

History of Formulary Changes Post-Single PDL Changes (after October 1, 2020)

Revised for 4/24/2026

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Medicaid Health Plan Common Formulary Changes Effective February 1, 2026

Drug Class	Drug Name	New Status
Analgesic, Anti-inflammatory or Antipyretic	HUMIRA PEN CROHN-UC-HS 40 MG HUMIRA PEN PS-UV-ADOL HS 40 MG	Not Covered on Formulary
Analgesic, Anti-inflammatory or Antipyretic	HUMIRA(CF) PEDI CROHN 80-40 MG HUMIRA(CF) PEDI CROHN 80MG/0.8	Not Covered on Formulary
Analgesic, Anti-inflammatory or Antipyretic	IBUPROFEN 300 MG TABLET	Covered on formulary with Prior Authorization – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic	IDACIO(CF) 40 MG/0.8 ML SYRINGE IDACIO(CF) PEN 40 MG/0.8 ML	Not Covered on Formulary
Cardiovascular Therapy Agents	EKTERLY 300 MG TABLET #	Not Covered on formulary; Carved Out
Cardiovascular Therapy Agents	YUTREPIA 26.5 MCG INHAL CAP YUTREPIA 53 MCG INHAL CAP YUTREPIA 79.5 MCG INHAL CAP YUTREPIA 106 MCG INHAL CAP	Covered on formulary with Prior Authorization – Non-Preferred
Central Nervous System Agents	QULIPTA 10 MG TABLET QULIPTA 30 MG TABLET QULIPTA 60 MG TABLET	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Central Nervous System Agents	UBRELVY 50 MG TABLET UBRELVY 100 MG TABLET	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Dermatological	FLUOCINOLONE 0.01% SOLUTION	Covered on formulary with Prior Authorization - Preferred
Dermatological	IMULDOSA 45 MG/0.5 ML SYRINGE IMULDOSA 90 MG/ML SYRINGE IMULDOSA 130 MG/26 ML VIAL	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological	SILIQ 210 MG/1.5 ML SYRINGE	Not Covered on Formulary
Electrolyte Balance-Nutritional Products	NU-MAG 71.5 MG TABLET *	Not Covered on Formulary
Endocrine	BONSITY 560 MCG/2.24 ML PEN	Covered on formulary with Prior Authorization – Non-Preferred
Endocrine	BRYNOVIN 25 MG/ML SOLUTION	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Endocrine	MERILOG 100 UNIT/ML VIAL	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Endocrine	MERILOG SOLOSTAR 100 UNIT/ML	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Hematological Agents	ANDEMBRY 200 MG/1.2 ML AUTOIN #	Not Covered on formulary; Carved Out
Locomotor System	METHOCARBAMOL 1,000 MG TABLET	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Ophthalmic Agents	TRYPTYR 0.003% EYE DROP	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic	HUMIRA PEN CROHN-UC-HS 40 MG HUMIRA PEN PS-UV-ADOL HS 40 MG	Not Covered on Formulary
Analgesic, Anti-inflammatory or Antipyretic	HUMIRA(CF) PEDI CROHN 80-40 MG HUMIRA(CF) PEDI CROHN 80MG/0.8	Not Covered on Formulary

Medicaid Health Plan Common Formulary Changes Effective January 1, 2026

Drug Class	Drug Name	New Status
Dermatological	USTEKINUMAB-AAUZ 45 MG SYRINGE USTEKINUMAB-AAUZ 90 MG/ML SYR	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Eating Disorder Therapy	ADIPEX-P 37.5 MG CAPSULE ADIPEX-P 37.5 MG TABLET	Covered on formulary with Prior Authorization, and Age Edit – Preferred
Eating Disorder Therapy	BENZPHETAMINE HCL 50 MG TABLET	Covered on formulary with Prior Authorization, and Age Edit – Preferred
Eating Disorder Therapy	DIETHYLPROPION 25 MG TABLET	Covered on formulary with Prior Authorization, and Age Edit – Preferred
Eating Disorder Therapy	DIETHYLPROPION ER 75 MG TABLET	Covered on formulary with Prior Authorization, and Age Edit – Preferred

Drug Class	Drug Name	New Status
Eating Disorder Therapy	Liraglutide 18 mg/3 ml pen (inner pack) Liraglutide 5-PAK 18 mg/ 3ml	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Preferred
Eating Disorder Therapy	LOMAIRA 8 MG TABLET	Covered on formulary with Prior Authorization, and Age Edit – Preferred
Eating Disorder Therapy	ORLISTAT 120 MG CAPSULE	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Preferred
Eating Disorder Therapy	PHENDIMETRAZINE 35 MG TABLET	Covered on formulary with Prior Authorization, and Age Edit – Preferred
Eating Disorder Therapy	PHENDIMETRAZINE ER 105 MG CAP	Covered on formulary with Prior Authorization, and Age Edit – Preferred
Eating Disorder Therapy	PHENTERMINE 15 MG CAPSULE PHENTERMINE 30 MG CAPSULE PHENTERMINE 37.5 MG CAPSULE PHENTERMINE 37.5 MG TABLET	Covered on formulary with Prior Authorization, and Age Edit – Preferred
Eating Disorder Therapy	PHENTERMINE-TOPIR ER 3.75-23MG PHENTERMINE-TOPIR ER 7.5-46 MG PHENTERMINE-TOPIR ER 11.25-69 PHENTERMINE-TOPIR ER 15-92 MG	Covered on formulary with Prior Authorization, and Age Edit – Preferred
Eating Disorder Therapy	SAXENDA 18 MG/3 ML PEN	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Preferred
Eating Disorder Therapy	WEGOVY 0.25 MG/0.5 ML PEN WEGOVY 0.5 MG/0.5 ML PEN WEGOVY 1 MG/0.5 ML PEN WEGOVY 1.7 MG/0.75 ML PEN WEGOVY 2.4 MG/0.75 ML PEN	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Preferred
Eating Disorder Therapy	XENICAL 120 MG CAPSULE	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Preferred
Eating Disorder Therapy	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	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Preferred

Drug Class	Drug Name	New Status
	ZEPBOUND 12.5 MG/0.5 ML PEN ZEPBOUND 15 MG/0.5 ML PEN	
Eating Disorder Therapy	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	Not Covered on Formulary
Electrolyte Balance-Nutritional Products	POKONZA 15 MEQ PACKET	Not Covered on Formulary
Endocrine	LINAGLIPTIN-METFOR 2.5-500 MG LINAGLIPTIN-METFOR 2.5-850 MG LINAGLIPTIN-METFOR 2.5-1,000MG	Covered on formulary with Prior Authorization – Non-Preferred
Multiple Sclerosis Agents	CLADRIBINE 10 MG X 4 TABLET PK CLADRIBINE 10 MG X 5 TABLET PK CLADRIBINE 10 MG X 6 TABLET PK CLADRIBINE 10 MG X 7 TABLET PK CLADRIBINE 10 MG X 8 TABLET PK CLADRIBINE 10 MG X 9 TABLET PK CLADRIBINE 10 MG X 10 TAB PK	Covered on formulary with Prior Authorization – Non-Preferred
Otic	CIPROFLOXACIN-HYDROCORT 0.2-1%	Covered on formulary with Prior Authorization – Non-Preferred

Medicaid Health Plan Common Formulary Changes Effective December 1, 2025

Drug Class	Drug Name	New Status
Analgesic, Anti-inflammatory or Antipyretic	FENTORA 100 MCG BUCCAL TABLET FENTORA 200 MCG BUCCAL TABLET FENTORA 400 MCG BUCCAL TABLET FENTORA 600 MCG BUCCAL TABLET FENTORA 800 MCG BUCCAL TABLET	Not Covered on Formulary

Drug Class	Drug Name	New Status
Cardiovascular Therapy Agents	ENTRESTO 24 MG-26 MG TABLET ENTRESTO 49 MG-51 MG TABLET ENTRESTO 97 MG-103 MG TABLET	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Cardiovascular Therapy Agents	SACUBITRIL-VALSARTAN 24-26 MG SACUBITRIL-VALSARTAN 49-51 MG SACUBITRIL-VALSARTAN 97-103 MG	Covered on formulary with Quantity Limit – Preferred
Central Nervous System Agents	Carbidopa-Levo ER 23.75-95 Cap Carbidopa-Levo ER 36.25-145 Cap Carbidopa-Levo ER 48.75-195 Cap Carbidopa-Levo ER 61.25-245 Cap	Covered on formulary with Prior Authorization – Non-Preferred
Dermatological	Selarsdi 45mg/0.5ml Vial	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological	TALTZ 20 MG/0.25 ML SYRINGE TALTZ 40 MG/0.5 ML SYRINGE TALTZ 80 MG/ML AUTOINJECTOR	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological	TREMFYA 100 MG/ML INJECTOR TREMFYA 100 MG/ML PEN TREMFYA 100 MG/ML SYRINGE TREMFYA 200 MG/2 ML PEN TREMFYA 200 MG/2 ML SYRINGE	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Hematological Agents	Empaveli 1,080 MG/20 VIAL #	Not Covered on formulary; Carved Out
Metabolic Modifiers	GLYCEROL PHENYLBUT 1.1 GRAM/ML #	Not Covered on formulary; Carved Out

Medicaid Health Plan Common Formulary Changes Effective November 1, 2025

Drug Class	Drug Name	New Status
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-ADBM(CF) 10 MG SYRG ADALIMUMAB-ADBM(CF) 20 MG SYRG	Covered on formulary - Preferred, Age Edit and Quantity Limit

Drug Class	Drug Name	New Status
	ADALIMUMAB-ADB(M) 40 MG SYRG	
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-ADB(M) CRHN 40MG	Covered on formulary - Preferred, Age Edit and Quantity Limit
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-ADB(M) PEN 40 MG	Covered on formulary - Preferred, Age Edit and Quantity Limit
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-ADB(M) PS-UV 40MG	Covered on formulary - Preferred, Age Edit and Quantity Limit
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	OTEZLA XR INITIATION PK 28 DAY OTEZLA XR 75 MG TABLET	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesics - NonNarcotic	Journavx 50 mg tablet	Covered, Age Edit and Quantity Limit
Anterior Pituitary Hormones and Hormone Antagonists	SKYTROFA 3 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	Covered on formulary with Prior Authorization – Non-Preferred
Antibacterial Agents	XIFAXAN 200 MG TABLET XIFAXAN 550 MG TABLET	Not Covered on formulary
Antihypertensive Therapy Agents	BOSENTAN 32 MG TABLET FOR SUSP	Covered on formulary with Prior Authorization – Non-Preferred
Antihypertensive Therapy Agents	TEZRULY 1 MG/ML SOLUTION	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Anti-Obesity Agents	Liraglutide 18 mg/3 ml pen (inner pack) Liraglutide 5-PAK 18 mg/ 3ml	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Antiparkinson Therapy	Onapgo 98 mg/20ml cartridge	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Asthma/COPD Therapy Agents	FLUTICASONE ELLIPTA 100MCG INH FLUTICASONE ELLIPTA 200MCG INH	Covered on formulary with Prior Authorization – Non-Preferred

Drug Class	Drug Name	New Status
Asthma/COPD Therapy Agents	FLUTICASONE ELLIPTA 50 MCG INH	Covered on formulary with Prior Authorization and Age Edit –Non-Preferred
Calcium & Bone Metabolism Regulators	FORTEO 600 MCG/2.4 ML PEN INJ	Covered on formulary - Preferred with Prior Authorization and Quantity Limit
Cognitive Disorder Therapy - Antidementia	Zunveyl 5 mg Tablet Dr Zunveyl 10 mg Tablet Dr Zunveyl 15 mg Tablet Dr	Covered on formulary with Prior Authorization – Non-Preferred
Dermatological - Antipsoriatics	BIMZELX 320 MG/2 ML AUTOINJECT BIMZELX 320 MG/2 ML SYRINGE	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Dermatological - Antipsoriatics	Otufi 45mg/0.5ml Vial Otufi 130mg/26ml vial	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	Otufi 45mg/0.5ml Syringe Otufi 90 mg/ml Syringe	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	Pyzchiva 45mg/0.5ml Vial Pyzchiva 130mg/26ml Vial	Covered on formulary - Preferred with Prior Authorization and Quantity Limit
Dermatological - Antipsoriatics	Pyzchiva 45mg/0.5ml Syringe Pyzchiva 90mg/ml Syringe	Covered on formulary - Preferred with Prior Authorization and Quantity Limit
Dermatological - Antipsoriatics	Selarsdi 130mg/26ml Vial	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	Selarsdi 45mg/0.5ml Syringe Selarsdi 90mg/ml Syringe	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	STEQEYMA 130 MG/26 ML VIAL	Covered on formulary - Preferred with Prior Authorization and Quantity Limit
Dermatological - Antipsoriatics	STEQEYMA 45 MG/0.5 ML SYRINGE STEQEYMA 90 MG/ML SYRINGE	Covered on formulary - Preferred with Prior Authorization and Quantity Limit
Dermatological - Antipsoriatics	TALTZ 80 MG/ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	USTEKINUMAB 45 MG/0.5 ML VIAL USTEKINUMAB 130 MG/26 ML VIAL	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Dermatological - Antipsoriatics	USTEKINUMAB 45MG/0.5ML SYRINGE USTEKINUMAB 90 MG/ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	USTEKINUMAB-AEKN 45mg/0.5ml Syringe USTEKINUMAB-AEKN 90mg/ml Syringe	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	USTEKINUMAB-TTWE 130MG/26ML VL	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	USTEKINUMAB-TTWE 45MG/0.5ML SY USTEKINUMAB-TTWE 90 MG/ML SYR	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Diabetic Therapy	APIDRA 100 UNIT/ML VIAL	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Diabetic Therapy	APIDRA SOLOSTAR 100 UNIT/ML	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Diabetic Therapy	GVOKE HYPOPEN 1PK 0.5MG/0.1 ML GVOKE HYPOPEN 1-PK 1 MG/0.2 ML	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Diabetic Therapy	GVOKE HYPOPEN 2PK 0.5MG/0.1 ML GVOKE HYPOPEN 2-PK 1 MG/0.2 ML	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Diabetic Therapy	HUMULIN N 100 UNIT/ML KWIKPEN	Covered on formulary with Quantity Limit – Preferred
Diabetic Therapy	JANUMET 50-500 MG TABLET JANUMET 50-1,000 MG TABLET	Covered on formulary - Preferred with Prior Authorization and Quantity Limit
Diabetic Therapy	JANUMET XR 50-500 MG TABLET JANUMET XR 50-1,000 MG TABLET JANUMET XR 100-1,000 MG TABLET	Covered on formulary - Preferred with Prior Authorization
Diabetic Therapy	JANUVIA 25 MG TABLET JANUVIA 50 MG TABLET JANUVIA 100 MG TABLET	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Diabetic Therapy	JENTADUETO 2.5 MG-500 MG TAB JENTADUETO 2.5 MG-850 MG TAB JENTADUETO 2.5 MG-1000 MG TAB	Covered on formulary - Preferred with Prior Authorization
Diabetic Therapy	JENTADUETO XR 2.5 MG-1,000 MG JENTADUETO XR 5 MG-1,000 MG TB	Covered on formulary - Preferred with Prior Authorization
Diabetic Therapy	NOVOLIN N 100 UNIT/ML FLEXPEN	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Diabetic Therapy	NOVOLIN N 100 UNIT/ML VIAL	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Diabetic Therapy	NOVOLIN R 100 UNIT/ML FLEXPEN	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Diabetic Therapy	NOVOLIN R 100 UNIT/ML VIAL	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Diabetic Therapy	RELION NOVOLIN N 100 UNIT/ML	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Diabetic Therapy	RELION NOVOLIN N U-100 FLEXPEN	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Diabetic Therapy	RELION NOVOLIN R 100 UNIT/ML	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Diabetic Therapy	RELION NOVOLIN R U-100 FLEXPEN	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Diabetic Therapy	TRADJENTA 5 MG TABLET	Covered on formulary - Preferred with Prior Authorization and Quantity Limit
Hematopoietic Agents	FULPHILA 6 MG/0.6 ML SYRINGE	Covered on formulary with Quantity Limit – Preferred
Hematopoietic Agents	FYLNETRA 6 MG/0.6 ML SYRINGE	Covered on formulary with Quantity Limit – Preferred

