

# FREEDOM HEALTH

## Formulary Changes- December 2022

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
12/1/2022	IMBRUVICA 70 MG/ML SUSPENSION	Formulary Addition		Tier 4	PA; QL (216 per 27 days)
12/1/2022	JAVYGTOR 500 MG PACKET	Formulary Addition		Tier 4	PA
12/1/2022	KETOPROFEN 50 MG CAP	Formulary Addition		Tier 1	
12/1/2022	TAZAROTENE 0.05 % GEL	Formulary Addition		Tier 3	PA
12/1/2022	TAZAROTENE 0.1 % GEL	Formulary Addition		Tier 3	PA
12/1/2022	VENLAFAXINE BESYLATE ER 112.5 MG TAB ER 24H	Formulary Addition		Tier 3	
12/1/2022	CAZIAN 0.1/0.125/0.15 -0.025 MG TAB	Deletion – No longer covered under Medicare Part D	VELIVET 0.1/0.125/0.15 - 0.025 MG TAB	Tier 1	
12/1/2022	TEKTURNA HCT 150-25 MG TAB	Deletion – No longer covered under Medicare Part D	Please talk to your health care provider about an alternative that may be right for you		

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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.

# FREEDOM HEALTH

## Formulary Changes- November 2022

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
11/1/2022	JAVYGTOR 100 MG TAB	Formulary Addition		Tier 4	PA
11/1/2022	LENALIDOMIDE 2.5 MG CAP	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
11/1/2022	LENALIDOMIDE 20 MG CAP	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
11/1/2022	MEGESTROL ACETATE 800 MG/20ML SUSPENSION	Formulary Addition		Tier 2	PA
11/1/2022	MORPHINE SULFATE (CONCENTRATE) 10 MG/0.5ML SOLUTION	Formulary Addition		Tier 1	QL (180 per 30 days)
11/1/2022	ORKAMBI 75-94 MG PACKET	Formulary Addition		Tier 4	PA; QL (60 per 30 days)
11/1/2022	PENTACEL RECON SUSP	Formulary Addition		Tier 3	
11/1/2022	PIRFENIDONE 534 MG TAB	Formulary Addition		Tier 4	PA; QL (90 per 30 days)
11/1/2022	QUADRACEL 0.5 ML SUSP PRSYR	Formulary Addition		Tier 3	
11/1/2022	QUETIAPINE FUMARATE 150 MG TAB	Formulary Addition		Tier 1	QL (90 per 30 days)
11/1/2022	SKYRIZI 360 MG/2.4ML SOLN CART	Formulary Addition		Tier 4	PA; QL (2.4 per 56 days)

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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***
11/1/2022	SKYRIZI 600 MG/10ML SOLUTION	Formulary Addition		Tier 4	PA; QL (10 per 28 days)
11/1/2022	ZTALMY 50 MG/ML SUSPENSION	Formulary Addition		Tier 4	QL (1100 per 30 days)
11/1/2022	PEPAXTO 20 MG RECON SOLN	Deletion – No longer covered under Medicare Part D	Please talk to your health care provider about an alternative that may be right for you		

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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.

# FREEDOM HEALTH

## Formulary Changes- October 2022

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
10/1/2022	CAPLYTA 10.5 MG CAP	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
10/1/2022	CAPLYTA 21 MG CAP	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
10/1/2022	CIMETIDINE HCL 400 MG/6.67ML SOLUTION	Formulary Addition		Tier 1	
10/1/2022	JAVYGTOR 100 MG PACKET	Formulary Addition		Tier 4	PA
10/1/2022	NURTEC 75 MG TAB DISP	Formulary Addition		Tier 4	PA; QL (16 per 30 days)
10/1/2022	OLANZAPINE-FLUOXETINE HCL 12-25 MG CAP	Formulary Addition		Tier 3	QL (30 per 30 days)
10/1/2022	OLANZAPINE-FLUOXETINE HCL 12-50 MG CAP	Formulary Addition		Tier 3	QL (30 per 30 days)
10/1/2022	OLANZAPINE-FLUOXETINE HCL 3-25 MG CAP	Formulary Addition		Tier 3	QL (90 per 30 days)
10/1/2022	OLANZAPINE-FLUOXETINE HCL 6-25 MG CAP	Formulary Addition		Tier 3	QL (90 per 30 days)
10/1/2022	OLANZAPINE-FLUOXETINE HCL 6-50 MG CAP	Formulary Addition		Tier 3	QL (30 per 30 days)
10/1/2022	PIPERACILLIN SOD-TAZOBACTAM SO 3-0.375 GM RECON SOLN	Formulary Addition		Tier 3	
10/1/2022	PRIORIX RECON SUSP	Formulary Addition		Tier 3	

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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.

