



Formulary Update

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Formulary Additions

- Granisetron (generic Kytril) 1mg tablet
- Hydrocortisone sodium succinate (generic Solu-Cortef) 100mg vials
- OTC naloxone (generic Narcan) 4mg nasal spray
- Venclexta (venetoclax)

Prior Authorization (QRM) Updates

- Arcalyst (riloncept)
- Botox (botulinum toxins)
- Dupixent (dupilumab)
- Egrifta (tesamorelin)
- Fasenna (benralizumab)
- Filspari (sparsentan)
- GLP-1 RAs
- Growth Hormones (somatropin)
- Hematology/Oncology Products
- Kerendia (finerenone)
- Leuprolide Products
- Litfulo (ritlecitinib)
- Olumiant (baricitinib)
- Omnipod 5 System and Pods
- Parathyroid Hormone Analogs
- Relistor (methylnaltrexone)
- Rezdifra (resmetirom)
- Rituxan (rituximab)
- Tarpeyo (budesonide)
- Strensiq (asfotase alfa)
- Tirzepatide Products for Weight Loss
- Tremfya (guselkumab)
- Xolair (omalizumab)

Prior Authorization (QRM) Additions

- Cablivi (caplacizumab)
- Hematology/ Oncology Products
- Neffy (epinephrine nasal spray)
- Nubeqa (darolutamide)
- Ojjaara (momelotinib)
- Pivya (pivmecillinam)
- Vafseo (vadadustat)
- Voquezna (vonoprazan)
- Winrevair (sotatercept)
- Zilbrysq (zilucoplan)

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 List](#) OR [Drug Formulary for Practitioners](#) for all KPGA Drug Formularies.

Upcoming Formulary Items:

An important aspect of the formulary process is the involvement of all clinicians. Please contact your P&T Committee representative or your clinical department chief by January 14, 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.



Medication Class Review February 2025

Antianginal
Antiarrhythmics
Antihistamines
Antihyperlipidemics
Antihypertensives
Beta Blockers
Calcium Channel Blockers
Cardiovascular Agents, Misc.
Cough/ Cold/ Allergy
Diuretics
Nasal Agents – Systemic & Topical
Passive Immunizing & Treatment Agents
Respiratory Agents, Misc.
Vaccines
Vasopressors

Commercial HMO/Closed Formulary Additions

The following medications will be **ADDED** to the Commercial Formulary effective **January 8, 2025**:

Note: Commercial Formulary additions may result in tier changes on the QHP (ACA)/Open Formulary.

Granisetron (generic Kytril) 1mg tablet	Indicated for the prevention of chemotherapy and radiotherapy-induced nausea and vomiting.
OTC Naloxone 4 mg nasal spray	Indicated for the emergency treatment of known or suspected opioid overdose as manifested by respiratory and/or CNS depression. OTC will be sold via the prescription benefit.

QHP-ACA/Open Formulary Step Therapy Additions

The following medication will have step therapy **ADDED** effective **January 1, 2026**:

Humatin (paromomycin)	Indicated for management of hepatic coma and treatment of acute and chronic intestinal amebiasis.
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The following medication will have step therapy **ADDED** effective **January 8, 2025**:

Jakafi (ruxolitinib)	Indicated for the treatment of the following: steroid refractory acute graft-versus host disease (GVHD) in adult and pediatric patients ≥ 12 years, chronic GVHD after failure of one or two lines of systemic therapy in adult and pediatric patients ≥ 12 years, treatment of intermediate or high-risk myelofibrosis in adults, and treatment of polycythemia vera in adults with inadequate or intolerance to hydroxyurea.
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QHP-ACA/Open Formulary Tier Changes

The following medication will have a tier change effective **January 8, 2025**:

Drug	Previous Tier	New Tier
Guanfacine IR 1 mg and 2 mg tablets	Non-Preferred Tier 4	Preferred Generic Tier 2

Days Supply Additions

The following medications will have days supply restrictions effective **January 8, 2025**:

Rinvoq (upadacitinib) 45 mg tablets	84 tablets per year
Solu-Cortef (hydrocortisone sodium succinate) 100 mg vial	Two, 2 mL vials per 30 days
Voquezna (vonoprazan) 10 mg and 20 mg tablets	30 tablets per 30 days

Approved Floor Stock List Changes

Medication	Department
Approved Floor Stock List Addition	
Monsef's Solution	Dermatology
Approved Floor Stock List Removals	
Alprostadil 10 mcg and 20 mcg kits	Urology
Depo-Testosterone 200 mg /mL	Urology
Rimso-50 solution vial	Urology

Approved Compounds List Changes

Compound	Approved Change
The following medication will be removed from the approved compound list effective <u>January 8, 2025</u>:	
Metronidazole 50 mg / mL oral suspension	Remove from the list of approved compounds

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 1-888-336-2676 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](#).



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 medications will be ADDED to the QRM PA Review List effective **January 8, 2025**:

Neffy (epinephrine nasal spray)	Indicated for emergency treatment of type I allergic reactions, including anaphylaxis, in adult and pediatric patients who weigh 30 kg or greater despite no clinical trials in the emergency treatment of type 1 allergic reactions and anaphylaxis. Self-injectable epinephrine remains the preferred treatment route to treat severe allergic reactions, including anaphylaxis.
Nubeqa (darolutamide)	Indicated for the treatment of adult patients with: 1) non-metastatic castration-resistant prostate cancer (nmCRPC) and 2) metastatic hormone-sensitive prostate cancer (mHSPC) in combination with docetaxel.
Ojjaara (momelotinib)	Indicated for the treatment of intermediate or high-risk myelofibrosis (MF), including primary MF or secondary MF (post-polycythemia vera and post-essential thrombocythemia), in adults with anemia.
Pivya (pivmecillinam)	Indicated for the treatment of female patients 18 years of age and older with uncomplicated urinary tract infections (uUTI) caused by susceptible isolates of Escherichia coli, Proteus mirabilis and Staphylococcus saprophyticus.
Vafseo (vadadustat)	Indicated for the treatment of anemia due to chronic kidney disease (CKD) in adults who have been receiving dialysis for at least three months.
Voquezna (vonoprazan)	Indicated for the following: 1) for healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis in adults, 2) to maintain healing of all grades of erosive esophagitis and relief of heartburn associated with erosive esophagitis in adults, 3) for the relief of heartburn associated with non-erosive gastroesophageal reflux disease in adults, 4) in combination with amoxicillin and clarithromycin for the treatment of Helicobacter pylori (H. pylori) infection in adults and 5) in combination with amoxicillin for the treatment of H. pylori infection in adults.
Winrevair (sotatercept-csrk)	Indicated for the treatment of adults with pulmonary arterial hypertension (PAH, WHO Group 1) to increase exercise capacity, improve WHO functional class and reduce the risk of clinical worsening events.
Zilbrysq (zilucoplan)	Indicated for the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive (Ab+).

