

**PRESCRIPTION DRUG PROGRAM FORMULARY UPDATES**  
**Select Drug Program®**

<b>Drug Name</b>	<b>Current (tier and edit)</b>	<b>New Tier and Edit</b>	<b>Formulary Alternatives</b>	<b>Tier Change</b>	<b>Edit Change</b>	<b>Effective Date</b>
baclofen sus 25mg/5ml <b>(Brand: Fleqsuvy®)</b>	G + PA + QL (16ml per day)	No Change (New Generic)		No Change	No Change	07/03/23
vancomycin sol 25mg/ml <b>(Brand: Firvanq®)</b>	G + AL (Max Age 12)	No Change (New Generic)		No Change	No Change	07/31/23
indomethacin sup 50mg <b>(Brand: Indocin®)</b>	G	No Change (New Generic)		No Change	No Change	08/07/23
saxagliptin tab 2.5mg, 5mg <b>(Brand: Onglyza™)</b>	G	No Change (New Generic)		No Change	No Change	08/07/23
saxa/metfor tab 2.5-1000mg, 5-1000mg, 5-500mg <b>(Brand: Kombiglyze™ XR)</b>	G	No Change (New Generic)		No Change	No Change	08/14/23
tiotrop brom cap 18mcg <b>(Brand: Spiriva® HandiHaler®)</b>	NPD + PA	No Change (New Generic)	<b>Spiriva®</b>	No Change	No Change	08/21/23
joyeaux tab 0.1-20 <b>(Brand: Balcoltra®)</b>	G	No Change (New Generic)		No Change	No Change	08/28/23
lisdexamfetamine chw <b>(Brand: Vyvanse® Chew)</b>	G + QL (1 tab per day)	No Change (New Generic)		No Change	No Change	09/04/23
lisdexamfetamine cap <b>(Brand: Vyvanse® Cap)</b>	G + QL (1 cap per day)	No Change (New Generic)		No Change	No Change	09/04/23
tretinoin gel 0.08% <b>(Brand: Retin-A Micro® Gel)</b>	G + AL (Max Age 25)	No Change (New Generic)		No Change	No Change	09/04/23
brimonidine sol 0.1% <b>(Brand: Alphagan® P)</b>	G	No Change (New Generic)		No Change	No Change	09/11/23

\* = for Specialty plans

\*\* = May be available as generic for certain plans

*(continued)*

Please note: Prescription drug benefits vary by group. Therefore, a drug on this formulary does not imply coverage.

(4/24 version)

Drug Name	Current (tier and edit)	New Tier and Edit	Formulary Alternatives	Tier Change	Edit Change	Effective Date
bexagliflozn tab 20mg (Brand: Brenzavvy®)	NPD + PA	No Change (New Authorized Generic)		No Change	No Change	11/06/23
Talzenna® Cap 0.1MG, 0.35MG	NPD/SP* + PA	No Change (New Drug)		No Change	No Change	07/03/23
Yuflyma® 2syr Kit 40/0.4ml	NPD/SP* + PA	No Change (New Drug)		No Change	No Change	08/07/23
Suflave™ Sol	NPD + PA + QL (4 per 365 days)	No Change (New Drug)	Suprep® or Clenpiq®	No Change	No Change	07/10/23
Austedo® XR Tab Titr Kit	NPD/SP* + PA	No Change (New Drug)		No Change	No Change	07/17/23
Brenzavvy™ Tab 20mg	NPD + PA	No Change (New Drug)	One of the following: Jardiance®, Synjardy® [XR], Glyxambi® or Trijardy® XR AND One of the following: Farxiga® or Xigduo® XR	No Change	No Change	07/24/23
Vanflyta® Tab 17.7mg, 26.5mg	NPD/SP* + PA	No Change (New Drug)		No Change	No Change	07/31/23
Cosentyx® Inj 300/2ml	NPD/SP* + PA	No Change (New Drug)		No Change	No Change	08/07/23
Ngenla™ Inj 24/1.2ml, 60/1.2ml	NPD/SP* + PA	No Change (New Drug)		No Change	No Change	08/07/23
Opvee® Spray 2.7/0.1	NPD + QL (6 units per 30 days)	No Change (New Drug)		No Change	No Change	08/21/23
Airsupra™ AER 90-80mcg	NPD + PA	No Change (New Drug)	Both of the following: one inhaled corticosteroid (ICS) with albuterol AND minimum 30-day supply of brand Symbicort®	No Change	No Change	08/28/23

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(continued)

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(4/24 version)

