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Formulary Update

At A Glance

Prior Authorization (QRM) Additions

- Inpefa (sotagliflozin)
- Leqembi (lecanemab)
- Veozah (fezolinetant)

Prior Authorization (QRM) Updates

- Adbry (tralokinumab)
- Aduhelm (aducanumab)
- Calcitonin gene-related peptide (CGRP) inhibitors
- Contrave (Naltrexone/Bupropion)
- Cosentyx (secukinumab)
- Daybue (trofinetide)
- Dupixent (dupilumab)
- GLP-1 Receptor Agonists (Weight Loss Treatments)
- Growth Hormones (somatropin)
- Ilaris (canakinumab)
- Ingrezza (valbenazine)
- Kerendia (finerenone)
- Otezla (apremilast)
- Prevymis (letermovir)
- Qulipta (atogepant)
- Rinvoq (upadacitinib)
- Skytrofa (lonapegsomatropin)
- Soliris (eculizumab)
- Stelara (ustekinumab)
- Syprine (trientine)
- Talzenna (talazoparib)
- Zejula (niraparib)
- Zoryve (roflumilast)



A PUBLICATION OF THE GEORGIA PHARMACY AND THERAPEUTICS (P&T) COMMITTEE. The Formulary Update contains information regarding formulary additions, deletions, exclusions, brief descriptions of products, and current drug related news. It also lists items to be discussed at upcoming P&T meetings. Please refer to the web pages: [KP Georgia Formulary and Drug Lists](#) OR [Drug Formulary for Practitioners](#) for the full KPGA Drug Formulary.

QHP-ACA/Open Formulary Tier Changes

(Effective 1.10.2024)

- **Generic fingolimod 0.5 mg capsule:** Down-tier to Preferred Generic Tier 2

QHP-ACA/Open Formulary Step Therapy Addition

(Effective 1.10.2024)

- **Paxlovid (nirmatrelvir-ritonavir) tablets**

Interregional Practice Recommendations

The Emerging Therapeutics Strategy Program (ETSP) is a centralized effort that applies our evidence-based model to develop interregional practice recommendations with KP physician specialists, coordinates KP HealthConnect clinical content for decision support, and monitors outcomes to measure uptake of the clinical and strategy recommendations. Through the collaboration of Pharmacy, Permanente physicians, and Federation partners, the ETSP offers a unified approach in the provision and management of specialty drugs to help ensure that our members derive the greatest value from these products.

The following IR Practice Recommendation ADDITION was recently approved:

- **Daybue (trofinetide):** Indicated for the treatment of Rett syndrome in adults and pediatric patients two years of age and older.
- **Elevidys (delandistrogene moxeparvovec):** Indicated for the treatment of ambulatory pediatric patients aged 4 through 5 years with Duchene muscular dystrophy (DMD) with a confirmed mutation in the DMD gene.
- **Roctavian (valoctocogene roxaparvovec):** Indicated for the treatment of adults with severe hemophilia A (congenital factor VIII deficiency with factor VIII activity <1 IU/dL) without pre-existing antibodies to adenoassociated virus serotype 5 detected by an FDA-approved test.

ETSP recommendations as well as pipeline candidates can be found here: [Emerging Therapeutics Strategy Program](#). Please note: Newly marketed medications requiring ETSP review will also receive prior authorization (PA) review. These medications will not be eligible for consideration of drug benefit coverage until completion of drug specific ETSP and PA criteria review processes.

Additions to the QRM Prior Authorization Review List of Medications for the Commercial/HMO Closed Formularies & QHP-ACA/Open Formularies

Note: The updates below DO NOT APPLY to Medicare Part D or Dual Choice Prescription Benefit Plans. Optum and MedImpact are the external PBMs for each of these plans, respectively, externally administering all non-formulary or prior authorization criteria and coverage review.

The following QRM additions will be effective January 10, 2024:

- **Inpefa (sotagliflozin):** Indicated to reduce the risk of cardiovascular death, hospitalization for heart failure, and urgent heart failure visit in adults with: heart failure or type 2 diabetes mellitus, chronic kidney disease, and other cardiovascular risk factors.
- **Leqembi (lecanemab):** Indicated for the treatment of Alzheimer's disease.
- **Veozah (fezolinetant):** Indicated for the treatment of moderate to severe vasomotor symptoms (VMS) due to menopause.

The following QRM additions will be effective January 1, 2024:

- **Attention deficit hyperactivity disorder (ADHD) Stimulants:**
 - Adderall XR (dextroamphetamine-amphetamine)
 - Concerta (methylphenidate)
 - Jornay PM (methylphenidate)
 - Mydayis (amphetamine-dextroamphetamine)
 - Quillichew (methylphenidate)

Upcoming Formulary Items



An important aspect of the formulary process is the involvement of all practitioners. Please contact your P&T Committee representative or your clinical service chief by January 26 if you wish to comment on any of the medications, class reviews, or other agenda items under consideration. To make formulary addition requests, you must submit a Formulary Additions/Deletions Form and Conflict of Interest Form to Drug Information Services or call (404) 439-4417 OR (404) 777-3784.

