1/2024
BUTRANS 5 MCG/HR PATCH BUTRANS 7.5 MCG/HR PATCH BUTRANS 10 MCG/HR PATCH BUTRANS 15 MCG/HR PATCH BUTRANS 20 MCG/HR PATCH	MME limit no longer applies, PA required with QL of 6 patches per 28 days	2/1/2024
CALCIUM CITRATE 250 MG CAPLET CALCIUM CITRATE 250 MG TABLET	Moved to Tier4 covered for CSHCS members only	2/1/2024
CALCIUM GLUC 1,000 MG/10 ML VL	Covered for CSHCS only and removed NDC 00143918001 from formulary * Inner pack not on MPPL	2/1/2024
CALCIUM GLUC 5,000 MG/50 ML VL CALCIUM GLUC 10,000 MG/100 ML	Moved to Tier 4 covered for CSHCS members only	2/1/2024
CIPRODEX OTIC SUSPENSION	Removed brand over generic requirement	2/1/2024
CIPROFLOX-DEXAMETH OTIC SUSP	Moved to Tier 1	2/1/2024
CYLTEZO(CF) 10 MG/0.2 ML SYRING CYLTEZO(CF) 20 MG/0.4 ML SYRING	Added to formulary as Tier 3 with PA required	2/1/2024

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Medication Name	Preferred Drug List Update*	Effective Date
CYLTEZO(CF) 40 MG//0.8 ML SYRING CYLTEZO(CF) PEN 40 MG/0.8 ML CYLTEZO(CF) PEN CRH-UC-HS 40 MG CYLTEZO(CF) PEN PSORIASIS 40 MG		
ENTACAPONE 20 MG TABLET	Moved to Tier 1; removed PA requirement	2/1/2024
EPINEPHRINE 0.15 MG AUTO-INJECT EPINEPHRINE 0.3 MG AUTO-INJECT	Moved to Tier 1 with QL of 4 pens/claim	2/1/2024
ERGOCALCIFEROL 200 MCG/ML DROP ERGOCALCIFEROL 8,000 UNITS/ML	Covered for CSHCS members only	2/1/2024
FINGOLIMOD 0.5 MG CAPSULE	Moved to Tier 1; removed PA requirement	2/1/2024
FLUTICASONE PROP 50 MCG DISKUS FLUTICASONE PROP 100 MCG DISKUS FLUTICASONE PROP 250 MCG DISK	Added to formulary under Tier 3 with PA required	2/1/2024
GILENYA 0.25 MG CAPSULE	Moved to Tier 3 with PA required	2/1/2024
GILENYA 0.5 MG CAPSULE	Moved to Tier 3 with PA required and removed brand over generic requirement	2/1/2024
HADLIMA 40 MG/0.8 ML SYRINGE HADLIMA PUSHTOUCH 40 MG/0.8 ML HADLIMA(CF) 40 MG/0.8 ML SYRINGE HADLIMA(CF) PUSHTOUCH 40 MG/0.8 ML	Added to formulary as Tier 3 with PA required	2/1/2024
HULIO(CF) 20 MG/0.4 ML SYRINGE HULIO(CF) 40 MG/0.8 ML SYRINGE HULIO(CF) PEN 40 MG/0.8 ML SYRINE	Added to formulary as Tier 3 with PA required	2/1/2024
HYRIMOZ(CF) 10 MG/0.1 ML SYRING HYRIMOZ(CF) 20 MG/0.5 ML SYRING HYRIMOZ(CF) 40 MG/0.4 ML SYRING HYRIMOZ(CF) PEDI CROHN 80 MG HYRIMOZ(CF) PEDI CROHN 80-40 MG HYRIMOZ(CF) PEN 40 MG/0.4 ML HYRIMOZ(CF) PEN 80 MG/0.8 ML HYRIMOZ(CF) PEN CROHN-UC 80 MG HYRIMOZ(CF) PEN PSORIA 80-40 MG	Added to formulary as Tier 3 with PA required	2/1/2024
IDACIO(CF) 40 MG/0.8 ML SYRING IDACIO(CF) PEN 40 MG/0.8 ML IDACIO(CF) PEN CROHNS-UC 40 MG IDACIO(CF) PEN PSIRUASIS 40 MG	Added to formulary as Tier 3 with PA required	2/1/2024

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PDL Maintenance List = drugs included on this list are eligible for up to a 102-day supply.

