FREEDOM HEALTH

Formulary Changes- October 2023

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
10/1/2023	ABRYSVO 120 MCG/0.5ML RECON SOLN	Formulary Addition		Tier 2	
10/1/2023	AREXVY 120 MCG/0.5ML RECON SUSP	Formulary Addition		Tier 2	
10/1/2023	CYCLOPHOSPHAMIDE 500 MG/ML SOLUTION	Formulary Addition		Tier 4	
10/1/2023	NAPROXEN DR 500 MG TAB DR	Formulary Addition		Tier 1	
10/1/2023	TOLMETIN SODIUM 400 MG CAP	Formulary Addition		Tier 1	
10/1/2023	VARENICLINE TARTRATE (STARTER) 0.5 MG X 11 & 1 MG X 42 TAB THPK	Formulary Addition		Tier 3	PA
10/1/2023	ZEJULA 100 MG TAB	Formulary Addition		Tier 4	PA; QL (90 per 30 days)
10/1/2023	ZEJULA 200 MG TAB	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
10/1/2023	ZEJULA 300 MG TAB	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
10/1/2023	BUPRENORPHINE HCL-NALOXONE HCL 2-0.5 MG FILM	Quantity Limit increased to 480 per 30 days		Tier 2	QL (480 per 30 days)

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******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***
10/1/2023	BUPRENORPHINE HCL-NALOXONE HCL 2-0.5 MG SL TAB	Quantity Limit increased to 480 per 30 days		Tier 1	QL (480 per 30 days)
10/1/2023	BUPRENORPHINE HCL-NALOXONE HCL 4-1 MG FILM	Quantity Limit increased to 240 per 30 days		Tier 2	QL (240 per 30 days)
10/1/2023	BUPRENORPHINE HCL-NALOXONE HCL 8-2 MG FILM	Quantity Limit increased to 120 per 30 days		Tier 2	QL (120 per 30 days)
10/1/2023	BUPRENORPHINE HCL-NALOXONE HCL 8-2 MG SL TAB	Quantity Limit increased to 120 per 30 days		Tier 1	QL (120 per 30 days)
10/1/2023	BYETTA 10 MCG PEN 10 MCG/0.04ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 3	PA; QL (2.4 per 30 days)
10/1/2023	BYETTA 5 MCG PEN 5 MCG/0.02ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 3	PA; QL (1.2 per 30 days)
10/1/2023	OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/1.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA
10/1/2023	OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/3ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA
10/1/2023	OZEMPIC (1 MG/DOSE) 2 MG/1.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA
10/1/2023	OZEMPIC (1 MG/DOSE) 4 MG/3ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA

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Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
10/1/2023	OZEMPIC (2 MG/DOSE) 8 MG/3ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA
10/1/2023	SILDENAFIL CITRATE 20 MG TAB	Quantity Limit increased to 360 per 30 days		Tier 2	PA; QL (360 per 30 days)
10/1/2023	TAFINLAR 10 MG TAB SOL	Quantity Limit increased to 900 per 30 days		Tier 4	PA; QL (900 per 30 days)
10/1/2023	TRULICITY 0.75 MG/0.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (2 per 28 days)
10/1/2023	TRULICITY 1.5 MG/0.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (2 per 28 days)
10/1/2023	TRULICITY 3 MG/0.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (2 per 28 days)
10/1/2023	TRULICITY 4.5 MG/0.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (2 per 28 days)
10/1/2023	VICTOZA 18 MG/3ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (9 per 30 days)
10/1/2023	KYNMOBI 10 MG FILM	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		

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Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
10/1/2023	KYNMOBI 15 MG FILM	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
10/1/2023	KYNMOBI 20 MG FILM	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
10/1/2023	KYNMOBI 25 MG FILM	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
10/1/2023	KYNMOBI 30 MG FILM	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
10/1/2023	PROCALAMINE 3 % SOLUTION	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		

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FREEDOM HEALTH

Formulary Changes- September 2023

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
9/1/2023	MULTIPLE ELECTRO TYPE 1 PH 5.5 SOLUTION	Formulary Addition		Tier 2	
9/1/2023	MULTIPLE ELECTRO TYPE 1 PH 7.4 SOLUTION	Formulary Addition		Tier 2	
9/1/2023	POSACONAZOLE 40 MG/ML SUSPENSION	Formulary Addition		Tier 4	PA
9/1/2023	ROFLUMILAST 250 MCG TAB	Formulary Addition		Tier 2	PA; QL (30 per 30 days)
9/1/2023	TALZENNA 0.1 MG CAP	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
9/1/2023	TALZENNA 0.35 MG CAP	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
9/1/2023	VIGADRONE 500 MG TAB	Formulary Addition		Tier 4	PA; QL (180 per 30 days)
9/1/2023	SELZENTRY 25 MG TAB	Quantity Limit Increased		Tier 2	QL (240 per 30 days)
10/1/2023	BYETTA 10 MCG PEN	Prior Authorization needed for members starting on drug		Tier 3	PA; QL (2.4 per 30 days)
10/1/2023	BYETTA 5 MCG PEN	Prior Authorization needed for members starting on drug		Tier 3	PA; QL (1.2 per 30 days)

