

Umpqua Health Alliance

List of Medication Coverage Changes



(Updated 11/1/2023)

INTRODUCTION

The Umpqua Health Alliance (UHA) Pharmacy and Therapeutics (P&T) Committee composed of pharmacists and physicians determine which drugs should be covered, the coverage restrictions, and the PA guidelines. The goal of the P&T Committee is to create a formulary (list of covered drugs) with medications that are safe and effective and that offer the best value.

Our formulary and prior authorization guidelines are usually updated quarterly. **This document contains all updates made to the UHA formulary and PA guidelines since January 1, 2020.** The current versions of our formulary and PA guidelines are available on the UHA Pharmacy Services webpage: <https://www.umpquahealth.com/pharmacy-services/>.

LEGEND

The following are restriction and coverage abbreviations found in this document:

ABBREVIATIONS	DEFINITION	EXPLANATION
PA	Prior Authorization Required	Prior authorization (e.g. prior approval) is required before filling a prescription for this drug. Without prior authorization, we may not cover this drug. The provider must submit a request for prior authorization with the appropriate documentation (including recent chart notes) before the drug is covered. A specific PA guideline policy number beginning with “RX” may be referenced in the “Description” column. Visit the UHA Pharmacy Services webpage for our PA guidelines: https://www.umpquahealth.com/pharmacy-services/ .
ST	Step Therapy Restriction	We require trial and failure of one or more lower-cost or preferred drug(s) (“Step 1 drug”) before using the more expensive or non-preferred drug (“Step 2 drug”). If it is medically necessary for a member to use a Step 2 drug first, the prescriber will need to submit a request for prior authorization.
AR	Age Restriction	Coverage of this drug is limited to a specific age range. Covered ages are listed. A prior authorization is required for members outside of the listed age range.
QL	Quantity Limit	We will cover this drug only up to a certain quantity or limit per time or per fill. The specific quantity limit is listed. If it is medically necessary to exceed the quantity limit, the prescriber will need to submit a request for prior authorization.
SPEC	Specialty Drug	Coverage for specialty drugs will only be provided if the drug is obtained through our contracted specialty pharmacy, MedImpact Direct Specialty Hub. <i>MedImpact Direct Specialty Hub</i> <i>Telephone: (877) 391-1103</i> <i>Fax: (888) 807-5716</i> <i>Website: www.medimactedirect.com</i>

MEDICATION COVERAGE CHANGES

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	9/1/23	ABRYSVO	VIRAL/TUMORIGENIC VACCINES	120MCG/0.5	INTRAMU SC.	VIAL	ADDED TO FORMULARY WITH A QUANTITY LIMIT	QL (1 PER LIFETIME)
PHARMACY	9/1/23	AREXVY	VIRAL/TUMORIGENIC VACCINES	120MCG/0.5	INTRAMU SC.	KIT	ADDED TO FORMULARY WITH A QUANTITY LIMIT	QL (1 PER LIFETIME)
PHARMACY	9/1/23	AREXVY ANTIGEN COMPONENT	VIRAL/TUMORIGENIC VACCINES	120 MCG	INTRAMU SC.	VIAL	ADDED TO FORMULARY WITH A QUANTITY LIMIT	QL (1 PER LIFETIME)
PHARMACY	9/1/23	BUPRENORPHINE HCL	NARCOTIC WITHDRAWAL THERAPY AGENTS	2 MG	SUBLINGU AL	TAB SUBL	UPDATED QUANTITY LIMITS	QL (16 IN 1 DAY, MUST NOT EXCEED 32MG OF BUPRENORPHINE)
PHARMACY	9/1/23	BUPRENORPHINE HCL	NARCOTIC WITHDRAWAL THERAPY AGENTS	8 MG	SUBLINGU AL	TAB SUBL	UPDATED MAX MG/QUANTITY LIMITS	QL (4 IN 1 DAY, MUST NOT EXCEED 32MG OF BUPRENORPHINE)
PHARMACY	9/1/23	BUPRENORPHINE-NALOXONE	NARCOTIC WITHDRAWAL THERAPY AGENTS	2 MG-0.5MG	SUBLINGU AL	FILM	UPDATED MAX MG/QUANTITY LIMITS	QL (16 IN 1 DAY, MUST NOT EXCEED 32MG OF BUPRENORPHINE)
PHARMACY	9/1/23	BUPRENORPHINE-NALOXONE	NARCOTIC WITHDRAWAL THERAPY AGENTS	4MG-1MG	SUBLINGU AL	FILM	UPDATED MAX MG/QUANTITY LIMITS	QL (9 IN 1 DAY, MUST NOT EXCEED 32MG OF BUPRENORPHINE)
PHARMACY	9/1/23	BUPRENORPHINE-NALOXONE	NARCOTIC WITHDRAWAL THERAPY AGENTS	8 MG-2 MG	SUBLINGU AL	FILM	UPDATED MAX MG/QUANTITY LIMITS	QL (4 IN 1 DAY, MUST NOT EXCEED 32MG OF BUPRENORPHINE)
PHARMACY	9/1/23	BUPRENORPHINE-NALOXONE	NARCOTIC WITHDRAWAL THERAPY AGENTS	12 MG-3 MG	SUBLINGU AL	FILM	UPDATED MAX MG/QUANTITY LIMITS	QL (2 IN 1 DAY, MUST NOT EXCEED 32MG OF BUPRENORPHINE)
PHARMACY	9/1/23	BUPRENORPHINE-NALOXONE	NARCOTIC WITHDRAWAL THERAPY AGENTS	2 MG-0.5MG	SUBLINGU AL	TAB SUBL	UPDATED MAX MG/QUANTITY LIMITS	QL (16 IN 1 DAY, MUST NOT EXCEED 32MG OF BUPRENORPHINE)
PHARMACY	9/1/23	BUPRENORPHINE-NALOXONE	NARCOTIC WITHDRAWAL THERAPY AGENTS	8 MG-2 MG	SUBLINGU AL	TAB SUBL	UPDATED MAX MG/QUANTITY LIMITS	QL (4 IN 1 DAY, MUST NOT EXCEED 32MG OF BUPRENORPHINE)
PHARMACY	9/1/23	FLUCELVAX QUAD 2023-2024	INFLUENZA VIRUS VACCINES	60MCG/.5 ML	INTRAMU SC.	VIAL	ADDED TO FORMULARY WITH AN AGE RESTRICTION	COVERED FOR AGE 19 AND OLDER.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	9/1/23	FLUCELVAX QUAD 2023-2024	INFLUENZA VIRUS VACCINES	60MCG/.5 ML	INTRAMU SC.	SYRINGE	ADDED TO FORMULARY WITH AN AGE RESTRICTION	COVERED FOR AGE 19 AND OLDER.
PHARMACY	9/1/23	FLUBLOK QUAD 2023-2024	INFLUENZA VIRUS VACCINES	180MCG/0.5	INTRAMU SC.	SYRINGE	ADDED TO FORMULARY WITH AN AGE RESTRICTION	COVERED FOR AGE 19 AND OLDER.
PHARMACY	9/1/23	AFLURIA QUAD 2023-2024	INFLUENZA VIRUS VACCINES	60MCG/.5 ML	INTRAMU SC.	VIAL	ADDED TO FORMULARY WITH AN AGE RESTRICTION	COVERED FOR AGE 19 AND OLDER.
PHARMACY	9/1/23	FLUZONE QUAD 2023-2024	INFLUENZA VIRUS VACCINES	60MCG/.5 ML	INTRAMU SC.	VIAL	ADDED TO FORMULARY WITH AN AGE RESTRICTION	COVERED FOR AGE 19 AND OLDER.
PHARMACY	9/1/23	FLUAD QUAD 2023-2024	INFLUENZA VIRUS VACCINES	60MCG/.5 ML	INTRAMU SC.	SYRINGE	ADDED TO FORMULARY WITH AN AGE RESTRICTION	COVERED FOR AGE 19 AND OLDER.
PHARMACY	9/1/23	AFLURIA QUAD 2023-24 (3YR UP)	INFLUENZA VIRUS VACCINES	60MCG/.5 ML	INTRAMU SC.	SYRINGE	ADDED TO FORMULARY WITH AN AGE RESTRICTION	COVERED FOR AGE 19 AND OLDER.
PHARMACY	9/1/23	FLUZONE HIGH-DOSE QUAD 2023-24	INFLUENZA VIRUS VACCINES	240MCG/0.7	INTRAMU SC.	SYRINGE	ADDED TO FORMULARY WITH AN AGE RESTRICTION	COVERED FOR AGE 19 AND OLDER.
PHARMACY	9/1/23	FLULAVAL QUAD 2023-2024	INFLUENZA VIRUS VACCINES	60MCG/.5 ML	INTRAMU SC.	SYRINGE	ADDED TO FORMULARY WITH AN AGE RESTRICTION	COVERED FOR AGE 19 AND OLDER.
PHARMACY	9/1/23	FLUZONE QUAD 2023-2024	INFLUENZA VIRUS VACCINES	60MCG/.5 ML	INTRAMU SC.	SYRINGE	ADDED TO FORMULARY WITH AN AGE RESTRICTION	COVERED FOR AGE 19 AND OLDER.
PHARMACY	9/1/23	FLUARIX QUAD 2023-2024	INFLUENZA VIRUS VACCINES	60MCG/.5 ML	INTRAMU SC.	SYRINGE	ADDED TO FORMULARY WITH AN AGE RESTRICTION	COVERED FOR AGE 19 AND OLDER.
PHARMACY	9/1/23	FLUMIST QUAD 2023-2024	INFLUENZA VIRUS VACCINES	10E6.5-7.5	NASAL	NAS SP SYR	ADDED TO FORMULARY WITH AN AGE RESTRICTION	COVERED FOR AGE 19 AND OLDER.
PHARMACY	8/1/23	PRASUGREL HCL	PLATELET AGGREGATION INHIBITORS	5 MG	ORAL	TABLET	REMOVED DEA PHYSICIAN SPECIALTY RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	8/1/23	PRASUGREL HCL	PLATELET AGGREGATION INHIBITORS	10 MG	ORAL	TABLET	REMOVED DEA PHYSICIAN SPECIALTY RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	5/1/23	ANTIHYPERGLY,INC RETIN MIMETIC(GLP-1 RECEP.AGONIST)	TRULICITY	0.75MG/0.5	SUBCUTANE.	PEN INJCTR	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX007).
PHARMACY	5/1/23	ANTIHYPERGLY,INC RETIN MIMETIC(GLP-1 RECEP.AGONIST)	TRULICITY	1.5 MG/0.5	SUBCUTANE.	PEN INJCTR	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX007).
PHARMACY	5/1/23	BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED	BREZTRI AEROSPHERE	160-9-4.8	INHALATION	HFA AERAD	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX041).
PHARMACY	5/1/23	INFLAMMATORY DISEASE	HUMIRA PEN PSOR- UVEITS-ADOL HS	40MG/0.8 ML	SUBCUTANE.	PEN IJ KIT	REMOVED FROM FORMULARY	PREFERRED ALTERNATIVES ARE AVAILABLE. SEE PA GUIDELINES (RX040)
PHARMACY	5/1/23	INFLAMMATORY DISEASE	HUMIRA PEN	40MG/0.8 ML	SUBCUTANE.	PEN IJ KIT	REMOVED FROM FORMULARY	PREFERRED ALTERNATIVES ARE AVAILABLE. SEE PA GUIDELINES (RX040)
PHARMACY	5/1/23	INFLAMMATORY DISEASE	HUMIRA	20MG/0.4 ML	SUBCUTANE.	SYRINGE KIT	REMOVED FROM FORMULARY	PREFERRED ALTERNATIVES ARE AVAILABLE. SEE PA GUIDELINES (RX040)
PHARMACY	3/1/23	TOPICAL ANTI-INFLAMMATORY STEROIDAL	HYDROCORTISONE	2.5 %	TOPICAL	CREAM	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	3/1/23	TOPICAL ANTI-INFLAMMATORY STEROIDAL	HYDROCORTISONE	1 %	TOPICAL	CREAM	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	3/1/23	TOPICAL ANTI-INFLAMMATORY STEROIDAL	HYDROCORTISONE	2.5 %	TOPICAL	OINTMENT	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	3/1/23	TOPICAL ANTI-INFLAMMATORY STEROIDAL	HYDROCORTISONE	1 %	TOPICAL	OINTMENT	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	2/1/23	ANTIDIARRHEAL MICROORGANISMS AGENTS	ACIDOPHILUS	175 MG	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	1/1/23	SMOKING DETERRENT-NICOTINIC	VARENICLINE TARTRATE	1 MG	ORAL	TABLET	UPDATED QUANTITY LIMITS	QL (2 TABLETS PER DAY, 180 TABLETS PER 180 DAYS)

