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Re: Summary of Formulary Changes Effective APRIL 1, 2024

Dear Health Partner,

We are dedicated to partnering with you in the most effective way to manage our members' care. CareSource routinely reviews medications available on the Preferred Drug List (PDL). Medications are added, changed or removed periodically based on industry standard, market availability and/or usage. We encourage you to actively work with your CareSource patients in advance of the effective date above to ensure a smooth transition.

THE FOLLOWING MEDICATIONS WILL BE NON-PREFERRED ON THE PDL effective APRIL 1, 2024

Brand Name	Generic Name	Strength(s)	Notes if Applicable
Bimzelx autoinjector, syringe	BIMEKIZUMA B-BKZX	160 MG/ML	Quantity limit of 2mL per 28 days
Brenzavvy tablet	BEXAGLIFLO ZIN	20 MG	Also applicable to Inter-Pregnancy Care
Cabtreo gel	ADAPALENE/ BENZOYL/CLINDAMYCIN	0.15%-3.1%	
Entyvio pen	VEDOLIZUMA B	108 MG/0.68 ML	Added to Pharmacy benefit; Quantity limit of 2 pens per 28 days
Lodoco tablet	COLCHICINE	0.5 MG	
Omvoh pen, vial	MIRIKIZUMAB -MRKZ	ALL	Coverage on both: Pharmacy benefit - Non-Preferred; Quantity limit of 2mL per 28 days; Medical Benefit - Medical Benefit with Medical Necessity Review
Sohonos capsule	PALOVAROT ENE	ALL	
Velsipity tablet	ETRASIMOD ARGININE	2 MG	Quantity limit of 1 tablet per day

Xalkori capsule, pellet	CRIZOTINIB	ALL	Quantity limit of 4 capsules per day and 8 pellets per day
Zurzuvae capsule	ZURANOLON E	ALL	Quantity Limit of 28 capsules per 14 days

We will provide a list of CareSource patients who are taking any medication above upon your request. Please email your request to PharmacyConversionProgram@CareSource.com. In your request, include the medication names and your secure fax number. We will fax you a list of patients who have been prescribed these medications.

THE FOLLOWING MEDICATIONS WILL BE PREFERRED ON THE PDL effective APRIL 1, 2024

Brand Name	Generic Name	Strength(s)	Notes if Applicable
Austedo XR tablet/titration pack	DEUTETRABENAZINE	ALL	Prior Authorization is required
Dexcom G7	CONTINUOUS GLUCOSE MONITOR	N/A	Took effect 1/1/2024

THE FOLLOWING MEDICATIONS HAVE A CHANGE IN STATUS effective APRIL 1, 2024

Brand Name	Generic Name	Strength(s)	Notes if Applicable
Breo Ellipta blister	FLUTICASONE/VILANTEROL	ALL	Quantity limit of 2 blisters per day; Not applicable to Inter-Pregnancy Care or Family Planning
Brixadi solution, extended release syringe	BUPRENORPHINE	ALL	Quantity limit of 32 mg per week or 128 mg per month
Cablivi kit	CAPLACIZUMAB-YHDP	11 MG	Quantity limit of 1 vial per day
Cosentyx vial	SECUKINUMAB	125 MG/5ML	Medical Benefit with Medical Necessity Review
Cystaran drops, Cystadrops	CYSTEAMINE HCL	0.44 %	Quantity limit of 4 bottles per 28 days

Brand Name	Generic Name	Strength(s)	Notes if Applicable
Daxxify vial	DAXIBOTULINUMTOXINA-LANM	100 UNITS	Medical Benefit with Medical Necessity Review; *Prior authorization is required for medical benefit code: C9160 *Took effect 1/1/2024
Dexcom G7 Sensor, Reader	CONTINUOUS GLUCOSE MONITOR	N/A	Quantity limit of 3 Sensors per month & 1 Reader per 720 days: Took effect 1/19/2024
Dysport vial	ABOBOTULINUMTOXINA	ALL	Prior authorization is required for medical benefit code: J0586
Enspryng syringe	SATRALIZUMAB-MWGE	120 MG/ML	Quantity limit of 1 syringe per 28 days
Eylea vial	AFLIBERCEPT	2MG/0.05ML	*Prior authorization is required for medical benefit code: J0178
Eylea HD vial	AFLIBERCEPT	8MG/0.07ML	*Prior authorization is required for medical benefit code: C9161 *Took effect 1/1/2024
Feraheme vial	FERUMOXYTOL	ALL	Prior authorization is required for medical benefit code: Q0138