*****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***
10/1/2023	OZEMPIC 2 MG/3ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA
10/1/2023	OZEMPIC 2 MG/1.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA
10/1/2023	OZEMPIC 8 MG/3ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA
10/1/2023	OZEMPIC 4 MG/3ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA
10/1/2023	TRULICITY 4.5 MG/0.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (2 per 28 days)
10/1/2023	TRULICITY 1.5 MG/0.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (2 per 28 days)
10/1/2023	TRULICITY 3 MG/0.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (2 per 28 days)
10/1/2023	TRULICITY 0.75 MG/0.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (2 per 28 days)
10/1/2023	VICTOZA 18 MG/3ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (9 per 30 days)

*****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.
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FREEDOM HEALTH

Formulary Changes- August 2023

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
8/1/2023	ABILIFY ASIMTUFII 720 MG/2.4ML PRSYR	Formulary Addition		Tier 4	QL (2.4 per 56 days)
8/1/2023	ABILIFY ASIMTUFII 960 MG/3.2ML PRSYR	Formulary Addition		Tier 4	QL (3.2 per 56 days)
8/1/2023	DARUNAVIR 600 MG TAB	Formulary Addition		Tier 4	QL (60 per 30 days)
8/1/2023	DARUNAVIR 800 MG TAB	Formulary Addition		Tier 4	QL (60 per 30 days)
8/1/2023	KCL IN DEXTROSE-NACL 20-5-0.225 MEQ/L-%-% SOLUTION	Formulary Addition		Tier 2	
8/1/2023	MEKINIST 0.05 MG/ML RECON SOLN	Formulary Addition		Tier 4	PA; QL (1200 per 30 days)
8/1/2023	METHSUXIMIDE 300 MG CAP	Formulary Addition		Tier 2	
8/1/2023	OXYBUTYNIN CHLORIDE 2.5 MG TAB	Formulary Addition		Tier 1	QL (90 per 30 days)
8/1/2023	TAFINLAR 10 MG TAB SOL	Formulary Addition		Tier 4	PA; QL (450 per 30 days)
8/1/2023	UZEDY 100 MG/0.28ML SUSP PRSYR	Formulary Addition		Tier 4	QL (0.28 per 30 days)
8/1/2023	UZEDY 125 MG/0.35ML SUSP PRSYR	Formulary Addition		Tier 4	QL (0.35 per 30 days)

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Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
8/1/2023	UZEDY 150 MG/0.42ML SUSP PRSYR	Formulary Addition		Tier 4	QL (0.42 per 60 days)
8/1/2023	UZEDY 200 MG/0.56ML SUSP PRSYR	Formulary Addition		Tier 4	QL (0.56 per 60 days)
8/1/2023	UZEDY 250 MG/0.7ML SUSP PRSYR	Formulary Addition		Tier 4	QL (0.7 per 60 days)
8/1/2023	UZEDY 50 MG/0.14ML SUSP PRSYR	Formulary Addition		Tier 4	QL (0.14 per 30 days)
8/1/2023	UZEDY 75 MG/0.21ML SUSP PRSYR	Formulary Addition		Tier 4	QL (0.21 per 30 days)
10/1/2023	BYETTA 10 MCG PEN	Prior Authorization needed for members starting on drug		Tier 3	PA; QL (2.4 per 30 days)
10/1/2023	BYETTA 5 MCG PEN	Prior Authorization needed for members starting on drug		Tier 3	PA; QL (1.2 per 30 days)
10/1/2023	OZEMPIC 2 MG/3ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA
10/1/2023	OZEMPIC 2 MG/1.5ML SOLN PEN	Prior Authorization needed for		Tier 2	PA

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Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
		members starting on drug			
10/1/2023	OZEMPIC 8 MG/3ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA
10/1/2023	OZEMPIC 4 MG/3ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA
10/1/2023	TRULICITY 4.5 MG/0.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (2 per 28 days)
10/1/2023	TRULICITY 1.5 MG/0.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (2 per 28 days)
10/1/2023	TRULICITY 3 MG/0.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (2 per 28 days)
10/1/2023	TRULICITY 0.75 MG/0.5ML SOLN PEN	Prior Authorization needed for		Tier 2	PA; QL (2 per 28 days)