QRM Prior Authorization Review Criteria Updates

Note: The updates below DO NOT APPLY to Medicare Part D or Dual Choice Prescription Benefit Plans. Optum and MedImpact are the external PBMs for each of these plans, respectively, externally administering all non-formulary or prior authorization criteria and coverage review.

- **Adbry (tralokinumab):** Criteria updated to clarify/specify the criteria for new members.
- **Aduhelm (aducanumab):** Criteria updated to align with the ETSP IR Practice Recommendations.
- **Calcitonin gene-related peptide (CGRP) inhibitors (Aimovig (erenumab), Emgality (galcanezumab), and Vyepti (eptinezumab)):** Criteria updated to clarify/specify the criteria for new members on anti-CGRP therapy.
- **Contrave (Naltrexone/Bupropion):** Criteria updated to align with the Class III Obesity rider language changes effective January 2024.
- **Cosentyx (secukinumab):** Criteria updated to include the recent FDA approval for the treatment of Hidradenitis Suppurativa.
- **Daybue (trofinetide):** Criteria updated to align with the ETSP IR Practice Recommendations.
- **Dupilixent (dupilumab):** Criteria updated to clarify/specify the criteria for new members.
- **GLP-1 Receptor Agonists (Weight Loss Treatments):** Criteria updated to 1) align with the Class III Obesity rider language changes effective January 2024 2) clarify the continuation timeline for the QRM reviewers and 3) require a patient to achieve $\geq 5\%$ weight loss at 4 months to align with the initial approval period and $\geq 10\%$ by 11 months.
- **Growth Hormones (somatropin):** Criteria updated to 1) include a table of growth hormone products and their FDA labeled indications into the criteria 2) move “open epiphyses” from the reasons for non-coverage to a regular criteria bullet 3) add language to require preferred somatropin growth hormone products OR contraindication to somatropin before non-preferred agents 4) add language to comply with FEHB mandate to allow coverage of medications used in IVF 5) combine all agents into the criteria to streamline for the reviewers and 6) remove the “reasons for non-coverage” in the adult criteria.
- **Ilaris (canakinumab):** Criteria updated with language to require administration of Ilaris at a KPGA facility only.
- **Ingrezza (valbenazine):** Criteria updated to include the recent FDA approval for the treatment of adults with chorea associated with Huntington’s disease (HD).
- **Kerendia (finerenone):** Criteria updated to promote half-tablet utilization.
- **Otezla (apremilast):** Criteria updated under the Hidradenitis Suppurativa criteria to 1) require Amjevita or Infliximab prior to Otezla and 2) clarify/specify the criteria for new members.
- **Prevymis (letermovir):** Criteria updated to 1) remove the requirement of valganciclovir prior to Prevymis for prophylaxis of cytomegalovirus for allogeneic hematopoietic stem cell transplant and 2) include infectious disease specialist as an approved prescriber.
- **Qulipta (atogepant):** Criteria updated to promote half-tablet utilization.
- **Rinvoq (upadacitinib):** Criteria updated under Crohn’s disease or ulcerative colitis to clarify that Xeljanz is only required for ulcerative colitis.
- **Skytrofa (lonapegsomatropin):** Removed as a single entry and added to the Growth Hormones QRM PA Criteria.
- **Soliris (eculizumab):** Criteria updated to include criteria for generalized myasthenia gravis.
- **Stelara (ustekinumab):** Criteria updated to 1) require Xeljanz (preferred JAK inhibitor) before Cimzia/Simponi 2) indicate that Cimzia is only approved for Crohn’s disease and if patient is in remission 3) indicate that Simponi is only approved for ulcerative colitis
- **Syprine (trientine):** Criteria updated to define intolerance and separate duration of use for allergy from that of intolerance.
- **Talzenna (talazoparib):** Criteria updated to include the recent FDA approval for the treatment of adult patients with homologous recombination repair (HRR) gene–mutated metastatic castration-resistant prostate cancer (mCRPC) in combination with Xtandi (enzalutamide).
- **Zejula (niraparib):** Criteria updated to include the recent FDA approval for the treatment of adult patients with deleterious or suspected deleterious germline BRCA-mutated cancer.
- **Zoryve (roflumilast):** Criteria updated to include the expanded indication of Zoryve for the topical treatment of plaque psoriasis, to include children 6 to 11 years of age.

Information Concerning Coverage Determinations

Medicare Part D: Medicare Part D Plan Non Formulary and Prior Authorization criteria and coverage determination are made externally by the Pharmacy Benefit Manager Optum Rx.

Prescriber completes the .NFRequestForm when entering drug order. Your documentation is used by OptumRx to determine whether the prescribed drug is eligible for drug benefit coverage. No documentation = No coverage.

The KP Pharmacy Consult Service will send your documentation to OptumRx for their coverage determination decision within the labeled time frame (standard: 72 hours; urgent: 24 hours). If not received by the deadline, the PBM will deny the request. If OptumRx has further questions, you will be contacted for responses. You may phone OptumRx at **1-888-791-7255** to address any patient / drug coverage specific questions. To see the MPD Formulary, please visit: [Medicare Part D Formulary](#)

Dual Choice: Dual Choice Plan Non Formulary and Prior Authorization criteria and coverage determination are made externally by the Pharmacy Benefit Manager MedImpact.