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 medication will be ADDED to the QRM PA Review List effective **March 24, 2025**:

Cablivi (caplacizumab)	Indicated for the treatment of adult patients with acquired thrombotic thrombocytopenic purpura (aTTP), in combination with plasma exchange and immunosuppressive therapy.
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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.

- **Akeega (niraparib-abiraterone):** Criteria updated to (1) require separate prescriptions for individual ingredients in combination product and (2) remove moderate or severe hepatic impairment under reasons for non-coverage.
- **Anktiva (nogapendekin alfa inbakicept-pmIn):** Criteria updated to remove the criteria requirement for a baseline pregnancy test as it is already listed under reasons for non-coverage.
- **Arcalyst (rilonacept):** Criteria updated to reflect for initial dose allow member to fill via the outpatient pharmacy benefit with nurse visit scheduled for injection teaching.
- **Augtyro (repotrecitinib):** Criteria updated to (1) not require documentation that Rozlytrek is not appropriate, (2) remove baseline pregnancy test requirement prior to initiation of therapy.
- **Botox (botulinum toxins):** Criteria updated to remove statement that medical complications from hyperhidrosis including skin maceration or dermatitis.
- **Breyanzi (lisocabtagnene maraleucel):** Criteria updated to (1) remove absolute neutrophil count, absolute lymphocyte count, and platelet count based on TRANSCEND FL study.
- **Dupixent (dupilumab):** Criteria updated to (1) include new FDA approved indication for eosinophilic COPD and (2) reflect only examples of LAMA/LABA combination therapies.
- **Egrifta SV (tesamorelin):** Criteria updated to (1) change continued approval for current KP members newly starting treatment to 6 months, (2) change initial approval for new members currently taking treatment to 3 months and 6 months for continued approval with evaluation by endocrinology, and (3) add age over 65 years old to reasons for non-coverage.
- **Fasenra (benralizumab):** Criteria updated to include new FDA approved indication for eosinophilic granulomatosis with polyangiitis (EGPA).
- **Filspari (sparsentan):** Criteria updated to (1) include blood pressure criteria, (2) change documented trial period to 3 months, and add currently prescribed SGLT2i for at least 3 months to criteria.
- **GLP-1 RAs for Weight Management Indication:** Criteria updated to (1) add GLP-1 RA drug holiday requirement, (2) include administrative changes, and (3) remove continued approval criteria for Ozempic 2 mg dose.
- **Growth Hormones (somatropin):** Criteria updated to set a preference for once weekly options.
- **Imdeltra (tarlatamab-dlle):** Criteria updated to (1) reflect administrative edits, (2) remove requirement of disease progression on or after platinum-based chemotherapy, and (3) add note that reviewer must obtain approval from the Physician Program Director of QRM or AAMD prior to providing QRM PA approval.
- **Jaypirca (pirtobrutinib):** Criteria updated to (1) remove presence of significant cardiovascular disease as a reason for non-coverage, (2) clarify the definition of major hemorrhage, (3) include quantity limit updates, and (4) update the continued approval period criteria.
- **Kerendia (finerenone):** Criteria updated to (1) require prescribing by nephrologist or endocrinologist to ensure appropriate use and (2) align with ADA guidelines.
- **Leuprolide Products:** Criteria updated to add an additional PED strength that has an equivalent Lupron Depot formulation.
- **Litfulo (ritlecitinib):** Criteria updated to reflect indication for alopecia areata.
- **Ogsiveo (nirogacestat):** Criteria updated to (1) state physician documents medication will not be used with CYP3A inducers/inhibitors and removing from reasons of non-coverage and (2) add note that reviewers must obtain approval from the Physician Program Director of QRM or AAMD prior to providing QRM PA approval.
- **Ojjaara (momelotinib):** Criteria update to (1) add prescribed by hematologist or oncologist, (2) include documentation that patient has developed adverse events to transfusions or cannot tolerate RBC transfusions.
- **Olumiant (baricitinib):** Criteria updated to (1) reflect indication for alopecia areata.
- **Omnipod 5 System and Pods:** Criteria updated to include use in adults with type 2 diabetes.
- **Orgovyx (relugolix):** Criteria updated to (1) add that patient with history of major cardiovascular events is a relative contraindication and (2) remove the statement to not give concurrently with other agents such as abiraterone and enzalutamide.
- **Orserdu (elacestrant):** Criteria was updated to (1) provide examples of CDK4/6 inhibitors, (2) include breastfeeding and concomitant use with CYP3A4 inducers/inhibitors as reasons for non-coverage, and (3) added note that reviewer must obtain approval from the Physician Program Director of QRM or AAMD prior to providing QRM PA approval.
- **Parathyroid Hormone Analogs:** Criteria was updated to (1) remove osteopenia diagnosis and (2) provide more clarity and guidance for reviewers.
- **Relistor (tesamorelin):** Criteria updated to (1) require one osmotic laxative and one stimulant laxative and (2) update duration of trial requirement.
- **Rezdiffra (resmetirom):** Criteria updated to (1) reflect initial approval criteria changed to 6 months with follow-up questions and (2) lifestyle changes have been itemized.
- **Rituxan (rituximab):** Criteria updated to add FDA approved indication pephigus vulgaris and pemphigus foliaceus to the current bullous pemphigoid criteria.
- **Rozlytrek (entrectinib):** Criteria updated to (1) include pregnancy and breastfeeding as reasons for non-coverage and (2) change the continued approval criteria to define evidence of progressive disease.