Drug Class	Drug Name	New Status
Hematopoietic Agents	NYVEPRIA 6 MG/0.6 ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Hyperuricemia Therapy	FEBUXOSTAT 40 MG TABLET FEBUXOSTAT 80 MG TABLET	Covered on formulary - Preferred
Migraine Therapy	Symbravo 10 mg-20mg Tablet	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Overactive Bladder Agents	MYRBETRIQ ER 25 MG TABLET MYRBETRIQ ER 50 MG TABLET	Covered on formulary - Preferred
Overactive Bladder Agents	MYRBETRIQ ER 8 MG/ML SUSP	Covered on formulary - Preferred
Urinary Antispasmodics	TOLTERODINE TART ER 2 MG CAP TOLTERODINE TART ER 4 MG CAP	Covered on formulary - Preferred
Urinary Antispasmodics	TOLTERODINE TARTRATE 1 MG TAB TOLTERODINE TARTRATE 2 MG TAB	Covered on formulary - Preferred
Urinary Antispasmodics	TROSPIUM CHLORIDE 20 MG TABLET	Covered on formulary - Preferred
Urinary Antispasmodics	TROSPIUM CHLORIDE ER 60 MG CAP	Covered on formulary - Preferred

Medicaid Health Plan Common Formulary Changes Effective August 1, 2025

Drug Class	Drug Name	New Status
Amyloidosis Agents - Transthyretin (TTR) Stabilizer	Attruby 356mg Tablet	Not Covered on formulary
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ABRILADA(CF) 20 MG/0.4 ML SYRN	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ABRILADA(CF) 40 MG/0.8 ML SYRN	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred

Drug Class	Drug Name	New Status
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ABRILADA(CF) PEN 40 MG/0.8 ML	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ACTEMRA 162 MG/0.9 ML SYRINGE	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ACTEMRA ACTPEN 162 MG/0.9 ML	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-AACF(CF) CROHN 40MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-AACF(CF) PEN 40 MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-AACF(CF) PS-UV 40MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-AACF(CF) SYR 40 MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-AATY(CF) 20MG/0.2ML	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-AATY(CF) 40MG/0.4ML	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-AATY(CF) 80MG/0.8ML	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-ADAZ(CF) 10MG/0.1ML	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-ADAZ(CF) 40 MG SYRG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred

Drug Class	Drug Name	New Status
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-ADAZ(CF) PEN 40 MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-ADAZ(CF) PEN 80 MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-ADB(M)(CF) 10 MG SYRG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-ADB(M)(CF) 20 MG SYRG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-ADB(M)(CF) 40 MG SYRG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-ADB(M)(CF) CRHN 40MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-ADB(M)(CF) PEN 40 MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-ADB(M)(CF) PS-UV 40MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-FKJP(CF) 20 MG SYRG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-FKJP(CF) 40 MG SYRG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-FKJP(CF) PEN 40 MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-RYVK(CF) 40 MG SYRG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred

Drug Class	Drug Name	New Status
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ADALIMUMAB-RYVK(CF) AI 40 MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	AMJEVITA(CF) 10MG/0.2ML SYRING	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	AMJEVITA(CF) 20MG/0.4ML SYRING	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	AMJEVITA(CF) 40MG/0.8ML AUTOIN	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	AMJEVITA(CF) 40MG/0.8ML SYRING	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	CYLTEZO(CF) 10 MG/0.2 ML SYRNG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	CYLTEZO(CF) 20 MG/0.4 ML SYRNG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	CYLTEZO(CF) 40 MG/0.4 ML SYRNG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	CYLTEZO(CF) 40 MG/0.8 ML SYRNG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	CYLTEZO(CF) PEN 40 MG/0.4 ML	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	CYLTEZO(CF) PEN 40 MG/0.8 ML	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	CYLTEZO(CF) PEN CRH-UC-HS 40MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred

Drug Class	Drug Name	New Status
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	CYLTEZO(CF) PEN PSORIASIS 40MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	CYLTEZO(CF) PEN PSORIA-UV 40MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ENBREL 25 MG/0.5 ML SYRINGE	Covered on formulary with Quantity Limit – Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ENBREL 50 MG/ML MINI CARTRIDGE	Covered on formulary with Quantity Limit – Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ENBREL 50 MG/ML SURECLICK	Covered on formulary with Quantity Limit – Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ENBREL 50 MG/ML SYRINGE	Covered on formulary with Quantity Limit – Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HADLIMA 40 MG/0.8 ML SYRINGE	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HADLIMA PUSH TOUCH 40 MG/0.8 ML	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HADLIMA(CF) 40 MG/0.4 ML SYRNG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HADLIMA(CF) PUSH TOUCH 40MG/0.4	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HULIO(CF) 20 MG/0.4 ML SYRINGE	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HULIO(CF) 40 MG/0.8 ML SYRINGE	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HULIO(CF) PEN 40 MG/0.8 ML	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HUMIRA 40 MG/0.8 ML SYRINGE	Covered on formulary with Quantity Limit – Preferred

Drug Class	Drug Name	New Status
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HUMIRA PEN 40 MG/0.8 ML	Covered on formulary with Quantity Limit – Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HUMIRA PEN CROHN-UC-HS 40 MG	Covered on formulary with Quantity Limit – Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HUMIRA PEN PS-UV-ADOL HS 40 MG	Covered on formulary with Quantity Limit – Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HUMIRA(CF) 10 MG/0.1 ML SYRING	Covered on formulary with Quantity Limit – Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HUMIRA(CF) 20 MG/0.2 ML SYRING	Covered on formulary with Quantity Limit – Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HUMIRA(CF) 40 MG/0.4 ML SYRING	Covered on formulary with Quantity Limit – Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HUMIRA(CF) PEN 40 MG/0.4 ML	Covered on formulary with Quantity Limit – Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HUMIRA(CF) PEN 80 MG/0.8 ML	Covered on formulary with Quantity Limit – Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HUMIRA(CF) PEN CRHN-UC-HS 80MG	Covered on formulary with Quantity Limit – Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HUMIRA(CF) PEN PS-UV-AHS 80-40	Covered on formulary with Quantity Limit – Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HYRIMOZ(CF) 10 MG/0.1 ML SYRNG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HYRIMOZ(CF) 20 MG/0.2 ML SYRNG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HYRIMOZ(CF) 40 MG/0.4 ML SYRNG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HYRIMOZ(CF) PEDI CROHN 80 MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HYRIMOZ(CF) PEDI CROHN 80-40MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred

Drug Class	Drug Name	New Status
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HYRIMOZ(CF) PEN 40 MG/0.4 ML	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HYRIMOZ(CF) PEN 80 MG/0.8 ML	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HYRIMOZ(CF) PEN CROHN-UC 80 MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	HYRIMOZ(CF) PEN PSORIA 80-40MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	IDACIO(CF) 40 MG/0.8 ML SYRING	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	IDACIO(CF) PEN 40 MG/0.8 ML	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	IDACIO(CF) PEN CROHNS-UC 40 MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	IDACIO(CF) PEN PSORIASIS 40 MG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	KEVZARA 150 MG/1.14 ML PEN INJ	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	KEVZARA 150 MG/1.14 ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	KEVZARA 200 MG/1.14 ML PEN INJ	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	KEVZARA 200 MG/1.14 ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	OLUMIANT 1 MG TABLET	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	OLUMIANT 2 MG TABLET	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	OLUMIANT 4 MG TABLET	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ORENCIA 125 MG/ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ORENCIA 50 MG/0.4 ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ORENCIA 87.5 MG/0.7 ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	ORENCIA CLICKJECT 125 MG/ML	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	OTEZLA 10-20 MG STARTER 28 DAY	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	OTEZLA 10-20-30MG START 28 DAY	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	OTEZLA 20 MG TABLET	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	OTEZLA 30 MG TABLET	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	RINVOQ ER 15 MG TABLET	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	RINVOQ ER 30 MG TABLET	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	RINVOQ ER 45 MG TABLET	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	RINVOQ LQ 1 MG/ML SOLUTION	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	SIMLANDI(CF) 20 MG/0.2 ML SYRG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	SIMLANDI(CF) 40 MG/0.4 ML SYRG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	SIMLANDI(CF) 80 MG/0.8 ML SYRG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	SIMLANDI(CF) AI 40 MG/0.4 ML	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	SIMLANDI(CF) AI 80 MG/0.8 ML	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	SIMPONI 100 MG/ML PEN INJECTOR	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	SIMPONI 100 MG/ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	SIMPONI 50 MG/0.5 ML PEN INJEC	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	SIMPONI 50 MG/0.5 ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	TYENNE 162 MG/0.9 ML AUTOINJCT	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	TYENNE 162 MG/0.9 ML SYRINGE	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	XELJANZ 1 MG/ML SOLUTION	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	XELJANZ 10 MG TABLET	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	XELJANZ 5 MG TABLET	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	XELJANZ XR 11 MG TABLET	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	XELJANZ XR 22 MG TABLET	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	YUFLYMA(CF) 20 MG/0.2 ML SYRNG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	YUFLYMA(CF) 40 MG/0.4 ML SYRNG	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	YUFLYMA(CF) 40MG/0.4ML AUTOINJ	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	YUFLYMA(CF) 80MG/0.8ML AUTOINJ	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	YUFLYMA(CF) AI CROHNS-UC-HS 80	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred

Drug Class	Drug Name	New Status
Analgesic, Anti-inflammatory or Antipyretic - Non-Narcotic	YUSIMRY(CF) 40 MG/0.8 ML PEN	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Androgen - Single Agents	Azmiro 200mg/ml Syringe	Not Covered on formulary
Anorexic Agents	PHENTERMINE-TOPIR ER 11.25-69	Covered on formulary with Prior Authorization and Age Edit - Preferred
Anorexic Agents	PHENTERMINE-TOPIR ER 15-92 MG	Covered on formulary with Prior Authorization and Age Edit - Preferred
Anorexic Agents	PHENTERMINE-TOPIR ER 3.75-23MG	Covered on formulary with Prior Authorization and Age Edit - Preferred
Anorexic Agents	PHENTERMINE-TOPIR ER 7.5-46 MG	Covered on formulary with Prior Authorization and Age Edit - Preferred
Antibacterial Agents	DIFICID 40 MG/ML SUSPENSION	Covered on formulary with Prior Authorization and Age Edit –Non-Preferred
Antibacterial Agents	FIDAXOMICIN 200 MG TABLET	Covered on formulary with Prior Authorization – Non-Preferred
Antibacterial Agents	LEVOFLOXACIN 250 MG TABLET	Covered on formulary with Quantity Limit - Preferred
Antibacterial Agents	LEVOFLOXACIN 500 MG TABLET	Covered on formulary with Quantity Limit - Preferred
Antibacterial Agents	LEVOFLOXACIN 750 MG TABLET	Covered on formulary with Quantity Limit - Preferred
Antibacterial Agents	XIFAXAN 550 MG TABLET	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Anticoagulants	DABIGATRAN ETEXILATE 110 MG CP	Covered on formulary with Quantity Limit – Preferred
Anticoagulants	DABIGATRAN ETEXILATE 150 MG	Covered on formulary with Quantity Limit – Preferred
Anticoagulants	DABIGATRAN ETEXILATE 75 CAP	Covered on formulary with Quantity Limit – Preferred
Anticoagulants	PRADAXA 110 MG CAPSULE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Anticoagulants	PRADAXA 150 MG CAPSULE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Anticoagulants	PRADAXA 75 MG CAPSULE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Anticoagulants	Rivaroxaban 1 MG/ML oral suspension	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Antihyperlipidemic - apolipoprotein B-100 Synthesis Inhibitor	Tryngolza 80mg/0.8ml Autoinjector	Not Covered on formulary
Antivirals	PAXLOVID 150-100 MG DOSE PACK	Covered on formulary - Preferred
Antivirals	PAXLOVID 300/150-100MG(SEVERE)	Covered on formulary - Preferred
Antivirals	PAXLOVID 300-100 MG DOSE PACK	Covered on formulary - Preferred
Antivirals	XOFLUZA 40 MG TABLET	Covered on formulary with Prior Authorization – Non-Preferred
Antivirals	XOFLUZA 80 MG TABLET	Covered on formulary with Prior Authorization – Non-Preferred
Antivirals	YEZTUGO 300 MG tablet #	Not Covered on formulary
Antivirals	YEZTUGO 463.5 MG/1.5 ML Vial #	Not Covered on formulary
Asthma/COPD Therapy Agents	ALBUTEROL HFA 90 MCG INHALER	Covered on formulary with Quantity Limit – Preferred
Asthma/COPD Therapy Agents	ALBUTEROL HFA 90 MCG INHALER - PRASCO	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Beta Adrenergic Blockers	BISOPROLOL FUMARATE 2.5 MG TAB	Covered on formulary - Preferred
Corticotropin-Releasing Factor Type 1 Receptor Antagonist	Crenessity 100mg Capsule	Not Covered on formulary
Corticotropin-Releasing Factor Type 1 Receptor Antagonist	Crenessity 50mg Capsule	Not Covered on formulary
Corticotropin-Releasing Factor Type 1 Receptor Antagonist	Crenessity 50mg/ml Solution	Not Covered on formulary
Dermatological - Anti-infectives	ECONAZOLE NITRATE 1% CREAM	Covered on formulary - Preferred
Dermatological - Antipsoriatic Agents Topical	Vtama 1% Cream	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit

Drug Class	Drug Name	New Status
Dermatological - Antipsoriatics	BIMZELX 160 MG/ML AUTOINJECTOR	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Dermatological - Antipsoriatics	BIMZELX 160 MG/ML SYRINGE	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Dermatological - Antipsoriatics	COSENTYX 150 MG/ML SYRINGE	Covered on formulary with Quantity Limit – Preferred
Dermatological - Antipsoriatics	COSENTYX 300 MG DOSE-2 SYRINGE	Covered on formulary with Quantity Limit – Preferred
Dermatological - Antipsoriatics	COSENTYX 75 MG/0.5 ML SYRINGE	Covered on formulary with Quantity Limit – Preferred
Dermatological - Antipsoriatics	COSENTYX SENSOREADY 150 MG PEN	Covered on formulary with Quantity Limit – Preferred
Dermatological - Antipsoriatics	COSENTYX SNRDY 300MG DOSE-2PEN	Covered on formulary with Quantity Limit – Preferred
Dermatological - Antipsoriatics	COSENTYX UNOREADY 300 MG PEN	Covered on formulary with Quantity Limit – Preferred
Dermatological - Antipsoriatics	ILUMYA 100 MG/ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	SKYRIZI 150 MG/ML PEN	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	SKYRIZI 150 MG/ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	SKYRIZI 180 MG/1.2 ML ON-BODY	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	SKYRIZI 360 MG/2.4 ML ON-BODY	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	STEQEYMA 130 MG/26 ML VIAL	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Dermatological - Antipsoriatics	STEQEYMA 45 MG/0.5 ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	STEQEYMA 90 MG/ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	TALTZ 80 MG/ML AUTOINJ (2-PK)	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	TALTZ 80 MG/ML AUTOINJ (3-PK)	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	TREMFYA 100 MG/ML INJECTOR	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	TREMFYA 100 MG/ML PEN	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	TREMFYA 100 MG/ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	TREMFYA 200 MG/2 ML PEN	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	TREMFYA 200 MG/2 ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	YESINTEK 130 MG/26 ML VIAL	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	YESINTEK 45 MG/0.5 ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatics	YESINTEK 45 MG/0.5 ML VIAL	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Dermatological - Antipsoriatics	YESINTEK 90 MG/ML SYRINGE	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Diabetic Therapy	HUMALOG MIX 75-25 KWIKPEN	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Diabetic Therapy	INSULIN ASPART 100 UNIT/ML CRT	Covered on formulary with Quantity Limit – Preferred
Diabetic Therapy	INSULIN LISPRO MIX 75-25 KWKPN	Covered on formulary with Quantity Limit – Preferred
Diabetic Therapy	NOVOLOG PENFILL 100 UNIT/ML	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Diuretics	KERENDIA 40 MG TABLET	Covered on formulary with Prior Authorization, Age Edit and Quantity Limit
Inflammatory Bowel Agents	CIMZIA 200 MG VIAL KIT	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Inflammatory Bowel Agents	CIMZIA 2X200 MG/ML SYRINGE KIT	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Inflammatory Bowel Agents	CIMZIA 2X200 MG/ML(X3)START KT	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Inflammatory Bowel Agents	ENTYVIO 108 MG/0.68 ML PEN	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Inflammatory Bowel Agents	OMVOH 100 MG/ML PEN	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Inflammatory Bowel Agents	OMVOH 100 MG/ML SYRINGE	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Inflammatory Bowel Agents	OMVOH 300 MG DOSE - 2 PENS	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred

