| Drug Label Name          | Tier | Description of Change | Requirements/Limits  | Effective<br>Date | Alternative Drug | Alternative<br>Drug Tier |
|--------------------------|------|-----------------------|--|-------------------|------------------|--------------------------|
| KALYDECO GRA 5.8MG       | 5    | Formulary<br>Addition | Prior Authorization Required, Quantity Limit (56 packets every 28 days)        | 2/1/24            |                  |                          |
| MOUNJARO INJ 2.5/0.5     | 3    | Formulary<br>Addition | Prior Authorization Required,<br>Quantity Limit (4 pens every 28<br>days)      | 2/1/24            |                  |                          |
| MOUNJARO INJ<br>5MG/0.5  | 3    | Formulary<br>Addition | Prior Authorization Required,<br>Quantity Limit (4 pens every 28<br>days)      | 2/1/24            |                  |                          |
| MOUNJARO INJ 7.5/0.5     | 3    | Formulary<br>Addition | Prior Authorization Required,<br>Quantity Limit (4 pens every 28<br>days)      | 2/1/24            |                  |                          |
| MOUNJARO INJ<br>10MG/0.5 | 3    | Formulary<br>Addition | Prior Authorization Required,<br>Quantity Limit (4 pens every 28<br>days)      | 2/1/24            |                  |                          |
| MOUNJARO INJ<br>12.5/0.5 | 3    | Formulary<br>Addition | Prior Authorization Required,<br>Quantity Limit (4 pens every 28<br>days)      | 2/1/24            |                  |                          |
| MOUNJARO INJ<br>15MG/0.5 | 3    | Formulary<br>Addition | Prior Authorization Required,<br>Quantity Limit (4 pens every 28<br>days)      | 2/1/24            |                  |                          |
| ROZLYTREK PAK 50MG       | 5    | Formulary<br>Addition | Prior Authorization Required,<br>Quantity Limit (336 packets every<br>28 days) | 2/1/24            |                  |                          |
| ZURZUVAE CAP 20MG        | 5    | Formulary<br>Addition | Prior Authorization Required,<br>Quantity Limit (28 caps every 14<br>days)     | 2/1/24            |                  |                          |
| ZURZUVAE CAP 25MG        | 5    | Formulary<br>Addition | Prior Authorization Required,<br>Quantity Limit (28 caps every 14<br>days)     | 2/1/24            |                  |                          |

| XALKORI CAP 20MG     | 5 | Formulary | Prior Authorization Required,     | 2/1/24 |                           |        |
|----------------------|---|-----------|-----------------------------------|--------|---------------------------|--------|
|                      |   | Addition  | Quantity Limit (240 caps every 30 |        |                           |        |
|                      |   |           | days)                             |        |                           |        |
| XALKORI CAP 150MG    | 5 | Formulary | Prior Authorization Required,     | 2/1/24 |                           |        |
|                      |   | Addition  | Quantity Limit (180 caps every 30 |        |                           |        |
|                      |   |           | days)                             |        |                           |        |
| ZURZUVAE CAP 30MG    | 5 | Formulary | Prior Authorization Required,     | 2/1/24 |                           |        |
|                      |   | Addition  | Quantity Limit (14 caps every 14  |        |                           |        |
|                      |   |           | days)                             |        |                           |        |
| XALKORI CAP 50MG     | 5 | Formulary | Prior Authorization Required,     | 2/1/24 |                           |        |
|                      |   | Addition  | Quantity Limit (120 caps every 30 |        |                           |        |
|                      |   |           | days)                             |        |                           |        |
| CEFACLOR SUS 125/5ML | 4 | Formulary |                                   | 2/1/24 | CEFACLOR SUS 250MG/5ML    | Tier 4 |
|                      |   | Removal   |                                   |        |                           |        |
| CEFACLOR SUS 375/5ML | 4 | Formulary |                                   | 2/1/24 | CEFACLOR SUS 250MG/5ML    | Tier 4 |
|                      |   | Removal   |                                   |        |                           |        |
| CEFTAZIDIME/ SOL D5W | 4 | Formulary |                                   | 2/1/24 | CEFTAZIDIME INJ           | Tier 4 |
| 1GM                  |   | Removal   |                                   |        |                           |        |
| CEFTAZIDIME/ SOL D5W | 4 | Formulary |                                   | 2/1/24 | CEFTAZIDIME INJ           | Tier 4 |
| 2GM                  |   | Removal   |                                   |        |                           |        |
| CIPROFLOXACN TAB     | 4 | Formulary |                                   | 2/1/24 | CIPROFLOXACIN HCL TAB 250 | Tier 1 |
| 100MG                |   | Removal   |                                   |        | MG                        |        |
| CLINDAMYCIN INJ      | 3 | Formulary |                                   | 2/1/24 | CLINDAMYCIN INJ           | Tier 3 |
| 300/2ML              |   | Removal   |                                   |        | 600MG/4ML                 |        |
| NEVIRAPINE TAB       | 4 | Formulary |                                   | 2/1/24 | NEVIRAPINE TAB ER 400MG   | Tier 4 |
| 100MG                |   | Removal   |                                   |        |                           |        |
| OLOPATADINE DRO      | 3 | Formulary |                                   | 2/1/24 | AZELASTINE HCL OPHTH      | Tier 3 |
| 0.1%                 |   | Removal   |                                   |        | SOLN 0.05%                |        |
| SYMJEPI INJ 0.15MG   | 4 | Formulary |                                   | 2/1/24 | EPINEPHRINE INJ 0.15MG    | Tier 3 |
|                      |   | Removal   |                                   |        |                           |        |
| SYMJEPI INJ 0.3MG    | 4 | Formulary |                                   | 2/1/24 | EPINEPHRINE INJ 0.3MG     | Tier 3 |
|                      |   | Removal   |                                   |        |                           |        |