QRM Prior Authorization Review Criteria Updates (continued)

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.

- **Spinraza (nusinersen):** Criteria updated to (1) remove if patient is age 22 to 65 years, patient is ambulatory with baseline Hammersmith Functional Motor Scale Expanded Exam (HFME) score greater than or equal to 35 and documented disease progression, (2) remove urinalysis within one week prior to each dose, (3) remove requirement of 6-Minute Walk Test (6MWT) for ambulatory patients, and (4) remove age greater than 65 as a reason for non-coverage.
- **Sprycel (dasatinib):** Criteria updated to (1) remove prior authorization from generic dasatinib on Commercial/Closed and QHP/Open Formularies, (2) reflect new preferred generic is dasatinib, (3) retain brand Sprycel on the QRM/Prior Authorization List of Medications, and (4) address the use of authorized generic dasatinib.
- **Talzenna (talazoparib):** Criteria updated to (1) remove pregnancy test as baseline testing, (2) add history of myelodysplastic syndrome (MDS) and history of acute myeloid leukemia (AML) as reasons for non-coverage, and (3) update initial approval period to 12 months.
- **Tarpeyo (budesonide):** Criteria updated to (1) include blood pressure criteria, (2) change documented trial period to 3 months, (3) add currently prescribed SGLT2i for at least 3 months to criteria, and (4) update continued approval to 9 months with documented clinically significant reduction in proteinuria (>=30 % from baseline).
- **Tirzepatide Products for Weight Loss:** Criteria updated to align with the updated oral therapy requirements for GLP-1 RAs for weight loss.
- **Tremfya (guselkumab):** Criteria updated to add FDA indication for ulcerative colitis (UC).
- **Trodelyv (sacituzumab govitecan-hziy):** Criteria updated to remove indication of local advanced or metastatic urothelial cancer (mUC).
- **Truqap (capivasertib):** Criteria updated to (1) remove disease progression on or following other PI3K/T/PTEN inhibitors and (2) add reviewers must obtain approval from the Physician Program Director of QRM or AAMD prior to provide QRM PA approval.
- **Turalio (pexidartinib):** Criteria updated to (1) add hematologist, oncologist, rheumatologist, OR orthopedic specialist as prescriber, (2) clarify and define TGCT tumor associated with severe morbidity, (3) remove pregnancy status prior to treatment initiation, (3) add reviewers must obtain approval from the Physician Program Director of QRM or AAMD prior to provide QRM PA approval.
- **Vigabatrin products:** Criteria updated to (1) reflect order of preference of non-preferred products, (2) reflect new indication for complex partial seizures in pediatric patients 2 years and older, and (3) provide updated REMS information.
- **Vyvgart (efartigimod alfa):** Criteria updated to define myasthenia gravis as an indication for use.
- **Vyvgart Hytrulo (efartigimod alfa and hyaluronidase):** Criteria updated to (1) define myasthenia gravis as an indication for use, (2) include criteria for chronic inflammatory demyelinating polyneuropathy (CIDP), and (3) define administration of use is only by healthcare professional.
- **Xolair (omalizumab):** Criteria updated to (1) align food allergy criteria with the new literature and FDA indications and (2) to specify an objective timeframe for patients to follow up with the prescriber to align with other criteria.

Medications Reviewed But Not Accepted to the Commercial HMO Formulary		
Note: Medications that can be dispensed via the outpatient pharmacy benefit but are not accepted to the closed Commercial HMO formulary, will be placed on a tier for the QHP-ACA/ Open formularies.		
Drug Name <small>*QRM Criteria Pending Review</small>	Commercial HMO/Closed Formulary Status	QHP-ACA/ Open Formulary Status
Daxxify (daxibotulinumtoxinA-ianm)	<ul style="list-style-type: none"> • Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage 	
Elevidys (delandistrogene moxeparvovec)*	<ul style="list-style-type: none"> • Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage • Require QRM PA review 	
Neffy (epinephrine)	<ul style="list-style-type: none"> • Non-Formulary • Require QRM PA review 	<ul style="list-style-type: none"> • Specialty Tier 5 • Require QRM PA review
Nubeqa (darolutamide)	<ul style="list-style-type: none"> • Non-Formulary • Require QRM PA review 	<ul style="list-style-type: none"> • Non-Preferred Tier 4 • Require QRM PA review
Ojjaara (momelotinib)	<ul style="list-style-type: none"> • Non-Formulary • Require QRM PA review 	<ul style="list-style-type: none"> • Specialty Tier 5 • Require QRM PA review
Rytelo (imeteelstat)*	<ul style="list-style-type: none"> • Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage • Require QRM PA review 	
Vafseo (vadadustat)*	<ul style="list-style-type: none"> • Non-Formulary • Require QRM PA review 	<ul style="list-style-type: none"> • Specialty Tier 5 • Require QRM PA review
Winrevair (sotatercept-csrk)	<ul style="list-style-type: none"> • Non-Formulary • Require QRM PA review 	<ul style="list-style-type: none"> • Specialty Tier 5 • Require QRM PA review



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

P&T Committee Voting Members:

Debbi Baker, PharmD, BCPS
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Obstetrics and Gynecology

Lesia Jackson, RN
Clinical Services

Satya Jayanthi, MD
Hospitalist

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 to maintain one National MPD Formulary for Kaiser Permanente.