Drug Class	Drug Name	New Status
Inflammatory Bowel Agents	OMVOH 300 MG DOSE - 2 SYRINGES	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Inflammatory Bowel Agents	VELSIPITY 2 MG TABLET	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Inflammatory Bowel Agents	ZYMFENTRA 120 MG/ML PEN KIT	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Narcotic Antagonists	NALOXONE 0.4 MG/ML VIAL	Covered on formulary
Narcotic Antagonists	NALOXONE 2 MG/2 ML SYRINGE	Covered on formulary
Narcotic Antagonists	NALOXONE 4 MG/10 ML VIAL	Covered on formulary
Narcotic Antagonists	NALOXONE HCL 4 MG NASAL SPRAY	Covered on formulary
Narcotic Antagonists	Narcan 4mg Nasal Spray (prescription & OTC)	Covered on formulary
Narcotic Antagonists	Rextovy 4mg Nasal Spray	Covered on formulary
Sickle Cell Anemia Agents	Siklos 1,000mg Tablets	Covered on formulary with Age Edit
Sickle Cell Anemia Agents	Siklos 100mg Tablets	Covered on formulary with Age Edit
Sickle Cell Anemia Agents	Xromi 100mg/ml Solution	Covered on formulary

Medicaid Health Plan Common Formulary Changes Effective May 1, 2025

Drug Class	Drug Name	New Status
Cardiovascular Anti-inflammatory/Immune Modulators	Lodoco 0.5mg Tablet	Not Covered on formulary
Androgen - Single Agents	Undecatrex 200mg Capsule	Not Covered on formulary
Dermatological - Antiperspirants	Sofdra 12.45% Gel	Not Covered on formulary
Beta Blockers Cardiac Selective	bisoprolol fumarate 5mg, 10mg tablets	Covered on formulary – Preferred
Beta Blockers Cardiac Selective	Bystolic 2.5mg, 5mg, 10mg, 20mg Tablets	Covered on formulary with Prior Authorization – Non-Preferred
Beta Blockers Non-Cardiac Selective	Nadolol 20mg, 40mg 80mg tablet	Covered on formulary – Preferred
Beta Blockers Non-Cardiac Selective	Hemangeol 4.28mg/ml Oral Solution	Covered on formulary with Age Edit – Preferred

Drug Class	Drug Name	New Status
Ophthalmic - Carbonic Anhydrase Inhibitors	Azopt 1% Eye Drops	Covered on formulary with Prior Authorization – Non-Preferred
Ophthalmic - Carbonic Anhydrase Inhibitors	brinzolamide 1% eye drops	Covered on formulary – Preferred
Angiotensin II Receptor Blocker-Nepriylsin Inhibitor Comb. (ARNi)	Entresto 24mg-26mg, 49mg-51mg, 97mg-103mg Tablets	Covered on formulary with Prior Authorization and Quantity Limit – Preferred
Angiotensin II Receptor Blocker-Nepriylsin Inhibitor Comb. (ARNi)	Entresto Sprinkle 6-6mg, 15-16mh Pellet	Covered on formulary with Prior Authorization and Quantity Limit –Non-Preferred
Antihyperlipidemic-HMG CoA Reduct Inhib & Cholesterol Absorption Inhib	ezetimibe-simvastatin 10-10mg, 10-20mg, 10-40mg, 10-80mg	Covered on formulary with Quantity Limit – Preferred
Alpha-Beta Blockers	carvedilol ER 10mg, 20mg, 40mg, 80mg capsules	Covered on formulary with Prior Authorization – Non-Preferred 90 days grandfathering from 5/1/2025 effective date
Ophthalmic - Anti-inflammatory, Immunomodulators	Restasis Multidose 0.05% Eye Drops	Covered on formulary with Prior Authorization and Quantity Limit –Non-Preferred
Calcium Channel Blockers - Dihydropyridines	Norliqva 1mg/ml Solution	Covered on formulary with Prior Authorization and Age Edit – Preferred
Antiparkinson - Dopaminerg-Peripheral Dopa-decarboxylase Inhibit Comb	Crexont 35mg-140mg, 52.5mg-210mg, 70mg-280mg, 87.5mg-350mg Capsules	Covered on formulary with Prior Authorization – Non-Preferred
Eczema Agents, Interleukin-13 (IL-13) Inhibitors, MAB	Ebglyss 250mg/2ml Syringe, 250mg/2ml Pen	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Cardiovascular Sympathomimetic - Anaphylaxis Therapy Single Agents	Neffy 2mg/0.1ml Nasal Spray	Covered on formulary with Prior Authorization and Quantity Limit –Non-Preferred
Eczema Agents, Interleukin-13 (IL-13) Receptor Alpha Antagonist, MAB	Nemludio 30mg Pen	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Antiparkinson - Dopaminerg-Peripheral Dopa-decarboxylase Inhibit Comb	Vyalev 120mg-2,400mg/10ml Vial	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred

Medicaid Health Plan Common Formulary Changes Effective February 1, 2025

Drug Class	Drug Name	New Status
Peroxisome Proliferator PPAR Agonists	Iqirvo 80mg Tablet	Not Covered on formulary
Peroxisome Proliferator PPAR Agonists	Livdelzi 10mg Capsule	Not Covered on formulary
Phosphodiesterase (PDE) Inhibitors	Ohtuvayre 3mg/2.5ml Inhalation Suspension	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Hypoparathyroid Treatment - Parathyroid Hormone Analogs	Yorvipath 168mcg/0.56ml, 294mcg/0.98ml, 420 mcg/1.4ml Pen	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Analgesic Narcotic Agonists	Oxycontin ER 10mg, 15mg, 20mg, 30mg, 40mg, 60mg, 80mg Tablet	Covered on formulary with Quantity Limit – Preferred
Dermatological - Glucocorticoid	Fluocinonide Cream, Gel, Ointment and Solution	Covered on formulary – Preferred
Analgesic Narcotic Agonists	Roxybond 5mg, 15mg, 30mg Tablet	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Multiple Sclerosis Agent - Sphingosine 1-phosphate receptor modulator	Zeposia Starter Pack (7-Day) Starter Kit (28-Day), 0.92mg Capsule	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Multiple Sclerosis Agent - CD20-Directed Cytolytic Antibody	Kesimpta 20mg/0.4ml Pen	Covered on formulary – Preferred
Antihyperglycemic, DPP-4 Inhibitor-Biguanide Combinations	Sitagliptin-Metformin 50-500, 50-1000 Tablet	Covered on formulary with Prior Authorization – Non-Preferred
Hypoxia Inducible Factor Prolyl Hydroxylase (HIF PH) Inhibitor	Vafseo 150mg, 300mg Tablet	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Antihyperglycemic, DPP-4 Inhibitor-Biguanide Combinations	Zituvimet 50-500mg, 50-1000mg, XR 50-500mg, XR 50-1000mg, XR 100-1000mg Tablet	Covered on formulary with Prior Authorization – Non-Preferred

Medicaid Health Plan Common Formulary Changes Effective November 1, 2024

Drug Class	Drug Name	New Status
Thrombopoietin Receptor Agonists	Alvaiz 9mg, 36mg, 54mg, 18mg, Tablet	Not Covered on formulary
Thyroid Hormone Receptor-Beta Agonists	Rezdiffra 60mg, 80mg, 100mg Tablet	Not Covered on formulary
Antipsoriatic Agents - MC Antibody, Interleukin-36 Receptor	Spevigo 150 mg/ml Syringe	Not Covered on formulary
Endothelin Receptor Antagonists	Tryvio 12.5 mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
DMARD - Interleukin-6 (IL-6) Receptor Inhibitors, Monoclonal Antibody	Actemra 162 mg/0.9 ml Syringe	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
DMARD - Janus Kinase (JAK) Inhibitors	Xeljanz 5 mg Tablet	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Antipsoriatic Agents - MC Antibody, Human Interleukin 12/23 Inhibitors	Stelara 45mg/0.5ml, 90mg/ml Syringe	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Calcineurin Inhibitors	Tacrolimus 0.03%, 0.1% Ointment	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Preferred
Bone Formation Stimulating Agents - Parathyroid Hormone-Type	Forteo 600 cg/2.4 ml Pen Injector	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Agents to treat Hypoglycemia (Hyperglycemics)	Glucagon 1 mg Emergency Kit	Covered on formulary with Prior Authorization – Non-Preferred
Antihyperglycemic - SGLT-2 Inhibitor & Biguanide Combinations	Invokamet 50-500mg, 50-1,000mg, 150-500mg, 150-1,000mg Tablet	Covered on formulary with Prior Authorization – Non-Preferred
Antihyperglycemic - Sodium Glucose Cotransporter-2 (SGLT2) Inhibitors	Invokana 100mg, 300mg Tablet	Covered on formulary with Prior Authorization – Non-Preferred
Inflammatory Bowel Agent - Aminosalicylates and Related Agents	Pentasa 250mg, 500mg Capsule	Covered on formulary – Preferred
IBS Agent - Gastrointestinal Chloride Channel Activator Agents	Amitiza 8mcg, 24mcg Capsule	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
IBS-C/CIC Agents, Guanylate Cyclase-C Agonist	Linzess 145mcg, 290mcg Capsule	Covered on formulary with Quantity Limit and Age Edit – Preferred

Drug Class	Drug Name	New Status
Gastric Acid Secretion Reducing Agents - Proton Pump Inhibitors (PPIs)	Protonix DR 20mg, 40mg Tablet	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
PDE Inhibitor-Endothelin Receptor Antagonist Comb-Two Ingrid	Opsynvi 10-20mg, 10-40mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts,TNF-alpha Sel	Simlandi (CF) AI 40mg/0.4ml	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts,TNF-alpha Sel	Adalimumab-RYVK(CF) AI 40mg, 40mg Syringe	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Interleukin 6 (IL-6) Receptor Inhibitors	Tyenne 162 mg/0.9 ml Autoinjector and Syringe	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
PAH Agents - Activin Signaling Inhibitor	Winrevair 45mg One-Vial Kit, Two-Vial Kit, Winrevair 60mg One-Vial Kit, Two-Vial Kit	Covered on formulary with Prior Authorization – Non-Preferred
Inflammatory Bowel Agent - Tumor Necrosis Factor Alpha Blockers	Zymfentra 120mg/ml Pen Kit and Syringe Kit	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Electrolyte Depleters - Ion Exchange Resin	Kionex 15 gm/60ml Suspension	Covered on formulary – Preferred
Electrolyte Depleters - Ion Exchange Resin	SPS 15 gm/60ml, 30 gm/120ml Enema Suspension	Covered on formulary – Preferred

Medicaid Health Plan Common Formulary Changes Effective September 1, 2024

Drug Class	Drug Name	New Status
Migraine Therapy - Selective Serotonin Agonists 5-HT(1)	sumatriptan 5mg, 20mg nasal spray	Covered on formulary with Quantity Limit – Preferred
Sickle Cell Anemia Agents	l-glutamine 5 gram powder packet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit

Drug Class	Drug Name	New Status
Dermatological - Antidermatitis	Zoryve 0.15% Cream	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Skeletal Muscle Relaxant - Central Muscle Relaxants	Tanlor 1,000mg Tablet	Covered on formulary with Prior Authorization – Non-Preferred
Ophthalmic - Intraocular Pressure Reducing Agents, Beta-blockers	timolol maleate 0.25% eye drop	Covered on formulary with Prior Authorization – Non-Preferred
Movement Disorder Therapy - Huntington's Disease	Austedo XR Titration (12-18-24-30mg); 18mg Tablet	Covered on formulary with Prior Authorization and Age Edit

Medicaid Health Plan Common Formulary Changes Effective August 1, 2024

Drug Class	Drug Name	New Status
Scabicide & Pediculicide Single Agents	lindane 1% shampoo	Not Covered on formulary
Scabicide & Pediculicide Single Agents	malathion 0.5% lotion	Covered on formulary with Quantity Limit and Age Edit
Scabicide & Pediculicide Single Agents	spinosad 0.9% topical suspension	Covered on formulary with Quantity Limit and Age Edit
Scabicide & Pediculicide Single Agents	ivermectin 0.5% lotion	Covered on formulary with Age Edit
Periodontal Product - Tetracycline-Type, Collagenase Inhibitors	doxycycline hyclate 20mg tablet	Covered on formulary
CMV Antiviral Agent - Nucleoside Analogs	Prevymis 240mg, 480mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Glucocorticoids	Agamree 40mg/ml Suspension	Covered on formulary
Acne Therapy Topical - Anti-infective-Keratolytic Combinations	Cabtreo 1.2%-0.15%-3.15% Gel	Covered on formulary with Prior Authorization – Non-Preferred
Glucocorticosteroids	Eohilia 2mg/10ml Stick pack	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Birch Triterpenes	Filsuvez 10% Gel	Not Covered on formulary

Drug Class	Drug Name	New Status
Interleukin Antagonists	Omvo 100 mg/ml pen	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Ophthalmic - Anti-inflammatory	Vevye 0.1% Eye Drop	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
PPI - Potassium-Competitive Acid Blockers (P-CAB)	Voquezna 10mg, 20mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Peptic Ulcer - Treatment of H. Pylori: PCAB Combinations - Three Ingredient	Voquezna Dual Pak, Voquezna Triple Pak	Covered on formulary with Prior Authorization – Non-Preferred
Amyloidosis Agents-TTR Suppression, Antisense Oligonucleotide-based	Wainua 45mg/0.8ml AutoInject	Not Covered on formulary
Phosphate Binders	Xphozah 20mg, 30mg Tablet	Covered on formulary with Prior Authorization – Non-Preferred
Antihyperglycemic - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	Zituvio 25mg, 50mg, 100mg Tablet	Covered on formulary with Prior Authorization – Non-Preferred
Antihyperglycemic - Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	sitagliptin 25mg, 50mg, 100mg tablet	Covered on formulary with Prior Authorization – Non-Preferred
Asthma/COPD Therapy - Beta Adrenergic-Glucocorticoid Combinations	fluticasone-salmeterol 45-21, 115-21, 230-21	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Asthma/COPD Therapy - Beta Adrenergic-Glucocorticoid Combinations	fluticasone-salmeterol 100-50, 250-50, 500-50	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Glycopeptide Antibiotics	vancomycin 25 mg/ml, 50 mg/ml solution	Covered on formulary – Preferred
Dermatological - Antiviral, Herpes	Zovirax 5% Cream	Covered on formulary with Prior Authorization – Non-Preferred
Dermatological - Antiviral, Herpes	acyclovir 5% cream	Covered on formulary – Preferred
Otic - Fluoroquinolones	ciprofloxacin 0.2% otic solution	Covered on formulary with Prior Authorization – Non-Preferred
Otic - Fluoroquinolones	ofloxacin 0.3% ear drops	Covered on formulary – Preferred
Otic - Anti-infective-Glucocorticoid Combinations	Ciprodex Otic Suspension	Covered on formulary – Preferred
Otic - Anti-infective-Glucocorticoid Combinations	Cipro HC Otic Suspension	Covered on formulary with Prior Authorization – Non-Preferred