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
		RECEPT.PARTIAL AGONIST						
PHARMACY	12/7/22	ANTIDIURETIC AND VASOPRESSOR HORMONES	DESMOPRESSIN ACETATE	0.1 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	12/7/22	ANTIDIURETIC AND VASOPRESSOR HORMONES	DESMOPRESSIN ACETATE	0.2 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	12/7/22	HEP C - NS5A, NS3/4A, NUCLEOTIDE NS5B INHIB COMBO	VOSEVI	400-100 MG	ORAL	TABLET	REMOVED FROM FORMULARY	MAVYRET AND SOFOSBUVIR-VELPATASVIR ARE PREFERRED AGENTS. SEE PA GUIDELINES FOR DETAILS (RX019).
PHARMACY	12/7/22	HEPATITIS C VIRUS-NS5A AND NS3/4A INHIBITOR COMB	MAVYRET (GLECAPREVIR/PIBREN TASVIR)	100MG-40MG	ORAL	TABLET	REMOVED PA RESTRICTION, ADDED QUANTITY LIMITS	QL (168 TABLETS PER LIFETIME).
PHARMACY	12/7/22	HEP C VIRUS - NS5A & NS5B POLYMERASE INHIB. COMBO.	SOFOSBUVIR-VELPATASVIR	400-100 MG	ORAL	TABLET	REMOVED PA RESTRICTION, ADDED QUANTITY LIMITS	QL (168 TABLETS PER LIFETIME).
PHARMACY	12/7/22	INSULINS	INSULIN GLARGINE	100/ML	SUBCUTANE.	VIAL	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	12/7/22	INSULINS	INSULIN GLARGINE SOLOSTAR	100/ML	SUBCUTANE.	PEN	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	8/1/2022	GLUCOCORTICOID, ORALLY INHALED	FLUTICASONE PROPIONATE HFA	220 MCG	INHALATION	AER W/ADAP	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	8/1/2022	ANTIHYPERGLYCEM C-SOD/GLUC COTRANSPORT2(SGLT2)INHIB	STEGLATRO (ERTUGLIFLOZIN PIDOLATE)	5 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	8/1/2022	ANTIHYPERGLYCEM C-SOD/GLUC COTRANSPORT2(SGLT2)INHIB	STEGLATRO (ERTUGLIFLOZIN PIDOLATE)	15 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	8/1/2022	ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS	ALOGLIPTIN	6.25 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	8/1/2022	ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS	ALOGLIPTIN	12.5 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	8/1/2022	ANTIHYPERGLYCEMIC, DPP-4 INHIBITORS	ALOGLIPTIN	25 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	8/1/2022	ANTIHYPERGLY, (DPP-4) INHIBITOR & BIGUANIDE COMB.	ALOGLIPTIN-METFORMIN	12.5-500MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	8/1/2022	ANTIHYPERGLY, (DPP-4) INHIBITOR & BIGUANIDE COMB.	ALOGLIPTIN-METFORMIN	12.5-1000	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	8/1/2022	ANTIHYPERGLY, DPP-4 ENZYME INHIB & THIAZOLIDINEDIONE	ALOGLIPTIN-PIOGLITAZONE	12.5-15 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	8/1/2022	ANTIHYPERGLY, DPP-4 ENZYME INHIB & THIAZOLIDINEDIONE	ALOGLIPTIN-PIOGLITAZONE	12.5-30 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	8/1/2022	ANTIHYPERGLY, DPP-4 ENZYME INHIB & THIAZOLIDINEDIONE	ALOGLIPTIN-PIOGLITAZONE	12.5-45 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	8/1/2022	ANTIHYPERGLY, DPP-4 ENZYME INHIB & THIAZOLIDINEDIONE	ALOGLIPTIN-PIOGLITAZONE	25 MG-15MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	8/1/2022	ANTIHYPERGLY, DPP-4 ENZYME INHIB & THIAZOLIDINEDIONE	ALOGLIPTIN-PIOGLITAZONE	25 MG-30MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.
PHARMACY	8/1/2022	ANTIHYPERGLY, DPP-4 ENZYME INHIB & THIAZOLIDINEDIONE	ALOGLIPTIN-PIOGLITAZONE	25 MG-45MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTIONS.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	5/1/2022	XANTHINES	THEOPHYLLINE (THEOPHYLLINE ANHYDROUS)	400 MG	ORAL	TAB ER 24H	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2022	TOPICAL ANTIBIOTICS	FIRST AID ANTIBIOTIC (NEOMYCIN/BACITRACIN/POLYMYXINB)	3.5-500/G	TOPICAL	OINT. (G)	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2022	TOPICAL ANTIBIOTICS	BACITRACIN	500 UNIT/G	TOPICAL	OINT. (G)	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2022	TOPICAL ANTIBIOTICS	BACITRACIN ZINC	500 UNIT/G	TOPICAL	OINT. (G)	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2022	TOPICAL ANTIBIOTICS	BACITRACIN ZINC	500 UNIT/G	TOPICAL	OINT. (G)	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2022	TOPICAL ANTIBIOTICS	ANTIBIOTIC (BACITRACIN ZINC)	500 UNIT/G	TOPICAL	OINT. (G)	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2022	TOPICAL ANTIBIOTICS	BACITRAYCIN PLUS (BACITRACIN)	500 UNIT/G	TOPICAL	OINT. (G)	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	MAGNESIUM SALTS REPLACEMENT	MAGNESIUM OXIDE	200 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	MAGNESIUM SALTS REPLACEMENT	MAG-OXIDE (MAGNESIUM OXIDE)	200 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ANTACIDS	MAGNESIUM OXIDE	400 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	MAGNESIUM SALTS REPLACEMENT	MAGNESIUM OXIDE	400 MG	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	MAGNESIUM SALTS REPLACEMENT	MAGNESIUM (MAGNESIUM OXIDE)	400 MG	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ZINC REPLACEMENT	ZINC GLUCONATE	10 MG	ORAL	LOZENGE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	11/1/2021	ZINC REPLACEMENT	ZINC GLUCONATE	30 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ZINC REPLACEMENT	ZINC GLUCONATE	50 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ZINC REPLACEMENT	ZINC GLUCONATE	100 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ZINC REPLACEMENT	ZINC SULFATE	50(220)MG	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ZINC REPLACEMENT	ORAZINC (ZINC SULFATE)	25(110) MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ZINC REPLACEMENT	ZINC SULFATE	50(220)MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ZINC REPLACEMENT	ZINC-15 (ZINC SULFATE)	66 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ZINC REPLACEMENT	ZINC AMINO ACID CHELATE	50 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	LAXATIVES, LOCAL/RECTAL	GLYCERIN	ADULT	RECTAL	SUPP.RE CT	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	LAXATIVES, LOCAL/RECTAL	GLYCERIN	PEDIATRIC	RECTAL	SUPP.RE CT	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	LAXATIVES, LOCAL/RECTAL	GLYCERIN	ADULT	RECTAL	SUPP.RE CT	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	LAXATIVES, LOCAL/RECTAL	GLYCERIN	PEDIATRIC	RECTAL	SUPP.RE CT	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ANTICONVULSANTS	OXCARBAZEPINE	150 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	11/1/2021	ANTICONVULSANTS	OXCARBAZEPINE	300 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ANTICONVULSANTS	OXCARBAZEPINE	600 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ANTICONVULSANTS	ZONISAMIDE	25 MG	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ANTICONVULSANTS	ZONISAMIDE	50 MG	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ANTICONVULSANTS	ZONISAMIDE	100 MG	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ANTIHYPERTENSIVE S, ANGIOTENSIN RECEPTOR ANTAGONIST	OLMESARTAN MEDOXOMIL	5 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ANTIHYPERTENSIVE S, ANGIOTENSIN RECEPTOR ANTAGONIST	OLMESARTAN MEDOXOMIL	20 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ANTIHYPERTENSIVE S, ANGIOTENSIN RECEPTOR ANTAGONIST	OLMESARTAN MEDOXOMIL	40 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	ANTIHYPERTENSIVE S, ANGIOTENSIN RECEPTOR ANTAGONIST	TELMISARTAN	20 MG	ORAL	TABLET	CHANGED ST RESTRICTION	MUST FIRST TRY IRBESARTAN, LOSARTAN, OR OLMESARTAN.
PHARMACY	11/1/2021	ANTIHYPERTENSIVE S, ANGIOTENSIN RECEPTOR ANTAGONIST	TELMISARTAN	40 MG	ORAL	TABLET	CHANGED ST RESTRICTION	MUST FIRST TRY IRBESARTAN, LOSARTAN, OR OLMESARTAN.
PHARMACY	11/1/2021	ANTIHYPERTENSIVE S, ANGIOTENSIN RECEPTOR ANTAGONIST	TELMISARTAN	80 MG	ORAL	TABLET	CHANGED ST RESTRICTION	MUST FIRST TRY IRBESARTAN, LOSARTAN, OR OLMESARTAN.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	11/1/2021	ANTIHYPERTENSIVE S, ANGIOTENSIN RECEPTOR ANTAGONIST	VALSARTAN	40 MG	ORAL	TABLET	CHANGED ST RESTRICTION	MUST FIRST TRY IRBESARTAN, LOSARTAN, OR OLMESARTAN.
PHARMACY	11/1/2021	ANTIHYPERTENSIVE S, ANGIOTENSIN RECEPTOR ANTAGONIST	VALSARTAN	80 MG	ORAL	TABLET	CHANGED ST RESTRICTION	MUST FIRST TRY IRBESARTAN, LOSARTAN, OR OLMESARTAN.
PHARMACY	11/1/2021	ANTIHYPERTENSIVE S, ANGIOTENSIN RECEPTOR ANTAGONIST	VALSARTAN	160 MG	ORAL	TABLET	CHANGED ST RESTRICTION	MUST FIRST TRY IRBESARTAN, LOSARTAN, OR OLMESARTAN.
PHARMACY	11/1/2021	ANTIHYPERTENSIVE S, ANGIOTENSIN RECEPTOR ANTAGONIST	VALSARTAN	320 MG	ORAL	TABLET	CHANGED ST RESTRICTION	MUST FIRST TRY IRBESARTAN, LOSARTAN, OR OLMESARTAN.
PHARMACY	11/1/2021	URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT	FLAVOXATE HCL	100 MG	ORAL	TABLET	REMOVED FROM FORMULARY	ALTERNATIVES: OXYBUTYNIN IR, OXYBUTYNIN ER, AND TROSPIUM CHLORIDE.
PHARMACY	11/1/2021	URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT	TOLTERODINE TARTRATE	1 MG	ORAL	TABLET	REMOVED PA RESTRICTION; ADDED ST RESTRICTION	MUST FIRST TRY OXYBUTYNIN IR, OXYBUTYNIN ER, OR TROSPIUM CHLORIDE.
PHARMACY	11/1/2021	URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT	TOLTERODINE TARTRATE	2 MG	ORAL	TABLET	REMOVED PA RESTRICTION; ADDED ST RESTRICTION	MUST FIRST TRY OXYBUTYNIN IR, OXYBUTYNIN ER, OR TROSPIUM CHLORIDE.
PHARMACY	11/1/2021	URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT	TOLTERODINE TARTRATE	2 MG	ORAL	CAP ER 24H	REMOVED PA RESTRICTION; ADDED ST RESTRICTION	MUST FIRST TRY OXYBUTYNIN IR, OXYBUTYNIN ER, OR TROSPIUM CHLORIDE.
PHARMACY	11/1/2021	URINARY TRACT ANTISPASMODIC/ANTIINCONTINENCE AGENT	TOLTERODINE TARTRATE	4 MG	ORAL	CAP ER 24H	REMOVED PA RESTRICTION; ADDED ST RESTRICTION	MUST FIRST TRY OXYBUTYNIN IR, OXYBUTYNIN ER, OR TROSPIUM CHLORIDE.
PHARMACY	11/1/2021	ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB	PREZISTA (DARUNAVIR ETHANOLATE)	75 MG	ORAL	TABLET	REMOVED FROM FORMULARY	PREZCOBIX IS PREFERRED AGENT.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	11/1/2021	ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB	PREZISTA (DARUNAVIR ETHANOLATE)	150 MG	ORAL	TABLET	REMOVED FROM FORMULARY	PREZCOBIX IS PREFERRED AGENT.
PHARMACY	11/1/2021	ANTIVIRALS, HIV-SPEC, NON-PEPTIDIC PROTEASE INHIB	PREZISTA (DARUNAVIR ETHANOLATE)	600 MG	ORAL	TABLET	REMOVED FROM FORMULARY	PREZCOBIX IS PREFERRED AGENT.
PHARMACY	11/1/2021	ARTV CMB NUCLEOSIDE,NUCLEOTIDE,&NON-NUCLEOSIDE RTI	EFAVIRENZ/EMTRICIT AB/TENOFOVIR	600-200MG	ORAL	TABLET	REMOVED FROM FORMULARY	SYMFI IS PREFERRED AGENT.
PHARMACY	11/1/2021	ARTV CMB NUCLEOSIDE,NUCLEOTIDE,&NON-NUCLEOSIDE RTI	EFAVIRENZ/LAMIVU/T ENOFOV DISOP	400-300 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX020).
PHARMACY	11/1/2021	ARTV CMB NUCLEOSIDE,NUCLEOTIDE,&NON-NUCLEOSIDE RTI	EFAVIRENZ/LAMIVU/T ENOFOV DISOP	600-300MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX020).
PHARMACY	11/1/2021	ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG	TEMIXYS (LAMIVUDINE/TENOF OVIR DISOP FUM)	300-300 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX020).
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PV W-O CAL/FERROUS FUMARATE/FA	29 MG-1 MG	ORAL	TAB CHEW	REMOVED FROM FORMULARY	MULTIPLE ALTERNATIVES; SEE FORMULARY.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	COMPLETE NATAL DHA (PNV CMB 52/IRON/FA/OMEGA-3/DHA)	29-1-200MG	ORAL	COMBO. PKG	REMOVED FROM FORMULARY	MULTIPLE ALTERNATIVES; SEE FORMULARY.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	TRUST NATAL DHA (PNV CMB 52/IRON/FA/OMEGA-3/DHA)	29-1-200MG	ORAL	COMBO. PKG	REMOVED FROM FORMULARY	MULTIPLE ALTERNATIVES; SEE FORMULARY.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PV W-O CAL/FE PS CMLPX/FA	29 MG-1 MG	ORAL	TAB CHEW	REMOVED FROM FORMULARY	MULTIPLE ALTERNATIVES; SEE FORMULARY.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PNV19/IRON BG HCL SUC-P/FA/OM3	29-1-400MG	ORAL	CMBPKG DRCP	REMOVED FROM FORMULARY	MULTIPLE ALTERNATIVES; SEE FORMULARY.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PNV 11-IRON FUM-FOLIC ACID-OM3	28-1-200MG	ORAL	CAPSULE	REMOVED FROM FORMULARY	MULTIPLE ALTERNATIVES; SEE FORMULARY.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PNV NO12/IRON,CARB/FA/DSS/OM-3	29-1-50 MG	ORAL	CMBPKG DRCP	REMOVED FROM FORMULARY	MULTIPLE ALTERNATIVES; SEE FORMULARY.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PNV W-CA #40/IRON FUM/FA CMB#1	27 MG-1 MG	ORAL	TABLET	REMOVED FROM FORMULARY	MULTIPLE ALTERNATIVES; SEE FORMULARY.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	SELECT-OB + DHA (PRENATAL VIT 33/IRON/FOLIC/DHA)	29-1-250MG	ORAL	COMBO. PKG	REMOVED FROM FORMULARY	MULTIPLE ALTERNATIVES; SEE FORMULARY.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PNV53/IRON B-G HCL-P/FA/OMEGA3	29-1-400MG	ORAL	COMBO. PKG	REMOVED FROM FORMULARY	MULTIPLE ALTERNATIVES; SEE FORMULARY.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PNV54/IRON B-G HCL-P/FA/OMEGA3	29-1-430MG	ORAL	COMBO. PKG	REMOVED FROM FORMULARY	MULTIPLE ALTERNATIVES; SEE FORMULARY.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PNV55/IRON BG HCL SUC-P/FA/OM3	29-1-430MG	ORAL	CMBPKG DRCP	REMOVED FROM FORMULARY	MULTIPLE ALTERNATIVES; SEE FORMULARY.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	TRICARE (PRENATAL VIT103/IRON FUM/FOLIC)	27 MG-1 MG	ORAL	TABLET	REMOVED FROM FORMULARY	MULTIPLE ALTERNATIVES; SEE FORMULARY.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PRENATAL COMPLETE (PRENATAL 21/IRON FU/FOLIC ACID)	14 MG-400	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PNV WITH CA,NO.61/IRON/FA/DHA	28-975-200	ORAL	COMBO. PKG	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PNV#75/IRON FUM/FA/OM3/DHA/EPA	28-800-440	ORAL	COMBO. PKG	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PNV#75/IRON FUM/FA/OM3/DHA/EPA	28-800-223	ORAL	COMBO. PKG	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PRENATAL VIT NO.78/IRON/FA	29 MG-1 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	THERANATAL (PRENATAL VIT 28/IRON FUM/FOLIC)	27 MG-1 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PRENATAL FORMULA (PRENATAL VIT 93/IRON FUM/FOLIC)	9MG-267MCG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PNV CMB#95/FERROUS FUMARATE/FA	28MG-0.8MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PRENATA (PRENATAL VIT37/IRON/FOLIC ACID)	29 MG-1 MG	ORAL	TAB CHEW	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	KPN (PRENATAL VIT 98/IRON FUM/FOLIC)	9MG-267MCG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PRENATAL NO.40/IRON/FA/DHA	27-0.8-250	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	SIMILAC PRENATAL (PNV 102/IRON/FOLIC/DHA /LUTEIN)	27-800-200	ORAL	COMBO. PKG	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	MINI PRENATAL (PRENATAL VIT 49/IRON FUM/FOLIC)	6.75-0.2MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	STUART ONE (PNV NO.63/IRON,CARB/FO LIC/DHA)	27-800-200	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PNV115/IRON FUMARATE/FA/DSS	29-1-25 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PNV NO.115/IRON FUMARATE/FA	29 MG-1 MG	ORAL	TAB CHEW	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	EXPECTA PRENATAL (PRENATAL NO.116/IRON/FOLIC/DHA)	28-800-200	ORAL	COMBO. PKG	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	THERANATAL OVAVITE (PNV NO.74/IRON FUM/FA/COQ10)	18-1-125MG	ORAL	COMBO. PKG	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	THERANATAL PLUS (PNV NO.74/IRON FUM/FA/DHA)	27-1-300MG	ORAL	COMBO. PKG	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PRENATAL MULTI (PRENATAL NO122/IRON/FOLIC ACID)	27MG-0.8MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PRENATAL VIT NO.124/IRON/FA	27MG-0.8MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PNV103/FA/OMEGA3/DHA/FISH OIL	0.4-32.5MG	ORAL	TAB CHEW	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PNV133/FERROUS FUMARATE/FA	28MG-0.8MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PRENATAL FORMULA-DHA (PRENATAL VIT116/IRON/FOLIC/DHA)	28-800-200	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PRENATAL PLUS-DHA (PRENATAL72/IRON FUM/FA/OM3/DHA)	27-1-250MG	ORAL	COMBO. PKG	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PNV NO.121/IRON/FOLIC ACID	28MG-0.8MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PRENATAL NO.137/IRON/FOLIC ACD	27MG-0.8MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PRENATAL MULTI-DHA (PNV151/IRON/FA/O3/DHA/EPA/FISH)	27-800-260	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	PRENATAL MULTI-DHA (PNV151/IRON/FA/O3/DHA/EPA/FISH)	27-800-260	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	ULTRA PRENATAL PLUS DHA (PNV166/IRON/FA/O3/DHA/EPA/FISH)	27MG-0.8MG	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2021	PRENATAL VITAMIN PREPARATIONS	ONE-A-DAY PRENATAL-1 (PRENATAL	27-800-235	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
			168/IRON/FOLIC/OME GA3)					
PHARMACY	8/1/2021	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	2000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	REMOVED PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
PHARMACY	8/1/2021	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	3000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	REMOVED PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
PHARMACY	8/1/2021	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	4000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	REMOVED PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
PHARMACY	8/1/2021	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	10000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	REMOVED PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
PHARMACY	8/1/2021	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	20000/2ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	REMOVED PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
PHARMACY	8/1/2021	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	20000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	REMOVED PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
PHARMACY	8/1/2021	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	2000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	REMOVED PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
PHARMACY	8/1/2021	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	3000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	REMOVED PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
PHARMACY	8/1/2021	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	4000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	REMOVED PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
PHARMACY	8/1/2021	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	10000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	REMOVED PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
PHARMACY	8/1/2021	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	20000/2ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	REMOVED PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
PHARMACY	8/1/2021	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	20000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	REMOVED PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	8/1/2021	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	40000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	REMOVED PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
PHARMACY	8/1/2021	HEMATINICS,OTHER	RETACRIT (EPOETIN ALFA-EPBX)	20000/2ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	REMOVED PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
PHARMACY	8/1/2021	HEMATINICS,OTHER	RETACRIT (EPOETIN ALFA-EPBX)	20000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	REMOVED PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
PHARMACY & MEDICAL	8/1/2021	ALL ONCOLOGY (MULTIPLE)	MULTIPLE				CHANGED PA CRITERIA	SEE PA GUIDELINES FOR DETAILS (RX018).
PHARMACY & MEDICAL	8/1/2021	ANTINEOPLASTIC LHRH(GNRH) AGONIST,PITUITARY SUPPR.	MULTIPLE				CHANGED PA CRITERIA	SEE PA GUIDELINES FOR DETAILS (RX028).
PHARMACY	8/1/2021	SMOKING DETERRENT-NICOTINIC RECEPT.PARTIAL AGONIST	CHANTIX (VARENICLINE)	1 MG	ORAL	TABLET	CHANGED QL RESTRICTION	QL (2 TABLETS PER DAY, 168 TABLETS PER 180 DAYS). SEE QE GUIDELINES FOR DETAILS (RX055).
PHARMACY	6/1/2021	INSULINS	BASAGLAR KWIKPEN (INSULIN GLARGINE)	100/ML (3)	SUBCUTANE.	INSULIN PEN	REMOVED FROM FORMULARY	SEMGLEE IS PREFERRED INSULIN GLARGINE.
PHARMACY	6/1/2021	INSULINS	LANTUS SOLOSTAR (INSULIN GLARGINE)	100/ML (3)	SUBCUTANE.	INSULIN PEN	REMOVED FROM FORMULARY	SEMGLEE IS PREFERRED INSULIN GLARGINE.
PHARMACY	6/1/2021	INSULINS	LANTUS (INSULIN GLARGINE)	100/ML	SUBCUTANE.	VIAL	REMOVED FROM FORMULARY	SEMGLEE IS PREFERRED INSULIN GLARGINE.
PHARMACY	5/1/2021	NARCOTIC ANTAGONISTS	NALOXONE HCL	0.4 MG/ML	INJECTION	VIAL	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2021	BETA-ADRENERGIC AND GLUCOCORTICOID COMBINATIONS	BUDESONIDE-FORMOTEROL FUMARATE (BUDESONIDE/FORMOTEROL FUMARATE)	80-4.5 MCG	INHALATION	HFA AERAD	REMOVED ST RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2021	BETA-ADRENERGIC AND GLUCOCORTICOID COMBINATIONS	BUDESONIDE-FORMOTEROL FUMARATE (BUDESONIDE/FORMOTEROL FUMARATE)	160-4.5MCG	INHALATION	HFA AERAD	REMOVED ST RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	5/1/2021	BETA-ADRENERGIC-ANTICHOLINERGIC-GLUCOCORT, INHALED	TRELEGY ELLIPTA (FLUTICASONE/UMECLIDIN/VILANTER)	200-62.5	INHALATION	BLST W/DEV	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX041).
PHARMACY	5/1/2021	GLUCOCORTICIDS, ORALLY INHALED	ASMANEX (MOMETASONE FUROATE)	110MCG	INHALATION	AER POW BA	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2021	GLUCOCORTICIDS, ORALLY INHALED	ASMANEX (MOMETASONE FUROATE)	220MCG	INHALATION	AER POW BA	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2021	GLUCOCORTICIDS, ORALLY INHALED	ASMANEX HFA (MOMETASONE FUROATE)	50 MCG	INHALATION	HFA AER AD	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2021	GLUCOCORTICIDS, ORALLY INHALED	ASMANEX HFA (MOMETASONE FUROATE)	100 MCG	INHALATION	HFA AER AD	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2021	GLUCOCORTICIDS, ORALLY INHALED	ASMANEX HFA (MOMETASONE FUROATE)	200 MCG	INHALATION	HFA AER AD	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2021	ACNE AGENTS, SYSTEMIC	ISOTRETINOIN (MULTIPLE LABEL NAMES)	10 MG	ORAL	CAPSULE	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX053).
PHARMACY	5/1/2021	ACNE AGENTS, SYSTEMIC	ISOTRETINOIN (MULTIPLE LABEL NAMES)	20 MG	ORAL	CAPSULE	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX053).
PHARMACY	5/1/2021	ACNE AGENTS, SYSTEMIC	ISOTRETINOIN (MULTIPLE LABEL NAMES)	30 MG	ORAL	CAPSULE	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX053).
PHARMACY	5/1/2021	ACNE AGENTS, SYSTEMIC	ISOTRETINOIN (MULTIPLE LABEL NAMES)	40 MG	ORAL	CAPSULE	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX053).
PHARMACY	5/1/2021	VITAMIN A DERIVATIVES	ADAPALENE	0.1 %	TOPICAL	GEL (GRAM)	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX053).
PHARMACY	5/1/2021	VITAMIN A DERIVATIVES	ADAPALENE	0.3 %	TOPICAL	GEL (GRAM)	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX053).
PHARMACY	5/1/2021	VITAMIN A DERIVATIVES	TRETINOIN	0.025 %	TOPICAL	CREAM (G)	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX053).
PHARMACY	5/1/2021	VITAMIN A DERIVATIVES	TRETINOIN	0.05 %	TOPICAL	CREAM (G)	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX053).