Medicare Part D Initial Tier Placement

Initial tier placements for recently launched and approved medications

#	Drug Name	Tier Status	Implementation Date
1	revumenib citrate 110 mg, 160 mg tablets (Revuforj)	Specialty Tier 5	11/21/2024
2	minocycline HCl (rosacea) 40 mg micronized capsules (Emrosi)	Specialty Tier 5	11/20/2024
3	aripiprazole 2 mg, 5 mg, 10 mg oral film (Opipza)	Specialty Tier 5	11/18/2024
4	edaravone 60 mg/100 mL injection (generic)	Specialty Tier 5	11/15/2024
5	sotorasib 240 mg tablets (Lumakras)	Specialty Tier 5	11/7/2024
6	lebrikizumab-lbkz 250 mg/2 mL injection (Ebglyss)	Specialty Tier 5	11/4/2024
7	paliperidone 78 mg/0.5 mL, 117 mg/0.75 mL, 156 mg/mL, 234 mg/1.5 mL, 351 mg /2.25 mL ER injection (Erzofri)	Specialty Tier 5	11/4/2024
8	repotrectinib 160 mg capsules (Augtyro)	Specialty Tier 5	11/4/2024
9	inavolisib 3 mg, 9 mg tablets (Itovebi)**	Specialty Tier 5	10/30/2024
10	aflibercept-ayyh 40 mg/mL injection; 40 mg/mL prefilled injection (Pavblu)	Specialty Tier 5	10/24/2024
11	zolbetuximab-clzb 100 mg injection (Vyloy)	Specialty Tier 5	10/23/2024
12	oxycodone HCl 10 mg abuse deterrent tablets (Roxybond)	Specialty Tier 5	10/17/2024
13	oxycodone HCl 5 mg, 10 mg, 30 mg abuse deterrent tablets (generic)	Specialty Tier 5	10/3/2024
14	xanomeline tartrate-trospium chloride 100 mg-20 mg capsules (Cobenfy)**	Specialty Tier 5	10/3/2024
15	sodium oxybate 4.5 g, 6 g, 7.5 g extended-release oral suspension packets (Lumryz Starter Pack)	Specialty Tier 5	10/2/2024
16	xanomeline tartrate-trospium chloride 50 mg-20 mg, 125 mg-30 mg capsules (Cobenfy)**	Specialty Tier 5	10/2/2024
17	octreotide acetate 20 mg, 30 mg injection kit (generic)	Specialty Tier 5	10/1/2024
18	capivasertib 160 mg, 200 mg tablet therapy packs (Truqap)**	Specialty Tier 5	9/30/2024
19	levacetylleucine 1 gm suspension packets (Aqneursa)	Specialty Tier 5	9/27/2024
20	arimoclomol citrate cap 47 mg, 62 mg, 93 mg, 124 mg capsules (Miplyffa)	Specialty Tier 5	9/26/2024
21	ocrelizumab-hyaluronidase-ocsq 920 mg-23,000 mg-unit/23 mL injection (Ocrevus Zunovo)	Specialty Tier 5	9/24/2024
22	guselkumab 200 mg/20mL injection; 200 mg/2mL auto-injector; 200 mg/2mL prefilled injection (Tremfya)	Specialty Tier 5	9/19/2024
23	atezolizumab-hyaluronidase-tqjs 1,875 mg-30,000 units/15 mL injection (Tecentriq Hybreza)**	Specialty Tier 5	9/18/2024
24	lebrikizumab-lbkz 250 mg/2 mL injection (Ebglyss)	Specialty Tier 5	9/17/2024
25	palopegteriparatide 168 mcg/0.56 mL, 294 mcg/0.98 mL, 420 mcg/1.4 mL pen-injector (Yorvipath)	Specialty Tier 5	9/5/2024
26	dasatinib 20 mg, 50 mg, 70 mg, 80 mg, 100 mg, 140 mg tablets (generic)**	Specialty Tier 5	9/3/2024