Drug Class	Drug Name	New Status
Otic - Anti-infective-Glucocorticoid Combinations	neomycin-polymyxin-HC ear suspension	Covered on formulary – Preferred
Otic - Fluoroquinolones -Combination	ciprofloxacin-fluocinolone 0.3-0.025%	Covered on formulary with Prior Authorization – Non-Preferred
Otic - Anti-infective-Glucocorticoid Combinations	ciprofloxacin-dexamethasone otic suspension	Covered on formulary – Preferred
Asthma Therapy - Glucocorticoids	Pulmicort 90 mcg, 180 mcg Flexhaler	Covered on formulary with Prior Authorization and Quantity Limit – Preferred
Asthma Therapy - Glucocorticoids	Arnuity Ellipta 100 mcg, 200 mcg Inhaler	Covered on formulary – Preferred
Asthma/COPD Therapy - Beta Adrenergic-Glucocorticoid Combinations	Advair HFA 45-21 mcg, 115-21 mcg, 230-21 mcg Inhaler	Covered on formulary with Quantity Limit – Preferred
Asthma/COPD Therapy - Beta Adrenergic-Glucocorticoid Combinations	Advair 100-50, 250-50, 500-50 Diskus	Covered on formulary with Quantity Limit – Preferred
Asthma Therapy - Glucocorticoids	Qvar Redihaler 40 mcg, 80 mcg	Covered on formulary – Preferred
Glycopeptide Antibiotics	Firvanq 25mg/ml, 50mg/ml Solution	Covered on formulary with Prior Authorization – Non-Preferred
Asthma Therapy - Glucocorticoids	Arnuity Ellipta 50 mcg Inhaler	Covered on formulary – Preferred

Medicaid Health Plan Common Formulary Changes Effective May 1, 2024

Drug Class	Drug Name	New Status
Analgesic Narcotic Agonists	Qdolo 5 mg/ml Solution	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred Effective 3/28/2024
Antihyperlipidemic - Fibrin Acid Derivatives	Fibracor 35mg, 105mg Tablet	Covered on formulary with Prior Authorization – Non-Preferred Effective 3/28/2024
NSAID Analgesics (COX Non-Specific) - Propionic Acid Derivatives	Naprosyn 125mg/5ml Suspension	Covered on formulary with Prior Authorization – Non-Preferred Effective 3/28/2024
Central Alpha-2 Receptor Agonists	Nexiclon XR 0.17mg Tablet	Covered on formulary – Preferred Effective 3/28/2024

Drug Class	Drug Name	New Status
Antiarrhythmic - Class III	dofetilide 125mcg, 250mcg, 500mcg capsule	Covered on formulary
Diuretic - Selective Arginine Vasopressin V2 Receptor Antagonists	Jynarque 15mg-15mg, 30mg-15mg, 45mg-15mg, 60mg-30mg, 90mg-30mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Diuretic - Selective Arginine Vasopressin V2 Receptor Antagonists	Jynarque 15mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts, TNF-alpha Sel	Abrilada(Cf) 20mg/0.4ml, 40mg/0.8ml Syringe, Abrilada(Cf) Pen 40mg/0.8ml	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Asthma/COPD Therapy - Beta Adrenergic-Glucocorticoid Combinations	Airsupra 90-80mcg Inhaler	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Dermatological - Antipsoriatic Agents Systemic	Bimzelx 160 mg/ml Autoinjector & Syringe	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Asthma/COPD Therapy - Beta Adrenergic-Glucocorticoid Combinations	Breyna 80-4.5mcg, 160-4.5mcg Inhaler	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Ophthalmic-Intraocular Pressure Reducing Agents, Prostaglandin Analogs	Iyuzeh 0.005% Eye Drop	Covered on formulary with Prior Authorization – Non-Preferred
Hypoxia Inducible Factor Prolyl Hydroxylase (HIF PH) Inhibitor	Jesduvroq 1mg, 2mg, 4mg, 6mg, 8mg Tablet	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Anaerobic Antiprotozoal-Antibacterial Agents	Likmez 500mg/5ml Suspension	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Growth Hormones	Ngenla Pen 24mg/1.2ml, 60mcg/1.2ml	Covered on formulary with Prior Authorization – Non-Preferred
Minerals & Electrolytes - Potassium, Oral	Pokonza 10 meq Packet	Not Covered on formulary
Inflammatory Bowel Agent - Sphingosine 1-phosphate receptor modulator	Velsipity 2mg Tablet	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Anti-Obesity - Incretin Mimetics Combination	Zepbound 2.5mg/0.5ml, 5mg/0.5ml, 7.5mg/0.5ml, 10mg/0.5ml, 12.5/0.5ml, 15mg/0.5ml Pen	Covered on formulary with Prior Authorization and Age Edit – Preferred

Drug Class	Drug Name	New Status
Beta Blockers Cardiac Selective	Bystolic 2.5mg, 5mg, 10mg, 20mg Tablet	Covered on formulary – Preferred
Ophthalmic - Antihistamines	Zaditor 0.025% (0.035%) Drops	Covered on formulary with Prior Authorization – Non-Preferred
Ophthalmic Antibiotic - Fluoroquinolones	Vigamox 0.5% Eye Drops	Covered on formulary with Prior Authorization – Non-Preferred
Ophthalmic - Antihistamines	olopatadine hcl 0.1%, 0.2% eye drops	Covered on formulary with Prior Authorization – Non-Preferred
Ophthalmic Antibiotic - Fluoroquinolones	moxifloxacin 0.5% eye drops	Covered on formulary – Preferred
Beta Blockers Cardiac Selective	nebivolol 2.5mg, 5mg, 10mg, 20mg tablet	Covered on formulary – Preferred

Medicaid Health Plan Common Formulary Changes Effective February 1, 2024

Drug Class	Drug Name	New Status
Asthma Therapy - Monoclonal Antibodies to Immunoglobulin E (IgE)	Xolair 75 mg/0.5 ml, 150 mg/ml, 300 mg/2ml Autoinjector, 300 mg/3ml Syringe	Covered on formulary with Prior Authorization and Age Edit – Preferred Effective 3/1/2024
Dermatological - Antipsoriatic Agents Topical	Zoryve 0.3% Foam	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Digestive Enzyme Mixtures	Zenpep DR 60,000 Unit Capsule	Covered on formulary with Prior Authorization – Preferred
Granulocyte Colony-Stimulating Factor (G-CSF)	Udenyca 6 mg/0.6 ml OnBody	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Alopecia Agents, Janus Kinase (JAK) Inhibitors	Litfulo 50 mg Capsule	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit

Drug Class	Drug Name	New Status
Laxative - Saline/Osmotic Mixtures	sodium-potassium sulfate-magnesium sulfate solution	Covered on formulary with Quantity Limit
Laxative - Saline/Osmotic Mixtures	Suflave Powder	Not Covered on formulary
Menopausal Symptoms Suppressant - NK3 Receptor Antagonist	Veozah 45 mg Tablet	Not Covered on formulary
Ophthalmic Antibiotic - Antiparasitics	Xdemvy 0.25% Drop	Not Covered on formulary
Antiparkinson Adjuvant - Peripheral COMT Inhibitors	entacapone 200 mg tablet	Covered on formulary – Preferred
Multiple Sclerosis Agent - Sphingosine 1-phosphate receptor modulator	Gilenya 0.25 mg, 0.5 mg Capsule	Covered on formulary with Prior Authorization – Non-Preferred
Migraine Therapy - Calcitonin Gene-Related Peptide Inhibitors	Ajovy 225 mg/1.5 ml Syringe, Ajovy 225 mg/1.5 ml Autoinject	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Preferred
Multiple Sclerosis Agent - Sphingosine 1-phosphate receptor modulator	fingolimod 0.5 mg capsule	Covered on formulary – Preferred
Multiple Sclerosis Agent - Pyrimidine Synthesis Inhibitors	teriflunomide 7 mg, 14 mg tablet	Covered on formulary – Preferred
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts,TNF-alpha Sel	Cyltezo(Cf) 40 mg/0.8 ml, Cyltezo(Cf) Psoriasis 40mg, Cyltezo(Cf) Crh-Uc-Hs 40mg Pen; Cyltezo(Cf) 40 mg/0.8 ml, Cyltezo(Cf) 10 mg/0.2 ml, Cyltezo(Cf) 20 mg/0.4 ml Syringe	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts,TNF-alpha Sel	Hadlima(Cf) 40 mg/0.4 ml, Hadlima 40 mg/0.8 ml Syringe; Hadlima(Cf) 40mg/0.4, Hadlima 40 mg/0.8 ml Pushtouch	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts,TNF-alpha Sel	Hulio(Cf) Pen 40 mg/0.8 ml; Hulio(Cf) 40 mg/0.8 ml, Hulio(Cf) 20 g/0.4 ml Syringe	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts,TNF-alpha Sel	Hyrimoz(Cf) 40 mg/0.4 ml, Hyrimoz(Cf) 80 mg/0.8 ml, Hyrimoz(Cf) Crohn-Uc 80 mg, Hyrimoz(Cf) Psoria 80-40mg Pen; Hyrimoz(Cf) Pedi Crohn 80-40mg, Hyrimoz(Cf) Pedi Crohn 80 mg; Hyrimoz(Cf) 10 mg/0.1 ml, Hyrimoz(Cf) 20 mg/0.2 ml, Hyrimoz(Cf) 40 mg/0.4 ml Syringe	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred

Drug Class	Drug Name	New Status
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts, TNF-alpha Sel	Idacio(Cf) 40 mg/0.8 ml, Idacio(Cf) Crohns-Uc 40 mg, Idacio(Cf) Psoriasis 40 mg Pen; Idacio(Cf) 40 mg/0.8 ml Syringe	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts, TNF-alpha Sel	Yuflyma(Cf) 40 mg/0.4 ml Syringe; Yuflyma(Cf) 40mg/0.4ml Autoinjector	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts, TNF-alpha Sel	Yusimry(Cf) 40 mg/0.8 ml Pen	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Antihyperglycemic - Sodium Glucose Cotransporter-2 (SGLT2) Inhibitors	Inpefa 200 mg Tablet	Covered on formulary with Prior Authorization – Non-Preferred
Pulmonary Antihypertensive Agents - Selective c-GMP PDE Type 5 Inhib.	Liqrev 10 mg/ml Oral Suspension	Covered on formulary with Prior Authorization – Non-Preferred
Ophthalmic Others	Miebo 100% Eye Drops	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Growth Hormones	Sogroya 5 mg/1.5 ml, 10 mg/1.5 ml, Sogroya 15 mg/1.5 ml Pen	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Migraine Therapy - CGRP Receptor Blockers (gepants)	Zavzpret 10 mg Nasal Spray	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts, TNF-alpha Sel	Adalimumab-Fkjp(Cf) Pen 40 mg; Adalimumab-Fkjp(Cf) 20 mg, 40 Mg Syringe	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts, TNF-alpha Sel	Adalimumab-Adaz(Cf) Pen 40 mg; Adalimumab-Adaz(Cf) 40 mg Syringe	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred

Medicaid Health Plan Common Formulary Changes Effective December 1, 2023

Changes Effective December 1, 2023		
Drug Class	Drug Name	New Status
Antiviral Monoclonal Antibodies	Beyfortus 50mg/0.5ml, 100mg/ml Syringe	Covered on formulary with Prior Authorization Effective 10/1/2023
RSV Pre-Fusion F3 Protein (RSVPreF3) Vac Recomb Adjuvanted	Arexvy Vial Kit	Covered on formulary with Quantity Limit and Age Edit
RSV Pre-Fusion F A&B Vaccine Recomb Reconstituted Solution	Abrysvo Vial with Diluent	Covered on formulary with Quantity Limit
Sickle Cell Anemia Agents	Siklos 100mg, 1,000mg Tablet	Covered on formulary with Age Edit

Medicaid Health Plan Common Formulary Changes Effective November 1, 2023

Drug Class	Drug Name	New Status
Spermicides	Phexxi 1.8-1-0.4% Vaginal Gel	Covered on formulary with Quantity Limit
Amyloidosis Agents - Transthyretin (TTR) Stabilizer	Vyndaqel 20mg Capsule	Not Covered on formulary
Amyloidosis Agents - Transthyretin (TTR) Stabilizer	Vyndamax 61mg Capsule	Not Covered on formulary
Insulin-like Growth Factor-1 (IGF-1)	Increlex 40mg/4ml Vial	Not Covered on formulary
Mu-Opioid Receptor Antagonists, Peripherally-Acting	Movantik 12.5, 25mg Tablet	Covered on formulary with Prior Authorization – Non-Preferred
Insulin Analogs - Fixed Combinations	Novolog Mix 70-30 FlexPen	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Insulin Analogs - Fixed Combinations	Insulin Aspart Pro Mix 70-30 Pen	Covered on formulary with Quantity Limit – Preferred
Insulin Analogs - Rapid Acting	Novolog 100 Unit/ml Vial, FlexPen	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Insulin Analogs - Rapid Acting	Insulin Aspart 100 Unit/ml Vial, Pen	Covered on formulary with Quantity Limit – Preferred

Drug Class	Drug Name	New Status
Insulin Analogs - Long Acting	Rezvoglar 100 Unit/ml KwikPen	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Eczema Agents, Interleukin-13 (IL-13) Inhibitors, MAB	Adbry 150 mg/ml Syringe	Covered on formulary with Prior Authorization and Quantity Limit – Preferred
Asthma Therapy - Monoclonal Antibody - Interleukin-5 (IL-5) Antagonists	Fasenra Pen 30 mg/ml	Covered on formulary with Prior Authorization and Age Edit – Preferred
Anti-inflammatory Tumor Necrosis Factor Inhibiting Agnts, TNF-alpha Sel	Amjevita(CF) 10mg/0.2ml, 20mg/0.4ml, 40mg/0.8ml Syringe; 40mg/0.8ml AutoInjector	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Antihyperlipidemic - HMG CoA Reductase Inhibitors (statins)	Atorvaliq 20mg/5ml Suspension	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Gastric Acid Secretion Reducing- Proton Pump Inhibitor & Antacid Comb.	Konvomep 2-84 mg/ml Oral Suspension	Covered on formulary with Prior Authorization – Non-Preferred
Fecal Microbiota Transplantation (FMT)	Vowst Capsule	Not Covered on formulary
Chelating Agents - Copper	Cuvrior 300mg Tablet	Not Covered on formulary
Activated Phosphoinositide 3-Kinase Delta (PI3Kδ) Syndrome Agent	Joenja 70mg Tablet	Not Covered on formulary
Glucagon Analog Antihypoglycemic Agent	Zegalogue 0.6mg/0.6ml Syringe, AutoInjecor	Covered on formulary – Preferred
Antihyperglycemic, Incretin Mimetic, GLP-1 Receptor Agonist Analog-Type	Trulicity 0.75mg/0.5ml, 1.5mg/0.5ml, 3mg/0.5ml, 4.5mg/0.5ml Pen	Covered on formulary with Quantity Limit – Preferred
Antihyperglycemic, Incretin Mimetic, GLP-1 Receptor Agonist Analog-Type	Byetta 5mcg, 10mcg Dose Pen Injector	Covered on formulary with Quantity Limit – Preferred
Antihyperglycemic, Incretin Mimetic, GLP-1 Receptor Agonist Analog-Type	Victoza 2-Pak 18mg/3ml, 3-Pak 18mg/3ml Pen	Covered on formulary with Quantity Limit – Preferred
Antihyperglycemic, Incretin Mimetic, GLP-1 Receptor Agonist Analog-Type	Adlyxin 10-20mcg Starter Pack, 20mcg Maintenance Pack	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Antihyperglycemic, Incretin Mimetic Combinations, Long Acting-GLP-1 Recept. Agonist	Soliqua 100 Unit-33mcg/ml Pen	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Antihyperglycemic, Incretin Mimetic Combinations, Long Acting-GLP-1 Recept. Agonist	Xultophy 100 Unit-3.6mg/ml Pen	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Antihyperglycemic, Incretin Mimetic, GLP-1 Receptor Agonist Analog-Type	Bydureon Bcise 2mg Autoinjector	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Antihyperglycemic, Incretin Mimetic, GLP-1 Receptor Agonist Analog-Type	Ozempic 0.25-0.5mg/Dose Pen, 1mg/Dose (4mg/3ml), 2mg/Dose (8mg/3ml)	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Antihyperglycemic, Incretin Mimetic, GLP-1 Receptor Agonist Analog-Type	Rybelsus 3mg, 7mg, 14mg Tablet	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Antihyperglycemic, Incretin Mimetic, GLP-1 Receptor Agonist Analog-Type	Mounjaro 2.5mg/0.5ml, 5mg/0.5ml, 7.5mg/0.5ml, 10mg/0.5ml, 12mg/0.5ml, 15mg/0.5ml Pen	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Medicaid Health Plan Common Formulary Changes Effective August 1, 2023