# FREEDOM HEALTH

## Formulary Changes- September 2022

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
9/1/2022	BEXAROTENE 1 % GEL	Formulary Addition		Tier 4	PA; QL (60 per 30 days)
9/1/2022	DABIGATRAN ETEXILATE MESYLATE 150 MG CAP	Formulary Addition		Tier 3	QL (60 per 30 days)
9/1/2022	DABIGATRAN ETEXILATE MESYLATE 75 MG CAP	Formulary Addition		Tier 3	QL (60 per 30 days)
9/1/2022	LACOSAMIDE 10 MG/ML SOLUTION	Formulary Addition		Tier 3	QL (1200 per 30 days)
9/1/2022	NUCALA 40 MG/0.4ML SOLN PRSYR	Formulary Addition		Tier 4	PA
9/1/2022	PEMETREXED DISODIUM 100 MG RECON SOLN	Formulary Addition		Tier 4	PA
9/1/2022	PEMETREXED DISODIUM 1000 MG RECON SOLN	Formulary Addition		Tier 4	PA
9/1/2022	PEMETREXED DISODIUM 500 MG RECON SOLN	Formulary Addition		Tier 4	PA
9/1/2022	PEMETREXED DISODIUM 750 MG RECON SOLN	Formulary Addition		Tier 4	PA
9/1/2022	SORAFENIB TOSYLATE 200 MG TAB	Formulary Addition		Tier 4	PA; QL (120 per 30 days)
9/1/2022	TICOVAC 1.2 MCG/0.25ML SUSP PRSYR	Formulary Addition		Tier 2	
9/1/2022	TRIZIVIR 300-150-300 MG TAB	Formulary Addition		Tier 4	QL (60 per 30 days)
9/1/2022	VILAZODONE HCL 10 MG TAB	Formulary Addition		Tier 3	QL (30 per 30 days)

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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***
9/1/2022	VILAZODONE HCL 20 MG TAB	Formulary Addition		Tier 3	QL (30 per 30 days)
9/1/2022	VILAZODONE HCL 40 MG TAB	Formulary Addition		Tier 3	QL (30 per 30 days)
9/1/2022	VONJO 100 MG CAP	Formulary Addition		Tier 4	PA; QL (120 per 30 days)
9/1/2022	APTIVUS 100 MG/ML SOLUTION	Deletion – No longer covered under Medicare Part D	Please talk to your health care provider about an alternative that may be right for you		
9/1/2022	BLEPHAMIDE 10-0.2 % SUSPENSION	Deletion – No longer covered under Medicare Part D	Please talk to your health care provider about an alternative that may be right for you		
9/1/2022	OKEBO 75 MG CAP	Deletion - Manufacturer Discontinuation	DOXYCYCLINE MONOHYDRATE CAP	Tier 1	
9/1/2022	PREVIFEM 0.25-35 MG-MCG TAB	Deletion – No longer covered under Medicare Part D	NORGESTIMATE/ETHINYL ESTRADIOL TAB	Tier 1	
9/1/2022	TULANA 0.35 MG TAB	Deletion – No longer covered under Medicare Part D	NORETHINDRONE TAB	Tier 1	
9/1/2022	UKONIQ 200 MG TAB	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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.