Prescriber completes the .NFRequestForm when entering drug order. Your documentation is used by MedImpact to determine whether the prescribed drug is eligible for drug benefit coverage. No documentation = No coverage.

The KP Pharmacy Consult Service will send your documentation to MedImpact for their coverage determination decision within the labeled time frame (standard: 72 hours; urgent: 24 hours). If not received by the deadline, the PBM will deny the request. If MedImpact has further questions, you will be contacted to provide responses. You may phone MedImpact at **1-844-336-2676** to address any patient / drug coverage specific questions. The Dual Choice formulary differs from the KPHC formulary (i.e. DOACs, ADHD, asthma). Please visit: [Choice Formulary](#)



If you have any questions or concerns, please contact any of the following P&T Committee members and designated alternates:

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Clinical Services

Hector Clarke, PharmD, BCOP
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Lesia Jackson, RN
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Satya Jayanthi, MD
Hospitalist

Commercial HMO/Closed Formulary & QHP-ACA/Open Formulary Dispensing/ Quantity Limit Additions

(Effective 1.10.2024)

Medication	Quantity Limit
Mounjaro (tirzepatide)	2 mL per 28 days

Medication	Dispensing Limit	Effective Date
Brand/Generic Pulmicort (budesonide) inhalation solution	30 days	10.26.2023
Ozempic (semaglutide)	28 days	12.14.2023
Rybelsus (semaglutide)	30 days	12.1.2023
Saxenda (liraglutide)	28 days	12.1.2023
Victoza (liraglutide)	28 days	12.1.2023
Wegovy (semaglutide)	28 days	12.1.2023

Approved Floor Stock List Additions

(Effective 1.10.2024)

Medication	Department
DAKIN'S HALF SOLUTION	Podiatry
GENTAMICIN 40MG/ML INJECTION, VIALS	OB/GYN
LIDOCAINE 4% TOPICAL LIQUID	Wound Care

Approved Floor Stock List Removals

(Effective 1.10.2024)

Medication	Department
ANTIPYRINE/BENZOCAINE 10 ML OTIC SOLN (AURODEX)	Pediatrics
PREDNISOLONE 15 MG/5 ML SYRUP, 8 OZ BTL (PRELONE)	
ASPIRIN 325 MG UD TAB	Podiatry
VASELINE PETROLEUM JELLY 75GM	
ZINC OXIDE 20% OINT 28.35GM	
DIPHENHYDRAMINE 50 MG/ML, 1 ML VIAL (BENADRYL)	
DIPHENHYDRAMINE 50MG/ML SYRINGE	
EPINEPHRINE 0.15 MG KIT (EPIPEN JR)	
EPINEPHRINE 0.3 MG KIT (EPIPEN)	
SODIUM CHLORIDE 0.9% INHALATION SOLN, 15 ML VIAL	Urology
DEPO-TESTOSTERONE 200MG/ML VIAL 1ML	
BLEOMYCIN SULFATE VIAL	Dermatology
FLUOROURACIL 500MG/10ML	

KP Approved Outpatient Sterile Compounds List Changes

(Effective 1.10.2024)

- Transitioned compounding documents to link directly to the [National Sterile Compounding SharePoint Site](#) for the following compounds:
 - Amikacin Sulfate 25 mg/ml Ophthalmic Solution
 - Ceftazidime 50 mg/mL Ophthalmic Solution
 - Tobramycin 13.6 mg/ml Ophthalmic Solution

Medicare Part D Formulary Changes

Kaiser Permanente has a National Medicare Part D (MPD) Formulary. Each regional P&T Committee reviews drugs and decides on tier status. The National Medicare Part D Pharmacy and Therapeutics Committee is charged with reconciling regional differences in MPD Formulary recommendations through consensus building in order to maintain one National MPD Formulary for Kaiser Permanente.

Medicare Part D Initial Tier Placement

Initial Tier Placements: Recently launched and approved medications

Drug Name	Tier Status	Implementation Date
teriparatide (recombinant) 600 mcg/2.4 mL injection	Specialty Tier 5	11/21/2023
adalimumab-aaty 20 mg/0.8 mL injection kit (Yuflyma)	Specialty Tier 5	11/20/2023
capivasertib 160 mg, 200 mg tablets (Truqap)	Specialty Tier 5	11/20/2023
fruquintinib 1 mg, 5 mg capsules (Fruzaqla)	Specialty Tier 5	11/10/2023
zuranolone 20 mg, 25 mg, 30 mg capsules (Zurzuvae)	Specialty Tier 5	11/7/2023
tenapanor HCl 20 mg, 30 mg tablets (Xphozah)	Specialty Tier 5	11/6/2023
entrectinib 50 mg pellet packs (Rozlytrek)	Specialty Tier 5	11/6/2023
mirikizumab-mrkz 300 mg/15 mL injection; 100 mg/mL auto-injector (Omvoh)	Specialty Tier 5	11/1/2023
bimekizumab-bkzx 160 mg/mL auto-injection, prefilled injection (Bimzelx)	Specialty Tier 5	10/25/2023
etrasimod 2 mg tablets (Velsipity)	Specialty Tier 5	10/25/2023
adalimumab-afzb 40 mg/0.8 mL auto-injection kit; 20 mg/0.4 mL, 40 MG/0.8 mL prefilled injection kit (Abrilada)	Specialty Tier 5	10/24/2023
baclofen 10 mg/5 mL oral solution (Ozobax)	Specialty Tier 5	10/23/2023