| SYNRIBO INJ 3.5MG           | 5 | Formulary<br>Removal  |   | 2/1/24 | ICLUSIG TAB; SCEMBLIX TAB | Tier 5 |
|-----------------------------|---|-----------------------|---|--------|---------------------------|--------|
| FRUZAQLA CAP 1MG            | 5 | Formulary<br>Addition | Prior Authorization Required,<br>Quantity Limit (84 caps every 28<br>days)  | 3/1/24 |                           |        |
| FRUZAQLA CAP 5MG            | 5 | Formulary<br>Addition | Prior Authorization Required,<br>Quantity Limit (21 caps every 28<br>days)  | 3/1/24 |                           |        |
| TRUQAP TAB 160MG            | 5 | Formulary<br>Addition | Prior Authorization Required,<br>Quantity Limit (64 tabs every 28<br>days)  | 3/1/24 |                           |        |
| TRUQAP TAB 200MG            | 5 | Formulary<br>Addition | Prior Authorization Required,<br>Quantity Limit (64 tabs every 28<br>days)  | 3/1/24 |                           |        |
| AUGTYRO CAP 40MG            | 5 | Formulary<br>Addition | Prior Authorization Required,<br>Quantity Limit (240 caps every 30<br>days) | 3/1/24 |                           |        |
| ZEMAIRA INJ 4000MG          | 5 | Formulary<br>Addition | Prior Authorization Required  | 3/1/24 |                           |        |
| ZEMAIRA INJ 5000MG          | 5 | Formulary<br>Addition | Prior Authorization Required  | 3/1/24 |                           |        |
| MORPHINE SUL INJ<br>50MG/ML | 4 | Formulary<br>Addition | Prior Authorization Required  | 3/1/24 |                           |        |
| OGSIVEO TAB 50MG            | 5 | Formulary<br>Addition | Prior Authorization Required,<br>Quantity Limit (180 tabs every 30<br>days) | 3/1/24 |                           |        |
| AUVELITY TAB 45-<br>105MG   | 4 | Formulary<br>Addition | Prior Authorization Required,<br>Quantity Limit (60 tabs every 30<br>days)  | 3/1/24 |                           |        |
| NORELGE/ETHI DIS<br>150/35  | 4 | Formulary<br>Addition |   | 3/1/24 |                           |        |

| PENBRAYA INJ          | 1 | Formulary            |                                | 3/1/24  |  |        |
|-----------------------|---|----------------------|--------------------------------|---------|--|--------|
| FLINDINATATING        | _ | Addition             |                                | 3/1/24  |  |        |
| BROMFENAC DRO         | 3 | Formulary            |                                | 3/1/24  |  |        |
| 0.07% OP              |   | Addition             |                                | 3/1/24  |  |        |
| KLAYESTA POW 100000   | 3 | Formulary            | Quantity Limit (60 gm every 30 | 3/1/24  |  |        |
| REALESTATION 100000   |   | Addition             | days)                          | 3/1/24  |  |        |
| FLEBOGAMMA INJ DIF    | 5 | Formulary            | uaysj                          | 3/1/24  | OCTAGAM INJ 2.5GM/50ML                   | Tier 5 |
| 5%                    | ر | Removal              |                                | 3/1/24  | OCTAGAINTING 2.3GIN/30INL                | Hel 3  |
| FLEBOGAMMA INJ        | 5 |                      |                                | 2/1/24  | DIVUCANA INIL 10CNA/100NAL.              | Tier 5 |
|                       | 5 | Formulary<br>Removal |                                | 3/1/24  | BIVIGAM INJ 10GM/100ML;<br>GAMMAPLEX INJ | Her 5  |
| 10/100ML              |   | Removai              |                                |         | -  |        |
|                       |   |                      |                                |         | 10GM/100ML; OCTAGAM INJ                  |        |
|                       |   |                      |                                |         | 10GM/100ML; PRIVIGEN INJ                 |        |
| EL EDOCANANA INI      | _ | Frank Inc.           |                                | 2/4/24  | 10GM/100ML                               |        |
| FLEBOGAMMA INJ        | 5 | Formulary            |                                | 3/1/24  | GAMMAPLEX INJ                            | Tier 5 |
| 20/200ML              |   | Removal              |                                |         | 20GM/200ML; OCTAGAM INJ                  |        |
|                       |   |                      |                                |         | 20GM/200ML; PRIVIGEN INJ                 |        |
|                       |   |                      |                                | - / - / | 20GM/200ML                               |        |
| AMABELZ TAB 1-0.5MG   | 3 | Formulary            |                                | 3/1/24  | ESTRADIOL &                              | Tier 3 |
|                       |   | Removal              |                                |         | NORETHINDRONE ACETATE                    |        |
|                       |   |                      |                                |         | TAB 1-0.5 MG; MIMVEY TAB                 |        |
|                       |   | _                    |                                |         | 1-0.5 MG                                 |        |
| PEN G PROC INJ 600000 | 4 | Formulary            |                                | 3/1/24  | PENICILLIN G POTASSIUM INJ               | Tier 4 |
|                       |   | Removal              |                                |         | SOLR 5000000 UNIT,                       |        |
|                       |   |                      |                                |         | 20000000 UNIT                            |        |
| FLEBOGAMMA INJ        | 5 | Formulary            |                                | 3/1/24  | BIVIGAM INJ 5GM/50ML;                    | Tier 5 |
| 5GM/50ML              |   | Removal              |                                |         | GAMMAPLEX INJ                            |        |
|                       |   |                      |                                |         | 5GM/50ML; OCTAGAM INJ                    |        |
|                       |   |                      |                                |         | 5GM/50ML; PRIVIGEN INJ                   |        |
|                       |   |                      |                                |         | 5GM/50ML                                 |        |
| GVOKE PFS INJ         | 3 | Formulary            |                                | 3/1/24  | GVOKE PFS INJ PREF SYRINGE               | Tier 3 |
|                       |   | Removal              |                                |         | 1MG/0.2ML; GVOKE                         |        |
|                       |   |                      |                                |         | HYPOPEN; GVOKE KIT                       |        |

| VANADOM TAB 350MG         | 3 | Formulary<br>Removal        |   | 3/1/24 | CARISOPRODOL TAB 350 MG | Tier 3 |
|---------------------------|---|-----------------------------|---|--------|-------------------------|--------|
| PEMAZYRE TAB 4.5MG        | 5 | Quantity<br>Limit<br>Change | Quantity Limit (28 tabs every 28 days)                                      | 3/1/24 |                         |        |
| PEMAZYRE TAB 13.5MG       | 5 | Quantity<br>Limit<br>Change | Quantity Limit (28 tabs every 28 days)                                      | 3/1/24 |                         |        |
| PEMAZYRE TAB 9MG          | 5 | Quantity<br>Limit<br>Change | Quantity Limit (28 tabs every 28 days)                                      | 3/1/24 |                         |        |
| MIFEPRISTONE TAB<br>300MG | 5 | Formulary<br>Addition       | Prior Authorization Required  | 4/1/24 |                         |        |
| OMNIPOD 5 G7 KIT<br>INTRO | 4 | Formulary<br>Addition       | Prior Authorization Required, Quantity Limit (1 kit every year)             | 4/1/24 |                         |        |
| OMNIPOD 5 G7 MIS<br>PODS  | 4 | Formulary<br>Addition       | Prior Authorization Required, Quantity Limit (15 pods every 30 days)        | 4/1/24 |                         |        |
| BOSULIF CAP 100MG         | 5 | Formulary<br>Addition       | Prior Authorization Required,<br>Quantity Limit (150 caps every 25<br>days) | 4/1/24 |                         |        |
| IWILFIN TAB 192MG         | 5 | Formulary<br>Addition       | Prior Authorization Required, Quantity Limit (240 tabs every 30 days)       | 4/1/24 |                         |        |
| LIDOCAN III PAD 5%        | 4 | Formulary<br>Addition       | Prior Authorization Required, Quantity Limit (3 patches every 1 day)        | 4/1/24 |                         |        |
| BOSULIF CAP 50MG          | 5 | Formulary<br>Addition       | Prior Authorization Required,<br>Quantity Limit (360 caps every 30<br>days) | 4/1/24 |                         |        |
| DABIGATRAN CAP<br>110MG   | 4 | Formulary<br>Addition       | Quantity Limit (120 caps every 30 days)                                     | 4/1/24 |                         |        |