Drug Class	Drug Name	New Status
Endothelin & Angiotensin II Receptor Antag	Filspari 200mg, 400mg Tablet	Not Covered on formulary
Gastric Acid Secretion Reducing Agents - Proton Pump Inhibitors (PPIs)	Nexium DR 2.5mg, 5mg, 10mg, 20mg, 40mg Packet	Covered on formulary with Quantity Limit – Preferred
Gastric Acid Secretion Reducing Agents - Proton Pump Inhibitors (PPIs)	omeprazole DR 10mg, 20mg, 40mg capsule	Covered on formulary with Quantity Limit – Preferred
Gastric Acid Secretion Reducing Agents - Proton Pump Inhibitors (PPIs)	Protonix Dr 20mg, 40mg Tablet, 40mg Suspension	Covered on formulary with Quantity Limit – Preferred
Gastric Acid Secretion Reducing Agents - Proton Pump Inhibitors (PPIs)	pantoprazole sodium DR 20mg, 40mg tablet	Covered on formulary with Quantity Limit – Preferred
Direct Factor Xa Inhibitors	Eliquis 2.5mg, 5mg Tablet	Covered on formulary with Quantity Limit – Preferred
Direct Factor Xa Inhibitors	Xarelto 2.5mg, 10mg, 15mg, 20mg Tablet, Xarelto Starter Pack, Xarelto 1mg/ml Susp	Covered on formulary with Quantity Limit – Preferred
Thrombin Inhibitor - Selective Direct & Reversible	Pradaxa 75mg, 110mg, 150mg Capsule	Covered on formulary with Quantity Limit – Preferred
Platelet Aggregation Inhibitors - Thienopyridine Agents	clopidogrel 75mg tablet	Covered on formulary with Quantity Limit – Preferred

Drug Class	Drug Name	New Status
Asthma Therapy - Glucocorticoids	budesonide 0.25mg/2ml suspension	Covered on formulary with Quantity Limit – Preferred
Asthma/COPD - Anticholinergic Agents, Inhaled Long Acting	Incruse Ellipta 62.5mcg Inhaler	Covered on formulary with Quantity Limit – Preferred
Asthma/COPD Therapy - Beta Adrenergic-Anticholinergic Combinations	Combivent Respimat 20-100mcg	Covered on formulary with Quantity Limit – Preferred
Asthma/COPD Therapy - Beta Adrenergic-Anticholinergic Combinations	Stiolto Respimat Inhaler Spray	Covered on formulary with Quantity Limit – Preferred
Asthma/COPD Therapy - Beta Adrenergic-Anticholinergic Combinations	Anoro Ellipta 62.5-25mcg Inhaler	Covered on formulary with Quantity Limit – Preferred
Asthma Therapy - Glucocorticoids	budesonide 1mg/2ml Inhaler Suspension	Covered on formulary with Quantity Limit – Preferred
Beta-Adrenergic and Anticholinergic Combo, Inhaled	Bevespi Aerosphere Inhaler	Covered on formulary with Quantity Limit – Preferred
Direct Factor Xa Inhibitors	Eliquis DVT-PE Treatment Start 5mg	Covered on formulary with Quantity Limit – Preferred
Asthma/COPD Therapy - Beta Adrenergic-Glucocorticoid Combinations	Trelegy Ellipta 100-62.5-25, 200-62.5-25	Covered on formulary with Quantity Limit – Preferred
COPD Therapy Agents	Breztri Aerosphere Inhaler	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Thrombin Inhibitor - Selective Direct & Reversible	dabigatran etexilate 75mg, 150mg capsule	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Cystinosis Therapy (Cystine Depleting Agents)	Cystagon 50mg, 150mg Capsule	Not Covered on formulary Carved Out to FFS effective 6/1/2023
Cystinosis Therapy (Cystine Depleting Agents)	Procysbi DR 25mg, 75mg Capsule, Procysbi DR 75mg, 300mg Granule Packet	Not Covered on formulary Carved Out to FFS effective 6/1/2023
NSAID Analgesic, Cyclooxygenase-2 (COX-2) Selective Inhibitors	Celebrex 50mg, 100mg, 200mg, 400mg	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
NSAID Analgesic, Cyclooxygenase-2 (COX-2) Selective Inhibitors	celecoxib 50mg, 100mg, 200mg, 400mg	Covered on formulary with Quantity Limit – Preferred
Aminoglycoside Antibiotic	tobramycin 300mg/5ml ampule	Covered on formulary – Preferred
Macrolides	Dificid 200mg Tablet, 40mg/ml Suspension	Covered on formulary – Preferred

Drug Class	Drug Name	New Status
Asthma Therapy - Glucocorticoids	Alvesco 80mcg, 160mcg Inhaler	Covered on formulary – Preferred
Asthma/COPD Therapy - Beta 2-Adrenergic Agents, Inhaled, Short Acting	Xopenex HFA 45mcg Inhaler	Covered on formulary with Quantity Limit – Preferred
Asthma/COPD - Phosphodiesterase-4 (PDE4) inhibitors	Roflumilast 250mcg, 500mcg Tablet	Covered on formulary with Prior Authorization – Preferred
Vaginal Antibacterial - Lincosamides	Clindesse 2% Vaginal Cream	Covered on formulary – Preferred
Granulocyte Colony-Stimulating Factor (G-CSF)	Stimufend 6mg/0.6ml Syringe	Covered on formulary with Prior Authorization and Quantity Limit

Medicaid Health Plan Common Formulary Changes Effective June 1, 2023

Drug Class	Drug Name	New Status
Thyroid Hormones - Animal Source (Porcine)	Armour Thyroid 15mg, 30mg, 60mg, 90mg, 120mg, 180mg, 240mg, 300mg Tablet	Covered on formulary
Thyroid Hormones - Animal Source (Porcine)	NP Thyroid 15mg, 30mg, 60mg, 90mg, 120mg Tablet	Covered on formulary
Thyroid Hormones - Animal Source (Porcine)	Adthyza 16.25mg, 32.5mg, 65mg, 97.5mg, 130mg Tablet	Covered on formulary
Antithyroid Agents, Thionamides - Imidazole Derivatives	Tapazole 5mg, 10mg Tablet	Covered on formulary
Thyroid Hormone Combinations - Synthetic T3 and T4	Thyrolar-1/4 Strength, 1/2 Strength, 1 Strength, 2 Strength, 3 Strength Tablet	Covered on formulary
Thyroid Hormones - Synthetic T3 (Triiodothyronine)	Cytomel 5mcg, 25mcg, 50mcg Tablet	Covered on formulary
Thyroid Hormones - Synthetic T3 (Triiodothyronine)	liothyronine sodium 10 mcg/ml vial	Covered on formulary
Thyroid Hormones - Synthetic T3 (Triiodothyronine)	Triostat 10 mcg/ml Vial	Covered on formulary
Thyroid Hormones - Synthetic T4 (Thyroxine)	levothyroxine 100mcg, 200mcg, 500mcg vial	Covered on formulary

Drug Class	Drug Name	New Status
Thyroid Hormones - Synthetic T4 (Thyroxine)	Synthroid 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg Tablet	Covered on formulary
Thyroid Hormones - Synthetic T4 (Thyroxine)	thyquidity 100 mcg/5 ml solution	Covered on formulary
Thyroid Hormones - Synthetic T4 (Thyroxine)	Tirosint 13mcg, 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg Capsule	Covered on formulary
Thyroid Hormones - Synthetic T4 (Thyroxine)	Tirosint-Sol 13mcg/ml, 25mcg/ml, 50mcg/ml, 75mcg/ml, 88mcg/ml, 100mcg/ml, 112mcg/ml, 125mcg/ml, 137mcg/ml, 150mcg/ml, 175mcg/ml, 200mcg/ml Solution	Covered on formulary
Thyroid Hormones - Synthetic T4 (Thyroxine)	Unithroid 25mcg, 50mcg, 75mcg, 88mcg, 100mcg, 112mcg, 125mcg, 137mcg, 150mcg, 175mcg, 200mcg, 300mcg Tablet	Covered on formulary
Thyroid Hormones - Synthetic T4 (Thyroxine)	Ermeza 150 mcg/5ml Solution	Covered on formulary
Immunosuppressive - Calcineurin Inhibitors	Lupkynis 7.9mg Capsule	Not Covered on formulary 6 months grandfathering from 6/1/2023 effective date

Medicaid Health Plan Common Formulary Changes Effective May 1, 2023

Drug Class	Drug Name	New Status
Acne Therapy Topical - Retinoids & Derivatives	tretinoin 0.025% cream	Covered on formulary with Quantity Limit and Age Edit
Dermatological - Antipsoriatic Agents Topical	calcipotriene 0.005% cream, ointment, solution	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Dermatological - Antipsoriatic Agents Topical	calcitriol 3 mcg/g ointment	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit

Drug Class	Drug Name	New Status
Dermatological - Antipsoriatic Agents Topical	tazarotene 0.1% cream	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Dermatological - Antipsoriatic Agents Topical	Vtama 1% Cream	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Dermatological - Antipsoriatic Agents Topical	Zoryve 0.3% Cream	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Dermatological - Antipsoriatic Agents Topical	Tazarotene 0.05%, 0.1% Gel	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
ALS Agent Combinations	Relyvrio 3 Gm-1 Gm Powder Pkt	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Androgen - Single Agents	Tlando 112.5mg Capsule	Not Covered on formulary
ACE Inhibitors	ramipril 1.25mg, 2.5mg, 5mg, 10mg capsule	Covered on formulary – Preferred
Alpha-Beta Blockers	Coreg CR 10mg, 20mg, 40mg, 80mg Capsule	Covered on formulary – Preferred
Pulmonary Antihypertensive Agents - Selective c-GMP PDE Type 5 Inhib.	Revatio 10 mg/ml Oral Suspension	Covered on formulary with Prior Authorization – Non-Preferred
Pulmonary Antihypertensive Agents - Selective c-GMP PDE Type 5 Inhib.	sildenafil 10 mg/ml oral suspension	Covered on formulary with Prior Authorization – Preferred
Pulmonary Antihypertensive Agents-Soluble Guanylate Cyclase Stimulator	Adempas 0.5mg, 1mg, 1.5mg, 2mg, 2.5mg Tablet	Covered on formulary with Prior Authorization – Preferred
Pulmonary Antihypertensive Agents - Prostacyclin-type	Tyvaso DPI 16mcg 32mcg, 48mcg, 64mcg Cartridge, Tyvaso DPI 16-32-48mcg Titrat, Tyvaso DPI 16-32mcg Titr Kit, Tyvaso DPI 32-48mcg Maintenance Kit	Covered on formulary with Prior Authorization – Non-Preferred
BPH Agent - 5-alpha Reductase Inhib. & PDE5 Inhib. Comb	Entadfi 5-5mg Capsule	Covered on formulary with Prior Authorization and Length of Approval Limit – Non-Preferred
Granulocyte Colony-Stimulating Factor (G-CSF)	Fylnetra 6 mg/0.6 ml Syringe	Covered on formulary with Prior Authorization, and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Nasal Antihistamine and Anti-inflammatory Steroid Combinations	Ryaltris 665-25mcg Spray	Covered on formulary with Prior Authorization – Non-Preferred
Antipsoriatic Agents, Systemic	Sotyktu 6mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Pulmonary Antihypertensive Agents - Selective c-GMP PDE Type 5 Inhib.	Tadliq 20mg/5ml Suspension	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Multiple Sclerosis Agent - Sphingosine 1-phosphate receptor modulator	Tascenso ODT 0.25mg, 0.5mg Tablet	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Vaginal Antibacterial - Lincosamides	Xaciato 2% Vaginal Gel	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred

Medicaid Health Plan Common Formulary Changes Effective March 1, 2023

Drug Class	Drug Name	New Status
Antitubercular - Diarylquinoline Antibiotics	Sirturo 20mg, 100mg Tablet	Covered on formulary with Prior Authorization
Antitubercular - Nitroimidazole Derivatives	Pretomanid 200mg Tablet	Covered on formulary with Prior Authorization
Sickle Cell Anemia Agents	Siklos 100mg, 1,000mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Antihyperlipidemic - Fibric Acid Derivatives	fenofibric acid 35 mg tablet	Covered on formulary with Prior Authorization – Non-Preferred
Antihyperlipidemic Agents - Dietary Source	icosapent ethyl 500 mg capsule	Covered on formulary with Prior Authorization – Non-Preferred
Antineoplastic - Selective Estrogen Receptor Modulators (SERMS)	Orserdu 86mg, 345mg Tablet	Covered on formulary
Cardiovascular Sympathomimetic - Anaphylaxis Therapy Single Agents	Auvi-Q 0.15mg, 0.3mg Auto-Injector	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Medicaid Health Plan Common Formulary Changes Effective February 1, 2023

Drug Class	Drug Name	New Status
Acne Therapy Topical - Anti-infective-Keratolytic Combinations	sodium sulfacet-sulfur cleanser	Not Covered on formulary
Antianginal and Anti-ischemic Agents, Non-hemodynamic	Aspruzyo 500mg, 1000mg Sprinkle ER Packet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Cardiac Myosin Inhibitor	Camzyos 2.5mg, 5mg, 10mg, 15mg Capsule	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Dermatological - Calcineurin Inhibitors	Hyftor 0.2% Gel	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit
Acne Therapy Topical - Keratolytic	Epsolay 5% Cream Pump	Not Covered on formulary
ALS Agent - Benzothiazoles	Radicava ORS Starter Kit, 105mg/5ml Suspension	Not Covered on formulary
Dermatological - Antipsoriatic Agents Topical	Vtama 1% Cream	Not Covered on formulary
Skeletal Muscle Relaxant - Central Muscle Relaxants	chlorzoxazone 250mg, 375mg, 500mg, 750mg tablet	Covered on formulary with Prior Authorization – Non-Preferred
Skeletal Muscle Relaxant - Central Muscle Relaxants	baclofen 5mg/5ml solution	Covered on formulary with Prior Authorization – Preferred
NSAID Analgesics (COX Non-Specific) - Propionic Acid Derivatives	ketoprofen 50mg, 75mg capsule	Covered on formulary with Prior Authorization – Non-Preferred
Dermatological - Glucocorticoid	clobetasol 0.05%gel	Covered on formulary with Prior Authorization – Non-Preferred
Dermatological - Glucocorticoid-Emollient Combinations	hydrocortisone-aloe 1%, SM hydrocortisone-aloe 1% cream	Covered on formulary - Preferred
Antiparkinson Therapy - Monoamine Oxidase Inhibitor(MAO-B)	rasagiline mesylate 0.5mg, 1mg tablet	Covered on formulary with Prior Authorization and Age Edit – Preferred
Migraine Therapy - Calcitonin Gene-Related Peptide Antagonist	Nurtec ODT 75mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Migraine Products - Cyclooxygenase 2 (COX-2) Inhibitors	Elyxyb 120mg/4.8ml Solution	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Alzheimer's Disease Therapy - Cholinesterase Inhibitors	Adlarity 5mg/day, 10mg/day Weekly Patch	Covered on formulary with Prior Authorization – Non-Preferred
Skeletal Muscle Relaxant - Central Muscle Relaxants	Lyvispah 5mg, 10mg, 20mg Granule Packet	Covered on formulary with Prior Authorization – Non-Preferred
Antihyperglycemic, Incretin Mimetic, GLP-1 Receptor Agonist Analog-Type	Mounjaro 2.5mg/0.5ml, 5mg/0.5ml, 7.5mg/0.5ml, 10mg/0.5ml, 12.5mg/0.5ml, 15mg/0.5ml Pen	Covered on formulary with Prior Authorization – Non-Preferred
Antifungal - Azole Antifungal Agent	Vivjoa 1% Cream	Covered on formulary with Prior Authorization, and Quantity Limit – Non-Preferred
Ophthalmic - Anti-inflammatory, Immunomodulators	Verkazia 0.1% Eye Emulsion	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred