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Medication Name	Preferred Drug List Update*	Effective Date
INPEFA 200 MG TABLET	Added to formulary as Tier 3 with PA required and PDL Maintenance	2/1/2024
LIQREV 10 MG/ML ORAL SUSP	Added to formulary as Tier 3 with PA required	2/1/2024
LITFULO 50 MG CAPSULE	Added to formulary as Tier 4 with AL ≥ 12 years old and QL of 1 capsule day with PA required	2/1/2024
L-METHYL-B6-B12 TABLET	Removed from formulary *covered for CSHCS only	2/1/2024
MIEBO 100% EYE DROP	Added to formulary as Tier 4 with PA required with PA required with AL ≥ 18 years old and QL of 3 mL/30 days	2/1/2024
MYFEMBREE 40 MG-1 MG-0.5 MG TB	Updated QL to 28 tablets/28 days	2/1/2024
ORIAHNN 300-1-0.5 MG/300 MG CAPS	Updated QL to 56 capsules/28 days	2/1/2024
ORILISSA 150 MG TABLET	Added QL of 28 tablets/28 days	2/1/2024
ORILISSA 200 MG TABLET	Added QL of 56 tablets/28 days	2/1/2024
PITAVASTATIN 1 MG TABLET PITVASATATIN 2 MG TABLET PITAVASTATIN 4 MG TABLET	Added to formulary as Tier 3 with PA required and QL of 1 tablet/day	2/1/2024
SOD SUL-POTSS SUL-MAG SUL SOL	Added to formulary as Tier 4 and QL of 1 bottle/30 days	2/1/2024
SOGROYA 5 MG/1.5 ML PEN SOGROYA 10 MG/1.5 ML PEN SOGROYA 15 MG/1.5 ML PEN	Added for formulary as Tier 3 with PA required and QL of 8 mg/week	2/1/2024
TERIFLUNOMIDE 7 MG TABLET TERIFLUNOMIDE 14 MG TABLET	Moved to Tier 1 and removed PA requirement	2/1/2024
TRULICITY 0.75 MG/0.5 ML PEN TRULICITY 1.5 MG/0.5 ML PEN TRULICITY 3 MG/0.5 ML PEN TRULICITY 4.5 MG/0.5 ML PEN	Moved to Tier 2 with PA required and QL of 2 mL/28 days	2/1/2024
VICTOZA 2-PAK 18 MG/3 ML PEN	Moved To Tier 2 with PA required and QL of 6 mL/30 days	2/1/2024

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Medication Name	Preferred Drug List Update*	Effective Date
VICTOZA 3-PAK 18 MG/3 ML PEN	Moved to Tier 2 with PA required and QL of 9 mL/30 days	2/1/2024
YUFLYMA (CF) 40 MG/0.4 ML AUTOINJ YUFLYMA (CF) 40 MG/0.4 ML SYRNG	Added to formulary as Tier 3 with PA required	2/1/2024
YUSMIRY(CF) 40 MG/0.8 ML PEN	Added to formulary as Tier 3 with PA required, AL and QL according to PA criteria	2/1/2024
ZAVZPRET 10 MG NASAL SPRAY	Added to formulary as Tier 3 with AL ≥ 18 years old, PA required and QL of 8 units per 30 days	2/1/2024
ZINC-220 CAPSULE ZINC 50 MG TABLET ZINC GLUCONATE 100 MG TABLET ZINC SULFATE 220 MG CAPSULE	Covered For CSHCS members only	2/1/2024
ZORYVE 0.3% CREAM	Update AL ≥ 6 years old	2/1/2024

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