**Protected Class

Medicare Part D Removals for 2025

Product Description			
ABACAVIR-LAMIVUDINE-ZIDOVUDINE TABS 300-150-200	ANTABUSE TABS 500 MG	CORTISPORIN OINT 1 %	EPIRUBICIN HCL SOLN 200 MG/100ML
ABILIFY MYCITE MAINTENANCE KIT TBPK 15 MG	ALENZIN TB24 174 MG	CRIVAN CAPS 200 MG	EPIRUBICIN HCL SOLN 50 MG/25ML
ABILIFY MYCITE MAINTENANCE KIT TBPK 2 MG	APREUDE SUER 600 MG/3ML	CRIVAN CAPS 400 MG	ERWINASE SOLR 10000 UNIT
ABILIFY MYCITE MAINTENANCE KIT TBPK 20 MG	APTIVUS SOLN 100 MG/ML	CUVRIOR TABS 300 MG	ERWINAZE SOLR 10000 UNIT
ABILIFY MYCITE MAINTENANCE KIT TBPK 30 MG	ARTICADENT DENTAL SOCT 4 %-1:200000	CYCLAFEM 1/35 TABS 1-35 MG-MCG	ESTRADIOL PTWK 0.025 MG/24HR
ABILIFY MYCITE MAINTENANCE KIT TBPK 5 MG	BAFIERTAM CPDR 95 MG	CYLTEZO (2 PEN) AJKT 40 MG/0.4ML	ESTRADIOL PTWK 0.0375 MG/24HR
ABILIFY MYCITE STARTER KIT TBPK 10 MG	BLEPHAMIDE SUSP 10-0.2 %	CYLTEZO (2 SYRINGE) PSKT 40 MG/0.4ML	ESTRADIOL PTWK 0.05 MG/24HR
ABILIFY MYCITE TABS 10 MG	BRAFTOVI CAPS 50 MG	CYLTEZO AJKT 40 MG/0.8ML	ESTRADIOL PTWK 0.06 MG/24HR
ABILIFY MYCITE TABS 15 MG	BROVANA NEBU 15 MCG/2ML	CYLTEZO PSKT 10 MG/0.2ML	ESTRADIOL PTWK 0.075 MG/24HR
ABILIFY MYCITE TABS 2 MG	BYLVAY (PELLETS) CPSP 200 MCG	CYLTEZO PSKT 20 MG/0.4ML	ESTRADIOL PTWK 0.1 MG/24HR
ABILIFY MYCITE TABS 20 MG	BYLVAY (PELLETS) CPSP 600 MCG	CYLTEZO PSKT 40 MG/0.8ML	EXKIVITY CAPS 40 MG
ABILIFY MYCITE TABS 30 MG	BYLVAY CAPS 1200 MCG	CYLTEZO-CD/UC/HS STARTER AJKT 40 MG/0.4ML	EXSERVAN FILM 50 MG
ABILIFY MYCITE TABS 5 MG	BYLVAY CAPS 400 MCG	CYLTEZO-CD/UC/HS STARTER AJKT 40 MG/0.8ML	EXTAVIA KIT 0.3 MG
ABSORICA LD CAPS 16 MG	CAMZYOS CAPS 15 MG	CYLTEZO-PSORIASIS STARTER AJKT 40 MG/0.8ML	FARYDAK CAPS 10 MG
ABSORICA LD CAPS 24 MG	CAMZYOS CAPS 2.5 MG	CYLTEZO-PSORIASIS/UV STARTER AJKT 40 MG/0.4ML	FARYDAK CAPS 15 MG
ABSORICA LD CAPS 32 MG	CAPASTAT SULFATE SOLR 1 GM	CYSTADROPS SOLN 0.37 %	FARYDAK CAPS 20 MG
ABSORICA LD CAPS 8 MG	CARDENE IV SOLN 20-4.8 MG/200ML-%	DEMSEER CAPS 250 MG	FENTANYL CITRATE (PF) SOCT 100 MCG/2ML
ADAGEN SOLN 250 UNIT/ML	CARNITOR SOLN 1 GM/10ML	DEPO-PROVERA SUSP 400 MG/ML	FENTANYL CITRATE (PF) SOCT 100 MCG/2ML
ADRIAMYCIN SOLN 2 MG/ML	CARNITOR TABS 330 MG	DIASTAT PEDIATRIC GEL 2.5 MG	FERRIPROX SOLN 100 MG/ML
ADRIAMYCIN SOLR 10 MG	CEFOTAXIME SODIUM SOLR 500 MG	DIDANOSINE CPDR 200 MG	FILSPARI TABS 200 MG
ADRUCIL SOLN 2.5 GM/50ML	CHLOROTHIAZIDE TABS 250 MG	DIDANOSINE CPDR 250 MG	FILSPARI TABS 400 MG
ADRUCIL SOLN 5 GM/100ML	CHLOROTHIAZIDE TABS 500 MG	DIDANOSINE CPDR 400 MG	FLOVENT HFA AERO 44 MCG/ACT
ADRUCIL SOLN 500 MG/10ML	CIBINQO TABS 200 MG	DIFFERIN CREA 0.1 %	FLUTICASONE-SALMETEROL AEPB 113-14 MCG/ACT
ALBUTEROL SULFATE ER TB12 4 MG	CIBINQO TABS 50 MG	DOCETAXEL (NON-ALCOHOL) SOLN 20 MG/ML	FLUTICASONE-SALMETEROL AEPB 232-14 MCG/ACT
ALBUTEROL SULFATE ER TB12 8 MG	CITANEST PLAIN DENTAL SOLN 4 %	DOCETAXEL (NON-ALCOHOL) SOLN 80 MG/4ML	FLUTICASONE-SALMETEROL AEPB 55-14 MCG/ACT
ALENDRONATE SODIUM TABS 40 MG	CLEOCIN PHOSPHATE SOLN 300 MG/2ML	DOCETAXEL CONC 200 MG/10ML	FYLNETRA SOSY 6 MG/0.6ML
ALKINDI SPRINKLE CPSP 1 MG	CLEOCIN SOLR 75 MG/5ML	DUAKLIR PRESSAIR AEPB 400-12 MCG/ACT	GAVILYTE-N WITH FLAVOR PACK SOLR 420 GM
ALKINDI SPRINKLE CPSP 2 MG	CLOVIQUE CAPS 250 MG	DUEXIS TABS 800-26.6 MG	GIMOTI SOLN 15 MG/ACT
ALKINDI SPRINKLE CPSP 5 MG	COLOCORT ENEM 100 MG/60ML	EGRIFTA SOLR 1 MG	GLASSIA SOLN 1000 MG/50ML
AMJEVITA SOAJ 40 MG/0.8ML	COLY-MYCIN S SUSP 3.3-3-10-0.5 MG/ML	EMFLAZA SUSP 22.75 MG/ML	GUANIDINE HCL TABS 125 MG
AMJEVITA SOSY 20 MG/0.4ML	CONSENSI TABS 10-200 MG	EMFLAZA TABS 18 MG	HADLIMA PUSHTOUCH SOAJ 40 MG/0.4ML
AMJEVITA SOSY 40 MG/0.8ML	CONSENSI TABS 2.5-200 MG	EMFLAZA TABS 30 MG	HADLIMA SOSY 40 MG/0.4ML
ANADROL-50 TABS 50 MG	CONSENSI TABS 5-200 MG	ENBREL SOLR 25 MG	HETLIOZ LQ SUSP 4 MG/ML
ANTABUSE TABS 250 MG	CORTISPORIN CREA 3.5-10000-0.5	ENSPRYNG SOSY 120 MG/ML	HULIO AJKT 40 MG/0.8ML

Medicare Part D Removals for 2025 (continued)