Medicaid Health Plan Common Formulary Changes Effective November 1, 2022

Drug Class	Drug Name	New Status
Central Alpha-2 Receptor Agonists	clonidine 0.1mg/day, 0.2mg/day, 0.3mg/day patch	Covered on formulary – Preferred with Quantity Limit Effective 9/1/2022
Glucocorticoids	Emflaza 6mg, 18mg, 30mg, 36mg Tablets, Emflaza 22.75mg/ml Oral Suspension	Covered on formulary without restrictions Effective 10/1/2022
Antiprotozoal Other	atovaquone 750 mg/5 ml suspension	Covered on formulary
CMV Antiviral Agent - Nucleoside Analogs	valganciclovir 450 mg tablet	Covered on formulary with Quantity Limit
GI Antispasmodic - Quaternary Ammonium Compounds	Dartisla ODT 1.7mg Tablet	Not Covered on formulary
Acne Therapy Topical - Retinoid Combinations Other	Twyneo 0.1%-3% Cream	Not Covered on formulary
Analgesic Narcotic Agonists	codeine sulfate 15mg, 30mg, 60mg tablet	Covered on formulary with Quantity Limit and Age Edit – Preferred
Analgesic Narcotic Agonists	Ultram 50mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred

Drug Class	Drug Name	New Status
Analgesic Narcotic Agonists	tramadol 50mg, 100mg tablet	Covered on formulary with Quantity Limit and Age Edit – Preferred
Analgesic Narcotic Codeine Combinations	acetaminophen-codeine #2, #3, #4 tablets	Covered on formulary with Quantity Limit and Age Edit – Preferred
Analgesic Narcotic Codeine Combinations	acetaminophen-codeine 120-12mg/5ml, 300-30mg/12.5ml solution	Covered on formulary with Quantity Limit and Age Edit – Preferred
Analgesic Narcotic Codeine Combinations	Fioricet-Cod 50-300-40-30 Capsule, butalbital comp-codeine #3 capsule, butalbital-acetaminophen-caffeine-codeine 50-300, butalbital-acetaminophen-caffeine-codeine 50-325, Fiorinal-Codeine 30-50-325-40 Capsule, Ascomp with Codeine Capsule, asa- butalbital - caffeine-codeine #3 capsule	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic Narcotic Tramadol Combinations	Ultracet Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic Narcotic Tramadol Combinations	Seglentis 56mg-44mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic Narcotic Tramadol Combinations	tramadol-acetaminophen 37.5-325 tablet	Covered on formulary with Quantity Limit and Age Edit – Preferred
Analgesic Narcotic Agonists	Conzip 100mg, 200mg, 300mg, tramadol ER 100mg, Er 200mg, Er 300mg capsule	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Analgesic Narcotic Agonists	tramadol ER 100mg, ER 200mg, ER 300mg tablet	Covered on formulary with Quantity Limit and Age Edit – Preferred
Cardiovascular Sympathomimetic - Anaphylaxis Therapy Single Agents	EpiPen JR 0.15mg, JR 2-Pak 0.15, 2-Pak 0.3mg Auto-Injector	Covered on formulary with Quantity Limit – Preferred
Cardiovascular Sympathomimetic - Anaphylaxis Therapy Single Agents	epinephrine 0.15mg, 0.3mg auto-injector	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Agents to treat Hypoglycemia (Hyperglycemics)	diazoxide 50mg/ml oral suspension	Covered on formulary with Prior Authorization – Non-Preferred
Agents to treat Hypoglycemia (Hyperglycemics)	Proglycem 50mg/ml Oral Suspension	Covered on formulary - Preferred

Drug Class	Drug Name	New Status
Agents to treat Hypoglycemia (Hyperglycemics)	Gvoke Hypopen 1 Pack 0.5mg/0.1ml, 1 Pack 1mg/0.2ml, 2 Pack 0.5mg/0.1ml, 2 Pack 1mg/0.2ml	Covered on formulary with Quantity Limit – Preferred
Antihyperglycemic - SGLT-2 Inhibitor & DPP-4 Inhibitor Combinations	Glyxambi 10mg-5mg, 25mg-5mg Tablet	Covered on formulary with Prior Authorization – Non-Preferred
Calcium Channel Blockers - Dihydropyridines	Levamlodipine Maleate 5mg Tablet	Covered on formulary with Prior Authorization – Non-Preferred
Calcium Channel Blockers - Dihydropyridines	Katerzia 1mg/ml Suspension	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Calcium Channel Blockers - Dihydropyridines	Norliqva 1mg/ml Solution	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Eczema Agents, Janus Kinase (JAK) Inhibitors	Cibinqo 50mg, 100mg, 200mg Tablet	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Gastric Acid Secretion Reducing Agents - Proton Pump Inhibitors (PPIs)	Protonix DR 20mg, DR 40mg Tablets, 40mg Suspension	Covered on formulary - Preferred
Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Estrogen and Progestin	Myfembree 40mg-1mg-0.5mg Tablet	Covered on formulary with Prior Authorization and Age Edit – Preferred
Granulocyte Colony-Stimulating Factor (G-CSF)	Releuko 300mcg/ml vial, 300mcg/0.5ml Syringe, Releuko 480mcg/1.6ml Vial, 480mcg/0.8ml Syringe	Covered on formulary with Prior Authorization – Non-Preferred
Granulocyte Colony-Stimulating Factor (G-CSF)	Udenyca 6mg/0.6ml Syringe	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Irritable Bowel Syndrome (IBS) Agents	Ibsrela 50mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Skeletal Muscle Relaxant - Central Muscle Relaxants	Fleqsuvy 25mg/5ml Suspension	Covered on formulary with Prior Authorization – Non-Preferred

Medicaid Health Plan Common Formulary Changes Effective August 1, 2022

Drug Class	Drug Name	New Status
Drugs Used for Treatment of Cancer Some products are carved out to FFS (HIC3 V16, V1Q & V3U)		Covered on formulary - Preferred Effective 6/8/2022 per Public Act 19 of 2022
Opioid Withdrawal Symptom Management – Alpha-2 Adrenergic Agonists	Lucemyra 0.18mg Tablet	Covered on formulary - Preferred Effective 6/8/2022 per Public Act 19 of 2022
Opioid Withdrawal Symptom Management – Alpha-2 Adrenergic Agonists	clonidine hcl 0.1mg, 0.2mg, 0.3mg tablet	Covered on formulary - Preferred Effective 6/8/2022 per Public Act 19 of 2022
Opioid Withdrawal Symptom Management – Alpha-2 Adrenergic Agonists	guanfacine 1mg, 2mg tablet	Covered on formulary - Preferred Effective 6/8/2022 per Public Act 19 of 2022
Hyperpolarization-Activated Cyclic Nucleotide- Gated Channel Inhibitors	Corlanor 5mg, 7.5mg Tablet	Covered on formulary with Prior Authorization
General Inhalation Agents	Hyper-Sal 3.5%, 7% Vial, Nebusal 3%, 6% Vial, Pulmosal 7% Vial, Sodium Chloride 3%, 7% Vial	Not Covered on formulary *Must be covered for CSHCS members
Insulin Analogs - Long Acting	insulin glargine 100 unit/ml	Covered on formulary with Prior Authorization – Non-Preferred
Dermatological - NSAID Single Agents	diclofenac 2% solution pump	Covered on formulary with Prior Authorization – Non-Preferred
Inflammatory Bowel Agent - Aminosalicylates and Related Agents	mesalamine ER 500mg capsule	Covered on formulary with Prior Authorization – Non-Preferred
Eczema Agents, Interleukin-13 (IL-13) Inhibitors, MAB	Adbry 150mg/ml Syringe	Covered on formulary with Prior Authorization and Quantity Limit – Non- Preferred
Antineoplastic - Ropeginterferon alfa-2b-njft	Besremi 500mcg/ml Syringe	Covered on formulary Effective 6/8/2022 per Public Act 19 of 2022
NSAID Analgesic, Cyclooxygenase-2 (COX-2) Selective Inhibitors	Elyxyb 120mg/4.8ml Solution	Covered on formulary with Prior Authorization – Non-Preferred
CMV Antiviral Agent - pUL97 Kinase Inhibitor	Livtencity 200mg Tablet	Covered on formulary with Prior Authorization
Cortisol synthesis inhibitor	Recorlev 150mg Tablet	Not Covered on formulary
Glucocorticosteroids	Tarpeyo DR 4mg Capsule	Not Covered on formulary
Cholinergic Muscarinic Receptor Agonist	Vuity 1.25% Eye Drop	Not Covered on formulary
Influenza Antiviral Agents - Neuraminidase Inhibitors	Tamiflu 30mg, 45mg, 75 mg Capsule, 6mg/ml Suspension	Covered on formulary with Prior Authorization and Quantity Limit – Non- Preferred

Drug Class	Drug Name	New Status
Ophthalmic Antibiotic - Fluoroquinolones	Vigamox 0.5% Eye Drops	Covered on formulary - Preferred
Ophthalmic Antibiotic - Fluoroquinolones	moxifloxacin 0.5% eye drops	Covered on formulary with Prior Authorization – Non-Preferred
Antihistamines - 2nd Generation	fexofenadine 60mg, 180mg tablet	Covered on formulary - Preferred
Asthma Therapy - Monoclonal Antibodies to Immunoglobulin E (IgE)	Xolair 150mg Vial	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Asthma Therapy - Monoclonal Antibodies to Immunoglobulin E (IgE)	Xolair 75mg/0.5ml, 150mg/ml Syringe	Covered on formulary with Prior Authorization and Age Edit – Preferred
Asthma/COPD Therapy - Beta 2-Adrenergic Agents, Inhaled, Short Acting	Proventil HFA 90mcg Inhaler	Covered on formulary with Quantity Limit –Preferred
Asthma Therapy - Monoclonal Antibody - Interleukin-5 (IL-5) Antagonists	Nucala 100mg Vial, 100mg/ml Syringe, 100mg/ml Auto-Injector	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Asthma Therapy - Monoclonal Antibody - Interleukin-5 (IL-5) Antagonists	Fasenra 30mg/ml Syringe	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Asthma Therapy - Interleukin-4 Rec. Antag Mab	Dupixent 100mg/0.67ml, 200mg/1.14ml, 300mg/2ml Syringe, Dupixent 200mg/1.14, 300mg/2ml Pen	Covered on formulary with Prior Authorization and Age Edit – Preferred

Medicaid Health Plan Common Formulary Changes Effective June 1, 2022

Drug Class	Drug Name	New Status
Dermatological - Antiviral, Herpes	Zovirax 5% Ointment	Covered on formulary with Prior Authorization – Non-Preferred
Dermatological - Antiviral, Herpes	acyclovir 5% ointment	Covered on formulary – Preferred
Insulin Analogs - Fixed Combinations	Novolog Mix 70-30 Vial	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Insulin Analogs - Fixed Combinations	insulin aspart pro mix 70-30 vial	Covered on formulary with Quantity Limit – Preferred
Insulin Analogs - Rapid Acting	insulin lispro 100 unit/ml vial, pen, JR 100 unit/ml	Covered on formulary with Quantity Limit – Preferred

Drug Class	Drug Name	New Status
Insulin Response Enhancers - Biguanides	Riomet 500mg/5 ml Solution	Covered on formulary with Prior Authorization – Non-Preferred
Multiple Sclerosis Agent - Others	Tecfidera DR 120mg, 240mg Capsules, Starter Pack	Covered on formulary with Prior Authorization – Non-Preferred
Multiple Sclerosis Agent - Others	dimethyl fumarate DR 120mg, 240mg capsules, starter Pack	Covered on formulary – Preferred

Medicaid Health Plan Common Formulary Changes Effective May 1, 2022

Drug Class	Drug Name	New Status
Minerals & Electrolytes - Magnesium	magnesium sulfate 2g/50ml, 4g/100ml, 20g/500ml, 40g/1,000ml, 4g/50ml bag	Not Covered on formulary
Minerals & Electrolytes - Magnesium	magnesium sulfate 50% syringe	Not Covered on formulary
Minerals & Electrolytes - Magnesium	magnesium sulfate 1 g/100 ml-d5w	Not Covered on formulary
Minerals & Electrolytes - Potassium, Oral	potassium cl er 20 meq tablet	Covered on formulary
Vitamins - D Derivatives	vitamin d3 25 mcg tablet	Covered on formulary
Migraine Therapy - Ergot Alkaloids and Derivatives	Trudhesa Nasal Spray	Not Covered on formulary
Dermatological - Androgen Receptor Inhibitor	Winlevi 1% Cream	Not Covered on formulary
Anti-PCSK9 Monoclonal Antibodies	Praluent 75mg/ml, 150mg/ml Pen	Covered on formulary with Prior Authorization and Quantity Limit – Preferred
Ophthalmic - Anti-inflammatory, Immunomodulators	Restasis 0.05% Eye Emulsion, Multidose 0.05% Eye	Covered on formulary with Quantity Limit – Preferred
Ophthalmic Anti-Inflammatory Immunomodulator-Type	Xiidra 5% Eye Drops	Covered on formulary with Quantity Limit – Preferred
Ophthalmic - Anti-inflammatory, Immunomodulators	Cequa 0.09% Solution	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Ophthalmic - Anti-inflammatory, Immunomodulators	cyclosporine 0.05% Eye Emulsion	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Ophthalmic - Anti-inflammatory, Glucocorticoids	Eysuvis 0.25% Eye Drops	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Ophthalmic - selective cholinergic agonist	Tyrvaya 0.03 Mg Nasal Spray	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Eczema Agents, Janus Kinase (JAK) Inhibitors	Opzelura 1.5% Cream	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Migraine Therapy - CGRP Receptor Blockers (gepants)	Qulipta 10 mg, 30 mg, 60 mg Tablet	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Growth Hormones	Skytrofa 3 mg, 3.6 mg, 4.3 mg, 5.2 mg, 6.3 mg, 7.6 mg, 9.1 mg, 11 mg, 13.3 mg Cartridge	Covered on formulary with Prior Authorization – Non-Preferred

