

OPTIMUM HEALTHCARE

Formulary Changes- April 2024

The table below outlines formulary changes for the AFC Enhanced

Effective Date	Drug Name	Reason Formulary.	Alternative Drug*	Drug Copay**	Restrictions***
4/1/2024	Bosulif Capsule 100 MG	Formulary Addition		Tier 4	PA, QL (120 per 30 days)
4/1/2024	Bosulif Capsule 50 MG	Formulary Addition		Tier 4	PA, QL (30 per 30 days)
4/1/2024	Flurazepam HCl Capsule 30 MG	Formulary Addition		Tier 1	QL (30 per 30 days)
4/1/2024	Iwilfin Tablet 192 MG	Formulary Addition		Tier 4	PA, QL (240 per 30 days)
4/1/2024	Risperidone 25 MG ER Intramuscular Suspension	Formulary Addition		Tier 3	QL (2 per 28 days)
4/1/2024	Risperidone 37.5 MG ER Intramuscular Suspension	Formulary Addition		Tier 3	QL (2 per 28 days)
4/1/2024	Risperidone 50 MG ER Intramuscular Suspension	Formulary Addition		Tier 4	QL (2 per 28 days)
4/1/2024	Risperidone 12.5 MG ER Intramuscular Suspension	Formulary Addition		Tier 3	QL (2 per 28 days)
4/1/2024	Synjardy 10-1000 MG ER tablet	Formulary Addition		Tier 2	QL (60 per 30 days)
4/1/2024	Synjardy 12.5-1000 MG ER tablet	Formulary Addition		Tier 2	QL (60 per 30 days)

Last Updated: 3/18/2024
AFC ENHANCED FORMULARY

Y0114_24_3005780_0000_I_C
H5594
1057181MUMENMUB

*Alternative drugs are drugs in the same therapeutic category/class or cost sharing tier as the affected drug. Only your health care provider can determine if the alternative(s) listed here is appropriate for you given the individualized nature of drug therapy.

**Please refer to the description of your plan for copay/coinsurance amounts.

***Prior Authorization (PA), Quantity Limits (QL), or Step Therapy (ST) restrictions may apply.

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
4/1/2024	Synjardy 25-1000 MG ER tablet	Formulary Addition		Tier 2	QL (30 per 30 days)
4/1/2024	Synjardy 5-1000 MG ER tablet	Formulary Addition		Tier 2	QL (60 per 30 days)
4/1/2024	Amcinonide Lotion 0.1 % External	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
4/1/2024	Zorbtive Solution Reconstituted 8.8 MG	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		

Last Updated: 3/18/2024
AFC ENHANCED FORMULARY

Y0114_24_3005780_0000_I_C
H5594
1057181MUMENMUB

*Alternative drugs are drugs in the same therapeutic category/class or cost sharing tier as the affected drug. Only your health care provider can determine if the alternative(s) listed here is appropriate for you given the individualized nature of drug therapy.

**Please refer to the description of your plan for copay/coinsurance amounts.

***Prior Authorization (PA), Quantity Limits (QL), or Step Therapy (ST) restrictions may apply.

OPTIMUM HEALTHCARE

Formulary Changes- March 2024

The table below outlines formulary changes for the AFC Enhanced Formulary.

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
3/1/2024	Augtyro 40MG Capsule	Formulary Addition		Tier 4	PA, QL (240 per 30 days)
3/1/2024	Klayesta 100000UNIT/GM Powder	Formulary Addition		Tier 1	
3/1/2024	Ogsiveo 50MG Tablet	Formulary Addition		Tier 4	PA, QL (180 per 30 days)
3/1/2024	Penbraya Intramuscular Suspension	Formulary Addition		Tier 2	
3/1/2024	Rozlytrek 50MG Packet	Formulary Addition		Tier 4	PA, QL (240 per 30 days)
3/1/2024	Vigpoder 500MG Packet	Formulary Addition		Tier 3	PA, QL (180 per 30 days)
3/1/2024	Xalkori 150MG Sprinkle Capsule	Formulary Addition		Tier 4	PA, QL (90 per 30 days)
3/1/2024	Xalkori 20MG Sprinkle Capsule	Formulary Addition		Tier 4	PA, QL (120 per 30 days)
3/1/2024	Xalkori 50MG Sprinkle Capsule	Formulary Addition		Tier 4	PA, QL (60 per 30 days)
3/1/2024	Duramorph 0.5MG/ML Injection	Quantity Limit Removal			

Last Updated: 3/18/2024
AFC ENHANCED FORMULARY

Y0114_24_3005780_0000_I_C
H5594
1057181MUMENMUB

*Alternative drugs are drugs in the same therapeutic category/class or cost sharing tier as the affected drug. Only your health care provider can determine if the alternative(s) listed here is appropriate for you given the individualized nature of drug therapy.