|                      |   | I         | T                                  |        |                          |        |
|----------------------|---|-----------|------------------------------------|--------|--------------------------|--------|
| RISPERIDONE INJ      | 4 | Formulary | Quantity Limit (2 injections every | 4/1/24 |                          |        |
| 12.5MG               |   | Addition  | 28 days)                           |        |                          |        |
| RISPERIDONE INJ 25MG | 4 | Formulary | Quantity Limit (2 injections every | 4/1/24 |                          |        |
| ER                   |   | Addition  | 28 days)                           |        |                          |        |
| RISPERIDONE INJ      | 5 | Formulary | Quantity Limit (2 injections every | 4/1/24 |                          |        |
| 37.5MG               |   | Addition  | 28 days)                           |        |                          |        |
| RISPERIDONE INJ 50MG | 5 | Formulary | Quantity Limit (2 injections every | 4/1/24 |                          |        |
| ER                   |   | Addition  | 28 days)                           |        |                          |        |
| PAXLOVID TAB 150-100 | 3 | Formulary | Quantity Limit (40 tabs every 30   | 4/1/24 |                          |        |
|                      |   | Addition  | days)                              |        |                          |        |
| PAXLOVID TAB 300-100 | 3 | Formulary | Quantity Limit (60 tabs every 30   | 4/1/24 |                          |        |
|                      |   | Addition  | days)                              |        |                          |        |
| ZENPEP CAP 60000UNT  | 4 | Formulary |                                    | 4/1/24 |                          |        |
|                      |   | Addition  |                                    |        |                          |        |
| BROMFENAC DRO        | 4 | Formulary |                                    | 4/1/24 |                          |        |
| 0.075%               |   | Addition  |                                    |        |                          |        |
| SODIUM/POTAS SOL     | 3 | Formulary |                                    | 4/1/24 |                          |        |
| MAGNESIU             |   | Addition  |                                    |        |                          |        |
| HUMIRA PEN INJ       | 5 | Formulary |                                    | 4/1/24 | HUMIRA PEN INJ           | Tier 5 |
| CD/UC/HS             |   | Removal   |                                    |        | 40MG/0.8ML               |        |
| PAROMOMYCIN CAP      | 4 | Formulary |                                    | 4/1/24 | Consult Your Health Care |        |
| 250MG                |   | Removal   |                                    |        | Provider                 |        |
| DULERA AER 50-5MCG   | 4 | Quantity  | Quantity Limit (3 inhalers every   | 4/1/24 |                          |        |
|                      |   | Limit     | 30 days)                           |        |                          |        |
|                      |   | Change    | -                                  |        |                          |        |
| DULERA AER 200-5MCG  | 4 | Quantity  | Quantity Limit (3 inhalers every   | 4/1/24 |                          |        |
|                      |   | Limit     | 30 days)                           |        |                          |        |
|                      |   | Change    |                                    |        |                          |        |
| DULERA AER 100-5MCG  | 4 | Quantity  | Quantity Limit (3 inhalers every   | 4/1/24 |                          |        |
|                      |   | Limit     | 30 days)                           |        |                          |        |
|                      |   | Change    |                                    |        |                          |        |

| VO. 415 111 75 /0 5 |   |           | T                                 | = /4 /0 4 |  |
|---------------------|---|-----------|-----------------------------------|-----------|--|
| XOLAIR INJ 75/0.5   |   | Formulary |                                   | 5/1/24    |  |
|                     | 5 | Addition  | Prior Authorization Required      |           |  |
| XOLAIR INJ 150MG/ML |   | Formulary |                                   | 5/1/24    |  |
|                     | 5 | Addition  | Prior Authorization Required      |           |  |
| XOLAIR INJ 300/2ML  |   | Formulary |                                   | 5/1/24    |  |
|                     | 5 | Addition  | Prior Authorization Required      |           |  |
| XOLAIR INJ 300/2ML  |   | Formulary |                                   | 5/1/24    |  |
|                     | 5 | Addition  | Prior Authorization Required      |           |  |
| VIGPODER POW 500MG  |   | Formulary | Prior Authorization Required,     | 5/1/24    |  |
|                     |   | Addition  | Quantity Limit (180 packets every |           |  |
|                     | 5 |           | 30 days)                          |           |  |
| LANTHANUM CHW       |   | Formulary | Quantity Limit (180 tabs every 30 | 5/1/24    |  |
| 750MG               | 3 | Addition  | days)                             |           |  |
| NITROGLYCERI OIN    |   | Formulary | Quantity Limit (30 gm every 30    | 5/1/24    |  |
| 0.4%                | 4 | Addition  | days)                             |           |  |
| LANTHANUM CHW       |   | Formulary | Quantity Limit (90 tabs every 30  | 5/1/24    |  |
| 500MG               | 3 | Addition  | days)                             |           |  |
| LANTHANUM CHW       |   | Formulary | Quantity Limit (90 tabs every 30  | 5/1/24    |  |
| 1000MG              | 3 | Addition  | days)                             |           |  |
| NAPROXEN DR TAB     |   | Formulary | Quantity Limit (90 tabs every 30  | 5/1/24    |  |
| 500MG               | 4 | Addition  | days)                             |           |  |
| MIEBO DRO 1.3GM/ML  |   | Formulary |                                   | 5/1/24    |  |
|                     | 3 | Addition  |                                   |           |  |
| LOTEPREDNOL SUS     |   | Formulary |                                   | 5/1/24    |  |
| 0.2%                | 3 | Addition  |                                   |           |  |
| IXCHIQ INJ          |   | Formulary |                                   | 5/1/24    |  |
|                     | 1 | Addition  |                                   |           |  |
| CEFAZOLIN INJ 3GM   |   | Formulary |                                   | 5/1/24    |  |
|                     | 3 | Addition  |                                   |           |  |
| EC-NAPROXEN TAB     |   | Formulary |                                   | 5/1/24    |  |
| 500MG               | 4 | Removal   |                                   |           |  |