Product Description			
HULIO PSKT 20 MG/0.4ML	JUXTAPID CAPS 5 MG	MAPROTILINE HCL TABS 75 MG	ORENITRAM MONTH 1 TEPK 0.125 & 0.25 MG
HULIO PSKT 40 MG/0.8ML	JUXTAPID CAPS 60 MG	MARQIBO SUSP 5 MG/31ML	ORENITRAM MONTH 2 TEPK 0.125 & 0.25 MG
HUMATROPE CART 12 MG	JYNARQUE TABS 15 MG	MAVENCLAD (10 TABS) TBPK 10 MG	ORENITRAM MONTH 3 TEPK 0.125 & 0.25 & 1 MG
HUMATROPE CART 24 MG	JYNARQUE TABS 30 MG	MAVENCLAD (4 TABS) TBPK 10 MG	ORFADIN SUSP 4 MG/ML
HUMATROPE SOLR 5 MG	JYNARQUE TBPK 15 MG	MAVENCLAD (6 TABS) TBPK 10 MG	ORLADEYO CAPS 110 MG
HUMIRA PEDIATRIC CROHNS START PSKT 40 MG/0.8ML	JYNARQUE TBPK 30 & 15 MG	MAVENCLAD (8 TABS) TBPK 10 MG	OXANDROLONE TABS 2.5 MG
HUMIRA PEDIATRIC CROHNS START PSKT 40 MG/0.8ML	JYNARQUE TBPK 45 & 15 MG	MAVENCLAD (9 TABS) TBPK 10 MG	OXBRYTA TABS 300 MG
HUMIRA PEN PNKT 40 MG/0.4ML	JYNARQUE TBPK 60 & 30 MG	MAYZENT STARTER PACK TBPK 12 x 0.25 MG	OXBRYTA TBSO 300 MG
HUMIRA PSKT 10 MG/0.2ML	JYNARQUE TBPK 90 & 30 MG	MAYZENT TABS 0.25 MG	OXYCODONE-ACETAMINOPHEN TABS 10-300 MG
HUMIRA PSKT 20 MG/0.4ML	KETOPROFEN CAPS 75 MG	MAYZENT TABS 1 MG	OXYCODONE-ACETAMINOPHEN TABS 5-300 MG
HYDROCODONE-ACETAMINOPHEN SOLN 10-325 MG/15ML	KEVZARA SOAJ 150 MG/1.14ML	METAPROTERENOL SULFATE TABS 10 MG	OXYCODONE-ACETAMINOPHEN TABS 7.5-300 MG
HYDROXYPROGESTERONE CAPROATE OIL 250 MG/ML	KHEDEZLA TB24 100 MG	METAPROTERENOL SULFATE TABS 20 MG	OXYCODONE-ASPIRIN TABS 4.8355-325 MG
HYFTOR GEL 0.2 %	KHEDEZLA TB24 50 MG	METFORMIN HCL TABS 625 MG	OZEMPIC (1 MG/DOSE) SOPN 2 MG/1.5ML
HYRIMOZ SOAJ 40 MG/0.4ML	KINRIX SUSP	METHOCARBAMOL TABS 1000 MG	PAMIDRONATE DISODIUM SOLR 30 MG
HYRIMOZ SOAJ 80 MG/0.8ML	KIONEX SUSP 15 GM/60ML	METHYLDOPA TABS 250 MG	PAMIDRONATE DISODIUM SOLR 90 MG
HYRIMOZ SOAJ 80 MG/0.8ML	LARTRUVO SOLN 190 MG/19ML	METRONIDAZOLE GEL 0.75 %	PANZYGA SOLN 1 GM/10ML
HYRIMOZ SOSY 10 MG/0.1 ML	LARTRUVO SOLN 500 MG/50ML	MINITRAN PT24 0.1 MG/HR	PANZYGA SOLN 10 GM/100ML
HYRIMOZ SOSY 20 MG/0.2ML	LAZANDA SOLN 100 MCG/ACT	MINITRAN PT24 0.2 MG/HR	PANZYGA SOLN 2.5 GM/25ML
HYRIMOZ SOSY 40 MG/0.4ML	LAZANDA SOLN 400 MCG/ACT	MINITRAN PT24 0.4 MG/HR	PANZYGA SOLN 20 GM/200ML
HYRIMOZ-CROHNS/UC STARTER PACK SOAJ 80 MG/0.8ML	LEVOXYL TABS 137 MCG	MINITRAN PT24 0.6 MG/HR	PANZYGA SOLN 30 GM/300ML
HYRIMOZ-PED CROHNS STARTER SOSY 80 MG/0.8ML & 40MG/0.4ML	LEXETTE FOAM 0.05 %	MULPLETA TABS 3 MG	PANZYGA SOLN 5 GM/50ML
HYRIMOZ-PLAQUE PSORIASIS START SOAJ 80 MG/0.8ML & 40MG/0.4ML	LIDOCAINE IN DEXTROSE SOLN 5-7.5 %	MYALEPT SOLR 11.3 MG	PAROMOMYCIN SULFATE CAPS 250 MG
IBSRELA TABS 50 MG	LIDOCAINE-EPINEPHRINE SOLN 2 %-1:50000	MYCAPSSA CPDR 20 MG	PEG 3350/ELECTROLYTES SOLR 240 GM
ILUMYA SOSY 100 MG/ML	LINDANE SHAM 1 %	MYFEMBREE TABS 40-1-0.5 MG	PEGANONE TABS 250 MG
INTRON A SOLN 10000000 UNIT/ML	LIQREV SUSP 10 MG/ML	NATPARA CART 100 MCG	PEGASYS PROCLICK SOAJ 180 MCG/0.5ML
INTRON A SOLN 6000000 UNIT/ML	LIVMARLI SOLN 9.5 MG/ML	NATPARA CART 25 MCG	PEGINTRON KIT 50 MCG/0.5ML
INTRON A SOLR 10000000 UNIT	LUCENTIS SOLN 0.5 MG/0.05ML	NATPARA CART 50 MCG	PEPAXTO SOLR 20 MG
INTRON A SOLR 18000000 UNIT	LUMRYZ PACK 4.5 GM	NATPARA CART 75 MCG	PAROMOMYCIN SULFATE CAPS 250 MG
INTRON A SOLR 50000000 UNIT	LUMRYZ PACK 6 GM	NITROPRESS SOLN 25 MG/ML	PEG 3350/ELECTROLYTES SOLR 240 GM
INVIRASE TABS 500 MG	LUMRYZ PACK 7.5 GM	NIZATIDINE SOLN 15 MG/ML	PEGANONE TABS 250 MG
ISOSORBIDE DINITRATE ER TBCR 40 MG	LUMRYZ PACK 9 GM	NORDITROPIN FLEXPPO SOPN 30 MG/3ML	PHEBURANE PLLT 483 MG/GM
JAVYGTOR PACK 100 MG	LUPANETA PACK KIT 11.25 & 5 MG	NOXAFIL PACK 300 MG	PLEGRIDY SOSY 125 MCG/0.5ML
JAVYGTOR PACK 500 MG	LUPANETA PACK KIT 3.75 & 5 MG	NUCALA SOLR 100 MG	PONVORY STARTER PACK TBPK 2-3-4-5-6-7-8-9 & 10 MG
JAVYGTOR TABS 100 MG	LUPKYNIS CAPS 7.9 MG	NUCYNTA ER TB12 250 MG	PONVORY TABS 20 MG
JOLIVETTE TABS 0.35 MG	LYVISPAH PACK 10 MG	NUTRILIPID EMUL 20 %	PRADAXA PACK 110 MG
JUXTAPID CAPS 10 MG	LYVISPAH PACK 20 MG	NUZYRA SOLR 100 MG	PRADAXA PACK 150 MG
JUXTAPID CAPS 20 MG	LYVISPAH PACK 5 MG	NYMALIZE SOLN 60 MG/20ML	PRADAXA PACK 20 MG
JUXTAPID CAPS 30 MG	MAPROTILINE HCL TABS 25 MG	NYVEPRIA SOSY 6 MG/0.6ML	PRADAXA PACK 30 MG
JUXTAPID CAPS 40 MG	MAPROTILINE HCL TABS 50 MG	OGESTREL TABS 0.5-50 MG-MCG	

