



**Re: Summary of Formulary Changes Effective January 1, 2024**

Dear CareSource Member:

Your Formulary is an important part of your Prescription Drug Benefit because it shows what drugs may be covered for you, what limits may apply, and what tier drugs are in. A committee of health care providers, like doctors and pharmacists, decide what will be included on your Formulary. This is called the Pharmacy and Therapeutics (P&T) Committee.

The P&T Committee looks at your Formulary regularly to make sure it is up to date. The P&T Committee met recently to update the Formulary. Please review the tables below to see how the Formulary is changing.

**Drugs in this table will be added to your Formulary effective January 1, 2024:**

| DRUG NAME                                    | FORMULARY TIER | COVERAGE LIMITS |
|--|----------------|-----------------|
| ADCIRCA                                      | 4              | PA, QL          |
| ADEMPAS                                      | 4              | PA, QL          |
| BELSOMRA                                     | 3              | PA, QL          |
| FLUTICASONE-VILANTEROL                       | 2              |                 |
| DUAVEE                                       | 3              | PA, QL          |
| FANAPT                                       | 3              | PA, QL          |
| FLUTICASONE PROPIONATE HFA                   | 1              |                 |
| FLURAZEPAM                                   | 1              |                 |
| FORMOTEROL                                   | 1              | QL              |
| GYANZOLE-1                                   | 3              | PA              |
| HADLIMA, ADALIMUMAB-ADAZ,<br>ADALIMUMAB-FKJP | 4              | PA              |
| LURASIDONE                                   | 1              | QL              |
| MOTOFEN                                      | 3              | PA, AR, QL      |
| NALOXONE NASAL OTC                           | 1              | QL              |
| OMNIPOD 5 & OMNIPOD DASH                     | 2              | PA              |
| OPVEE  | 2              | QL              |
| OSPHENA                                      | 3              | PA, QL          |
| OTC – LASTACAFT ONCE DAILY                   | 3              | PA              |
| OZEMPIC                                      | 2              | PA              |
| PRIFTIN                                      | 3              |                 |
| REZVOGLAR                                    | 2              | QL              |

|            |   |        |
|------------|---|--------|
| RUFINAMIDE | 1 | PA     |
| VELPHORO   | 3 | PA, QL |
| VERZENIO   | 4 | PA, QL |
| ZEPATIER   | 4 | PA, QL |

**Drugs in this table will be removed from your Formulary effective January 1, 2024:**

| DRUG NAME    | NOTES   |
|--------------|---|
| AMJEVITA     | Non-Formulary medical necessity review required                       |
| AUBAGIO      | Non-Formulary medical necessity review required                       |
| BREO ELLIPTA | Trial of fluticasone-salmeterol (Advair, Airduo) and Dulera required. |
| FLOVENT HFA  | Non-Formulary medical necessity review required; Moved to Tier 3      |
| GILENYA      | Non-Formulary medical necessity review required                       |

**Drugs in this table have had a change in how they are covered. This could include a change in their Formulary tier and/or adding or removing a coverage limit. The details are shown below.**

| DRUG NAME              | COVERAGE CHANGE   |
|------------------------|---|
| AIRSUPRA               | Trial of AG/generic Symbicort required.   |
| AVASTIN BIOSIMILARS    | AlymSYS and Vegzelma are non-preferred.   |
| BYLVAY                 | Trial of Livmarli required for ALGS (Alagille syndrome associated cholestatic pruritus) indication. |
| DALVANCE               | Billed to medical benefit. Prior authorization not required with diagnosis check.                   |
| DIMETHYL FUMARATE      | Changed from Tier 4 to Tier 1.  |
| GLASSIA                | Pharmacy benefit coverage added.  |
| GRALISE AND LYRICA CR  | Quantity limits added.  |
| LITFULO                | Conventional therapy trial required.  |
| OLUMIANT               | Trial of Litfulo required for Alopecia Areata (AA) indication.                                      |
| SOFOSBUVIR-VELPATASVIR | Changed from Tier 4 to Tier 1.  |

|           |   |
|-----------|---|
| SOLIRIS   | Trial of IV Vyvgart and Ultomiris required for new starts with gMG (Generalized Myasthenia Gravis). |
| ULTOMIRIS | Trial of IV Vyvgart required for new starts with gMG (Generalized Myasthenia Gravis).               |

Please talk to your provider or pharmacist about these changes. They can help you get a new prescription if needed. A new prescription may or may not be the best choice for you. If not, you or your provider can request an exception. You can find the request form on CareSource.com on the Drug Formulary page. Your provider can also submit a request electronically or by faxing it to 1-866-930-0019.

If you or your provider have any questions, please contact Member Services at the number on your ID card.

Sincerely,

CareSource RxInnovations

**You and your provider can find the full Formulary and other information on the Drug Formulary page on CareSource.com.**

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