Drug Name	Current (tier and edit)	New Tier and Edit	Formulary Alternatives	Tier Change	Edit Change	Effective Date
nitrofurantoin susp 50mg/5ml	G + AL (Max Age 12)	No Change (New Drug)		No Change	No Change	09/04/23
<b>Breo™ Ellipta® Inh 50-25mcg</b>	PB	No Change (New Drug)		No Change	No Change	09/04/23
<b>Ojjaara™</b>	NPD/SP* + PA	No Change (New Drug)		No Change	No Change	09/25/23
<b>Abrilada™ Inj 20/0.4ml, 40/0.8ml</b>	NPD/SP* + PA	No Change (New Drug)		No Change	No Change	10/30/23
<b>Lodoco®</b>	NPD + PA	No Change (New Drug)		No Change	No Change	09/11/23
<b>Zepbound™ Inj</b>	NPD + PA	No Change (New Drug)		No Change	No Change	11/06/23
<b>Breyna™ Aer 80/4.5, 160/4.5</b>	NPD + PA	No Change	TWO of the following: <b>Breo™ Ellipta®, Symbicort® or Advair® HFA</b>	No Change	No Change	07/31/23
vancomycin sol 50mg/ml	G + AL (Max Age 12)	No Change		No Change	No Change	08/14/23
<b>Iyuzeh™ Dro 0.005%</b>	NPD + PA	No Change	ONE of the following generics: latanoprost, bimatoprost, travoprost AND <b>Lumigan®</b>	No Change	No Change	08/21/23
<b>Jesduvroq®</b>	NPD + PA	No Change		No Change	No Change	09/18/23
<b>Sohonos™</b>	NPD/SP* + PA	No Change (New Drug)		No Change	No Change	09/04/23
<b>Akeega™</b>	NPD/SP* + PA	No Change (New Drug)		No Change	No Change	09/18/23
<b>Adalimumab® Kit 40/0.8ml</b>	NPD/SP* + PA	No Change (New Drug)		No Change	No Change	09/25/23
<b>Adalimumab®-Adbm Psoriasis/Uveitis Starter</b>	NPD/SP* + PA	No Change (New Drug)		No Change	No Change	09/25/23

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(continued)

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(4/24 version)

Drug Name	Current (tier and edit)	New Tier and Edit	Formulary Alternatives	Tier Change	Edit Change	Effective Date
<b>Adalimumab® Kit 10/0.2ml, 20/0.4ml, 40/0.8ml</b>	NPD/SP* + PA	No Change (New Drug)		No Change	No Change	09/25/23
<b>Adalimumab®-Adbm Crohns/Uc/Hs Starter</b>	NPD/SP* + PA	No Change (New Drug)		No Change	No Change	09/25/23
<b>Xdemvy® Dro 0.25%</b>	NPD + PA	NPD		No Change	PA Removal	04/01/24
<b>Zurzuvaе™ Cap 20mg, 25mg</b>	NPD	NPD + QL (2 caps per day; D/S 14 days per 365 days)		No Change	QL Addition	04/01/24
<b>Zurzuvaе™ Cap 30mg</b>	NPD	NPD + QL (1 cap per day; D/S 14 days per 365 days)		No Change	QL Addition	04/01/24
<b>Flovent® HFA Aerosol 44mcg/ACT, 110mcg/ACT, 220mcg/ACT Inhalation</b>	PB	NPD + PA* (Bypass PA for members 5 years of age and under)	Both of the following: <b>Arnuity® Ellipta®</b> and <b>Pulmicort Flexhaler™</b>	Brand Uptier	PA Addition	01/01/24
<b>Fluticasone propionate HFA aerosol 44mcg/ACT, 110mcg/ACT, 220mcg/ACT Inhalation</b>	NPD + PA	NPD + PA* (Bypass PA for members 5 years of age and under)	Both of the following: <b>Arnuity® Ellipta®</b> and <b>Pulmicort Flexhaler™</b>	No Change	No Change	01/01/24

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(4/24 version)

**Abbreviation Key**

<b>G</b>	Generic
<b>LCG</b>	Low Cost Generic. Benefit may vary; not all plans provide this incentive.
<b>ACA</b>	Affordable Care Act preventative drugs
<b>PB</b>	Preferred Brand
<b>NPD</b>	Non-Preferred Drug
<b>SP</b>	Specialty Drug. Specialty Tier cost-share will apply for those benefits that have a prescription drug specialty tier.
<b>PA</b>	Prior Authorization is required.
<b>MME</b>	Morphine Milligram Equivalent
<b>D/S</b>	Days Supply Limit
<b>QL</b>	Quantity Limit
<b>AL</b>	Age Limit
<b>Generic Addition</b>	A generic drug that recently became available in the marketplace
<b>Generic Downtier</b>	This generic drug will be covered at the appropriate preferred drug level of cost-sharing.
<b>Generic Uptier</b>	This generic drug will be covered at the appropriate non-preferred drug level of cost-sharing.
<b>Authorized Generic Addition</b>	An authorized generic drug that recently became available in the marketplace
<b>Authorized Generic Uptier</b>	Authorized generics are brand drugs that are marketed without the brand name on its label. An authorized generic may be marketed by the brand name drug company, or another company with the brand company's permission. Unlike a standard generic drug, the authorized generic is not approved by the Food and Drug Administration (FDA) abbreviated new drug application process (ANDA). This authorized generic drug will be covered at a higher level of cost-sharing similar to other brand name drugs.
<b>Brand Downtier</b>	These brand drugs were added to the formulary as of the date indicated and are covered at the appropriate preferred brand formulary level of cost-sharing.
<b>Brand Uptier</b>	These brand drugs will be covered at the appropriate non-preferred drug level of cost-sharing.
<b>Brand Addition</b>	Coverage was added to this drug.
<b>Brand/Authorized Generic/ Generic Deletion</b>	Coverage was removed from this drug. Formulary alternatives are available.