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	5/1/2021	TOPICAL ANTIBIOTICS	CLINDAMYCIN PHOSPHATE	1 %	TOPICAL	SOLUTION	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX053).
PHARMACY	5/1/2021	KERATOLYTICS	BENZOYL PEROXIDE	10 %	TOPICAL	GEL (GRAM)	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX053).
PHARMACY	5/1/2021	KERATOLYTICS	BENZOYL PEROXIDE	10 %	TOPICAL	CLEANSER	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX053).
PHARMACY	5/1/2021	OXAZOLIDINONES	LINEZOLID	600 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2021	ANALGESICS, NARCOTICS	FENTANYL	12 MCG/HR	TRANSDERM.	PATCH TD72	ADDED QL RESTRICTION	QL (1 PATCH PER 3 DAYS).
PHARMACY	5/1/2021	ANALGESICS, NARCOTICS	FENTANYL	25 MCG/HR	TRANSDERM.	PATCH TD72	ADDED QL RESTRICTION	QL (1 PATCH PER 3 DAYS).
PHARMACY	5/1/2021	ANALGESICS, NARCOTICS	FENTANYL	50MCG/HR	TRANSDERM.	PATCH TD72	ADDED QL RESTRICTION	QL (1 PATCH PER 3 DAYS).
PHARMACY	5/1/2021	ANALGESICS, NARCOTICS	FENTANYL	75MCG/HR	TRANSDERM.	PATCH TD72	ADDED QL RESTRICTION	QL (1 PATCH PER 3 DAYS).
PHARMACY	5/1/2021	ANALGESICS, NARCOTICS	FENTANYL	100 MCG/HR	TRANSDERM.	PATCH TD72	ADDED QL RESTRICTION	QL (1 PATCH PER 3 DAYS).
PHARMACY	5/1/2021	ANALGESICS, NARCOTICS	MORPHINE SULFATE ER (MORPHINE SULFATE)	30 MG	ORAL	CPMP 24HR	ADDED QL RESTRICTION	QL (2 CAPSULES PER DAY).
PHARMACY	5/1/2021	ANALGESICS, NARCOTICS	MORPHINE SULFATE ER (MORPHINE SULFATE)	45 MG	ORAL	CPMP 24HR	ADDED QL RESTRICTION	QL (2 CAPSULES PER DAY).
PHARMACY	5/1/2021	ANALGESICS, NARCOTICS	MORPHINE SULFATE ER (MORPHINE SULFATE)	60 MG	ORAL	CPMP 24HR	ADDED QL RESTRICTION	QL (2 CAPSULES PER DAY).
PHARMACY	5/1/2021	ANALGESICS, NARCOTICS	MORPHINE SULFATE ER (MORPHINE SULFATE)	75 MG	ORAL	CPMP 24HR	ADDED QL RESTRICTION	QL (2 CAPSULES PER DAY).
PHARMACY	5/1/2021	ANALGESICS, NARCOTICS	MORPHINE SULFATE ER (MORPHINE SULFATE)	90 MG	ORAL	CPMP 24HR	ADDED QL RESTRICTION	QL (2 CAPSULES PER DAY).
PHARMACY	5/1/2021	ANALGESICS, NARCOTICS	MORPHINE SULFATE ER (MORPHINE SULFATE)	120 MG	ORAL	CPMP 24HR	ADDED QL RESTRICTION	QL (2 CAPSULES PER DAY).
PHARMACY	5/1/2021	ANALGESICS, NARCOTICS	MORPHINE SULFATE ER (MORPHINE SULFATE)	15 MG	ORAL	TABLET ER	ADDED QL RESTRICTION	QL (3 TABLETS PER DAY).

