Jefferson Health Plans 1 Tier 2024 Formulary Changes

Changes occur, for example, because new drugs come on the market, a drug is moved to a different cost-sharing level (tier), or a generic version becomes available.

Requirements/Limits Key:

QL	**Quantity Limit**
PA	**Prior Authorization**
ST	**Step Therapy**

Drug Name	Dosage Form	Drug Tier	Requirements / Limits	Formulary Change Type	Effective Date
AUGTYRO 40 MG	CAP	1 – Covered	PA, NDS	Addition	02/01/2024
BREO ELLIPTA 50-25 MCG	INH	1 – Covered	QL 60/30 days	Addition	02/01/2024
breyna	INH	1 – Covered	QL 10.3/30 days	Addition	02/01/2024
brimonidine tartrate ophth 0.1%	SOLN	1 – Covered		Addition	02/01/2024
ciprofloxacin 3 mg/ml / dexamethasone 1 mg/ml otic	SOLN	1 – Covered		Addition	02/01/2024
enilloring 0.12-0.015 mg/24hr	VAG RING	1 – Covered		Addition	02/01/2024
fluticasone propionate aer powder 250 mcg/act	DISKUS	1 – Covered	QL 240/30 days	Addition	02/01/2024
fluticasone prop aer powder 50 mcg/act, 100 mcg/act	DISKUS	1 – Covered	QL 60/30 days	Addition	02/01/2024
FRUZAQLA	CAP	1 – Covered	PA, NDS	Addition	02/01/2024
kourzeq 0.1 %	PASTE	1 – Covered		Addition	02/01/2024
LITHIUM CITRATE 60 MG/ML ORAL	SOLN	1 – Covered		Addition	02/01/2024
norelgestromin-eth estradiol 150-35 mcg/24hr	PATCH	1 – Covered		Addition	02/01/2024
OJJAARA	TAB	1 – Covered	PA, NDS	Addition	02/01/2024
pazopanib 200 mg	TAB	1 – Covered	PA, NDS	Addition	02/01/2024
phenytek	CAP	1 – Covered		Addition	02/01/2024
pitavastatin calcium	TAB	1 – Covered	QL 30/30 days	Addition	02/01/2024

ROZLYTREK 50 MG	PACKET	1 – Covered	PA, NDS	Addition	02/01/2024
teriparatide (recombinant) soln pen	INJ	1 – Covered	PA, QL 2.4/28 days, NDS	Addition	02/01/2024
TRUQAP	TAB	1 – Covered	PA, NDS	Addition	02/01/2024
turqoz 0.3-30 mg-mcg	TAB	1 – Covered		Addition	02/01/2024
VANFLYTA	TAB	1 – Covered	PA, NDS	Addition	02/01/2024
XALKORI	CAP	1 – Covered	PA, NDS	Addition	02/01/2024
ZEMAIRA	SOLN	1 – Covered	PA, NDS	Addition	02/01/2024
ZURZUVAE 20 MG, 25 MG	CAP	1 – Covered	PA, QL 60/30 days, NDS	Addition	02/01/2024
ZURZUVAE 30 MG	CAP	1 – Covered	PA, QL 30/30 days, NDS	Addition	02/01/2024
Drug Name	**Dosage Form**	**Drug Tier**	**Requirements / Limits**	**Formulary Change Type**	**Effective Date**
PAXLOVID 150/100 MG	TAB	1 – Covered	QL 40/30 days	Addition	02/12/2024
PAXLOVID 300/100 MG	TAB	1 – Covered	QL 60/30 days	Addition	02/12/2024
BAQSIMI	POW	1 – Covered		Addition	03/01/2024
BOSULIF	CAP	1 – Covered	PA, NDS	Addition	03/01/2024
IWILFIN	TAB	1 – Covered	PA, NDS	Addition	03/01/2024
klayesta	POW	1 – Covered	QL 60/30 days	Addition	03/01/2024
mifepristone 300 mg	TAB	1 – Covered	PA, NDS	Addition	03/01/2024
mycophenolic acid dr	TAB	1 – Covered	PA	Addition	03/01/2024
OGSIVEO	TAB	1 – Covered	PA, NDS	Addition	03/01/2024
PENBRAYA RECON	SUSP	1 – Covered		Addition	03/01/2024
ZENPEP 60000-189600 UNIT	CAP	1 – Covered		Addition	03/01/2024
Drug Name	**Dosage Form**	**Drug Tier**	**Requirements / Limits**	**Formulary Change Type**	**Effective Date**
ciprofloxacin hcl 100 mg	TAB	99 - Non-Formulary		Deletion	04/01/2024
XOLAIR SOLN AUTOINJECTOR	SOLN	1 – Covered	PA, NDS	Addition	04/01/2024