|                      |   | Formulary |                                    | 5/1/24 | Consult Your Health Care  |        |
|----------------------|---|-----------|------------------------------------|--------|---------------------------|--------|
| EMCYT CAP 140MG      | 5 | Removal   |                                    |        | Provider                  |        |
|                      |   | Formulary |                                    | 5/1/24 | RISPERIDONE INJ 12.5MG ER | Tier 4 |
| RISPERDAL INJ 12.5MG | 4 | Removal   |                                    |        |                           |        |
|                      |   | Formulary |                                    | 5/1/24 | RISPERIDONE INJ 25MG ER   | Tier 4 |
| RISPERDAL INJ 25MG   | 4 | Removal   |                                    |        |                           |        |
|                      |   | Formulary |                                    | 5/1/24 | RISPERIDONE INJ 37.5MG ER | Tier 5 |
| RISPERDAL INJ 37.5MG | 5 | Removal   |                                    |        |                           |        |
|                      |   | Formulary |                                    | 5/1/24 | RISPERIDONE INJ 50MG ER   | Tier 5 |
| RISPERDAL INJ 50MG   | 5 | Removal   |                                    |        |                           |        |
|                      |   | Formulary |                                    | 5/1/24 | PAZOPANIB HCL TAB 200 MG  | Tier 5 |
| VOTRIENT TAB 200MG   | 5 | Removal   |                                    |        |                           |        |
| HEPARIN SOD INJ      |   | Formulary | Prior Authorization Required       | 6/1/24 |                           |        |
| 1000/ML              | 3 | Addition  |                                    |        |                           |        |
| TREMFYA INJ          |   | Formulary | Prior Authorization Required,      | 6/1/24 |                           |        |
| 100MG/ML             |   | Addition  | Quantity Limit (1 pen every 28     |        |                           |        |
|                      | 5 |           | days)                              |        |                           |        |
| TREMFYA INJ          |   | Formulary | Prior Authorization Required,      | 6/1/24 |                           |        |
| 100MG/ML             |   | Addition  | Quantity Limit (1 syringe every 28 |        |                           |        |
|                      | 5 |           | days)                              |        |                           |        |
| ALVAIZ TAB 9MG       |   | Formulary | Prior Authorization Required,      | 6/1/24 |                           |        |
|                      |   | Addition  | Quantity Limit (60 tabs every 30   |        |                           |        |
|                      | 5 |           | days)                              |        |                           |        |
| ALVAIZ TAB 54MG      |   | Formulary | Prior Authorization Required,      | 6/1/24 |                           |        |
|                      |   | Addition  | Quantity Limit (60 tabs every 30   |        |                           |        |
|                      | 5 |           | days)                              |        |                           |        |
| ALVAIZ TAB 18MG      |   | Formulary | Prior Authorization Required,      | 6/1/24 |                           |        |
|                      |   | Addition  | Quantity Limit (90 tabs every 30   |        |                           |        |
|                      | 5 |           | days)                              |        |                           |        |
| ALVAIZ TAB 36MG      |   | Formulary | Prior Authorization Required,      | 6/1/24 |                           |        |
|                      |   | Addition  | Quantity Limit (90 tabs every 30   |        |                           |        |
|                      | 5 |           | days)                              |        |                           |        |

| NEXLETOL TAB 180MG  |   | Formulary | Quantity Limit (30 tabs every 30 | 6/1/24 |             |        |
|---------------------|---|-----------|----------------------------------|--------|-------------|--------|
|                     | 3 | Addition  | days)                            |        |             |        |
| NEXLIZET TAB        |   | Formulary | Quantity Limit (30 tabs every 30 | 6/1/24 |             |        |
| 180/10MG            | 3 | Addition  | days)                            |        |             |        |
| CLINDAMYCIN GEL 1%  |   | Formulary | Quantity Limit (75 gm every 30   | 6/1/24 |             |        |
|                     | 3 | Addition  | days)                            |        |             |        |
| DEXAMETH PHO INJ    |   | Formulary |                                  | 6/1/24 |             |        |
| 4MG/ML              | 3 | Addition  |                                  |        |             |        |
| VANCOMYCIN INJ      |   | Formulary |                                  | 6/1/24 |             |        |
| 500MG               | 4 | Addition  |                                  |        |             |        |
| VANCOMYCIN INJ 1 GM |   | Formulary |                                  | 6/1/24 |             |        |
|                     | 4 | Addition  |                                  |        |             |        |
| VANCOMYCIN INJ 5GM  |   | Formulary |                                  | 6/1/24 |             |        |
|                     | 4 | Addition  |                                  |        |             |        |
| VANCOMYCIN INJ      |   | Formulary |                                  | 6/1/24 |             |        |
| 10GM                | 4 | Addition  |                                  |        |             |        |
| EMZAHH TAB 0.35MG   |   | Formulary |                                  | 6/1/24 |             |        |
|                     | 2 | Addition  |                                  |        |             |        |
|                     |   | Formulary |                                  | 6/1/24 | VRAYLAR CAP | Tier 4 |
| VRAYLAR CAP 1.5-3MG | 4 | Removal   |                                  |        |             |        |
| CLOTRIMAZOLE SOL 1% |   | Quantity  | Quantity Limit (60 mL every 30   | 6/1/24 |             |        |
|                     |   | Limit     | days)                            |        |             |        |
|                     | 3 | Change    |                                  |        |             |        |
| HUMIRA INJ 20/0.2ML |   | Quantity  | Quantity Limit (4 syringes every | 6/1/24 |             |        |
|                     |   | Limit     | 28 days)                         |        |             |        |
|                     | 5 | Change    |                                  |        |             |        |
| JYLAMVO SOL 2MG/ML  | 4 | Formulary |                                  | 7/1/24 |             |        |
|                     |   | Addition  | Prior Authorization Required     |        |             |        |
| ALVESCO AER 80MCG   | 4 | Formulary | Quantity Limit (3 inhalers every | 7/1/24 |             |        |
|                     |   | Addition  | 30 days)                         |        |             |        |
| ALVESCO AER 160MCG  | 4 | Formulary | Quantity Limit (2 inhalers every | 7/1/24 |             |        |
|                     |   | Addition  | 30 days)                         |        |             |        |