Class Review



February 2024:

Medication Class Review

Antianginal

Antiarrhythmics

Antihistamines

Antihyperlipidemics

Antihypertensives

Beta Blockers

Calcium Channel Blockers

Cardiovascular Agents -- Misc

Cough/Cold/Allergy

Diuretics

Nasal Agents -- Systemic & Topical

Passive Immunizing and Treatment Agents

Respiratory Agents -- Misc

Vaccines

Vasopressors

Medicare Part D Additions for 2024

Drug Name	2024 Tier
CIMETIDINE HCL SOLN 300 MG/5ML	2
CYCLOPHOSPHAMIDE SOLN 500 MG/ML	5
CYCLOPHOSPHAMIDE SOLN 500 MG/ML	5
CYCLOPHOSPHAMIDE SOLN 500 MG/ML	5
DICLOFENAC SODIUM GEL 3 %	4
LEVOCETIRIZINE DIHYDROCHLORIDE SOLN 2.5 MG/5ML	4
LINZESS CAPS 290 MCG	4
MOVANTIK TABS 25 MG	4
RANOLAZINE ER TB12 1000 MG	4
SUPREP BOWEL PREP KIT SOLN 17.5-3.13-1.6 GM/177ML	4
VANFLYTA TABS 17.7 MG	5
VANFLYTA TABS 26.5 MG	5
VENLAFAXINE HCL ER TB24 37.5 MG	2
VERQUVO TABS 10 MG	4
XENPOZYME SOLR 4 MG	5
YUFLYMA 2-PEN KIT AJKT 40 MG/0.4ML	5