Medicare Part D Removals for 2025 (continued)

Product Description			
PRADAXA PACK 40 MG	ROXYBOND TABA 15 MG	SYNERCID SOLR 150-350 MG	VIJOICE TBPK 200 & 50 MG
PRADAXA PACK 50 MG	ROXYBOND TABA 30 MG	TADLIQ SUSP 20 MG/5ML	VOXZOGO SOLR 0.4 MG
PRED-G SUSP 0.3-1 %	ROXYBOND TABA 5 MG	TARPEYO CPDR 4 MG	VOXZOGO SOLR 0.56 MG
PREDNICARBATE CREA 0.1 %	RUCONEST SOLR 2100 UNIT	TASCENSO ODT TBDP 0.25 MG	VOXZOGO SOLR 1.2 MG
PROCALAMINE SOLN 3 %	SECONAL CAPS 100 MG	TASCENSO ODT TBDP 0.5 MG	VUMERITY (STARTER) CPDR 231 MG
PROCHLORPERAZINE EDISYLATE SOLN 50 MG/10ML	SEYSARA TABS 150 MG	TEGSEDI SOSY 284 MG/1.5ML	XCOPRI (250 MG DAILY DOSE) TBPK 50 & 200 MG
PROCYSBI PACK 300 MG	SEYSARA TABS 60 MG	TENIPOSIDE SOLN 10 MG/ML	XENLETA TABS 600 MG
PROCYSBI PACK 75 MG	SIVEXTRO SOLR 200 MG	TOFRANIL TABS 10 MG	XOFLUZA (40 MG DOSE) TBPK 2 x 20 MG
PROLATE SOLN 10-300 MG/5ML	SKYRIZI (150 MG DOSE) PSKT 75 MG/0.83ML	TOFRANIL TABS 25 MG	XOFLUZA (80 MG DOSE) TBPK 2 x 40 MG
PROPANTHELINE BROMIDE TABS 15 MG	SKYTROFA CART 11 MG	TOFRANIL TABS 50 MG	XPOVIO (100 MG ONCE WEEKLY) TBPK 20 MG
REBETOL SOLN 40 MG/ML	SKYTROFA CART 13.3 MG	TOLBUTAMIDE TABS 500 MG	XPOVIO (40 MG ONCE WEEKLY) TBPK 20 MG
RECORLEV TABS 150 MG	SKYTROFA CART 3 MG	TOLSURA CAPS 65 MG	XPOVIO (40 MG TWICE WEEKLY) TBPK 20 MG
RELAFEN DS TABS 1000 MG	SKYTROFA CART 3.6 MG	TRUXIMA SOLN 100 MG/10ML	XPOVIO (60 MG ONCE WEEKLY) TBPK 20 MG
RELTONE CAPS 200 MG	SKYTROFA CART 4.3 MG	TRUXIMA SOLN 500 MG/50ML	XPOVIO (80 MG ONCE WEEKLY) TBPK 20 MG
RELTONE CAPS 400 MG	SKYTROFA CART 5.2 MG	TYVASO DPI MAINTENANCE KIT POWD 112 x 32MCG & 112 X48MCG	XURIDEN PACK 2 GM
RESCRIPTOR TABS 200 MG	SKYTROFA CART 6.3 MG	UKONIQ TABS 200 MG	XYLOCAINE DENTAL SOLN 2 %-1:100000
RETIN-A MICRO GEL 0.04 %	SKYTROFA CART 7.6 MG	ULTOMIRIS SOLN 300 MG/30ML	XYLOCAINE DENTAL SOLN 2 %-1:50000
RETIN-A MICRO GEL 0.1 %	SKYTROFA CART 9.1 MG	URSODIOL CAPS 200 MG	XYREM SOLN 500 MG/ML
REVCOSI SOLN 2.4 MG/1.5ML	SODIUM POLYSTYRENE SULFONATE SUSP 15 GM/60ML	URSODIOL CAPS 400 MG	XYWAV SOLN 500 MG/ML
RIBASPHERE CAPS 200 MG	SOGROYA SOPN 10 MG/1.5ML	VALSARTAN SOLN 4 MG/ML	YUSIMRY SOPN 40 MG/0.8ML
RIBASPHERE RIBAPAK (1000 PACK) TBPK 400 & 600 MG	SOGROYA SOPN 15 MG/1.5ML	VANTAS KIT 50 MG	ZEMDRI SOLN 500 MG/10ML
RIBASPHERE RIBAPAK (1200 PACK) TBPK 600 MG	SOGROYA SOPN 5 MG/1.5ML	VEKLURY SOLN 100 MG/20ML	ZEPATIER TABS 50-100 MG
RIBASPHERE TABS 600 MG	SPS SUSP 15 GM/60ML	VENTAVIS SOLN 10 MCG/ML	ZORBTIVE SOLR 8.8 MG
RIFAMATE CAPS 150-300 MG	STIMATE SOLN 1.5 MG/ML	VENTAVIS SOLN 20 MCG/ML	ZORTRESS TABS 1 MG
ROMIDEPSIN SOLN 27.5 MG/5.5ML	SUBSYS LIQD 1200 (600 X 2) MCG	VICTOZA SOPN 18 MG/3ML	ZOSTAVAX SUSR 19400 UNT/0.65ML
ROWEEPRA TABS 750 MG	SUBSYS LIQD 1600 (800 X 2) MCG	VIDEX EC CPDR 125 MG	ZYKADIA CAPS 150 MG
ROWEEPRA XR TB24 500 MG	SUMATRIPTAN SUCCINATE SOSY 6 MG/0.5ML	VIDEX SOLR 2 GM	
ROWEEPRA XR TB24 750 MG	SYNDROS SOLN 5 MG/ML	VIDEX SOLR 4 GM	