| AMABELZ TAB 0.5-0.1    | 3 | Formulary<br>Removal |                                      | 7/1/24    | ESTRADIOL & NORETHINDRONE ACETATE TAB 0.5-0.1 MG | Tier 3 |
|------------------------|---|----------------------|--------------------------------------|-----------|--|--------|
|                        | 5 | Ougntity             |                                      | 7/1/24    | TAB 0.5-0.1 IVIG                                 |        |
|                        | 5 | Quantity             | Overstitus Limeit (112 come overs 20 | //1/24    |  |        |
| THAT CAME CAR 400A4C   |   | Limit                | Quantity Limit (112 caps every 28    |           |  |        |
| THALOMID CAP 100MG     |   | Change               | days)                                | 7/1/01    | -  |        |
|                        | 5 | Quantity             |                                      | 7/1/24    |  |        |
|                        |   | Limit                | Quantity Limit (84 caps every 28     |           |  |        |
| THALOMID CAP 50MG      |   | Change               | days)                                |           |  |        |
|                        |   | Formulary            | Prior Authorization Required,        | 8/1/24    |  |        |
|                        |   | Addition             | Quantity Limit (24 tabs every 28     |           |  |        |
| OJEMDA TAB 100MG       | 5 |                      | days)                                |           |  |        |
|                        |   | Formulary            | Prior Authorization Required,        | 8/1/24    |  |        |
| AUSTEDO XR TAB 30MG    |   | Addition             | Quantity Limit (30 tabs every 30     |           |  |        |
| ER                     | 5 |                      | days)                                |           |  |        |
|                        |   | Formulary            | Prior Authorization Required,        | 8/1/24    |  |        |
| AUSTEDO XR TAB 36MG    |   | Addition             | Quantity Limit (30 tabs every 30     |           |  |        |
| ER                     | 5 |                      | days)                                |           |  |        |
|                        |   | Formulary            | Prior Authorization Required,        | 8/1/24    |  |        |
| AUSTEDO XR TAB 42MG    |   | Addition             | Quantity Limit (30 tabs every 30     |           |  |        |
| ER                     | 5 |                      | days)                                |           |  |        |
|                        |   | Formulary            | Prior Authorization Required,        | 8/1/24    |  |        |
| AUSTEDO XR TAB 48MG    |   | Addition             | Quantity Limit (30 tabs every 30     | -, ,      |  |        |
| ER                     | 5 |                      | days)                                |           |  |        |
|                        |   | Formulary            | Prior Authorization Required,        | 8/1/24    |  |        |
|                        |   | Addition             | Quantity Limit (56 tabs every 28     | 0, 2, 2 . |  |        |
| OGSIVEO TAB 100MG      | 5 |                      | days)                                |           |  |        |
| 2 23.120 17.12 2001110 |   | Formulary            | Prior Authorization Required,        | 8/1/24    |  |        |
|                        |   | Addition             | Quantity Limit (56 tabs every 28     | 0/1/27    |  |        |
| OGSIVEO TAB 150MG      | 5 | Addition             | days)                                |           |  |        |
| OGDIATO LAD TOOMIG     | J |                      | uaysj                                |           |  |        |

|                      |   | Formulary | Prior Authorization Required,    | 8/1/24    |  |
|----------------------|---|-----------|----------------------------------|-----------|--|
|                      |   | Addition  | Quantity Limit (96 mL every 28   | 5, 2, 2 . |  |
| OJEMDA SUS 25MG/ML   | 5 |           | days)                            |           |  |
| ,                    |   | Formulary | Quantity Limit (30 tabs every 30 | 8/1/24    |  |
| XCOPRI TAB 25MG      | 5 | Addition  | days)                            |           |  |
|                      |   | Formulary | Quantity Limit (56 tabs every 28 | 8/1/24    |  |
| VARENICLINE TAB 1MG  | 4 | Addition  | days)                            |           |  |
|                      |   | Formulary |                                  | 8/1/24    |  |
| ALYGLO INJ 5GM/50ML  | 5 | Addition  | Prior Authorization Required     |           |  |
|                      |   | Formulary |                                  | 8/1/24    |  |
| ALYGLO INJ 10/100ML  | 5 | Addition  | Prior Authorization Required     |           |  |
|                      |   | Formulary |                                  | 8/1/24    |  |
| ALYGLO INJ 20/200ML  | 5 | Addition  | Prior Authorization Required     |           |  |
| CYCLOPHOSPH INJ      |   | Formulary |                                  | 8/1/24    |  |
| 500/5ML              | 5 | Addition  | Prior Authorization Required     |           |  |
| CYCLOPHOSPH INJ      |   | Formulary |                                  | 8/1/24    |  |
| 1000MG               | 5 | Addition  | Prior Authorization Required     |           |  |
| CYCLOPHOSPH INJ      |   | Formulary |                                  | 8/1/24    |  |
| 2000MG               | 5 | Addition  | Prior Authorization Required     |           |  |
|                      |   | Formulary |                                  | 8/1/24    |  |
| FASENRA INJ 10MG/0.5 | 5 | Addition  | Prior Authorization Required     |           |  |
| LANREOTIDE INJ       |   | Formulary |                                  | 8/1/24    |  |
| 120/.5ML             | 5 | Addition  | Prior Authorization Required     |           |  |
|                      |   | Formulary |                                  | 8/1/24    |  |
| PROCTOCORT CRE 1%    | 3 | Addition  |                                  |           |  |
|                      |   | Formulary |                                  | 8/1/24    |  |
| LIBERVANT MIS 5MG    | 4 | Addition  |                                  |           |  |
|                      |   | Formulary |                                  | 8/1/24    |  |
| LIBERVANT MIS 7.5MG  | 4 | Addition  |                                  |           |  |
|                      |   | Formulary |                                  | 8/1/24    |  |
| LIBERVANT MIS 10MG   | 4 | Addition  |                                  |           |  |