Medicare Part D Removals for 2024

Drug Name					
AFREZZA POWD 90 x 8 UNIT & 90X12 UNIT	DESVENLAFAXINE ER TB24 50 MG	GENOTROPIN MINIQUICK PRSY 2 MG	METAPROTERENOL SYRP 10 MG/5ML	PARICALCITOL CAPS 4 MCG	SAPHRIS SUBL 10 MG
ALA-CORT CREA 1 %	DOXERCALCIFEROL CAPS 0.5 MCG	GLYBURIDE TABS 1.25 MG	METAXALONE TABS 800 MG	PEGASYS PROCLICK SOAJ 135 MCG/0.5ML	SAPHRIS SUBL 2.5 MG
ANDRODERM PT24 2 MG/24HR	ECONAZOLE NITRATE CR 1 %	GLYBURIDE TABS 2.5 MG	MICAFUNGIN SODIUM SOLR 50 MG	PENTAZOCINE-NALOXONE HCL TABS 50-0.5 MG	SAPHRIS SUBL 5 MG
ANDRODERM PT24 4 MG/24HR	EMPAVELI SOLN 1080 MG/20ML	GLYBURIDE TABS 5 MG	MOUNJARO SOPN 10 MG/0.5ML	PEPCID TABS 20 MG	SEROSTIM SOLR 4 MG
APO-VARENICLINE TABS 0.5 MG	EPLERENONE TABS 25 MG	GRANIX SOLN 300 MCG/ML	MOUNJARO SOPN 12.5 MG/0.5ML	PEXEVA TABS 10 MG	SEROSTIM SOLR 5 MG
APO-VARENICLINE TABS 1 MG	EQUETRO CP12 100 MG	GRANIX SOLN 480 MCG/1.6ML	MOUNJARO SOPN 15 MG/0.5ML	PEXEVA TABS 20 MG	SEROSTIM SOLR 6 MG
ASTAGRAF XL CP 0.5 MG	EQUETRO CP12 200 MG	GRANIX SOSY 300 MCG/0.5ML	MOUNJARO SOPN 2.5 MG/0.5ML	PEXEVA TABS 30 MG	SEVELAMER HCL TABS 800 MG
ASTAGRAF XL CP 1 MG	EQUETRO CP12 300 MG	GRANIX SOSY 480 MCG/0.8ML	MOUNJARO SOPN 5 MG/0.5ML	PEXEVA TABS 40 MG	SILODOSIN CAPS 4 MG
ASTAGRAF XL CP 5 MG	ERY-TAB TBEC 250 MG	HERCEPTIN SOLR 440 MG	MOUNJARO SOPN 7.5 MG/0.5ML	PREDNISOLONE SODIUM PHOSPHATE TBDP 10 MG	SODIUM POLYSTYRENE SULFONATE SUSP 30 GM/120ML
AVONEX KIT 30 MCG	ERY-TAB TBEC 333 MG	HYDROCODONE-IBUPROFEN TABS 7.5-200 MG	NAFTIFINE HCL CREA 2 %	PULMICORT FLEXHALER AEPB 180 MCG/ACT	SOTYLIZE SOLN 5 MG/ML
AZASAN TABS 100 MG	ERY-TAB TBEC 500 MG	INVIRASE CAPS 200 MG	NAPROXEN-ESOMEPRAZOLE TBEC 500-20 MG	QUINIDINE GLUCONATE SOLN 80 MG/ML	TERIPARATIDE (RECOMBINANT) SOPN 620 MCG/2.48ML
AZASAN TABS 75 MG	ERYTHRO ETHYLSUCCINATE 200 MG/5ML	IOPIDINE SOLN 1 %	NECON 7/7/7 TABS 0.5/0.75/1-35 MG-MCG	RANOLAZINE ER TB12 500 MG	TOLTERODINE TARTRATE ER CP24 4 MG
AZITHROMYCIN TABS 500 MG	ERYTHROMYCIN ETHYLSUCCINATE SUSR 400 MG/5ML	KETOROLAC TROMETHAMINE TABS 10 MG	NEULASTA SOSY 6 MG/0.6ML	REBIF SOSY 22 MCG/0.5ML	TRAMADOL HCL ER TB24 100 MG
BACTROBAN NASAL OINT 2 %	ESOMEPRAZOLE MAGNESIUM CPDR 40 MG	KLOR-CON M20 TBCR 20 MEQ	NEUPOGEN SOLN 300 MCG/ML	REBIF SOSY 44 MCG/0.5ML	TRIDERM CREA 0.1 %
BANZEL SUSP 40 MG/ML	EVENITY SOSY 105 MG/1.17ML	KLOR-CON PACK 20 MEQ	NEUPOGEN SOLN 480 MCG/1.6ML	RELEUKO 300 MCG/ML	TROKENDI XR CP24 100 MG
BANZEL TABS 200 MG	FENOFIBRIC ACID CPDR 135 MG	K-TAB TBCR 10 MEQ	NEUPOGEN SOSY 300 MCG/0.5ML	RELEUKO 480 MCG/1.6ML	TROKENDI XR CP24 200 MG
BANZEL TABS 400 MG	FLEBOGAMMA DIF SOLN 5 GM/50ML	LAMICTAL XR KIT 21 x 25 MG & 7 X 50 MG	NEUPOGEN SOSY 480 MCG/0.8ML	RELEUKO SOSY 300 MCG/0.5ML	TROKENDI XR CP24 25 MG
BRIMONIDINE TARTRATE SOLN 0.15%	FLEQSUVY SUSP 25 MG/5ML	LAMICTAL XR KIT 25 & 50 & 100 MG	NITISINONE CAPS 10 MG	RELEUKO SOSY 480 MCG/0.8ML	TROKENDI XR CP24 50 MG

Medicare Part D Removals for 2024 (cont)