# FREEDOM HEALTH

## Formulary Changes- July 2022

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
7/1/2022	LACOSAMIDE 100 MG TAB	Formulary Addition		Tier 3	QL (60 per 30 days)
7/1/2022	LACOSAMIDE 150 MG TAB	Formulary Addition		Tier 3	QL (60 per 30 days)
7/1/2022	LACOSAMIDE 200 MG TAB	Formulary Addition		Tier 3	QL (60 per 30 days)
7/1/2022	PIRFENIDONE 267 MG TAB	Formulary Addition		Tier 4	PA; QL (270 per 30 days)
7/1/2022	PIRFENIDONE 801 MG TAB	Formulary Addition		Tier 4	PA; QL (90 per 30 days)
7/1/2022	VARENICLINE TARTRATE 0.5 MG X 11 & 1 MG X 42 MISC	Formulary Addition		Tier 3	PA
7/1/2022	ZOLEDRONIC ACID 4 MG/5ML CONC	Formulary Addition		Tier 2	PA
7/1/2022	ZOLEDRONIC ACID 5 MG/100ML SOLUTION	Formulary Addition		Tier 2	PA
7/1/2022	NOVOLIN N FLEXPEN RELION 100 UNIT/ML SUSP PEN	Tier Change		Tier 1	
7/1/2022	CORTISONE ACETATE 25 MG TAB	Deletion - No longer covered under Medicare Part D	Please talk to your health care provider about an alternative that may be right for you		
7/1/2022	PAROEX 0.12 % SOLUTION	Deletion - No longer covered under Medicare Part D	CHLORHEXIDINE GLUCONATE	Tier 1	

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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.

# FREEDOM HEALTH

## Formulary Changes- June 2022

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
06/01/22	CEFAZOLIN SODIUM 2 GM RECON SOLN	Formulary Addition		Tier 3	
06/01/22	NOVOLIN 70/30 FLEXPEN (70-30) 100 UNIT/ML SUSP PEN	Formulary Addition		Tier 1	
06/01/22	OZEMPIC (2 MG/DOSE) 8 MG/3ML SOLN PEN	Formulary Addition		Tier 2	
06/01/22	PIPERACILLIN SOD-TAZOBACTAM SO 4-0.5 GM RECON SOLN	Formulary Addition		Tier 3	
06/01/22	TRIUMEQ PD 60-5-30 MG TAB SOL	Formulary Addition		Tier 4	QL (180 per 30 days)
06/01/22	VANCOMYCIN HCL 750 MG RECON SOLN	PA change		Tier 2	
06/01/22	DECADRON 0.5 MG TAB	Deletion – Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
06/01/22	DECADRON 0.75 MG TAB	Deletion – Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
06/01/22	DECADRON 4 MG TAB	Deletion – Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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.



<b>Effective Date</b>	<b>Drug Name</b>	<b>Reason</b>	<b>Alternative Drug*</b>	<b>Drug Copay**</b>	<b>Restrictions***</b>
06/01/22	DECADRON 6 MG TAB	Deletion – Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
06/01/22	FARYDAK CAP	Deletion – Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
06/01/22	KETOPROFEN 75 MG CAP	Deletion – Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
06/01/22	TRI-PREVIFEM 0.18/0.215/0.25 MG-35 MCG TAB	Deletion – Manufacturer Discontinuation	NORGESTIMATE/ETHINYL ESTRADIOL TABLET	Tier 1	

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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.

# FREEDOM HEALTH

## Formulary Changes- May 2022

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
05/01/22	AMPHOTERICIN B LIPOSOME 50 MG RECON SUSP	Formulary Addition		Tier 4	PA
05/01/22	APOMORPHINE HCL 30 MG/3ML SOLN CART	Formulary Addition		Tier 4	PA; QL (60 per 30 days)
05/01/22	BETAINE POWDER	Formulary Addition		Tier 4	
05/01/22	BREZTRI AEROSPHERE 160-9-4.8 MCG/ACT AEROSOL	Formulary Addition		Tier 2	QL (10.7 per 30 days)
05/01/22	CYCLOSPORINE 0.05 % EMULSION	Formulary Addition		Tier 3	QL (60 per 30 days)
05/01/22	DEFERIPRONE 1000 MG TAB	Formulary Addition		Tier 4	PA
05/01/22	DESCOVY 120-15 MG TAB	Formulary Addition		Tier 4	QL (30 per 30 days)
05/01/22	DEXTROSE-SODIUM CHLORIDE 5-0.225 % SOLUTION	Formulary Addition		Tier 2	
05/01/22	ERYTHROMYCIN LACTOBIONATE 500 MG RECON SOLN	Formulary Addition		Tier 3	
05/01/22	INSULIN GLARGINE-YFGN 100 UNIT/ML SOLN PEN	Formulary Addition		Tier 3	
05/01/22	INSULIN GLARGINE-YFGN 100 UNIT/ML SOLUTION	Formulary Addition		Tier 3	
05/01/22	LACOSAMIDE 100 MG TAB	Formulary Addition		Tier 4	QL (60 per 30 days)
05/01/22	LACOSAMIDE 150 MG TAB	Formulary Addition		Tier 4	QL (60 per 30 days)