XOLAIR 300 MG/2ML SOLN PREFILLED SYRINGE	SYR	1 – Covered	PA, NDS	Addition	04/01/2024
Drug Name	**Dosage Form**	**Drug Tier**	**Requirements / Limits**	**Formulary Change Type**	**Effective Date**
IXCHIQ	SOLN	1 – Covered		Addition	05/01/2024
nitroglycerin 0.4%	OINT	1 – Covered	QL 30/30 days	Addition	05/01/2024
Drug Name	**Dosage Form**	**Drug Tier**	**Requirements / Limits**	**Formulary Change Type**	**Effective Date**
ADALIMUMAB-AACF (2 PEN) 40 MG/0.8ML	INJ	1 – Covered	PA, NDS	Addition	06/01/2024
emzahh	TAB	1 – Covered		Addition	06/01/2024
IDACIO 40 MG/0.8ML AUTOINJECTOR	INJ	1 – Covered	PA, NDS	Addition	06/01/2024
IDACIO 40 MG/0.8ML PFS	SYR	1 – Covered	PA, NDS	Addition	06/01/2024
IDACIO FOR CROHNS DISEASE/UC 40 MG/0.8ML	INJ	1 – Covered	PA, NDS	Addition	06/01/2024
IDACIO FOR PLAQUE PSORIASIS 40 MG/0.8ML	INJ	1 – Covered	PA, NDS	Addition	06/01/2024
OGSIVEO 100 MG, 150 MG	TAB	1 – Covered	PA, NDS	Addition	06/01/2024
theophylline er 100 mg, 200 mg	TAB	1 – Covered		Addition	06/01/2024
UBRELVY	TAB	1 – Covered	ST, QL 16/30 days, NDS	Addition	06/01/2024
XCOPRI 25 MG	TAB	1 – Covered	PA, QL 30/30 days, NDS	Addition	06/01/2024
Drug Name	**Dosage Form**	**Drug Tier**	**Requirements / Limits**	**Formulary Change Type**	**Effective Date**
FASENRA 10 MG/0.5ML	SOLN	1 – Covered	PA, NDS	Addition	07/01/2024
OJEMDA 100 MG	TAB	1 – Covered	PA, QL 24/28 days, NDS	Addition	07/01/2024
OJEMDA 25 MG/ML	SUSP	1 – Covered	PA, QL 96/28 days, NDS	Addition	07/01/2024
Drug Name	**Dosage Form**	**Drug Tier**	**Requirements / Limits**	**Formulary Change Type**	**Effective Date**
AUSTEDO XR 30 MG, 36 MG, 42 MG, 48 MG	TAB	1 – Covered	PA, QL 30/30, NDS	Addition	08/01/2024
INGREZZA SPRINK	CAP	1 – Covered	PA, QL 30/30, NDS	Addition	08/01/2024
kionex	SUSP	1 – Covered		Addition	08/01/2024
LIBERVANT	FILM	1 – Covered	PA, QL 10/30, NDS	Addition	08/01/2024

RINVOQ LQ 1 MG/ML	SOLN	1 – Covered	PA, QL 360/30, NDS	Addition	08/01/2024
SCEMBLIX 100 MG	TAB	1 – Covered	PA, QL 120/30, NDS	Addition	08/01/2024
timolol maleate ophth 0.5% (once-daily)	SOLN	1 – Covered		Addition	08/01/2024
zomig 2.5 mg, 5 mg	TAB	1 – Covered	QL 9/30	Addition	08/01/2024
Drug Name	**Dosage Form**	**Drug Tier**	**Requirements / Limits**	**Formulary Change Type**	**Effective Date**
AUSTEDO XR 18 MG	TAB	1 – Covered	PA, QL 30/30, NDS	Addition	09/01/2024
AUSTEDO XR PATIENT TITRATION THPK	TAB	1 – Covered	PA, QL 28/28, NDS	Addition	09/01/2024
ENTRESTO SPRINKLE	CAP	1 – Covered	QL 240/30	Addition	09/01/2024
MRESVIA 50 MCG/0.5ML	SUSP	1 – Covered		Addition	09/01/2024
OTEZLA 20 MG	TAB	1 – Covered	PA, NDS	Addition	09/01/2024
OTEZLA 4 X 10 & 51 X 20 MG THPK	TAB	1 – Covered	PA, NDS	Addition	09/01/2024
TALTZ 20 MG/0.25ML	SOLN	1 – Covered	PA, NDS	Addition	09/01/2024
TALTZ 40 MG/0.5ML	SOLN	1 – Covered	PA, NDS	Addition	09/01/2024
Drug Name	**Dosage Form**	**Drug Tier**	**Requirements / Limits**	**Formulary Change Type**	**Effective Date**
ADALIMUMAB-AACF (2 SYRINGE) 40MG/0.8ML	SYR	1 – Covered	PA, NDS	Addition	10/01/2024
ADALIMUMAB-AACF(CD/UC/HS) 40MG/0.8ML	INJ	1 – Covered	PA, NDS	Addition	10/01/2024
ADALIMUMAB-AACF(PS/UV) 40 MG/0.8ML	INJ	1 – Covered	PA, NDS	Addition	10/01/2024
glutamine (sickle cell) 5 gm	POW	1 – Covered	PA, QL 180/30, NDS	Addition	10/01/2024
LAZCLUZE 80 MG	TAB	1 – Covered	PA, QL 60/30, NDS	Addition	10/01/2024
LAZCLUZE 240 MG	TAB	1 – Covered	PA, QL 30/30, NDS	Addition	10/01/2024
RETEVMO 40 MG	TAB	1 – Covered	PA, QL 90/30, NDS	Addition	10/01/2024
RETEVMO 80 MG, 120 MG, 160 MG	TAB	1 – Covered	PA, QL 60/30, NDS	Addition	10/01/2024
VIGAFYDE 100 MG/ML	SOLN	1 – Covered	PA, QL 900/30, NDS	Addition	10/01/2024
VORANIGO 10 MG	TAB	1 – Covered	PA, QL 60/30, NDS	Addition	10/01/2024
VORANIGO 40 MG	TAB	1 – Covered	PA, QL 30/30, NDS	Addition	10/01/2024