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	5/1/2021	ANALGESICS, NARCOTICS	MORPHINE SULFATE ER (MORPHINE SULFATE)	30 MG	ORAL	TABLET ER	ADDED QL RESTRICTION	QL (3 TABLETS PER DAY).
PHARMACY	5/1/2021	ANALGESICS, NARCOTICS	MORPHINE SULFATE ER (MORPHINE SULFATE)	60 MG	ORAL	TABLET ER	ADDED QL RESTRICTION	QL (3 TABLETS PER DAY).
PHARMACY	5/1/2021	ANALGESICS, NARCOTICS	MORPHINE SULFATE ER (MORPHINE SULFATE)	100 MG	ORAL	TABLET ER	ADDED QL RESTRICTION	QL (3 TABLETS PER DAY).
PHARMACY	5/1/2021	ANALGESICS, NARCOTICS	MORPHINE SULFATE ER (MORPHINE SULFATE)	200 MG	ORAL	TABLET ER	ADDED QL RESTRICTION	QL (3 TABLETS PER DAY).
PHARMACY	2/1/2021	ANTIVIRALS, HIV-SPEC, NUCLEOSIDE-NUCLEOTIDE ANALOG	EMTRICITABINE-TENOFOVIR DISOP	200-300 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	5 MG	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	10 MG	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	1 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	3 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	5 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	10 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	3 MG	ORAL	TAB RAPDIS	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	5 MG	ORAL	TAB RAPDIS	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.