|                      |   | F 1                   |                                 | 0/4/24    | T T                      |        |
|----------------------|---|-----------------------|---------------------------------|-----------|--------------------------|--------|
| LIBERVANT MIS 12.5MG | 4 | Formulary<br>Addition |                                 | 8/1/24    |                          |        |
| LIBERVANT WIS 12.5MG | 4 |                       |                                 | 0/4/24    |                          |        |
|                      |   | Formulary             |                                 | 8/1/24    |                          |        |
| LIBERVANT MIS 15MG   | 4 | Addition              |                                 | - 1 - 1   |                          |        |
| VANCOMYCIN INJ       |   | Formulary             |                                 | 8/1/24    |                          |        |
| 1.25GM               | 4 | Addition              |                                 |           |                          |        |
| VANCOMYCIN INJ       |   | Formulary             |                                 | 8/1/24    |                          |        |
| 1.5GM                | 4 | Addition              |                                 |           |                          |        |
|                      |   | Formulary             |                                 | 8/1/24    | Consult Your Health Care |        |
| EXKIVITY CAP 40MG    | 5 | Removal               |                                 |           | Provider                 |        |
| HUMIRA PEDIA INJ     |   | Formulary             |                                 | 8/1/24    | HUMIRA PEN STARTER KIT   | Tier 5 |
| CROHNS               | 5 | Removal               |                                 |           | CD/UC/HS                 |        |
| HUMIRA PEDIA INJ     |   | Formulary             |                                 | 8/1/24    | HUMIRA PEN STARTER KIT   | Tier 5 |
| CROHNS               | 5 | Removal               |                                 |           | CD/UC/HS                 |        |
|                      |   | Formulary             |                                 | 8/1/24    | HUMIRA PEN INJ KIT 40    | Tier 5 |
| HUMIRA PEN INJ PS/UV | 5 | Removal               |                                 |           | MG/0.8ML                 |        |
| DRIZALMA CAP 20MG    | 4 | Formulary             | Prior Authorization Required,   | 9/1/24    |                          |        |
| DR                   |   | Addition              | Quantity Limit (60 ea every 30  |           |                          |        |
|                      |   |                       | days)                           |           |                          |        |
| DRIZALMA CAP 30MG    | 4 | Formulary             | Prior Authorization Required,   | 9/1/24    |                          |        |
| DR                   |   | Addition              | Quantity Limit (60 ea every 30  |           |                          |        |
|                      |   |                       | days)                           |           |                          |        |
| DRIZALMA CAP 40MG    | 4 | Formulary             | Prior Authorization Required,   | 9/1/24    |                          |        |
| DR                   |   | Addition              | Quantity Limit (60 ea every 30  |           |                          |        |
|                      |   |                       | days)                           |           |                          |        |
| DRIZALMA CAP 60MG    | 4 | Formulary             | Prior Authorization Required,   | 9/1/24    |                          |        |
| DR                   | • | Addition              | Quantity Limit (60 ea every 30  | -, -, - : |                          |        |
|                      |   |                       | days)                           |           |                          |        |
| RINVOQ LQ SOL        | 5 | Formulary             | Prior Authorization Required,   | 9/1/24    |                          |        |
| 1MG/ML               | _ | Addition              | Quantity Limit (360 mL every 30 | -, -, - : |                          |        |
|                      |   |                       | days)                           |           |                          |        |
|                      |   |                       | uays <i>j</i>                   |           |                          |        |

| SCEMBLIX TAB 100MG     | 5 | Formulary             | Prior Authorization Required,     | 9/1/24    |                          |        |
|------------------------|---|-----------------------|-----------------------------------|-----------|--------------------------|--------|
| SCEIVIBLIX TAB 100IVIG | ) | Addition              | Quantity Limit (120 tabs every 30 | 3/1/24    |                          |        |
|                        |   | Addition              | days)                             |           |                          |        |
| XDEMVY DRO 0.25%       | 5 | Formulas:             | Prior Authorization Required      | 9/1/24    |                          |        |
| ADEIVIVY DRU 0.25%     | ) | Formulary<br>Addition | Prior Authorization Required      | 9/1/24    |                          |        |
| L CLUTANAINE DOW       | - |                       | Disch the death of the December 1 | 0/4/24    |                          |        |
| L-GLUTAMINE POW        | 5 | Formulary             | Prior Authorization Required      | 9/1/24    |                          |        |
| 5GM                    |   | Addition              |                                   |           |                          |        |
| KIONEX SUS 15GM/60     | 3 | Formulary             |                                   | 9/1/24    |                          |        |
|                        |   | Addition              |                                   |           |                          |        |
| POT CHLORIDE INJ       | 3 | Formulary             |                                   | 9/1/24    |                          |        |
| 10MEQ                  |   | Addition              |                                   |           |                          |        |
| CYCLOPHOSPHA INJ       | 5 | Formulary             |                                   | 9/1/24    | CYCLOPHOSPHAMIDE INJ     | Tier 5 |
| 2GM/4ML                |   | Removal               |                                   |           | 2GM/10ML                 |        |
| CYCLOSPORINE INJ       | 4 | Formulary             |                                   | 9/1/24    | Consult Your Health Care |        |
| 50MG/ML                |   | Removal               |                                   |           | Provider                 |        |
| TAZTIA XT CAP          | 2 | Formulary             |                                   | 9/1/24    | DILTIAZEM HCL ER BEADS   | Tier 2 |
| 120MG/24               |   | Removal               |                                   |           | CAP; TIADYLT CAP         |        |
| TAZTIA XT CAP          | 2 | Formulary             |                                   | 9/1/24    | DILTIAZEM HCL ER BEADS   | Tier 2 |
| 180MG/24               |   | Removal               |                                   |           | CAP; TIADYLT CAP         |        |
| TAZTIA XT CAP          | 2 | Formulary             |                                   | 9/1/24    | DILTIAZEM HCL ER BEADS   | Tier 2 |
| 240MG/24               |   | Removal               |                                   |           | CAP; TIADYLT CAP         |        |
| TAZTIA XT CAP 300MG    | 2 | Formulary             |                                   | 9/1/24    | DILTIAZEM HCL ER BEADS   | Tier 2 |
| ER                     |   | Removal               |                                   |           | CAP; TIADYLT CAP         |        |
| TAZTIA XT CAP          | 2 | Formulary             |                                   | 9/1/24    | DILTIAZEM HCL ER BEADS   | Tier 2 |
| 360MG/24               |   | Removal               |                                   |           | CAP; TIADYLT CAP         |        |
| ZEJULA CAP 100MG       | 5 | Formulary             |                                   | 9/1/24    | ZEJULA TAB               | Tier 5 |
|                        |   | Removal               |                                   | , ,       |                          |        |
| TRIDACAINE PAD 5%      | 4 | Formulary             |                                   |           |                          |        |
| 3,10,10,11,12,1,12,3,0 |   | Addition              | Prior Authorization Required      | 10/1/2024 |                          |        |
| MRESVIA INJ 50MCG      | 1 | Formulary             | ·                                 |           |                          |        |
|                        |   | Addition              |                                   | 10/1/2024 |                          |        |