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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***
05/01/22	LACOSAMIDE 200 MG TAB	Formulary Addition		Tier 4	QL (60 per 30 days)
05/01/22	LACOSAMIDE 50 MG TAB	Formulary Addition		Tier 3	QL (60 per 30 days)
05/01/22	LENALIDOMIDE 10 MG CAP	Formulary Addition		Tier 4	PA; QL (60 per 30 days)
05/01/22	LENALIDOMIDE 15 MG CAP	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
05/01/22	LENALIDOMIDE 25 MG CAP	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
05/01/22	LENALIDOMIDE 5 MG CAP	Formulary Addition		Tier 4	PA; QL (150 per 30 days)
05/01/22	MAVYRET 50-20 MG PACKET	Formulary Addition		Tier 4	PA; QL (180 per 30 days)
05/01/22	RINVOQ 45 MG TAB ER 24H	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
05/01/22	SOAANZ 40 MG TAB	Formulary Addition		Tier 1	
05/01/22	SOAANZ 60 MG TAB	Formulary Addition		Tier 1	
05/01/22	TICOVAC 2.4 MCG/0.5ML SUSP PRSYR	Formulary Addition		Tier 2	
05/01/22	TYPHIM VI 25 MCG/0.5ML SOLN PRSYR	Formulary Addition		Tier 2	
05/01/22	VITAMIN D (ERGOCALCIFEROL) 50000 UNIT CAP	Formulary Addition		Tier 1	QL (4 per 30 days)
05/01/22	FARXIGA 10 MG TAB	Tier Change		Tier 5	QL (30 per 30 days)

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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***
05/01/22	FARXIGA 5 MG TAB	Tier Change		Tier 5	QL (30 per 30 days)

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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.

# FREEDOM HEALTH

## Formulary Changes- April 2022

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
04/01/22	CARBIDOPA-LEVODOPA- ENTACAPONE 18.75-200-75 MG TAB	Formulary Addition		Tier 2	
04/01/22	HUMIRA PEN 80 MG/0.8ML PEN KIT	Formulary Addition		Tier 4	PA; QL (6 per 84 days)
04/01/22	INSULIN LISPRO JUNIOR KWIKPEN 100 UNIT/ML SOLN PEN	Formulary Addition		Tier 5	
04/01/22	LANREOTIDE ACETATE 120 MG/0.5ML SOLUTION	Formulary Addition		Tier 4	PA
04/01/22	MARAVIROC 150 MG TAB	Formulary Addition		Tier 4	QL (120 per 30 days)
04/01/22	MARAVIROC 300 MG TAB	Formulary Addition		Tier 4	QL (120 per 30 days)
04/01/22	PROCRIT 10000 UNIT/ML SOLUTION	Formulary Addition		Tier 2	PA
04/01/22	PROCRIT 2000 UNIT/ML SOLUTION	Formulary Addition		Tier 2	PA
04/01/22	PROCRIT 20000 UNIT/ML SOLUTION	Formulary Addition		Tier 2	PA
04/01/22	PROCRIT 3000 UNIT/ML SOLUTION	Formulary Addition		Tier 2	PA
04/01/22	PROCRIT 4000 UNIT/ML SOLUTION	Formulary Addition		Tier 2	PA
04/01/22	PROCRIT 40000 UNIT/ML SOLUTION	Formulary Addition		Tier 2	PA
04/01/22	SKYRIZI PEN 150 MG/ML SOLN A-INJ	Formulary Addition		Tier 4	PA; QL (6 per 365 days)
04/01/22	TALZENNA 0.5 MG CAP	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
04/01/22	TALZENNA 0.75 MG CAP	Formulary Addition		Tier 4	PA; QL (30 per 30 days)