Drug Name					
BUPRENORPHINE HCL-NALOXONE HCL FILM 2-0.5 MG	FLUNISOLIDE SOLN 25 MCG/ACT (0.025%)	LAMICTAL XR KIT 50 & 100 & 200 MG	NITISINONE CAPS 2 MG	RELISTOR SOLN 8 MG/0.4ML	TROSPIUM CHLORIDE ER CP24 60 MG
BUPRENORPHINE HCL-NALOXONE HCL FILM 4-1 MG	FLUORITAB CHEW 0.55 (0.25 F) MG	LANSOPRAZOLE CPDR 30 MG	NITISINONE CAPS 5 MG	RELISTOR TABS 150 MG	UDENYCA SOSY 6 MG/0.6ML
BUPRENORPHINE HCL-NALOXONE HCL FILM 8-2 MG	FLUORITAB CHEW 1.1 (0.5 F) MG	LANTUS SOLN 100 UNIT/ML	NITYR TABS 10 MG	REMICADE SOLR 100 MG	VELTASSA PACK 16.8 GM
BUTALBITAL-ASA-CAFF-CODEINE CAPS 50-325-40-30 MG	FLUORITAB CHEW 2.2 (1 F) MG	LANTUS SOLOSTAR SOPN 100 UNIT/ML	NITYR TABS 2 MG	RENFLXIS SOLR 100 MG	VELTASSA PACK 25.2 GM
BUTORPHANOL TARTRATE SOLN 10 MG/ML	FLUVASTATIN SODIUM CAPS 20 MG	LEUCOVORIN CALCIUM TABS 15 MG	NITYR TABS 5 MG	RESCRIPTOR TABS 100 MG	VELTASSA PACK 8.4 GM
CARISOPRODOL TABS 350 MG	FLUVASTATIN SODIUM ER TB24 80 MG	LEVOCARNITINE SOLN 1 GM/10ML	NORVIR CAPS 100 MG	RETACRIT SOLN 40000 UNIT/ML	VYVANSE CAPS 10 MG
CARVEDILOL PHOSPHATE ER CP24 80 MG	GENGRAF SOLN 100 MG/ML	LIDOCAINE HCL URETHRAL/MUCOSAL GEL 2 %	NUPLAZID TABS 17 MG	RISEDRONATE SODIUM TABS 35 MG	VYVANSE CAPS 20 MG
CASPOFUNGIN ACETATE SOLR 50 MG	GENOTROPIN CART 12 MG	LIPODOX 50 INJ 2 MG/ML	NUTROPIN AQ NUSPIN 10 SOPN 10 MG/2ML	RISEDRONATE SODIUM TABS 35 MG	VYVANSE CAPS 30 MG
CEVIMELINE HCL CAPS 30 MG	GENOTROPIN MINIQUICK PRSY 0.4 MG	LUDENT CHEW 0.55 (0.25 F) MG	ORFADIN CAPS 20 MG	RISEDRONATE SODIUM TABS 35 MG	VYVANSE CAPS 40 MG
CHLORZOXAZONE TABS 500 MG	GENOTROPIN MINIQUICK PRSY 0.6 MG	LUDENT CHEW 1.1 (0.5 F) MG	OXTELLAR XR TB24 150 MG	RIVASTIGMINE PT24 13.3 MG/24HR	VYVANSE CAPS 50 MG
CLOTRIMAZOLE CREA 1 %	GENOTROPIN MINIQUICK PRSY 0.8 MG	LUDENT CHEW 2.2 (1 F) MG	OXTELLAR XR TB24 300 MG	RIVASTIGMINE PT24 4.6 MG/24HR	VYVANSE CAPS 60 MG
COLCHICINE CAPS 0.6 MG	GENOTROPIN MINIQUICK PRSY 1 MG	MECLIZINE HCL TABS 12.5 MG	OXTELLAR XR TB24 600 MG	RIVASTIGMINE PT24 9.5 MG/24HR	VYVANSE CAPS 70 MG
DES Loratadine TABS 5 MG	GENOTROPIN MINIQUICK PRSY 1.2 MG	MEMANTINE HCL ER CP24 7 MG	OXYCODONE HCL CAPS 5 MG	SAIZEN SOLR 5 MG	ZARONTIN SOLN 250 MG/5ML
DESVENLAFAXINE ER TB24 100 MG	GENOTROPIN MINIQUICK 1.4 MG	MESALAMINE CPDR 400 MG	OXYMORPHONE HCL ER TB12 10 MG	SAIZEN SOLR 8.8 MG	ZIEXTENZO SOSY 6 MG/0.6ML
DESVENLAFAXINE ER TB24 50 MG	GENOTROPIN MINIQUICK PRSY 1.6 MG	MESALAMINE ER CP24 0.375 GM	OXYMORPHONE HCL ER TB12 20 MG	SAIZENPREP SOLR 8.8 MG	
DOXERCALCIFEROL CAPS 0.5 MCG	GENOTROPIN MINIQUICK PRSY 1.8 MG	MESALAMINE TBEC 800 MG	OXYMORPHONE HCL ER TB12 5 MG	SANCUSO PTCH 3.1 MG/24HR	

Medicare Part D Tier Changes for 2024

Drug Name	2024 TIER	2023 TIER
ALDURAZYME SOLN 2.9 MG/5ML	5	3
ALLOPURINOL TABS 100 MG	1	2
ALLOPURINOL TABS 300 MG	1	2
AMIODARONE HCL TABS 200 MG	1	2
ATROVENT HFA AERS 17 MCG/ACT	4	3
BELBUCA FILM 600 MCG	4	5
BRIMONIDINE TARTRATE SOLN 0.2 %	1	2
BUDESONIDE ER TB24 9 MG	4	5
CALCIPOTRIENE-BETAMETH DIPROP SUSP 0.005-0.064 %	4	5
CEFACLOR SUSR 125 MG/5ML	4	2
CEFACLOR SUSR 250 MG/5ML	4	2
CEFACLOR SUSR 375 MG/5ML	4	2
CHORIONIC GONADOTROPIN SOLR 10000 UNIT	4	5
CLONIDINE HCL TABS 0.1 MG	1	2
CLONIDINE HCL TABS 0.2 MG	1	2
CLONIDINE HCL TABS 0.3 MG	1	2
CLOPIDOGREL BISULFATE TABS 75 MG	1	2
COLISTIMETHATE SODIUM (CBA) SOLR 150 MG	4	5
COMBIVENT RESPIMAT AERS 20-100 MCG/ACT	4	3
DEFERASIROX GRANULES PACK 90 MG	4	5
DEPO-SUBQ PROVERA 104 SUSY 104 MG/0.65ML	4	3
DICLOFENAC SODIUM GEL 1 %	4	2
DIFLORASONE DIACETATE OINT 0.05 %	4	5
DONEPEZIL HCL TABS 10 MG	1	2
DONEPEZIL HCL TABS 5 MG	1	2
DORZOLAMIDE HCL-TIMOLOL MAL SOLN 22.3-6.8 MG/ML	1	2
ERGOMAR SUBL 2 MG	4	5
ESCITALOPRAM OXALATE TABS 10 MG	1	2
ESCITALOPRAM OXALATE TABS 20 MG	1	2
ESCITALOPRAM OXALATE TABS 5 MG	1	2
ESTRADIOL TABS 0.5 MG	1	2
ESTRADIOL TABS 1 MG	1	2
ESTRADIOL TABS 2 MG	1	2
ESTRING RING 2 MG	4	3
ESTRING RING 7.5 MCG/24HR	4	3
EVEROLIMUS TABS 0.25 MG	5	4
EVEROLIMUS TABS 0.25 MG	5	4
EVEROLIMUS TABS 0.75 MG	5	4
EXTAVIA KIT 0.3 MG	5	2
FINASTERIDE TABS 5 MG	1	2
GLATOPA SOSY 20 MG/ML	4	2
GLATOPA SOSY 40 MG/ML	4	2
HALOBETASOL PROPIONATE FOAM 0.05 %	4	5
INDAPAMIDE TABS 1.25 MG	1	2
INDAPAMIDE TABS 2.5 MG	1	2
LATANOPROST SOLN 0.005 %	1	2
LEVOCETIRIZINE DIHYDROCHLORIDE TABS 5 MG	4	2
LEVOTHYROXINE SODIUM TABS 100 MCG	1	2
LEVOTHYROXINE SODIUM TABS 112 MCG	1	2
LEVOTHYROXINE SODIUM TABS 125 MCG	1	2
LEVOTHYROXINE SODIUM TABS 137 MCG	1	2
LEVOTHYROXINE SODIUM TABS 150 MCG	1	2
LEVOTHYROXINE SODIUM TABS 175 MCG	1	2
LEVOTHYROXINE SODIUM TABS 200 MCG	1	2
LEVOTHYROXINE SODIUM TABS 25 MCG	1	2
LEVOTHYROXINE SODIUM TABS 300 MCG	1	2