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PHARMACY	2/1/2021	PINEAL HORMONE AGENTS	MELATONIN	10 MG	ORAL	TAB MPHASE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	SEDATIVE-HYPNOTICS, NON-BARBITURATE	ZOLPIDEM TARTRATE	5 MG	ORAL	TABLET	CHANGED QL RESTRICTION	QL (2 TABLETS PER DAY).
PHARMACY	2/1/2021	SEDATIVE-HYPNOTICS, NON-BARBITURATE	ZOLPIDEM TARTRATE	10 MG	ORAL	TABLET	CHANGED QL RESTRICTION	QL (1 TABLET PER DAY).
PHARMACY	2/1/2021	ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB(ARNI)	ENTRESTO (SACUBITRIL/VALSARTAN)	24 MG-26MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA AND QL RESTRICTIONS	SEE PA GUIDELINES FOR DETAILS (RX052). QL (60 TABLETS PER 30 DAYS).
PHARMACY	2/1/2021	ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB(ARNI)	ENTRESTO (SACUBITRIL/VALSARTAN)	49 MG-51MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA AND QL RESTRICTIONS	SEE PA GUIDELINES FOR DETAILS (RX052). QL (60 TABLETS PER 30 DAYS).
PHARMACY	2/1/2021	ANGIOTENSIN RECEPT-NEPRILYSIN INHIBITOR COMB(ARNI)	ENTRESTO (SACUBITRIL/VALSARTAN)	97MG-103MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA AND QL RESTRICTIONS	SEE PA GUIDELINES FOR DETAILS (RX052). QL (60 TABLETS PER 30 DAYS).
PHARMACY	2/1/2021	TOPICAL ANTIFUNGALS	MICONAZOLE NITRATE	2 %	TOPICAL	CREAM (G)	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	TOPICAL ANTIFUNGALS	NYSTATIN	100000/G	TOPICAL	CREAM (G)	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	TOPICAL ANTIFUNGALS	NYSTATIN	100000/G	TOPICAL	OINT. (G)	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	TOPICAL ANTIFUNGALS	NYSTATIN	100000/G	TOPICAL	POWDER	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	TOPICAL ANTIFUNGALS	TERBINAFINE HCL	1 %	TOPICAL	CREAM (G)	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	TOPICAL ANTI-INFLAMMATORY STEROIDAL	BETAMETHASONE DIPROP AUGMENTED	0.05 %	TOPICAL	CREAM (G)	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	2/1/2021	TOPICAL ANTI-INFLAMMATORY STEROIDAL	BETAMETHASONE DIPROP AUGMENTED	0.05 %	TOPICAL	OINT. (G)	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	TOPICAL ANTI-INFLAMMATORY STEROIDAL	BETAMETHASONE VALERATE	0.1 %	TOPICAL	CREAM (G)	REMOVED QL RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	TOPICAL ANTI-INFLAMMATORY STEROIDAL	BETAMETHASONE VALERATE	0.1 %	TOPICAL	OINT. (G)	REMOVED QL RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	TOPICAL ANTI-INFLAMMATORY, NSAIDS	DICLOFENAC SODIUM	1 %	TOPICAL	GEL (GRAM)	CHANGED QL RESTRICTION	QL (100 GRAMS PER 12 DAYS).
PHARMACY	2/1/2021	TOPICAL LOCAL ANESTHETICS	LIDOCAINE	5 %	TOPICAL	ADH. PATCH	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	TOPICAL LOCAL ANESTHETICS	LIDOCAINE-PRILOCAINE	2.5 %-2.5%	TOPICAL	CREAM (G)	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	ANTIFUNGAL AGENTS	TERBINAFINE HCL	250 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	NSAIDS, CYCLOOXYGENASE 2 INHIBITOR - TYPE	CELECOXIB	50 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	NSAIDS, CYCLOOXYGENASE 2 INHIBITOR - TYPE	CELECOXIB	100 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	NSAIDS, CYCLOOXYGENASE 2 INHIBITOR - TYPE	CELECOXIB	200 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	NSAIDS, CYCLOOXYGENASE 2 INHIBITOR - TYPE	CELECOXIB	400 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	LAXATIVES AND CATHARTICS	POLYETHYLENE GLYCOL 3350	17G/DOSE	ORAL	POWDER	CHANGED QL RESTRICTION	QL (510 GRAMS PER 30 DAYS).
PHARMACY	2/1/2021	ANTIPARKINSONISM DRUGS,OTHER	ROPINIROLE HCL	0.25 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	2/1/2021	ANTIPARKINSONISM DRUGS,OTHER	ROPINIROLE HCL	0.5 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	ANTIPARKINSONISM DRUGS,OTHER	ROPINIROLE HCL	1 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	ANTIPARKINSONISM DRUGS,OTHER	ROPINIROLE HCL	2 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	ANTIPARKINSONISM DRUGS,OTHER	ROPINIROLE HCL	3 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	ANTIPARKINSONISM DRUGS,OTHER	ROPINIROLE HCL	4 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	ANTIPARKINSONISM DRUGS,OTHER	ROPINIROLE HCL	5 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	100 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	250 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	500 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	1000 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	100 MG	ORAL	TAB CHEW	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	125 MG	ORAL	TAB CHEW	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	250 MG	ORAL	TAB CHEW	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	500 MG	ORAL	TAB CHEW	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	VITAMIN C PREPARATIONS	ASCORBIC ACID (VITAMIN C)	1000 MG	ORAL	TAB CHEW	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	VITAMIN D PREPARATIONS	CHOLECALCIFEROL (VITAMIN D3)	100 MCG	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	VITAMIN D PREPARATIONS	CHOLECALCIFEROL (VITAMIN D3)	250 MCG	ORAL	CAPSULE	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	2/1/2021	VITAMIN D PREPARATIONS	CHOLECALCIFEROL (VITAMIN D3)	25 MCG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2020	ANALGESICS,NARCO TICS	OXYCODONE HCL ER	10 MG	ORAL	TAB ER 12H	ADDED PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX005).
PHARMACY	11/1/2020	ANALGESICS,NARCO TICS	METHADONE HCL	10 MG	ORAL	TABLET	ADDED PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX005).
PHARMACY	11/1/2020	ANALGESICS,NARCO TICS	METHADONE HCL	5 MG	ORAL	TABLET	ADDED PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX005).
PHARMACY	11/1/2020	GLUCOCORTICOIDS, ORALLY INHALED	ARNUITY ELLIPTA (FLUTICASONE FUROATE)	100 MCG	INHALATION	BLST W/DEV	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2020	GLUCOCORTICOIDS, ORALLY INHALED	ARNUITY ELLIPTA (FLUTICASONE FUROATE)	200 MCG	INHALATION	BLST W/DEV	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2020	GLUCOCORTICOIDS, ORALLY INHALED	ARNUITY ELLIPTA (FLUTICASONE FUROATE)	50 MCG	INHALATION	BLST W/DEV	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	11/1/2020	ANTICHOLINERGICS, ORALLY INHALED LONG ACTING	SPIRIVA (TIOTROPIUM BROMIDE)	18 MCG	INHALATION	CAP W/DEV	CHANGED ST RESTRICTION	MUST FIRST TRY INCRUSE ELLIPTA (TUDORZA NO LONGER REQUIRED).
PHARMACY	11/1/2020	ANTICHOLINERGICS, ORALLY INHALED LONG ACTING	SPIRIVA RESPIMAT (TIOTROPIUM BROMIDE)	1.25 MCG	INHALATION	MIST INHAL	CHANGED ST RESTRICTION	MUST FIRST TRY INCRUSE ELLIPTA (TUDORZA NO LONGER REQUIRED).
PHARMACY	11/1/2020	ANTICHOLINERGICS, ORALLY INHALED LONG ACTING	SPIRIVA RESPIMAT (TIOTROPIUM BROMIDE)	2.5 MCG	INHALATION	MIST INHAL	CHANGED ST RESTRICTION	MUST FIRST TRY INCRUSE ELLIPTA (TUDORZA NO LONGER REQUIRED).