Medicaid Health Plan Common Formulary Changes Effective February 1, 2022

Drug Class	Drug Name	New Status
Antineoplastic - Antimetabolite - Urea Derivatives	hydroxyurea 500mg capsule	Covered on formulary (plans to allow up to a 102 day-supply)
ALS Agent - Benzothiazoles	riluzole 50mg tablet	Covered on formulary
ALS Agent - Benzothiazoles	Tiglutik 50mg/10 ml Susp	Covered on formulary with Prior Authorization and Age Edit
ALS Agent - Benzothiazoles	Exservan 50mg Film	Covered on formulary with Prior Authorization and Age Edit
Diuretic - Potassium Sparing-Mineralocorticoid Receptor Antagonists	Kerendia 10mg, 20mg Tablet	Covered on formulary with Prior Authorization, Age Edit and Quantity Limit
Progestins	hydroxyprogesterone 250mg/ml vial, hydroxyprogesterone 1.25g/5ml, hydroxyprogesterone 1,250 mg/5 ml	Covered on formulary with Prior Authorization– Preferred
Rifamycins and Related Derivative Antibiotics	Aemcolo Dr 194mg Tablet	Covered on formulary with Prior Authorization, Age Edit and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Antifungal - Glucan Synthesis Inhibitors	Brexafemme 150 mg Tablet	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Gonadotropin-Releasing Hormone (GnRH) Receptor Antagonist, Estrogen and Progestin	Myfembree 40mg-1mg-0.5mg Tablet	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Anorexiant Combinations	Qsymia 3.75mg-23mg, 7.5mg-46mg, 11.25mg-69mg, 15mg-92mg Capsule	Covered on formulary with Prior Authorization and Age Edit – Preferred
Anorexiants	benzphetamine hcl 50mg tablet	Covered on formulary with Prior Authorization and Age Edit – Preferred
Anorexiants	diethylpropion 25mg, ER 75mg tablet	Covered on formulary with Prior Authorization and Age Edit – Preferred
Anorexiants	phendimetrazine 35mg tablet, phendimetrazine ER 105mg capsule	Covered on formulary with Prior Authorization and Age Edit – Preferred
Anorexiants	phentermine 15mg, 30mg, 37.5mg capsule, phentermine 37.5 tablet	Covered on formulary with Prior Authorization and Age Edit – Preferred
Anorexiants	Adipex-P 37.5 Mg Capsule, Adipex-P 37.5 Mg Tablet	Covered on formulary with Prior Authorization and Age Edit – Preferred
Anti-Obesity - Fat Absorption Decreasing Agents	Xenical 120 Mg Capsule	Covered on formulary with Prior Authorization and Age Edit – Preferred
Anti-Obesity - Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists	Saxenda 18Mg/3MI Pen	Covered on formulary with Prior Authorization and Age Edit – Preferred
Anti-Obesity - Opioid Antag/Norepinephrine & Dopamine Reuptake Inhibit	Contrave ER 8-90Mg Tablet	Covered on formulary with Prior Authorization and Age Edit – Preferred
Anti-Obesity - Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists	Wegovy 0.25mg/0.5ml, 0.5mg/0.5ml, 1mg/0.5ml, 1.7mg/0.75ml, 2.4mg/0.75ml Pen	Covered on formulary with Prior Authorization and Age Edit – Preferred
Anorexiants	Lomaira 8 Mg Tablet	Covered on formulary with Prior Authorization and Age Edit – Preferred
Eczema Agents, Systemic, Interleukin-4 Rec. Antag Mab	Dupixent 100mg/0.67ml, 200mg/1.14ml, 300mg/2ml Syringe, Dupixent 200mg/1.14ml, 300mg/2ml Pen	Covered on formulary with Prior Authorization – Preferred

Medicaid Health Plan Common Formulary Changes Effective November 1, 2021

Drug Class	Drug Name	New Status
Anthelmintic Agents Other	ivermectin 3mg tablets	Covered on formulary with Quantity Limit Effective 9/14/2021
Antiemetic - Phenothiazines	promethazine 12.5mg, 25mg, 50mg suppository	Covered on formulary with Age Edit and Quantity Limit
Inflammatory Bowel Agent - Glucocorticoids	budesonide EC 3mg capsule	Covered on formulary with Prior Authorization Quantity Limit
Gastric Acid Secretion Reducers - Histamine H2-Receptor Antagonists	cimetidine 300mg/5ml solution	Covered on formulary with Age Edit and Quantity Limit
Narcotic Antagonists	Narcan 4mg Nasal Spray	Covered on formulary with Quantity Limit * Only QL adjustment with this effective date
Narcotic Antagonists	Kloxxado 8mg Nasal Spray	Covered on formulary with Quantity Limit
Cystic Fibrosis - Inhaled Osmotic Agents	Bronchitol 40mg Inhale Capsule	Covered on formulary with Prior Authorization, Age Edit and Quantity Limit
Agents to treat Hypoglycemia (Hyperglycemics)	Glucagon 1mg Emergency Kit (Lilly product)	Covered on formulary – Preferred
Agents to treat Hypoglycemia (Hyperglycemics)	Glucagon 1mg Emergency Kit (Fresenius product)	Covered on formulary with Prior Authorization– Non-Preferred
Agents to treat Hypoglycemia (Hyperglycemics)	Proglycem 50mg/mL Oral Suspension	Covered on formulary – Preferred
Agents to treat Hypoglycemia (Hyperglycemics)	Diazoxide 50mg/mL Oral Suspension	Covered on formulary with Prior Authorization– Non-Preferred
Agents to treat Hypoglycemia (Hyperglycemics)	Glucagen 1mg Hypokit	Covered on formulary – Preferred
Agents to treat Hypoglycemia (Hyperglycemics)	Baqsimi 3mg One Pack, Two Pack Spray	Covered on formulary with Quantity Limit – Preferred
Agents to treat Hypoglycemia (Hyperglycemics)	Gvoke 0.5mg/0.1ml, 1mg/0.2ml Syringe	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Agents to treat Hypoglycemia (Hyperglycemics)	Gvoke Hypopen 1pk 0.5mg/0.1ml, 1pk 1mg/0.2ml, 2pk 0.5ml/0.1ml, 2-pk 1mg/0.2ml	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Gout Acute Therapy - Antimitotics	Mitigare 0.6mg Capsule	Covered on formulary with Prior Authorization– Non-Preferred
Gout Acute Therapy - Antimitotics	colchicine 0.6mg tablet	Covered on formulary – Preferred
Antihyperglycemic - SGLT-2 Inhibitor and Biguanide Combinations	Synjardy 5-1,000mg, 12.5-1,000mg, 5-500mg, 12.5-500mg Tablet	Covered on formulary – Preferred
Granulocyte Colony-Stimulating Factor (G-CSF)	Fulphila 6mg/0.6ml Syringe	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Gastric Acid Secretion Reducing Agents - Proton Pump Inhibitors (PPIs)	pantoprazole 40mg suspension	Covered on formulary with Prior Authorization– Non-Preferred
Overactive Bladder Agents - Beta -3 Adrenergic Receptor Agonist	Gemtesa 75mg Tablet	Covered on formulary with Prior Authorization– Non-Preferred
Multiple Sclerosis Agent - Sphingosine 1-phosphate receptor modulator	Ponvory 20mg Tablet, 14-Day Starter Pack	Covered on formulary with Prior Authorization and Age Edit – Non-Preferred
Analgesic Narcotic Agonists	Qdolo 5mg/ml Solution	Covered on formulary with Prior Authorization, Age Edit and Quantity Limit – Non-Preferred
Gallstone Solubilizing (Litholysis) Agents	Reltone 200mg, 400mg Capsule	Covered on formulary with Prior Authorization– Non-Preferred
Glucagon Analog Antihypoglycemic Agent	Zegalogue 0.6mg/0.6ml Syringe, Autoinjector	Covered on formulary with Prior Authorization– Non-Preferred

Medicaid Health Plan Common Formulary Changes Effective August 1, 2021

Drug Class	Drug Name	New Status
Aminopenicillin Antibiotic	amoxicillin 125mg, 250mg chewable tablet	Covered on formulary
Aminopenicillin Antibiotic	amoxicillin 125mg/5ml, 200mg/5ml, 250mg/5ml, 400mg/5ml suspension	Covered on formulary
Aminopenicillin Antibiotic - Beta-lactamase Inhibitor Combinations	amoxicillin-clavulanate chewable tablet	Covered on formulary

Drug Class	Drug Name	New Status
Aminopenicillin Antibiotic - Beta-lactamase Inhibitor Combinations	amoxicillin-clavulanate 200-28.5/5ml, 250-62.5mg/5ml, 400-57mg/5ml, 600-42.9mg/5ml suspension	Covered on formulary
Penicillin Antibiotic - Natural	penicillin VK 125mg/5ml, 250mg/5ml solution	Covered on formulary
Tetracycline Antibiotics	doxycycline 25mg/5ml suspension	Covered on formulary
Contraceptive Oral - Monophasic	Ocella 3mg-0.03mg Tablet	Not Covered on formulary
Contraceptive Oral - Triphasic	Tilia FE 28 Tablet	Not Covered on formulary
Urinary Alkalinizer - Citrates	potassium citrate ER 15 MEQ tablet	Covered on formulary
Therapy for Drooling- primary or secondary sialorrhea-Anticholinergic	Cuvposa 1mg/5ml Solution	Covered on formulary with Age Edit
Antihistamines - 1st Generation	clemastine fumarate 2.68mg tablet	Not Covered on formulary
Asthma Therapy - Mast Cell Stabilizers	cromolyn 20mg/2ml nebulizer solution	Not Covered on formulary
Anorectal - Glucocorticoids	hydrocortisone 2.5% cream (generic Proctosol-HC 2.5% Cream)	Covered on formulary
Ophthalmic - Anti-inflammatory, Glucocorticoids	Eysuvis 0.25% Eye Drops	Covered on formulary with Prior Authorization, Age Edit and Quantity Limit
Gastrointestinal Prokinetic Agents - D2 Antagonist/5-HT4 Agonists	Gimoti 15mg Nasal Spray	Not Covered on formulary
Immunosuppressive - Calcineurin Inhibitors	Lupkynis 7.9mg Capsule	Not Covered on formulary
Tetracycline Antibiotics	Minolira ER 105mg, 135mg Tablet	Not Covered on formulary
DMARD - Antimetabolites	Reditrex 7.5mg/0.3ml, 10mg/0.4ml, 12.5mg/0.5ml, 15mg/0.6ml, 17.5mg/0.7ml, 20mg/0.8ml, 22.5mg/0.9ml, 25mg/ml Syringe	Not Covered on formulary
Soluble Guanylate Cyclase Stimulator	Verquvo 2.5mg, 5mg, 10mg Tablet	Covered on formulary with Prior Authorization, Age Edit and Quantity Limit
Aminoglycoside Antibiotic	neomycin 500mg tablet	Covered on formulary – Preferred
Cephalosporin Antibiotics - 3rd Generation	cefixime 100mg/5ml, 200mg/5ml suspension	Covered on formulary with Prior Authorization– Non-Preferred
Fluoroquinolone Antibiotics	Cipro 5%, 10% Suspension	Covered on formulary with Prior Authorization– Non-Preferred
Fluoroquinolone Antibiotics	ciprofloxacin 250mg/5ml, 500mg/5ml suspension	Covered on formulary – Preferred

Drug Class	Drug Name	New Status
Macrolides	E.E.S. 200mg/5ml Suspension	Covered on formulary with Prior Authorization– Non-Preferred
Macrolides	Zithromax 100mg/5ml, 200mg/5ml Suspension	Covered on formulary with Prior Authorization– Non-Preferred
Macrolides	azithromycin 100mg/5ml, 200mg/5ml suspension	Covered on formulary – Preferred
Antifungal - Amphoteric Polyene Macrolides	nystatin 500,000-unit oral tablet	Covered on formulary – Preferred
Antifungal - Imidazoles	ketoconazole 200mg tablet	Covered on formulary – Preferred
Antiprotozoal-Antibacterial 2nd Generation 2-methyl-5-nitroimidazole	tinidazole 250mg, 500mg tablet	Covered on formulary – Preferred
Dermatological - Antifungal Hydroxypyridinone	ciclopirox 8% solution	Covered on formulary with Prior Authorization – Preferred
Dermatological - Antifungal Hydroxypyridinone	ciclopirox 0.77% topical suspension	Covered on formulary with Prior Authorization– Non-Preferred
Dermatological - Antifungal Hydroxypyridinone	ciclopirox 0.77% cream	Covered on formulary – Preferred
Dermatological - Antiviral, Herpes	Zovirax 5% Ointment	Covered on formulary – Preferred
Ophthalmic Antibiotic - Fluoroquinolones	Vigamox 0.5% Eye Drops	Covered on formulary with Prior Authorization– Non-Preferred
Asthma Therapy - Glucocorticoids	Asmanex HFA 50mcg, 100mcg, 200mcg Inhaler	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Asthma/COPD - Anticholinergic Agents, Inhaled Long Acting	Spiriva Respimat 1.25mcg, 2.5mcg Inhaler	Covered on formulary with Quantity Limit – Preferred
Asthma/COPD - Anticholinergic Agents, Inhaled Long Acting	Incruse Ellipta 62.5 mcg Inhaler	Covered on formulary – Preferred
Asthma/COPD Therapy - Beta 2-Adrenergic Agents, Inhaled, Short Acting	Proventil HFA 90mcg Inhaler	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Asthma/COPD Therapy - Beta 2-Adrenergic Agents, Inhaled, Short Acting	Ventolin HFA 90mcg Inhaler	Covered on formulary with Quantity Limit – Preferred
Asthma/COPD Therapy - Beta Adrenergic-Anticholinergic Combinations	Anoro Ellipta 62.5-25mcg Inhaler	Covered on formulary – Preferred
Vaginal Antibacterial - Lincosamides	clindamycin 2% vaginal cream	Covered on formulary – Preferred
Vaginal Antibacterial - Lincosamides	Clindesse 2% Vaginal Cream	Covered on formulary with Prior Authorization– Non-Preferred
Vaginal Antiprotozoal-Antibacterial - Nitroimidazole Derivatives	Vandazole Vaginal 0.75% Gel	Covered on formulary with Prior Authorization– Non-Preferred

Drug Class	Drug Name	New Status
Vaginal Antiprotozoal-Antibacterial - Nitroimidazole Derivatives	metronidazole vaginal 0.75% gel	Covered on formulary – Preferred
Ophthalmic Antibiotic - Fluoroquinolones	moxifloxacin 0.5% eye drops	Covered on formulary – Preferred
Asthma/COPD Therapy - Beta Adrenergic-Glucocorticoid Combinations	Trelegy Ellipta 100-62.5-25, 200-62.5-25	Covered on formulary – Preferred
Dermatological - Glucocorticoid	Impeklo 0.05% Lotion	Covered on formulary with Prior Authorization– Non-Preferred
Granulocyte Colony-Stimulating Factor (G-CSF)	Nyvepria 6mg/0.6ml Syringe	Covered on formulary – Preferred

Medicaid Health Plan Common Formulary Changes Effective July 1, 2021

Drug Class	Drug Name	New Status
*Opioids – Cumulative High morphine milligram equivalents (MME) - 90 per day - Effective date July 1, 2021		
Movement Disorder Therapy - Tardive Dyskinesia and Huntington's Disease	Austedo 6mg, 9mg, 12mg Tablet	Covered on formulary with Prior Authorization and Age Edit
Movement Disorder Therapy - Tardive Dyskinesia	Ingrezza 40mg, 60mg, 80mg Capsules and Ingrezza Initiation Pack	Covered on formulary with Prior Authorization and Age Edit

Medicaid Health Plan Common Formulary Changes Effective May 1, 2021

Drug Class	Drug Name	New Status
Diuretic - Loop	bumetanide 0.5mg, 1mg, 2mg tablet	Not Covered on formulary
B-Complex Vitamins	Foltanx tablet, L-Methyl-B6-B12 tablet	Not Covered on formulary
Multivitamins	L-Methyl-MC tablet, Metafolbic tablet	Not Covered on formulary
Prenatal Vitamins and Minerals	Nestabs DHA Combo Pack	Not Covered on formulary
Vitamins - B Preparation Combinations	Folbic RF tablet, Foltx tablet	Not Covered on formulary
Glucocorticoids	Alkindi Sprinkle Capsule 0.5mg, 1mg, 2mg, 5mg,	Covered on formulary with Prior Authorization, and Age Edit