Drug Name	2024 TIER	2023 TIER
LEVOTHYROXINE SODIUM TABS 50 MCG	1	2
LEVOTHYROXINE SODIUM TABS 75 MCG	1	2
LEVOTHYROXINE SODIUM TABS 88 MCG	1	2
LITHOSTAT TABS 250 MG	4	5
LUPRON DEPOT-PED (3-MONTH) KIT 11.25 MG (PED)	5	4
LUPRON DEPOT-PED (3-MONTH) KIT 30 MG	5	4
MELOXICAM TABS 15 MG	1	2
MELOXICAM TABS 7.5 MG	1	2
METHIMAZOLE TABS 10 MG	1	2
METHIMAZOLE TABS 5 MG	1	2
METHITEST TABS 10 MG	5	2
METHYLTESTOSTERONE CAPS 10 MG	5	2
METOPROLOL SUCCINATE ER TB24 100 MG	1	2
METOPROLOL SUCCINATE ER TB24 200 MG	1	2
METOPROLOL SUCCINATE ER TB24 25 MG	1	2
METOPROLOL SUCCINATE ER TB24 50 MG	1	2
NITROFURANTOIN SUSP 25 MG/5ML	5	2
OLOPATADINE HCL SOLN 0.1 %	4	2
OMEGA-3-ACID ETHYL ESTERS CAPS 1 GM	4	2
POSACONAZOLE TBEC 100 MG	4	5
PRADAXA CAPS 110 MG	4	3
PRADAXA CAPS 150 MG	4	2
PRADAXA CAPS 75 MG	4	2
PRAVASTATIN SODIUM TABS 10 MG	1	2
PRAVASTATIN SODIUM TABS 20 MG	1	2
PRAVASTATIN SODIUM TABS 40 MG	1	2
PRAVASTATIN SODIUM TABS 80 MG	1	2
PREDNISON TABS 1 MG	1	2
PREDNISON TABS 10 MG	1	2
PREDNISON TABS 2.5 MG	1	2
PREDNISON TABS 20 MG	1	2
PREDNISON TABS 5 MG	1	2
PREDNISON TABS 50 MG	1	2
SEREVENT DISKUS AEPB 50 MCG/ACT	4	3
SERTRALINE HCL TABS 100 MG	1	2
SERTRALINE HCL TABS 25 MG	1	2
SERTRALINE HCL TABS 50 MG	1	2
SIROLIMUS TABS 2 MG	4	5
SYMFI LO TABS 400-300-300 MG	4	2
SYMFI TABS 600-300-300 MG	4	2
TABLOID TABS 40 MG	5	3
TAMSULOSIN HCL CAPS 0.4 MG	1	2
TIMOLOL MALEATE SOLN 0.25 %	1	2
TIMOLOL MALEATE SOLN 0.5 %	1	2
TRELSTAR MIXJECT SUSR 11.25 MG	4	5
TRELSTAR MIXJECT SUSR 22.5 MG	4	5
TRELSTAR MIXJECT SUSR 3.75 MG	4	5
TRIAMTERENE-HCTZ CAPS 37.5-25 MG	1	2
UBRELVY TABS 100 MG	4	5
VALTOCO 15 MG DOSE LQPK 7.5 MG/0.1ML	5	4
VALTOCO 20 MG DOSE LQPK 10 MG/0.1ML	5	4
VALTOCO 5 MG DOSE LIQD 5 MG/0.1ML	5	4
VASCEPA CAPS 0.5 GM	2	4
VERAPAMIL HCL TABS 120 MG	1	2
VERAPAMIL HCL TABS 40 MG	1	2
VERAPAMIL HCL TABS 80 MG	1	2
VIGABATRIN PACK 500 MG	5	2
XIFAXAN TABS 200 MG	4	5