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	11/1/2020	ANTICHOLINERGICS, ORALLY INHALED LONG ACTING	TUDORZA PRESSAIR (ACLIDINIUM BROMIDE)	400 MCG	INHALATION	AER POW BA	REMOVED FROM FORMULARY	INCRUSE ELLIPTA IS PREFERRED AGENT.
PHARMACY	11/1/2020	BETA-ADRENERGIC AND GLUCOCORTICOID COMBINATIONS	DULERA (MOMETASONE/FOR MOTEROL)	50MCG-5MCG	INHALATION	HFA AER AD	ADDED TO FORMULARY WITH ST RESTRICTION	MUST FIRST TRY FLUTICASONE/SALMETEROL (GENERIC ADVAIR OR AIRDUO).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	AIMOVIG AUTOINJECTOR (ERENUMAB-AOOE)	70 MG/ML	SUBCUTANEOUS	AUTO INJECT	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	AIMOVIG AUTOINJECTOR (2 PACK) (ERENUMAB-AOOE)	70 MG/ML	SUBCUTANEOUS	AUTO INJECT	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	AIMOVIG AUTOINJECTOR (ERENUMAB-AOOE)	140 MG/ML	SUBCUTANEOUS	AUTO INJECT	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	AJOVY SYRINGE (FREMANEZUMAB-VFRM)	225 MG/1.5	SUBCUTANEOUS	SYRINGE	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	AJOVY AUTOINJECTOR (FREMANEZUMAB-VFRM)	225 MG/1.5	SUBCUTANEOUS	AUTO INJECT	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	EMGALITY PEN (GALCANEZUMAB-GNLM)	120 MG/ML	SUBCUTANEOUS	PEN INJECTR	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	EMGALITY SYRINGE (GALCANEZUMAB-GNLM)	120 MG/ML	SUBCUTANEOUS	SYRINGE	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	EMGALITY SYRINGE (GALCANEZUMAB-GNLM)	300MG/3ML	SUBCUTANEOUS	SYRINGE	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	UBRELVY (UBROGEPANT)	50 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	UBRELVY (UBROGEPANT)	100 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	VYEPTI (EPTINEZUMAB-JJMR)	100 MG/ML	INTRAVEN	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	CALCITONIN GENE-RELATED PEPTIDE (CGRP) INHIBITORS	NURTEC ODT (RIMEGEPANT SULFATE)	75 MG	ORAL	TAB RAPDIS	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX051).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	ZOLMITRIPTAN ODT	5 MG	ORAL	TAB RAPDIS	CHANGED QL RESTRICTION	QL (9 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	ZOMIG ZMT (ZOLMITRIPTAN)	5 MG	ORAL	TAB RAPDIS	CHANGED QL RESTRICTION	QL (9 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	ZOLMITRIPTAN ODT	2.5 MG	ORAL	TAB RAPDIS	CHANGED QL RESTRICTION	QL (9 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	ZOMIG ZMT (ZOLMITRIPTAN)	2.5 MG	ORAL	TAB RAPDIS	CHANGED QL RESTRICTION	QL (9 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	ZOLMITRIPTAN	2.5 MG	ORAL	TABLET	CHANGED QL RESTRICTION	QL (9 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	ZOMIG (ZOLMITRIPTAN)	2.5 MG	ORAL	TABLET	CHANGED QL RESTRICTION	QL (9 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	ZOLMITRIPTAN	5 MG	ORAL	TABLET	CHANGED QL RESTRICTION	QL (9 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	ZOMIG (ZOLMITRIPTAN)	5 MG	ORAL	TABLET	CHANGED QL RESTRICTION	QL (9 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	REYVOW (LASMIDITAN SUCCINATE)	50 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA AND QL RESTRICTIONS	SEE PA GUIDELINES FOR DETAILS (RX023). QL (4 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	REYVOW (LASMIDITAN SUCCINATE)	100 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA AND QL RESTRICTIONS	SEE PA GUIDELINES FOR DETAILS (RX023). QL (4 TABLETS PER 30 DAYS).
PHARMACY	11/1/2020	ANTIMIGRAINE PREPARATIONS	SUMATRIPTAN SUCCINATE	6 MG/0.5ML	SUBCUTANEA	SYRINGE	ADDED TO FORMULARY WITH PA AND QL RESTRICTIONS	SEE PA GUIDELINES FOR DETAILS (RX023). QL (1 PACKAGE PER 30 DAYS).
PHARMACY	10/1/2020	BETA-ADRENERGIC AGENTS, INHALED, SHORT ACTING	PROAIR RESPICLICK (ALBUTEROL SULFATE)	90 MCG	INHALATION	AER POW BA	REMOVED FROM FORMULARY	GENERIC ALBUTEROL INHALERS ARE PREFERRED AGENTS.
PHARMACY	8/1/2020	THROMBIN INHIBITORS, SELECTIVE, DIRECT, & REVERSIBLE	PRADAXA (DABIGATRAN ETEXILATE MESYLATE)	110 MG	ORAL	CAPSULE	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITH PA; SEE PA GUIDELINES FOR DETAILS (RX014).