Brand Name	Generic Name	Strength(s)	Notes if Applicable
Gamifant vial	EMAPALUMAB-LZSG	ALL	Prior authorization is required for medical benefit code: J9210
Ibsrela tablet	TENAPANOR HCL	50 MG	Quantity limit of 2 tablets per day
Ingrezza capsule	VALBENAZINE TOSYLATE	ALL	Quantity limit of 1 capsule per day
Inpefa tablet	SOTAGLIFLOZIN	ALL	Quantity limit of 1 tablet per day
Injectafer vial	FERRIC CARBOXYMALTOSSE	ALL	Prior authorization is required for medical benefit code: J1439
Izervay vial	AVACINCAPTAD PEGOL SODIUM/PF	2 MG/0.1 ML	Medical benefit with medical necessity review; *Prior authorization is required for medical benefit code: C9162 *Took effect 1/1/2024
Jardiance tablet	EMPAGLIFLOZIN	ALL	Quantity limit of 1 tablet per day
Koselugo capsule	SELUMETINIB/VITAMIN E TPGS	ALL	Quantity limit for 10mg: 8 capsules per day & for 25mg: 4 capsules per day
Linzess capsule	LINACLOTIDE	ALL	Quantity limit of 1 capsule per day
Litfulo capsule	RITLECITINIB TOSYLATE	50 MG	Quantity limit of 1 capsule per
Miebo drops	PERFLUOROHEXYLOCTANE/PF	100 %	Quantity limit of 1 bottle (5 mL) per 12 days
Motegrity tablet	PRUCALOPRIDE SUCCINATE	ALL	Quantity limit of 1 tablet per day

Brand Name	Generic Name	Strength(s)	Notes if Applicable
Myalept vial	SOMATROPIN	5 MG/ML	Quantity limit of 1 vial per day
Myobloc vial	RIMABOTULINUMTOXINB	ALL	Prior authorization is required for medical benefit code: J0587
Nucala vial	MEPOLIZUMAB	100 MG	Prior authorization is required for medical benefit code: J2182
Ocaliva tablet	OBETICHOLIC ACID	ALL	Quantity limit of 2 tablets per day
Olumiant tablet	BARICITINIB	ALL	Quantity limit of 1 tablet per day
Opfolda capsule	MIGLUSTAT	65 MG	Medical benefit with medical necessity review
Oxlumo vial	LUMASIRAN SODIUM	94.5MG/0.5ML	Prior authorization is required for medical benefit code: J0224
Ozurdex implant	DEXAMETHASONE	0.7 MG	Prior authorization is required for medical benefit code: J7312
Pombiliti vial	CIPAGLUCOSIDASE ALFA-ATGA	105 MG	Medical benefit with medical necessity review
Prevymis tablet, vial	LETERMOVIR	ALL	Quantity limit of 28 tablets or 28 vials per 28 days
Retisert implant	FLUOCINOLONE ACETONIDE	0.59 MG	Prior authorization is required for medical benefit code: J7311
Rexulti tablet	BREXPIPIRAZOLE	ALL	Quantity limit of 1 tablet per day

Brand Name	Generic Name	Strength(s)	Notes if Applicable
Rivfloza syringe, vial	NEDOSIRAN SODIUM	ALL	Quantity limit of 1 syringe/vial per day
Serostim vial	SOMATROPIN	ALL	Quantity limit of 1 vial per day
Trulance tablet	PLECANATIDE	3 MG	Quantity limit of 1 tablet per day
Tysabri vial	NATALIZUMAB	N/A	Prior authorization is required for medical benefit code: J2323
Vegzelma vial	BEVACIZUMAB-ADCD	25 MG/ML	Prior authorization is required for medical benefit code: Q5129
Veopoz vial	POZELIMAB-BBFG	400 MG/2ML	Medical Benefit with Medical Necessity Review
Veozah tablet	FEZOLINETANT	45 MG	Quantity limit of 1 tablet per day
Voxzogo vial	VOSORITIDE	ALL	Quantity limit of 1 vial per day
Xdemvy drops	LOTILANER	0.25 %	Quantity limit of 1 bottle per 6 weeks
Xenazine tablet	TETRABENAZINE	ALL	Quantity limit of 4 tablets per day
Xeomin vial	INCOBOTULINUMTOXINA	ALL	Prior authorization is required for medical benefit code: J0588

What you should know

We know patient care is of the utmost importance to you. We are notifying our members of this change to help ensure their treatment plan is maintained. We have asked our members to contact their prescriber if they have questions.

Additional Resources

For the most up-to-date information, please utilize the [formulary search tools](#) online. To access the complete formulary, visit the Provider Pharmacy pages at CareSource.com. You may find your patient's plan formulary by clicking on:

- Your patient's CareSource plan
- Tools & Resources
- Drug Formulary

We recognize each patient is unique and we appreciate your partnership in making this a successful transition. We are here to help you with any questions. Call the CareSource Pharmacy Services Department at **1-855-202-1058**. The Department is open Monday through Friday, 7 a.m. to 7 p.m.

Thank you for being a CareSource health partner.

GA-P-0216a-V.24

DCH Approved: 02/21/2019