Medicare Part D Tier Changes for 2025

Drug Name	2024 Tier Level	2025 Tier Level
ALOSETRON HCL TABS 0.5 MG	5	4
ANASTROZOLE TABS 1 MG	2	1
ARANESP (ALBUMIN FREE) SOLN 60 MCG/ML	5	4
ARIPIRAZOLE TBDP 15 MG	5	4
ATENOLOL-CHLORTHALIDONE TABS 100-25 MG	2	1
ATENOLOL-CHLORTHALIDONE TABS 50-25 MG	2	1
BACLOFEN SOLN 10 MG/5ML	5	4
CHLORHEXIDINE GLUCONATE SOLN 0.12 %	2	1
CROMOLYN SODIUM NEBU 20 MG/2ML	5	3
DEPO-SUBQ PROVERA 104 SUSY 104 MG/0.65ML	4	3
ELITEK SOLR 1.5 MG	3	5
FELBAMATE SUSP 600 MG/5ML	5	4
FIRMAGON (240 MG DOSE) SOLR 120 MG/VIAL	4	5
FUROSEMIDE SOLN 10 MG/ML	2	1
GLIPIZIDE ER TB24 2.5 MG	2	1
GLIPIZIDE ER TB24 5 MG	2	1
HUMULIN 70/30 KWIKPEN SUPN (70-30) 100 UNIT/ML	2	3
HUMULIN 70/30 SUSP (70-30) 100 UNIT/ML	2	3
HUMULIN N KWIKPEN SUPN 100 UNIT/ML	2	3
HUMULIN N SUSP 100 UNIT/ML	2	3
METOCLOPRAMIDE HCL TABS 10 MG	2	1
METOCLOPRAMIDE HCL TABS 5 MG	2	1
MIEBO SOLN 1.338 GM/ML	5	4
NAYZILAM SOLN 5 MG/0.1ML	5	4
OMEPRAZOLE CPDR 10 MG	2	1
OMEPRAZOLE CPDR 40 MG	2	1
PANTOPRAZOLE SODIUM TBEC 20 MG	2	1
PANTOPRAZOLE SODIUM TBEC 40 MG	2	1
PAXLOVID (300/100) TBPX 20 x 150 MG & 10 X 100MG	3	5
PROPRANOLOL HCL TABS 10 MG	2	1
PROPRANOLOL HCL TABS 20 MG	2	1
PROPRANOLOL HCL TABS 40 MG	2	1
PROPRANOLOL HCL TABS 80 MG	2	1
PYRIDOSTIGMINE BROMIDE SOLN 60 MG/5ML	5	4
RIABNI SOLN 100 MG/10ML	5	3
RIABNI SOLN 500 MG/50ML	5	3
RISPERDAL CONSTA SRER 25 MG	5	4
RISPERIDONE ER SRER 25 MG	5	4
TERAZOSIN HCL CAPS 1 MG	2	1
TERAZOSIN HCL CAPS 10 MG	2	1
TERAZOSIN HCL CAPS 2 MG	2	1
TERAZOSIN HCL CAPS 5 MG	2	1
TOBRAMYCIN-DEXAMETHASONE SUSP 0.3-0.1 %	2	4
TRAMADOL HCL SOLN 5 MG/ML	5	4
UBRELVY TABS 100 MG	4	3
VALSARTAN-HYDROCHLOROTHIAZIDE TABS 160-12.5 MG	2	1
VALSARTAN-HYDROCHLOROTHIAZIDE TABS 160-25 MG	2	1
VALSARTAN-HYDROCHLOROTHIAZIDE TABS 320-12.5 MG	2	1
VALSARTAN-HYDROCHLOROTHIAZIDE TABS 320-25 MG	2	1
VALSARTAN-HYDROCHLOROTHIAZIDE TABS 80-12.5 MG	2	1
YERVOY SOLN 200 MG/40ML	3	5
YERVOY SOLN 50 MG/10ML	3	5

Medicare Part D Additions for 2025

Drug Name	2025 Tier
MIRENA (52 MG) IUD 20 MCG/DAY	3
NEXPLANON IMPL 68 MG	3
MIFEPRISTONE TABS 300 MG	5
DABIGATRAN ETEXILATE MESYLATE CAPS 75 MG	2
DABIGATRAN ETEXILATE MESYLATE CAPS 110 MG	2
DABIGATRAN ETEXILATE MESYLATE CAPS 150 MG	2
AZELASTINE HCL SOLN 0.05 %	4
CLOTRIMAZOLE CREA 1 %	4
DICLOFENAC SODIUM SOLN 1.5 %	4