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE HYCLATE	50 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE HYCLATE	100 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE HYCLATE	100 MG	ORAL	TABLET	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE MONOHYDRATE	75 MG	ORAL	CAPSULE	REMOVED FROM FORMULARY	50 MG OR 100 MG CAPSULES ARE AVAILABLE.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE MONOHYDRATE	150 MG	ORAL	CAPSULE	REMOVED FROM FORMULARY	50 MG OR 100 MG CAPSULES ARE AVAILABLE.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE MONOHYDRATE	50 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	8/1/2020	TETRACYCLINES	DOXYCYCLINE MONOHYDRATE	100 MG	ORAL	TABLET	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	8/1/2020	PEDIATRIC VITAMIN PREPARATIONS	PEDI MULTIVIT 75/FLUORIDE/IRON	0.25-10/ML	ORAL	DROPS	ADDED AGE RESTRICTION	COVERED FOR AGE 1 AND YOUNGER.
PHARMACY	8/1/2020	PEDIATRIC VITAMIN PREPARATIONS	PEDI MULTIVIT 45/FLUORIDE/IRON	0.25-10/ML	ORAL	DROPS	ADDED AGE RESTRICTION	COVERED FOR AGE 1 AND YOUNGER.
PHARMACY	8/1/2020	PEDIATRIC VITAMIN PREPARATIONS	PEDI MULTIVIT NO.2 W-FLUORIDE	0.25 MG/ML	ORAL	DROPS	ADDED TO FORMULARY WITH AR	COVERED FOR AGE 1 AND YOUNGER.
PHARMACY	8/1/2020	PEDIATRIC VITAMIN PREPARATIONS	PEDI MULTIVIT NO.2 W-FLUORIDE	0.5 MG/ML	ORAL	DROPS	ADDED TO FORMULARY WITH AR	COVERED FOR AGE 1 AND YOUNGER.
PHARMACY	8/1/2020	PEDIATRIC VITAMIN PREPARATIONS	PEDI MULTIVIT 45/FLUORIDE/IRON	0.25-10/ML	ORAL	DROPS	ADDED TO FORMULARY WITH AR	COVERED FOR AGE 1 AND YOUNGER.
PHARMACY	7/1/2020	DOACS (DIRECT FACTOR XA INHIBITORS; THROMBIN INHIBITORS,SELECTIVE,DIRECT, & REVERSIBLE)	BEVYXXA (BETRIXABAN MALEATE), PRADAXA (DABIGATRAN ETEXILATE MESYLATE), SAVAYSA (EDOXABAN TOSYLATE), XARELTO (RIVAROXABAN)				CHANGED PA CRITERIA	UPDATED PA GUIDELINES TO ALIGN WITH NATIONAL GUIDELINES. WARFARIN FAILURE NO LONGER REQUIRED FOR ATRIAL FIBRILLATION. SEE PA GUIDELINES FOR DETAILS (RX014).
PHARMACY	5/1/2020	ANTIHYPERGLY,INC RETIN	TANZEUM (ALBIGLUTIDE), TRULICITY				CHANGED PA CRITERIA	UPDATED PA GUIDELINES TO ALIGN WITH ADA GUIDELINES.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
		MIMETIC(GLP-1 RECEPTOR AGONIST)	(DULAGLUTIDE), BYETTA (EXENATIDE), BYDUREON (EXENATIDE MICROSPHERES), VICTOZA (LIRAGLUTIDE), ADLYXIN (LIXISENATIDE), OZEMPIC (SEMAGLUTIDE), RYBELSUS (SEMAGLUTIDE)					SEE PA GUIDELINES FOR DETAILS (RX007).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMIC RETIN MIMETIC(GLP-1 RECEPTOR AGONIST)	ADLYXIN (LIXISENATIDE)	20 MCG/0.2	SUBCUTANEOUS	PEN INJECTOR	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX007).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMIC RETIN MIMETIC(GLP-1 RECEPTOR AGONIST)	ADLYXIN (LIXISENATIDE)	10-20 (1)	SUBCUTANEOUS	PEN INJECTOR	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX007).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMIC RETIN MIMETIC(GLP-1 RECEPTOR AGONIST)	BYDUREON BCISE (EXENATIDE MICROSPHERES)	2MG/0.85 ML	SUBCUTANEOUS	AUTO INJECTOR	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX007).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMIC RETIN MIMETIC(GLP-1 RECEPTOR AGONIST)	RYBELSUS (SEMAGLUTIDE)	3 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX007).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMIC RETIN MIMETIC(GLP-1 RECEPTOR AGONIST)	RYBELSUS (SEMAGLUTIDE)	7 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX007).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMIC RETIN MIMETIC(GLP-1 RECEPTOR AGONIST)	RYBELSUS (SEMAGLUTIDE)	14 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX007).
PHARMACY	5/1/2020	ANTIHYPERGLYCEMIC SODIUM/GLUCAGON	FARXIGA (DAPAGLIFLOZIN PROPANEDIOL)	10 MG	ORAL	TABLET	REMOVED FROM FORMULARY	STEGLATRO IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX008).