| NALOXONE HCL SOL     | 2 | Formulary |                                    |           |  |
|----------------------|---|-----------|------------------------------------|-----------|--|
| 0.4MG/ML             |   | Addition  |                                    | 10/1/2024 |  |
| ENTRESTO CAP 6-6MG   | 3 | Formulary | Quantity Limit: 240 caps every 30  |           |  |
|                      |   | Addition  | days                               | 10/1/2024 |  |
| ENTRESTO CAP 15-     | 3 | Formulary | Quantity Limit: 240 caps every 30  |           |  |
| 16MG                 |   | Addition  | days                               | 10/1/2024 |  |
| BENDAMUSTINE SOL     | 5 | Formulary |                                    |           |  |
| 100/4ML              |   | Addition  | Prior Authorization Required       | 10/1/2024 |  |
| AUSTEDO XR TAB 18MG  | 5 |           | Prior Authorization Required;      |           |  |
|                      |   | Formulary | Quantity Limit: 60 tabs every 30   |           |  |
|                      |   | Addition  | days                               | 10/1/2024 |  |
| AUSTEDO XR TAB TITR  | 5 |           | Prior Authorization Required;      |           |  |
| KIT                  |   | Formulary | Quantity Limit: 2 packs every      |           |  |
|                      |   | Addition  | year                               | 10/1/2024 |  |
| IVABRADINE TAB 5MG   | 4 | Formulary | Quantity Limit: 60 tabs every 30   |           |  |
|                      |   | Addition  | days                               | 10/1/2024 |  |
| IVABRADINE TAB 7.5MG | 4 | Formulary | Quantity Limit: 60 tabs every 30   |           |  |
|                      |   | Addition  | days                               | 10/1/2024 |  |
| DOXORUBICIN INJ      | 4 | Formulary |                                    |           |  |
| 2MG/ML               |   | Addition  | Prior Authorization Required       | 10/1/2024 |  |
| OTEZLA TAB 20MG      | 5 |           | Prior Authorization Required;      |           |  |
|                      |   | Formulary | Quantity Limit: 60 tabs every 30   |           |  |
|                      |   | Addition  | days                               | 10/1/2024 |  |
| OTEZLA TAB 10/20     | 5 |           | Prior Authorization Required;      |           |  |
|                      |   | Formulary | Quantity Limit: 110 tabs every     |           |  |
|                      |   | Addition  | year                               | 10/1/2024 |  |
| TALTZ INJ 20/0.25    | 5 |           | Prior Authorization Required;      |           |  |
|                      |   | Formulary | Quantity Limit: 1 syringe every 28 |           |  |
|                      |   | Addition  | days                               | 10/1/2024 |  |
| TALTZ INJ 40/0.5ML   | 5 |           | Prior Authorization Required;      |           |  |
|                      |   | Formulary | Quantity Limit: 1 syringe every 28 |           |  |
|                      |   | Addition  | days                               | 10/1/2024 |  |

| TORPENZ TAB 2.5MG         | 5 |                       | Drier Authorization Deguired     |           |                        |        |
|---------------------------|---|-----------------------|----------------------------------|-----------|------------------------|--------|
| TORPENZ TAB 2.5IVIG       | ) | Fames dam.            | Prior Authorization Required;    |           |                        |        |
|                           |   | Formulary             | Quantity Limit: 30 tabs every 30 | 40/4/2024 |                        |        |
|                           |   | Addition              | days                             | 10/1/2024 |                        |        |
| TORPENZ TAB 5MG           | 5 |                       | Prior Authorization Required;    |           |                        |        |
|                           |   | Formulary             | Quantity Limit: 30 tabs every 30 |           |                        |        |
|                           |   | Addition              | days                             | 10/1/2024 |                        |        |
| TORPENZ TAB 7.5MG         | 5 |                       | Prior Authorization Required;    |           |                        |        |
|                           |   | Formulary             | Quantity Limit: 30 tabs every 30 |           |                        |        |
|                           |   | Addition              | days                             | 10/1/2024 |                        |        |
| TORPENZ TAB 10MG          | 5 |                       | Prior Authorization Required;    |           |                        |        |
|                           |   | Formulary             | Quantity Limit: 30 tabs every 30 |           |                        |        |
|                           |   | Addition              | days                             | 10/1/2024 |                        |        |
| RETEVMO TAB 40MG          | 5 |                       | Prior Authorization Required;    |           |                        |        |
|                           |   | Formulary             | Quantity Limit: 90 tabs every 30 |           |                        |        |
|                           |   | Addition              | days                             | 10/1/2024 |                        |        |
| RETEVMO TAB 160MG         | 5 |                       | Prior Authorization Required;    |           |                        |        |
|                           |   | Formulary             | Quantity Limit: 60 tabs every 30 |           |                        |        |
|                           |   | Addition              | days                             | 10/1/2024 |                        |        |
| RETEVMO TAB 80MG          | 5 |                       | Prior Authorization Required;    | , ,       |                        |        |
|                           |   | Formulary             | Quantity Limit: 60 tabs every 30 |           |                        |        |
|                           |   | Addition              | days                             | 10/1/2024 |                        |        |
| RETEVMO TAB 120MG         | 5 | Addition              | Prior Authorization Required;    | 10/1/2021 |                        |        |
| KETEVIVIO TAB 1201VIG     |   | Formulary             | Quantity Limit: 60 tabs every 30 |           |                        |        |
|                           |   | Addition              | days                             | 10/1/2024 |                        |        |
| DICLOFENAC SOL 1.5%       | 3 |                       | Quantity Limit: 300 mL every 28  | 10/1/2024 |                        |        |
| DICLOFENAC SOL 1.5%       | 3 | Formulary<br>Addition |                                  | 10/1/2024 |                        |        |
| 15/0/46 6116 500 46 /0 41 |   |                       | days                             | 10/1/2024 | 50044400544440 740 700 |        |
| LEXIVA SUS 50MG/ML        | _ | Formulary             |                                  | 40/4/222  | FOSAMPRENAVIR TAB 700  |        |
|                           | 4 | Removal               |                                  | 10/1/2024 | MG                     | Tier 5 |
| AMOX/K CLAV CHW           |   |                       |                                  |           | AMOXICILLIN & K        |        |
| 200MG                     |   | Formulary             |                                  |           | CLAVULANATE FOR SUSP   |        |
|                           | 4 | Removal               |                                  | 10/1/2024 | 200-28.5 MG/5ML        | Tier 2 |