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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***
04/01/22	BEKYREE 0.15-0.02/0.01 MG (21/5) TAB	No longer covered under Part D	DESOGESTREL-ETHINYL ESTRADIOL 0.15-0.02/0.01 MG (21/5) TAB		
04/01/22	FREAMINE HBC 6.9 % SOLUTION	No longer covered under Part D	Please talk to your health care provider about an alternative that may be right for you		
04/01/22	PHENADOZ 25 MG SUPPOS	No longer covered under Part D	Please talk to your health care provider about an alternative that may be right for you		

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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.

# FREEDOM HEALTH

## Formulary Changes- March 2022

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
03/01/2022	BESREMI 500 MCG/ML SOLN PRSYR	Formulary Addition		Tier 4	PA
03/01/2022	EPRONTIA 25 MG/ML SOLUTION	Formulary Addition		Tier 3	
03/01/2022	EVEROLIMUS 1 MG TAB	Formulary Addition		Tier 4	B/D PA
03/01/2022	EXKIVITY 40 MG CAP	Formulary Addition		Tier 4	PA; QL (120 per 30 days)
03/01/2022	MICROGESTIN 24 FE 1-20 MG-MCG TAB	Formulary Addition		Tier 1	
03/01/2022	NALOXONE HCL 4 MG/0.1ML LIQUID	Formulary Addition		Tier 3	
03/01/2022	NYLIA 1/35 1-35 MG-MCG TAB	Formulary Addition		Tier 1	
03/01/2022	SCSEMBLIX 20 MG TAB	Formulary Addition		Tier 4	PA; QL (60 per 30 days)
03/01/2022	SCSEMBLIX 40 MG TAB	Formulary Addition		Tier 4	PA; QL (300 per 30 days)
03/01/2022	DEXPAK 10 DAY 1.5 MG (35) TAB THPK	Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
03/01/2022	DEXPAK 13 DAY 1.5 MG (51) TAB THPK	Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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.

<b>Effective Date</b>	<b>Drug Name</b>	<b>Reason</b>	<b>Alternative Drug*</b>	<b>Drug Copay**</b>	<b>Restrictions***</b>
03/01/2022	DEXPAK 6 DAY 1.5 MG (21) TAB THPK	Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
03/01/2022	KETOPROFEN 50 MG CAP	Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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.



# FREEDOM HEALTH

## Formulary Changes - February 2022

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions** *
02/01/2022	AZATHIOPRINE 100 MG TAB	Formulary Addition		Tier 2	PA
02/01/2022	AZATHIOPRINE 75 MG TAB	Formulary Addition		Tier 2	PA
02/01/2022	COSENTYX 75 MG/0.5ML SOLN PRSYR	Formulary Addition		Tier 4	PA QL
02/01/2022	DIFLUPREDNATE 0.05 % EMULSION	Formulary Addition		Tier 3	
02/01/2022	EVEROLIMUS 10 MG TAB	Formulary Addition		Tier 4	PA
02/01/2022	EVEROLIMUS 2 MG TAB SOL	Formulary Addition		Tier 4	PA
02/01/2022	EVEROLIMUS 3 MG TAB SOL	Formulary Addition		Tier 4	PA
02/01/2022	EVEROLIMUS 5 MG TAB SOL	Formulary Addition		Tier 4	PA
02/01/2022	HUMIRA PEN-PEDIATRIC UC START 80 MG/0.8ML PEN KIT	Formulary Addition		Tier 4	PA QL
02/01/2022	INVEGA HAFYERA 1092 MG/3.5ML SUSP PRSYR	Formulary Addition		Tier 4	QL
02/01/2022	INVEGA HAFYERA 1560 MG/5ML SUSP PRSYR	Formulary Addition		Tier 4	QL
02/01/2022	LYBALVI 10-10 MG TAB	Formulary Addition		Tier 4	QL
02/01/2022	LYBALVI 15-10 MG TAB	Formulary Addition		Tier 4	QL
02/01/2022	LYBALVI 20-10 MG TAB	Formulary Addition		Tier 4	QL
02/01/2022	LYBALVI 5-10 MG TAB	Formulary Addition		Tier 4	QL
02/01/2022	NEBIVOLOL HCL 10 MG TAB	Formulary Addition		Tier 2	
02/01/2022	NEBIVOLOL HCL 2.5 MG TAB	Formulary Addition		Tier 2	
02/01/2022	NEBIVOLOL HCL 20 MG TAB	Formulary Addition		Tier 2	
02/01/2022	NEBIVOLOL HCL 5 MG TAB	Formulary Addition		Tier 2	
02/01/2022	PANRETIN 0.1 % GEL	Formulary Addition		Tier 2	