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
		COTRANSPORT2(SGLT2)INHIB						
PHARMACY	5/1/2020	ANTIHYPERGLYCEM C-SOD/GLUC COTRANSPORT2(SGLT2)INHIB	FARXIGA (DAPAGLIFLOZIN PROPANEDIOL)	5 MG	ORAL	TABLET	REMOVED FROM FORMULARY	STEGLATRO IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX008).
PHARMACY	5/1/2020	ANTIHYPERGLYCEM C-SOD/GLUC COTRANSPORT2(SGLT2)INHIB	JARDIANCE (EMPAGLIFLOZIN)	10 MG	ORAL	TABLET	REMOVED FROM FORMULARY	STEGLATRO IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX008).
PHARMACY	5/1/2020	ANTIHYPERGLYCEM C-SOD/GLUC COTRANSPORT2(SGLT2)INHIB	JARDIANCE (EMPAGLIFLOZIN)	25 MG	ORAL	TABLET	REMOVED FROM FORMULARY	STEGLATRO IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX008).
PHARMACY	5/1/2020	ANTIHYPERGLYCEM C-SOD/GLUC COTRANSPORT2(SGLT2)INHIB	STEGLATRO (ERTUGLIFLOZIN PIDOLATE)	5 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX008).
PHARMACY	5/1/2020	ANTIHYPERGLYCEM C-SOD/GLUC COTRANSPORT2(SGLT2)INHIB	STEGLATRO (ERTUGLIFLOZIN PIDOLATE)	15 MG	ORAL	TABLET	ADDED TO FORMULARY WITH PA RESTRICTION	SEE PA GUIDELINES FOR DETAILS (RX008).
MEDICAL	5/1/2020	LEUKOCYTE (WBC) STIMULANTS	NEUPOGEN (FILGRASTIM)	480MCG/1.6	INJECTION	VIAL	REMOVED FROM FORMULARY	GRANIX, NIVESTYM, AND ZARXIO ARE PREFERRED AGENTS. SEE PA GUIDELINES FOR DETAILS (RX043).
MEDICAL	5/1/2020	LEUKOCYTE (WBC) STIMULANTS	NEUPOGEN (FILGRASTIM)	480MCG/0.8	INJECTION	SYRINGE	REMOVED FROM FORMULARY	GRANIX, NIVESTYM, AND ZARXIO ARE PREFERRED AGENTS. SEE PA GUIDELINES FOR DETAILS (RX043).
MEDICAL	5/1/2020	LEUKOCYTE (WBC) STIMULANTS	NEUPOGEN (FILGRASTIM)	300MCG/0.5	INJECTION	SYRINGE	REMOVED FROM FORMULARY	GRANIX, NIVESTYM, AND ZARXIO ARE PREFERRED AGENTS. SEE PA GUIDELINES FOR DETAILS (RX043).
MEDICAL	5/1/2020	LEUKOCYTE (WBC) STIMULANTS	NEUPOGEN (FILGRASTIM)	300 MCG/ML	INJECTION	VIAL	REMOVED FROM FORMULARY	GRANIX, NIVESTYM, AND ZARXIO ARE PREFERRED AGENTS. SEE PA GUIDELINES FOR DETAILS (RX043).
MEDICAL	5/1/2020	LEUKOCYTE (WBC) STIMULANTS	NIVESTYM (FILGRASTIM-AAFI)	300 MCG/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITH PA (HCPCS =

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
								Q5110); SEE PA GUIDELINES FOR DETAILS (RX043).
MEDICAL	5/1/2020	LEUKOCYTE (WBC) STIMULANTS	NIVESTYM (FILGRASTIM-AAFI)	480MCG/1.6	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITH PA (HCPCS = Q5110); SEE PA GUIDELINES FOR DETAILS (RX043).
PHARMACY	5/1/2020	NITROFURAN DERIVATIVES	NITROFURANTOIN	25 MG/5 ML	ORAL	ORAL SUSP	REMOVED FROM FORMULARY	ALTERNATIVES: NITROFURANTOIN CAPSULES, SULFAMETHOXAZOLE/TRIMET HOPRIM ORAL SUSPENSION, CIPROFLOXACIN ORAL SUSPENSION, LEVOFLOXACIN ORAL SOLUTION.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	25 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	50 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	75 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	100 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	150 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	200 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	300 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	5/1/2020	ANTICONVULSANTS	PREGABALIN	225 MG	ORAL	CAPSULE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	4/10/2020	NARCOTIC ANTAGONISTS	NARCAN (NALOXONE HCL)	4 MG	NASAL	SPRAY	REMOVED QL RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
PHARMACY	3/4/2020	INSULINS	INSULIN ASPART	100/ML	SUBCUTANE.	VIAL	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	3/4/2020	INSULINS	INSULIN ASPART FLEXPEN	100/ML (3)	SUBCUTANE.	INSULNPEN	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	3/4/2020	INSULINS	INSULIN ASPART PENFILL	100/ML	SUBCUTANE.	CARTRIDGE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
PHARMACY	3/4/2020	INSULINS	NOVOLOG (INSULIN ASPART)	100/ML	SUBCUTANE.	CARTRIDGE	REMOVED PA RESTRICTION	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
MEDICAL	2/11/2020	ANTI-INFLAMMATORY TUMOR NECROSIS FACTOR INHIBITOR	REMICADE (INFLIXIMAB)	100 MG	INTRAVEN.	VIAL	REMOVED FROM FORMULARY	RENFLEXIS AND INFLECTRA ARE PREFERRED AGENTS. SEE PA GUIDELINES FOR DETAILS (RX040).
PHARMACY	1/1/2020	ANTI-ALCOHOLIC PREPARATIONS	ACAMPROSATE CALCIUM	333 MG	ORAL	TABLET DR	ADDED TO FORMULARY	COVERED UNDER PHARMACY BENEFIT WITHOUT RESTRICTION.
MEDICAL	1/1/2020	ANTI-ALCOHOLIC PREPARATIONS	VIVITROL (NALTREXONE MICROSPHERES)	380 MG	INTRAMUSC.	SUSPENSION	REMOVED PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT (HCPCS = J2315) WITHOUT RESTRICTION.
MEDICAL	1/1/2020	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	2000/ML	INJECTION	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	4000/ML	INJECTION	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	10000/ML	INJECTION	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	20000/2ML	INJECTION	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	3000/ML	INJECTION	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	EPOGEN (EPOETIN ALFA)	20000/ML	INJECTION	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
MEDICAL	1/1/2020	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	2000/ML	INJECTION	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	4000/ML	INJECTION	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	10000/ML	INJECTION	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	20000/2ML	INJECTION	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	3000/ML	INJECTION	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	20000/ML	INJECTION	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	PROCRIT (EPOETIN ALFA)	40000/ML	INJECTION	VIAL	REMOVED FROM FORMULARY	RETACRIT IS PREFERRED AGENT. SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	RETACRIT (EPOETIN ALFA-EPBX)	2000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITH PA (HCPCS = Q5105, Q5106); SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	RETACRIT (EPOETIN ALFA-EPBX)	3000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITH PA (HCPCS = Q5105, Q5106); SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	RETACRIT (EPOETIN ALFA-EPBX)	4000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITH PA (HCPCS = Q5105, Q5106); SEE PA GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	RETACRIT (EPOETIN ALFA-EPBX)	10000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITH PA (HCPCS = Q5105, Q5106); SEE PA

BENEFIT	EFFECTIVE DATE	DRUG CLASS	DRUG NAME	STRENGTH	ROUTE	DOSAGE	CHANGE	DESCRIPTION
								GUIDELINES FOR DETAILS (RX042).
MEDICAL	1/1/2020	HEMATINICS,OTHER	RETACRIT (EPOETIN ALFA-EPBX)	40000/ML	INJECTION	VIAL	ADDED TO FORMULARY WITH PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITH PA (HCPCS = Q5105, Q5106); SEE PA GUIDELINES FOR DETAILS (RX042).
PHARMACY	1/1/2020	NARCOTIC WITHDRAWAL THERAPY AGENTS	BUPRENORPHINE-NALOXONE	2 MG-0.5MG	SUBLINGUAL	FILM	ADDED TO FORMULARY WITH QL RESTRICTION	QL (12 FILMS PER DAY).
PHARMACY	1/1/2020	NARCOTIC WITHDRAWAL THERAPY AGENTS	BUPRENORPHINE-NALOXONE	8 MG-2 MG	SUBLINGUAL	FILM	ADDED TO FORMULARY WITH QL RESTRICTION	QL (3 FILMS PER DAY).
PHARMACY	1/1/2020	NARCOTIC WITHDRAWAL THERAPY AGENTS	BUPRENORPHINE-NALOXONE	4MG-1MG	SUBLINGUAL	FILM	ADDED TO FORMULARY WITH QL RESTRICTION	QL (6 FILMS PER DAY).
PHARMACY	1/1/2020	NARCOTIC WITHDRAWAL THERAPY AGENTS	BUPRENORPHINE-NALOXONE	12 MG-3 MG	SUBLINGUAL	FILM	ADDED TO FORMULARY WITH QL RESTRICTION	QL (2 FILMS PER DAY).
MEDICAL	1/1/2020	NARCOTIC WITHDRAWAL THERAPY AGENTS	SUBLOCADE (BUPRENORPHINE)	300 MG/1.5	SUBCUTANEOUS	SOLER SYR	REMOVED PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT. INDUCTION THERAPY DOES NOT REQUIRE PA (HCPCS = Q9992). MAINTENANCE THERAPY REQUIRES A PA (HCPCS = Q9991).
MEDICAL	1/1/2020	NARCOTIC WITHDRAWAL THERAPY AGENTS	BUPRENORPHINE-NALOXONE	MULTIPLE	ORAL	ORAL	REMOVED PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITHOUT PA (HCPCS = (HCPCS = J0572, J0573, J0574, J0575).
MEDICAL	1/1/2020	NARCOTIC WITHDRAWAL THERAPY AGENTS	BUPRENORPHINE	1 MG	ORAL	ORAL	REMOVED PA RESTRICTION	COVERED UNDER MEDICAL BENEFIT WITHOUT PA (HCPCS = J0571).