**Please refer to the description of your plan for copay/coinsurance amounts.

***Prior Authorization (PA), Quantity Limits (QL), or Step Therapy (ST) restrictions may apply.

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
3/1/2024	Duramorph 1MG/ML Injection	Quantity Limit Removal			
3/1/2024	Hydromorphone HCl 2MG/ML Injection	Quantity Limit Removal			
3/1/2024	Hydromorphone HCl PF 10MG/ML Injection	Quantity Limit Removal			
3/1/2024	Hydromorphone HCl PF 500MG/50ML Injection	Quantity Limit Removal			
3/1/2024	Hydromorphone HCl PF 50MG/5ML Injection	Quantity Limit Removal			
3/1/2024	Morphine Sulfate (PF) 0.5MG/ML Injection	Quantity Limit Removal			
3/1/2024	Morphine Sulfate (PF) 1MG/ML Injection	Quantity Limit Removal			
3/1/2024	Morphine Sulfate 2MG/ML Injection	Quantity Limit Removal			
3/1/2024	Morphine Sulfate 4MG/ML Injection	Quantity Limit Removal			
3/1/2024	Clindamycin Phosphate Solution 300 MG	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
3/1/2024	Nevirapine ER Tablet Extended Release	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative		

Last Updated: 3/18/2024
AFC ENHANCED FORMULARY

Y0114_24_3005780_0000_I_C
H5594
1057181MUMENMUB

*Alternative drugs are drugs in the same therapeutic category/class or cost sharing tier as the affected drug. Only your health care provider can determine if the alternative(s) listed here is appropriate for you given the individualized nature of drug therapy.

**Please refer to the description of your plan for copay/coinsurance amounts.

***Prior Authorization (PA), Quantity Limits (QL), or Step Therapy (ST) restrictions may apply.

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
			that may be right for you		
3/1/2024	Turalio Capsule 200 MG	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
3/1/2024	Viibryd Starter Pack Kit	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		

Last Updated: 3/18/2024
AFC ENHANCED FORMULARY

Y0114_24_3005780_0000_I_C
H5594
1057181MUMENMUB

*Alternative drugs are drugs in the same therapeutic category/class or cost sharing tier as the affected drug. Only your health care provider can determine if the alternative(s) listed here is appropriate for you given the individualized nature of drug therapy.

**Please refer to the description of your plan for copay/coinsurance amounts.

***Prior Authorization (PA), Quantity Limits (QL), or Step Therapy (ST) restrictions may apply.

OPTIMUM HEALTHCARE

Formulary Changes- February 2024

The table below outlines formulary changes for the AFC Enhanced Formulary.

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
2/1/2024	AKEEGA TAB 100/500MG	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
2/1/2024	AKEEGA TAB 50/500MG	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
2/1/2024	BREO ELLIPTA INH 50-25MCG	Formulary Addition		Tier 2	QL (60 per 30 days)
2/1/2024	BREYNA AER 160/4.5	Formulary Addition		Tier 2	QL (30.9 per 30 days)
2/1/2024	BREYNA AER 80/4.5	Formulary Addition		Tier 2	QL (30.9 per 30 days)
2/1/2024	FLUTICASONE AER 100MCG	Formulary Addition		Tier 2	QL (60 per 30 days)
2/1/2024	FLUTICASONE AER 250MCG	Formulary Addition		Tier 2	QL (240 per 30 days)
2/1/2024	FLUTICASONE AER 50MCG	Formulary Addition		Tier 2	QL (60 per 30 days)
2/1/2024	KALYDECO GRANULES 5.8MG	Formulary Addition		Tier 4	PA; QL (56 per 28 days)
2/1/2024	KOURZEQ PST 0.1%	Formulary Addition		Tier 1	

Last Updated: 3/18/2024
AFC ENHANCED FORMULARY

Y0114_24_3005780_0000_I_C
H5594
1057181MUMENMUB

*Alternative drugs are drugs in the same therapeutic category/class or cost sharing tier as the affected drug. Only your health care provider can determine if the alternative(s) listed here is appropriate for you given the individualized nature of drug therapy.