Drug Class	Drug Name	New Status
Interleukin-6 (IL-6) Receptor Inhibitors	Enspryng 120mg/ml Syringe	Covered on formulary with Prior Authorization, Age Edit and Quantity Limit
Antiprotozoal Other	Lampit 30mg, 120mg Tablet	Not Covered on formulary
Somatostatic Agents	Mycapssa DR 20mg Capsule	Not Covered on formulary
Narcolepsy & Cataplexy Therapy Agents - Sedative-Type	Xywav 0.5gm/ml Oral Solution	Covered on formulary with Prior Authorization, Age Edit and Quantity Limit
Dermatological - Topical Local Anesthetic Amides	lidocaine 5% patch	Covered on formulary with Prior Authorization
Antihyperlipidemic - Fibric Acid Derivatives	fenofibrate 67mg, 134mg, 200mg capsule	Covered on formulary - Preferred
ACE Inhibitors-Diuretic Combinations	enalapril-hctz 5-12.5mg, 10-25mg tablet	Covered on formulary - Preferred
Pulmonary Antihypertensive Agents - Endothelin Receptor Antagonists	Letairis 5mg, 10mg Tablet	Covered on formulary with Prior Authorization– Non-Preferred
Ophthalmic - Antihistamines	azelastine 0.05% drops	Covered on formulary - Preferred
Ophthalmic - Anti-inflammatory, NSAIDs	ketorolac 0.4% ophthalmic solution	Covered on formulary with Prior Authorization– Non-Preferred
Ophthalmic - Anti-inflammatory, NSAIDs	Acular 0.5% Eye Drop	Covered on formulary with Prior Authorization– Non-Preferred
Ophthalmic-Intraocular Pressure Reducing Agents, Prostaglandin Analogs	Travatan Z 0.004% Eye Drop	Covered on formulary with Prior Authorization– Non-Preferred
Angiotensin II Receptor Blockers (ARBs)	olmesartan medoxomil 5mg, 20mg, 40mg tablet	Covered on formulary - Preferred
Angiotensin II Receptor Blocker (ARB)-Calcium Channel Blocker Comb.	amlodipine-olmesartan 5-20mg, 5-40mg, 10-20mg, 10-40mg tablet	Covered on formulary - Preferred
Angiotensin II Receptor Blocker (ARB)-Diuretic Combinations	olmesartan-hctz 20-12.5mg, 40-12.5mg, 40-25mg tablet	Covered on formulary - Preferred
Ophthalmic - Beta blockers-Carbonic Anhydrase Inhibitor Combinations	dorzolamide-timolol 2%-0.5%	Covered on formulary with Prior Authorization– Non-Preferred
Ophthalmic - Intraocular Pressure Reducing Agents, Beta-blockers	timolol maleate 0.5% eye drop	Covered on formulary with Prior Authorization– Non-Preferred
Pulmonary Antihypertensive Agents - Endothelin Receptor Antagonists	ambrisentan 5mg, 10mg tablet	Covered on formulary with Prior Authorization– Preferred
Multiple Sclerosis Agent - Others	Bafiertam DR 95mg Capsule	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Multiple Sclerosis Agent - CD20-Directed Cytolytic Antibody	Kesimpta 20mg/0.4ml Pen	Covered on formulary with Prior Authorization– Non-Preferred
COPD Therapy Agents	Breztri Aerosphere Inhaler	Covered on formulary with Prior Authorization– Non-Preferred
Antiparkinson Adjuvant - Peripheral COMT Inhibitors	Ongentys 25mg, 50mg Capsule	Covered on formulary with Prior Authorization– Non-Preferred
Insulin Analogs - Long Acting	Semglee 100 unit/ml Vial, Pen	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Medicaid Health Plan Common Formulary Changes Effective February 1, 2021

Drug Class	Drug Name	New Status
Antineoplastic - Alkylating Agent - Nitrogen Mustards	cyclophosphamide 25mg, 50mg capsule	Covered on formulary with Quantity Limit
Acne Therapy Topical - Anti-infective-Keratolytic Combinations	erythromycin-benzoyl peroxide gel (generic Benzamycin Gel)	Covered on formulary
Dermatological Irritants-Counter-Irritant Single Agents	capsaicin 0.025% cream	Not Covered on formulary
Dermatological - Topical Local Anesthetic Amides	lidocaine 3% cream, 5% ointment	Covered on formulary with Quantity Limit
Antiemetic - Substance P-Neurokinin 1 (NK1) Receptor Antagonists	Emend 40mg Capsule	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Somatostatic Agents	Bynfezia 2,500 mcg/ml Pen	Not Covered on formulary
LHRH (GnRH) Agonist Analog Pit Suppres - Central Precocious Puberty	Fensolvi 45mg Syringe Kit	Not Covered on formulary
Inflammatory Bowel Agent - Glucocorticoids	Ortikos ER 6mg, 9mg Capsule	Not Covered on formulary
Acne Therapy Topical - Anti-infective - Tetracycline	Zilxi 1.5% Foam	Not Covered on formulary
Antimigraine Agents, Preventive Treatment	Aimovig 70mg/ml, 140mg/ml Autoinjector	Covered on formulary with Prior Authorization and Quantity Limit – Preferred <i>*Effective 12/15/2020</i>
Skeletal Muscle Relaxants	methocarbamol 500mg, 750mg tablet	Covered on formulary – Preferred <i>*Effective 12/15/2020</i>
Narcotics – Long Acting	tramadol ER 100mg, 200mg, 300mg tablet	Covered on formulary - Preferred
Narcotics – Transdermal	Butrans 5mcg/HR, 7.5mcg/ HR, 10mcg/HR, 15mcg/ HR, 20mcg/ HR Patch	Covered on formulary Quantity Limit – Preferred
Narcotics – Short and Intermediate Acting	tramadol-acetaminophen 37.5-325	Covered on formulary - Preferred
Alpha Adrenergic Agents	Catapres-TTS 1, Catapres-TTS 2, Catapres-TTS 3 Patch	Covered on formulary Quantity Limit – Preferred
Alpha Adrenergic Agents	clonidine 0.1mg/day, 0.2mg/day, 0.3mg/day patch	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred

Drug Class	Drug Name	New Status
Antiparkinson's Agents - Other	carbidopa-levodopa ER 25-100, 50-200 tablet	Covered on formulary - Preferred
Antiparkinson's Agents - Dopamine Agonists	Neupro 1 mg/24 HR, 2 mg/24 HR, 3 mg/24 HR, 4 mg/24 HR, 6 mg/24 HR, 8 mg/24 HR Patch	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Neuropathic Pain	Savella 12.5mg, 25mg, 50mg, 100mg Tablet, Savella Titration Pack	Covered on formulary with Quantity Limit – Preferred
Antimigraine Agents, Acute Treatment - Triptans	Relpax 20mg, 40mg Tablet	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Antimigraine Agents, Acute Treatment - Triptans	Imitrex 5mg, 20mg Nasal Spray	Covered on formulary with Quantity Limit – Preferred
Antimigraine Agents, Acute Treatment - Triptans	Zomig 2.5mg, 5mg Nasal Spray	Covered on formulary with Prior Authorization– Non-Preferred
Neuropathic Pain	Horizant ER 300mg Tablet	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Neuropathic Pain	Gralise ER 300mg Tablet	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Combination Benzoyl Peroxide and Clindamycin	clindamycin-benzoyl peroxide 1-5%, clind PH-benzoyl peroxide 1.2-5%, clinda-benzoyl peroxide 1-5% pump, clind PH-benzoyl pero 1.2-2.5%	Covered on formulary - Preferred
Topical Steroids – High Potency	betamethasone dipropionate 0.05% cream, lotion, ointment	Covered on formulary - Preferred
Multiple Sclerosis Agents	Rebif 22mcg/0.5ml Syringe, Rebif Titration Pack, Rebif Rebidose 22mcg/0.5ml, 44mcg/0.5ml, Rebif Rebidose Titration Pack	Covered on formulary with Prior Authorization– Non-Preferred
Multiple Sclerosis Agents	Rebif 44mcg/0.5ml Syringe	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Immunomodulators: Atopic Dermatitis	Eucrisa 2% Ointment	Covered on formulary with Prior Authorization and Quantity Limit – Preferred

Drug Class	Drug Name	New Status
Opioid Withdrawal Symptom Management	Lucemyra 0.18mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Uterine Disorder Treatments	Orilissa 150mg, 2000mg Tablet	Covered on formulary with Prior Authorization, and Age Edit – Preferred
Uterine Disorder Treatments	Oriahnn 300-1-0.5mg/300mg Capsule	Covered on formulary with Prior Authorization, and Age Edit – Preferred
Antiparkinson's Agents - Dopamine Agonists	Kynmobi 10mg, 15mg, 20mg, 25mg, 30mg SL Film, Kynmobi Titration Kit	Covered on formulary with Prior Authorization– Non-Preferred
Non-Steroidal Anti-Inflammatory Drugs (NSAIDS)	Licart 1.3% Patch	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Insulins, Rapid Acting	Lyumjev 100 Unit/ml KwikPen	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit – Non-Preferred
Lipotropics: Other	Nexlizet 180-10mg Tablet	Covered on formulary with Prior Authorization, and Age Edit – Non-Preferred
Topical Antibiotics	Xepi 1% Cream	Covered on formulary with Prior Authorization and Quantity Limit – Non-Preferred
Multiple Sclerosis Agents	Zeposia 0.23-0.46mg Starter Pack, 0.23-0.46-0.95mg Kit, Zeposia 0.92mg Capsule	Covered on formulary with Prior Authorization– Non-Preferred
Opioid Withdrawal Symptom Management	Clonidine HCL 0.1mg, 0.2mg, 0.3mg Tablet	Covered on formulary - Preferred
Opioid Withdrawal Symptom Management	Catapres 0.1mg, 0.2mg, 0.3mg Tablet	Covered on formulary with Prior Authorization– Non-Preferred
Gastric Acid Secretion Reducing Agents - Proton Pump Inhibitors (PPIs)	Nexium 2.5mg, 5mg, 10mg, 20mg, 40mg Suspension Packets	Covered on formulary - Preferred

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Drug Class	Drug Name	New Status
Dermatological - Antipsoriatic Agents Topical	Arazlo 0.045% Lotion	Not Covered on formulary
Cortisol synthesis inhibitor	Isturisa 1 mg, 5 mg, 10 mg	Not Covered on formulary
Allergenic Extracts - Peanuts	Palforzia initial Dose Pack, 3 mg (Level 1), 6 mg (Level 2), 12 mg (Level 3), 20 mg (Level 4), 40 mg (Level 5), 80 mg (Level 6), 120 mg (Level 7), 160 mg (Level 8), 200 mg (Level 9), 240 mg (Level 10), 300 mg (Level 11) 300 mg (Maintenance)	Covered on formulary with Prior Authorization and Age Edit
Progestins	Makena 275 mg/1.1 ml Autoinjector, 250 mg/ml, 1,250 mg/5 ml Vial	Covered on formulary with Prior Authorization and Quantity Limit - Non-Preferred
Progestins	hydroxyprogesterone 250 mg/ml, 1,250 mg/5 ml vial	Covered on formulary with Prior Authorization and Quantity Limit - Preferred
Granulocyte Colony-Stimulating Factor (G-CSF)	Neulasta 6 mg/0.6 ml Syringe, Neulasta Onpro 6 mg/0.6 ml Kit	Covered on formulary with Prior Authorization and Quantity Limit - Non-Preferred
Granulocyte Colony-Stimulating Factor (G-CSF)	Fulphila 6 mg/0.6 ml Syringe	Covered on formulary with Quantity Limit - Preferred
Granulocyte Colony-Stimulating Factor (G-CSF)	Udenyca 6 mg/0.6 ml Syringe	Covered on formulary with Quantity Limit - Preferred
Granulocyte Colony-Stimulating Factor (G-CSF)	Ziextenzo 6 mg/0.6 ml Syringe	Covered on formulary with Prior Authorization and Quantity Limit - Non-Preferred
Glucocorticoids	Emflaza	Covered on formulary with Prior Authorization and Age Edit <i>*This change is retroactively effective 10/1/2020</i>
Antihyperglycemic - Sodium Glucose Cotransporter-2 (SGLT2) Inhibitors	Invokana 100mg, 300mg Tablet	Covered on formulary - Preferred

Drug Class	Drug Name	New Status
Antihyperglycemic - Sodium Glucose Cotransporter-2 (SGLT2) Inhibitors	Farxiga 5mg, 10mg Tablet	Covered on formulary - Preferred
Antihyperglycemic - Sodium Glucose Cotransporter-2 (SGLT2) Inhibitors	Jardiance 10mg, 25mg Tablet	Covered on formulary - Preferred
Asthma/COPD - Anticholinergic Agents, Inhaled Long Acting	Spiriva 18mcg CP-Handihaler	Covered on formulary with Quantity Limit - Preferred

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Drug Class	Drug Name	New Status
Androgen - Single Agents	Androgel 1%(2.5G), 1%(5G), 1.62%(1.25G), 1.62%(2.5G) Gel Packet, 1.62% Gel Pump	Covered on formulary with Prior Authorization - Non-Preferred
Growth Hormones	Nutropin AQ Nuspin 5, 10, 20 Injector	Covered on formulary with Prior Authorization - Non-Preferred
Bone Formation Stimulating Agents - Parathyroid Hormone-Type	Forteo 600 mcg/2.4 ml Pen Inj	Covered on formulary with Prior Authorization - Non-Preferred
Human Insulins - Fixed Combinations	Humulin 70/30 KwikPen	Covered on formulary with Quantity Limit - Preferred
Human Insulins - Fixed Combinations	Novolin 70-30 Flexpen	Covered on formulary with Prior Authorization and Quantity Limit - Non-Preferred
Gallstone Solubilizing (Litholysis) Agents	ursodiol 300 mg capsule	Covered on formulary - Preferred
IBS Agent - Gastrointestinal Chloride Channel Activator Agents	Amitiza 8 mcg Capsule	Covered on formulary - Preferred
IBS-C/CIC Agents, Guanylate Cyclase-C Agonist	Linzess 72 mcg, 145 mcg, 290 mcg Capsule	Covered on formulary - Preferred
Urinary Antispasmodic - Antichol., M(3) Muscarinic Selective (Bladder)	Vesicare 5 mg, 10 mg Tablet	Covered on formulary with Prior Authorization - Non-Preferred
Erythropoietins	Epogen 2,000 units/ml, 3,000 units/ml, 4,000 units/ml, 10,000 units/ml, 20,000 units/ 2ml, 20,000 units/ml Vials	Covered on formulary with Prior Authorization - Preferred

Drug Class	Drug Name	New Status
Erythropoietins	Procrit 2,000 units/ml, 3,000 units/ml, 4,000 units/ml, 10,000 units/ml, 20,000 units/ml, 40,000 units/ml Vials	Covered on formulary with Prior Authorization - Non-Preferred
Antipsoriatic Agents, Systemic	Taltz 80 mg/ml Autoinj (2-Pk), Taltz 80 mg/ml Syringe, Taltz 80 mg/ml Autoinjector, Taltz 80 mg/ml Autoinj (3-Pk)	Covered on formulary with Prior Authorization - Non-Preferred
Phosphate Binders	sevelamer 0.8 gm, 2.4 gm powder packet, sevelamer 800 mg tablet	Covered on formulary with Prior Authorization - Non-Preferred
Bone Formation Stimulating Agents - Parathyroid Hormone-Type	Tymlos 80 mcg Dose Pen Injector	Covered on formulary with Prior Authorization - Non-Preferred
Antihyperglycemic, Incretin Mimetic, GLP-1 Receptor Agonist Analog-Type	Ozempic 0.25-0.5 mg, 1 mg Dose Pen	Covered on formulary with Prior Authorization - Non-Preferred
Androgen - Single Agents	testosterone 1.62% gel pump	Covered on formulary with Prior Authorization - Preferred
Urinary Antispasmodic - Antichol., M(3) Muscarinic Selective (Bladder)	solifenacin 5 mg, 10 mg tablet	Covered on formulary - Preferred
Insulin Response Enhancers - Biguanides	metformin hcl 500 mg/5 ml solution	Covered on formulary with Prior Authorization - Non-Preferred
Adenosine triphosphate-citrate lyase (ACL) inhibitor	Nexletol 180 mg Tablet	Covered on formulary with Prior Authorization and Age Edit - Non-Preferred
Migraine Therapy - Calcitonin Gene-Related Peptide Antagonist	Nurtec ODT 75 mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit - Preferred
Migraine Therapy - Selective Serotonin Agonists 5-HT(1)	Reyvow 50 mg, 100 mg Tablet	Covered on formulary with Prior Authorization, Quantity Limit and Age Edit - Non-Preferred
Peptic Ulcer-Treatment H. Pylori - Proton Pump Inhibitor & Antibiotics	Talicia DR 10-250-12.5 mg Capsule	Covered on formulary with Prior Authorization - Non-Preferred
Antihyperglycemic - SGLT-2 Inhibitor- DPP-4 Inhibitor & Biguanide Combinations	Trijardy XR 5-2.5-1,000 mg, 12.5-2.5-1,000 mg, 10-5-1,000 mg, 25-5-1,000 mg	Covered on formulary with Prior Authorization - Non-Preferred
Ophthalmic - Antihistamines	Zerviate 0.24% Eye Drop	Covered on formulary with Prior Authorization - Non-Preferred