KPGA Commercial HMO/Closed Formulary & QHP-ACA/Open Formulary Changes

(Effective 1.1.2024)

QRM Prior Authorization Additions

Product Description				
AUVELITY TBCR 45-105 MG	KYZATREX CAPS 150 MG	SOTYKTU TABS 6 MG	VTAMA CREA 1 %	TURALIO CAPS 125 MG
HYFTOR GEL 0.2 %	KYZATREX CAPS 200 MG	TASCENSO ODT TBDP 0.25	ZORYVE CREA 0.3 %	REZLIDHIA CAPS 150 MG
IMBRUVICA SUSP 70 MG/ML	NOXAFIL PACK 300 MG	TASCENSO ODT TBDP 0.5 MG	BRONCHITOL CAPS 40 MG	TURALIO CAPS 125 MG
KRAZATI TABS 200 MG	ORKAMBI PACK 75-94 MG	VIJOICE TBP 125 MG	OXBRYTA TBSO 300 MG	LYNPARZA TABS 100 MG
KYZATREX CAPS 100 MG	OXBRYTA TABS 300 MG	VIJOICE TBP 200 & 50 MG	RADICAVA ORS STARTER KIT SUSP 105 MG/5ML	LYNPARZA TABS 150 MG

Step Therapy Additions

Product Description			
BASAGLAR TEMPO PEN SOPN 100 UNIT/ML	DYANAVEL XR CHER 5 MG	NA SULFATE-K SULFATE-MG SULF SOLN 17.5-3.13-1.6 GM/177ML	TAZAROTENE GEL 0.05 %
DORYX MPC TBEC 60 MG	HUMALOG TEMPO PEN SOPN 100 UNIT/ML	INSULIN DEGLUDEC FLEXTOUCH SOPN 100 UNIT/ML	TIMOLOL MALEATE PF SOLN 0.25 %
DYANAVEL XR CHER 10 MG	HYDROCORTISONE ACE-PRAMOXINE SUPP 25-18 MG	INSULIN DEGLUDEC FLEXTOUCH SOPN 200 UNIT/ML	TOLVAPTAN TABS 15 MG
DYANAVEL XR CHER 15 MG	INSULIN GLARGINE SOLN 100 UNIT/ML	INSULIN DEGLUDEC SOLN 100 UNIT/ML	XARELTO SUSR 1 MG/ML
DYANAVEL XR CHER 20 MG	INSULIN GLARGINE SOLOSTAR SOPN 100 UNIT/ML	LOREEV XR CS24 1.5 MG	PENCICLOVIR CREA 1 %
DYANAVEL XR CHER 20 MG	LYUMJEV TEMPO PEN SOPN 100 UNIT/ML	NAPROXEN SODIUM ER TB24 750 MG	

Step Therapy Removals

Product Description		
PROTRIPTYLINE HYDROCHLORIDE 10 MG ORAL TABLET	NEBIVOLOL HCL TABS 10 MG	NEBIVOLOL HCL TABS 20 MG
TRIMIPRAMINE 100 MG ORAL CAPSULE	NEBIVOLOL HCL TABS 2.5 MG	NEBIVOLOL HCL TABS 5 MG

Tier Changes

Product Description	2024 Tier Level
ACTEMRA INJ 162/0.9	3
AMJEVITA SOAJ 40 MG/0.8ML	3
AMJEVITA SOSY 20 MG/0.4ML	3
AMJEVITA SOSY 40 MG/0.8ML	3
BETASERON (INTERFERON BETA-1B) 0.3 MG	2
BD PEN NEEDLE MINI U/F MISC 31G X 5 MM	3
BD PEN NEEDLE SHORT U/F MISC 31G X 8 MM	3
DALIRESP TABS 500 MCG	4
DEXAMETHASONE SODIUM PHOSPHATE SOLN 4 MG/ML	2
EFAVIREN-EMTRICITAB-TENOFOVIR TABS 600-200-300 MG	2
MEDROXYPROGESTERONE ACETATE INJ 150MG/ML	2
METHOTREXATE SODIUM (PF) SOLN 1 GM/40ML	2
METHOTREXATE SODIUM (PF) SOLN 250 MG/10ML	2
METHOTREXATE SODIUM (PF) SOLN 50 MG/2ML	2
TADLIQ SUSP 20 MG/5ML	5
TESTOSTERONE PROPIONATE POWD	3
VANCOMYCIN HCL SOLR 1 GM	2
XCOPRI TABS 100 MG	5
XCOPRI TABS 150 MG	5
XCOPRI TABS 50 MG	5
XELJANZ TABS 10 MG	3