

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-Form		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 days, NDS	Addition	08/01/2024
INGREZZA SPRINK	CAP	1 – Covered	PA, QL 30/30 days, NDS	Addition	08/01/2024
kionex	SUSP	1 – Covered		Addition	08/01/2024
LIBERVANT	FILM	1 – Covered	PA, QL 10/30 days, NDS	Addition	08/01/2024
RINVOQ LQ 1 MG/ML	SOLN	1 – Covered	PA, QL 360/30 days, NDS	Addition	08/01/2024
SCEMBLIX 100 MG	TAB	1 – Covered	PA, QL 120/30 days, NDS	Addition	08/01/2024
<i>timolol maleate ophth 0.5% (once-daily)</i>	SOLN	1 – Covered		Addition	08/01/2024
zomig 2.5 mg, 5 mg	TAB	1 – Covered	QL 9/30 days	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 days, NDS	Addition	09/01/2024
AUSTEDO XR PATIENT TITRATION THPK	TAB	1 – Covered	PA, QL 28/28 days, NDS	Addition	09/01/2024
ENTRESTO SPRINKLE	CAP	1 – Covered	QL 240/30 days	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 days, NDS	Addition	10/01/2024

LAZCLUZE 80 MG	TAB	1 – Covered	PA, QL 60/30 days, NDS	Addition	10/01/2024
LAZCLUZE 240 MG	TAB	1 – Covered	PA, QL 30/30 days, NDS	Addition	10/01/2024
RETEVMO 40 MG	TAB	1 – Covered	PA, QL 90/30 days, NDS	Addition	10/01/2024
RETEVMO 80 MG, 120 MG, 160 MG	TAB	1 – Covered	PA, QL 60/30 days, NDS	Addition	10/01/2024
VIGAFYDE 100 MG/ML	SOLN	1 – Covered	PA, QL 900/30 days, NDS	Addition	10/01/2024
VORANIGO 10 MG	TAB	1 – Covered	PA, QL 60/30 days, NDS	Addition	10/01/2024
VORANIGO 40 MG	TAB	1 – Covered	PA, QL 30/30 days, NDS	Addition	10/01/2024
Drug Name	Dosage Form	Drug Tier	Requirements / Limits	Formulary Change Type	Effective Date
dasatinib	TAB	1 – Covered	PA, NDS	Addition	11/01/2024
FIASP 100 UNIT/ML	SOLN	1 – Covered		Addition	11/01/2024
FIASP FLEXTOUCH 100 UNIT/ML PEN	SOLN	1 – Covered		Addition	11/01/2024
FIASP PENFILL 100 UNIT/ML CART	SOLN	1 – Covered		Addition	11/01/2024
FIASP PUMPCART 100 UNIT/ML CART	SOLN	1 – Covered		Addition	11/01/2024
INCRUSE ELLIPTA 62.5 MCG/ACT	INH	1 – Covered	QL 30/30 days	Addition	11/01/2024
NOVOLIN 70/30 (70-30) 100 UNIT/ML	SUSP	1 – Covered		Addition	11/01/2024
NOVOLIN 70/30 FLEXPEN (70-30) 100 UNIT/ML	SUSP	1 – Covered		Addition	11/01/2024
NOVOLIN N 100 UNIT/ML	SUSP	1 – Covered		Addition	11/01/2024
NOVOLIN N FLEXPEN 100 UNIT/ML PEN	SUSP	1 – Covered		Addition	11/01/2024
NOVOLIN R 100 UNIT/ML	SOLN	1 – Covered		Addition	11/01/2024
NOVOLIN R FLEXPEN 100 UNIT/ML PEN	SOLN	1 – Covered		Addition	11/01/2024
NOVOLOG 100 UNIT/ML	SOLN	1 – Covered		Addition	11/01/2024
NOVOLOG FLEXPEN 100 UNIT/ML PEN	SOLN	1 – Covered		Addition	11/01/2024
NOVOLOG MIX 70/30 (70-30) 100 UNIT/ML	SUSP	1 – Covered		Addition	11/01/2024
NOVOLOG MIX 70/30 FLEXPEN (70-30) 100 UNIT/ML	SUSP	1 – Covered		Addition	11/01/2024
NOVOLOG PENFILL 100 UNIT/ML CART	SOLN	1 – Covered		Addition	11/01/2024

wixela	INH	1 – Covered	QL 60/30 days	Addition	11/01/2024
Drug Name	Dosage Form	Drug Tier	Requirements / Limits	Formulary Change Type	Effective Date
COBENFY	CAP	1 – Covered	QL 60/30 days	Addition	12/01/2024
COBENFY STARTER PACK	CAP	1 – Covered	QL 56/28 days	Addition	12/01/2024
fentanyl citrate	LOZ	99 – Non-Form		Deletion	12/01/2024
ITOVEBI 3 MG	TAB	1 – Covered	PA, QL 60/30 days	Addition	12/01/2024
ITOVEBI 9 MG	TAB	1 – Covered	PA, 30/30 days	Addition	12/01/2024
lofexidine hcl 0.18 mg	TAB	1 – Covered	PA, QL 16/1 day	Addition	12/01/2024
OPVEE 2.7 MG/0.1ML	SOLN	1 – Covered		Addition	12/01/2024
TRUQAP THERAPY PACK	TAB	1 – Covered	PA	Addition	12/01/2024