**Please refer to the description of your plan for copay/coinsurance amounts.

***Prior Authorization (PA), Quantity Limits (QL), or Step Therapy (ST) restrictions may apply.

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
2/1/2024	LAGEVRIO 200 MG CAP	Formulary Addition		Tier 4	QL (40 per 90 days)
2/1/2024	OJJAARA TAB 100MG	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
2/1/2024	OJJAARA TAB 150MG	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
2/1/2024	OJJAARA TAB 200MG	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
2/1/2024	PAXLOVID TAB 150-100 MG	Formulary Addition		Tier 4	QL (20 per 90 days)
2/1/2024	PAXLOVID TAB 300-100 MG	Formulary Addition		Tier 4	PA; QL (30 per 90 days)
2/1/2024	PAZOPANIB TAB 200MG	Formulary Addition		Tier 4	PA; QL (120 per 30 days)
2/1/2024	RISPERIDONE INJ 12.5MG	Formulary Addition		Tier 3	QL (2 per 28 days)
2/1/2024	RISPERIDONE INJ 25MG ER	Formulary Addition		Tier 3	QL (2 per 28 days)
2/1/2024	RISPERIDONE INJ 37.5MG	Formulary Addition		Tier 4	QL (2 per 28 days)
2/1/2024	RISPERIDONE INJ 50MG ER	Formulary Addition		Tier 4	QL (2 per 28 days)
2/1/2024	ROZLYTREK PAK 50MG	Formulary Addition		Tier 4	PA; QL (240 per 30 days)

Last Updated: 3/18/2024
AFC ENHANCED FORMULARY

Y0114_24_3005780_0000_I_C
H5594
1057181MUMENMUB

*Alternative drugs are drugs in the same therapeutic category/class or cost sharing tier as the affected drug. Only your health care provider can determine if the alternative(s) listed here is appropriate for you given the individualized nature of drug therapy.

**Please refer to the description of your plan for copay/coinsurance amounts.

***Prior Authorization (PA), Quantity Limits (QL), or Step Therapy (ST) restrictions may apply.

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
2/1/2024	TERIPARATIDE INJ 20MCG	Formulary Addition		Tier 4	PA; QL (3 per 28 days)
2/1/2024	TERIPARATIDE INJ 600MCG	Formulary Addition		Tier 4	PA; QL (3 per 28 days)
2/1/2024	VANFLYTA TAB 17.7MG	Formulary Addition		Tier 4	PA; QL (56 per 28 days)
2/1/2024	VANFLYTA TAB 26.5MG	Formulary Addition		Tier 4	PA; QL (56 per 28 days)
2/1/2024	ZEJULA 100 MG TAB	Formulary Addition		Tier 4	PA; QL (90 per 90 days)
2/1/2024	ZEJULA 200 MG TAB	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
2/1/2024	ZEJULA 300 MG TAB	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
2/1/2024	ZURZUVAE CAP 20MG	Formulary Addition		Tier 4	
2/1/2024	ZURZUVAE CAP 25MG	Formulary Addition		Tier 4	
2/1/2024	ZURZUVAE CAP 30MG	Formulary Addition		Tier 4	
2/1/2024	AVITA CREAM 0.025 %	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		

Last Updated: 3/18/2024
AFC ENHANCED FORMULARY

Y0114_24_3005780_0000_I_C
H5594
1057181MUMENMUB

*Alternative drugs are drugs in the same therapeutic category/class or cost sharing tier as the affected drug. Only your health care provider can determine if the alternative(s) listed here is appropriate for you given the individualized nature of drug therapy.

**Please refer to the description of your plan for copay/coinsurance amounts.

***Prior Authorization (PA), Quantity Limits (QL), or Step Therapy (ST) restrictions may apply.

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
2/1/2024	FLUTAMIDE CAP 125 MG	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
2/1/2024	ISOPTO ATROPINE SOLUTION 1% OPHTHALMIC	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
2/1/2024	LARISSIA TAB 0.1-20 MG-MCG	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
2/1/2024	LILLOW TAB 0.15-30 MG-MCG	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
2/1/2024	STAVUDINE CAP 15 MG	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
2/1/2024	STAVUDINE CAP 20 MG	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		

Last Updated: 3/18/2024
AFC ENHANCED FORMULARY

Y0114_24_3005780_0000_I_C
H5594
1057181MUMENMUB

*Alternative drugs are drugs in the same therapeutic category/class or cost sharing tier as the affected drug. Only your health care provider can determine if the alternative(s) listed here is appropriate for you given the individualized nature of drug therapy.

**Please refer to the description of your plan for copay/coinsurance amounts.

***Prior Authorization (PA), Quantity Limits (QL), or Step Therapy (ST) restrictions may apply.

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
2/1/2024	STAVUDINE CAP 30 MG	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
2/1/2024	STAVUDINE CAP 40 MG	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
2/1/2024	TEKTURNA HCT TAB 300-12.5 MG	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
2/1/2024	TEKTURNA HCT TAB 300-25 MG	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		

Last Updated: 3/18/2024
AFC ENHANCED FORMULARY

Y0114_24_3005780_0000_I_C
H5594
1057181MUMENMUB

*Alternative drugs are drugs in the same therapeutic category/class or cost sharing tier as the affected drug. Only your health care provider can determine if the alternative(s) listed here is appropriate for you given the individualized nature of drug therapy.

**Please refer to the description of your plan for copay/coinsurance amounts.

***Prior Authorization (PA), Quantity Limits (QL), or Step Therapy (ST) restrictions may apply.