P.O. Box 8738, Dayton, OH 45401-8738 | www.CareSource.com

Re: Summary of Formulary Changes Effective January 1, 2023

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). 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 JANUARY 1, 2023.

Brand Name	Generic Name	Strength(s)	Notes if Applicable
Arcapta Neohaler Capsule	Indacaterol Maleate	75 mcg	No longer made
Blephamide Eye Drops	Sulfacetamide-Prednisolone	10%-0.2%	No longer made

- 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 JANUARY 1, 2023.

Brand Name	Generic Name	Strength(s)	Notes if Applicable
Adlarity Weekly Patch	Donepezil HCL	5 mg/day, 10 mg/day	Preferred without prior authorization for members 18 and older. Quantity limit applies
Aimovig Autoinjector	Erenumab-aooe	70 mg/mL, 140 mg/mL	Preferred with prior authorization required
Auvelity ER Tablet	Dextromethorphan HBR- Bupropion	45-105 mg	Preferred without prior authorization for members 18 and older. Quantity limit applies
Caya Contoured Diaphragm			Preferred without prior authorization. Quantity limit applies

Brand Name	Generic Name	Strength(s)	Notes if Applicable
Femcap Cervical Cap		22 mm, 26 mm, 30 mm	Preferred without prior authorization. Quantity limit applies
Firazyr Syringe	Icatibant acetate	30 mg/3 mL	Now accepted on pharmacy benefit. Generic Icatibant preferred with prior authorization required
Haegarda Vial	C1 Esterase Inhibitor	2,000 unit, 3,000 unit	Now accepted on pharmacy benefit. Preferred with prior authorization required
Quetiapine Tablet	Quetiapine Fumarate	150 mg	Preferred without prior authorization. Quantity limit applies
Relexxii ER Tablet	Methylphenidate HCL	18 mg, 27 mg, 36 mg, 45 mg, 54 mg, 63 mg	Preferred without prior authorization for members 6 – 18 years old. Quantity limit applies
Venlafaxine Besylate ER Tablet	Venlafaxine Besylate	112.5 mg	Preferred without prior authorization. Quantity limit applies
Xelstrym Patch	Dextroamphetamine	4.5 mg/9 hr, 9 mg/9 hr, 13.5 mg/9 hr, 18 mg/9 hr	Preferred without prior authorization for members 6 – 18 years old. Quantity limit applies

THE FOLLOWING MEDICATIONS HAVE A CHANGE IN STATUS EFFECTIVE JANUARY 1, 2023.

Brand Name	Generic Name	Strength(s)	Notes if Applicable
Berinert Kit	C1 Esterase Inhibitor	500 unit	Now accepted on pharmacy benefit. Prior authorization required
Bicillin L-A Syringe	Penicillin G Benzathine	600,000 unit, 1,200,000 unit, 2,400,000 unit	Now accepted on pharmacy benefit
Cinryze Vial	C1 Esterase Inhibitor	500 unit	Now accepted on pharmacy benefit. Prior authorization required
Gralise ER Tablet, Horizant ER Tablet, Neurontin Capsule/Tablet	Gabapentin, Gabapentin Enacarbil	All	Quantity limit of 3,600 mg per day added across all gabapentin products

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Brand Name	Generic Name	Strength(s)	Notes if Applicable
Hetlioz Capsule, LQ Suspension	Tasimelteon	20 mg, 4 mg/mL	Prior authorization required for all ages. Quantity limit applies
Kalbitor Vial	Ecallantide	10 mg/mL	Now accepted on pharmacy benefit. Prior authorization required
Mayzent Tablet	Siponimod	1 mg	Quantity limit of 1 tablet per day added
Nesina Tablet	Alogliptin	6.25 mg, 12.5 mg, 25 mg	Quantity limit of 1 tablet per day added
Paxil CR Tablet	Paroxetine ER	37.5 mg	Quantity limit updated to 2 tablets per day
Ruconest Vial	C1 Esterase Inhibitor	2,100 unit	Now accepted on pharmacy benefit. Prior authorization required
Sajazir Syringe	Icatibant acetate	30 mg/3 mL	Now accepted on pharmacy benefit. Prior authorization required
Takhzyro Syringe, Vial	Lanadelumab-flyo	300 mg/2 mL	Now accepted on pharmacy benefit. Prior authorization required
Vascepa Capsule	Icosapent Ethyl	0.5 gram, 1 gram	Quantity limit of 4 capsules per day added
Xywav Solution	Calcium, Magnesium, Potassium, Sodium Oxybates	0.5 gram/mL	Prior authorization required for all ages. Quantity limit applies
Zenzedi Tablet	Dextroamphetamine Sulfate	2.5 mg, 5 mg, 15 mg	Quantity limit updated to 2 tablets per day

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 RX Innovations Department at **1-844-607-2831**. The Department is open Monday through Friday, 8 a.m. to 5 p.m. Thank you for being a CareSource health partner.

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