| ZOLEDRONIC INJ      |   | Formulary |                                   |           | ZOLEDRONIC ACID INJ    |        |
|---------------------|---|-----------|-----------------------------------|-----------|------------------------|--------|
| 4MG/100             | 4 | Removal   |                                   | 10/1/2024 | 4MG/5ML                | Tier 2 |
| ERYTHROCIN TAB      |   | Formulary |                                   |           | ERYTHROMYCIN TAB 250MG |        |
| 250MG               | 4 | Removal   |                                   | 10/1/2024 | EC                     | Tier 2 |
| ADALIMU-AACF KIT    | 5 |           | Prior Authorization Required;     |           |                        |        |
| 40/0.8ML            |   | Formulary | Quantity Limit: 56 syringes every |           |                        |        |
|                     |   | Add       | 365 days                          | 11/1/2024 |                        |        |
| VIGAFYDE SOL        | 5 |           | Prior Authorization Required;     |           |                        |        |
| 100MG/ML            |   | Formulary | Quantity Limit: 900 mL every 30   |           |                        |        |
|                     |   | Add       | days                              | 11/1/2024 |                        |        |
| VAXCHORA SUS        | 1 | Formulary |                                   |           |                        |        |
|                     |   | Add       |                                   | 11/1/2024 |                        |        |
| VRAYLAR CAP 1.5-3MG | 4 | Formulary | Quantity Limit: 2 packs every     |           |                        |        |
|                     |   | Add       | year                              | 11/1/2024 |                        |        |
| DASATINIB TAB 20MG  | 5 |           | Prior Authorization Required;     |           |                        |        |
|                     |   | Formulary | Quantity Limit: 90 tabs every 30  |           |                        |        |
|                     |   | Add       | days                              | 11/1/2024 |                        |        |
| DASATINIB TAB 50MG  | 5 |           | Prior Authorization Required;     |           |                        |        |
|                     |   | Formulary | Quantity Limit: 30 tabs every 30  |           |                        |        |
|                     |   | Add       | days                              | 11/1/2024 |                        |        |
| DASATINIB TAB 70MG  | 5 |           | Prior Authorization Required;     |           |                        |        |
|                     |   | Formulary | Quantity Limit: 30 tabs every 30  |           |                        |        |
|                     |   | Add       | days                              | 11/1/2024 |                        |        |
| DASATINIB TAB 80MG  | 5 |           | Prior Authorization Required;     |           |                        |        |
|                     |   | Formulary | Quantity Limit: 30 tabs every 30  |           |                        |        |
|                     |   | Add       | days                              | 11/1/2024 |                        |        |
| DASATINIB TAB 100MG | 5 |           | Prior Authorization Required;     |           |                        |        |
|                     |   | Formulary | Quantity Limit: 30 tabs every 30  |           |                        |        |
|                     |   | Add       | days                              | 11/1/2024 |                        |        |
| DASATINIB TAB 140MG | 5 |           | Prior Authorization Required;     |           |                        |        |
|                     |   | Formulary | Quantity Limit: 30 tabs every 30  |           |                        |        |
|                     |   | Add       | days                              | 11/1/2024 |                        |        |

| AIRSUPRA AER 90-    | 3 | Formulary | Quantity Limit: 3 inhalers every |           |                     |        |
|---------------------|---|-----------|----------------------------------|-----------|---------------------|--------|
| 80MCG               |   | Add       | 30 days                          | 11/1/2024 |                     |        |
| OJEMDA TAB 100MG    | 5 |           | Prior Authorization Required;    |           |                     |        |
|                     |   | Formulary | Quantity Limit: 24 tabs every 28 |           |                     |        |
|                     |   | Add       | days                             | 11/1/2024 |                     |        |
| OJEMDA TAB 100MG    | 5 |           | Prior Authorization Required;    |           |                     |        |
|                     |   | Formulary | Quantity Limit: 24 tabs every 28 |           |                     |        |
|                     |   | Add       | days                             | 11/1/2024 |                     |        |
| GAVILYTE-N SOL FLAV | 2 | Formulary |                                  |           |                     |        |
| PK                  |   | Add       |                                  | 11/1/2024 |                     |        |
| EFAVIRENZ CAP 50MG  | 4 | Formulary |                                  | 11/1/2024 |                     |        |
|                     |   | Removal   |                                  |           | EFAVIRENZ TAB 600MG | Tier 4 |
| EFAVIRENZ CAP 200MG | 4 | Formulary |                                  | 11/1/2024 |                     |        |
|                     |   | Removal   |                                  |           | EFAVIRENZ TAB 600MG | Tier 4 |
| VORANIGO TAB 10MG   | 5 | Formulary | Prior Authorization Required;    | 12/1/2024 |                     |        |
|                     |   | Addition  | Quantity Limit (60 tabs every 30 |           |                     |        |
|                     |   |           | days)                            |           |                     |        |
| VORANIGO TAB 40MG   | 5 | Formulary | Prior Authorization Required;    | 12/1/2024 |                     |        |
|                     |   | Addition  | Quantity Limit (30 tabs every 30 |           |                     |        |
|                     |   |           | days)                            |           |                     |        |
| LAZCLUZE TAB 80MG   | 5 | Formulary | Prior Authorization Required;    | 12/1/2024 |                     |        |
|                     |   | Addition  | Quantity Limit (60 tabs every 30 |           |                     |        |
|                     |   |           | days)                            |           |                     |        |
| LAZCLUZE TAB 240MG  | 5 | Formulary | Prior Authorization Required;    | 12/1/2024 |                     |        |
|                     |   | Addition  | Quantity Limit (30 tabs every 30 |           |                     |        |
|                     |   |           | days)                            |           |                     |        |
| SPS SUS 30GM/120    | 3 | Formulary |                                  | 12/1/2024 |                     |        |
|                     |   | Addition  |                                  |           |                     |        |
| TAZAROTENE CRE      | 3 | Formulary | Prior Authorization Required;    | 12/1/2024 |                     |        |
| 0.05%               |   | Addition  | Quantity Limit (60 gm every 30   |           |                     |        |
|                     |   |           | days)                            |           |                     |        |

| CEFAZOLIN INJ<br>DEXTROSE    | 4 | Formulary<br>Addition |   | 12/1/2024 |                                      |
|------------------------------|---|-----------------------|---|-----------|--------------------------------------|
| ADALIMU-AACF INJ<br>40/0.8ML | 5 | Formulary<br>Addition | Prior Authorization Required;<br>Quantity Limit (2 packs every<br>year) | 12/1/2024 |                                      |
| ADALIMU-AACF INJ<br>40/0.8ML | 5 | Formulary<br>Addition | Prior Authorization Required;<br>Quantity Limit (2 packs every<br>year) | 12/1/2024 |                                      |
| HYDRO SOD SU INJ<br>100MG    | 4 | Formulary<br>Addition |   | 12/1/2024 |                                      |
| TRIZIVIR TAB                 | 5 | Formulary<br>Removal  |   | 12/1/2024 | Consult Your Health Care<br>Provider |