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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** *
02/01/2022	PAROXETINE HCL 10 MG/5ML SUSPENSION	Formulary Addition		Tier 2	QL
02/01/2022	RESTASIS 0.05 % EMULSION	Formulary Addition		Tier 3	QL
02/01/2022	SAJAZIR 30 MG/3ML SOLUTION	Formulary Addition		Tier 4	PA
02/01/2022	TRUSELTIQ (100MG DAILY DOSE) 100 MG CAP THPK	Formulary Addition		Tier 4	PA QL
02/01/2022	TRUSELTIQ (125MG DAILY DOSE) 100 & 25 MG CAP THPK	Formulary Addition		Tier 4	PA QL
02/01/2022	TRUSELTIQ (50MG DAILY DOSE) 25 MG CAP THPK	Formulary Addition		Tier 4	PA QL
02/01/2022	TRUSELTIQ (75MG DAILY DOSE) 25 MG CAP THPK	Formulary Addition		Tier 4	PA QL
02/01/2022	VARENICLINE TARTRATE 0.5 MG TAB	Formulary Addition		Tier 3	PA QL
02/01/2022	VARENICLINE TARTRATE 1 MG TAB	Formulary Addition		Tier 3	PA QL
02/01/2022	WELIREG 40 MG TAB	Formulary Addition		Tier 4	PA QL
02/01/2022	XOFLUZA (80 MG DOSE) 1 X 80 MG TAB THPK	Formulary Addition		Tier 3	
02/01/2022	BESER 0.05 % LOTION	Deletion – Manufacturer Discontinuation	FLUTICASONE PROPIONATE LOTION	Tier 3	
02/01/2022	CYCLAFEM 1/35 1-35 MG-MCG TAB	Deletion – Manufacturer Discontinuation	NORTREL 1/35 TAB	Tier 1	
02/01/2022	CYCLAFEM 7/7/7 0.5/0.75/1-35 MG-MCG TAB	Deletion – Manufacturer Discontinuation	NORTREL 7/7/7 TAB	Tier 1	
02/01/2022	MINITRAN 0.1 MG/HR PATCH 24HR	Deletion – Manufacturer Discontinuation	NITROGLYCERIN PATCH 24HR	Tier 1	

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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** *
02/01/2022	MINITRAN 0.2 MG/HR PATCH 24HR	Deletion – Manufacturer Discontinuation	NITROGLYCERIN PATCH 24HR	Tier 1	
02/01/2022	MINITRAN 0.4 MG/HR PATCH 24HR	Deletion – Manufacturer Discontinuation	NITROGLYCERIN PATCH 24HR	Tier 1	
02/01/2022	MINITRAN 0.6 MG/HR PATCH 24HR	Deletion – Manufacturer Discontinuation	NITROGLYCERIN PATCH 24HR	Tier 1	
02/01/2022	MONDOXYNE NL 100 MG CAP	Deletion – Manufacturer Discontinuation	DOXYCYCLINE MONOHYDRATE 100 MG CAP	Tier 1	
02/01/2022	MONDOXYNE NL 75 MG CAP	Deletion – Manufacturer Discontinuation	DOXYCYCLINE MONOHYDRATE 75 MG CAP	Tier 1	

Last Updated: 11/17/2022  
AFC DIABETES FORMULARY

H5427\_22\_3001885\_I\_C  
1038984MUSENMUB

\*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.