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Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
		members starting on drug			
10/1/2023	VICTOZA 18 MG/3ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (9 per 30 days)

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FREEDOM HEALTH

Formulary Changes- July 2023

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
7/1/2023	DEPO-TESTOSTERONE 100 MG/ML SOLUTION	Formulary Addition		Tier 1	PA
7/1/2023	DEPO-TESTOSTERONE 200 MG/ML SOLUTION	Formulary Addition		Tier 1	PA
7/1/2023	DORZOLAMIDE HCL-TIMOLOL MAL PF 22.3-6.8 MG/ML SOLUTION	Formulary Addition		Tier 1	
7/1/2023	GEFITINIB 250 MG TAB	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
7/1/2023	KALYDECO 13.4 MG PACKET	Formulary Addition		Tier 4	PA; QL (56 per 28 days)
7/1/2023	NITISINONE 20 MG CAP	Formulary Addition		Tier 4	PA
7/1/2023	PRIMIDONE 125 MG TAB	Formulary Addition		Tier 1	
7/1/2023	TOLMETIN SODIUM 600 MG TAB	Formulary Addition		Tier 1	
7/1/2023	CYRED 0.15-30 MG-MCG TAB	Deletion - Manufacturer Discontinuation	DESOGESTREL/ETHINYL ESTRADIOL 0.15-30 MG-MCG TAB	Tier 2	
10/1/2023	BYETTA 10 MCG PEN	Prior Authorization needed for members starting on drug		Tier 3	PA; QL (2.4 per 30 days)

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Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
10/1/2023	BYETTA 5 MCG PEN	Prior Authorization needed for members starting on drug		Tier 3	PA; QL (1.2 per 30 days)
10/1/2023	OZEMPIC 2 MG/3ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA
10/1/2023	OZEMPIC 2 MG/1.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA
10/1/2023	OZEMPIC 8 MG/3ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA
10/1/2023	OZEMPIC 4 MG/3ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA
10/1/2023	TRULICITY 4.5 MG/0.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (2 per 28 days)

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Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
10/1/2023	TRULICITY 1.5 MG/0.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (2 per 28 days)
10/1/2023	TRULICITY 3 MG/0.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (2 per 28 days)
10/1/2023	TRULICITY 0.75 MG/0.5ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (2 per 28 days)
10/1/2023	VICTOZA 18 MG/3ML SOLN PEN	Prior Authorization needed for members starting on drug		Tier 2	PA; QL (9 per 30 days)

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FREEDOM HEALTH

Formulary Changes- June 2023

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
6/1/2023	DUPIXENT 200 MG/1.14ML SOLN PEN	Formulary Addition		Tier 4	PA; QL (4.56 per 28 days)
6/1/2023	FLUTICASONE PROPIONATE HFA 110 MCG/ACT AEROSOL	Formulary Addition		Tier 2	QL (12 per 30 days)
6/1/2023	FLUTICASONE PROPIONATE HFA 220 MCG/ACT AEROSOL	Formulary Addition		Tier 2	QL (24 per 30 days)
6/1/2023	FLUTICASONE PROPIONATE HFA 44 MCG/ACT AEROSOL	Formulary Addition		Tier 2	QL (11 per 30 days)
6/1/2023	KYNMOBI 10 MG FILM	Formulary Addition		Tier 4	PA; QL (150 per 30 days)
6/1/2023	KYNMOBI 15 MG FILM	Formulary Addition		Tier 4	PA; QL (150 per 30 days)
6/1/2023	KYNMOBI 20 MG FILM	Formulary Addition		Tier 4	PA; QL (150 per 30 days)
6/1/2023	KYNMOBI 25 MG FILM	Formulary Addition		Tier 4	PA; QL (150 per 30 days)
6/1/2023	KYNMOBI 30 MG FILM	Formulary Addition		Tier 4	PA; QL (150 per 30 days)
6/1/2023	OTEZLA 10 & 20 & 30 MG TAB THPK	Formulary Addition		Tier 4	PA
6/1/2023	OTEZLA 30 MG TAB	Formulary Addition		Tier 4	PA; QL (60 per 30 days)

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Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
6/1/2023	PREDNISOLONE 5 MG TAB	Formulary Addition		Tier 2	
6/1/2023	REZVOGLAR KWIKPEN 100 UNIT/ML SOLN PEN	Formulary Addition		Tier 2	
6/1/2023	CAPLYTA 10.5 MG CAP	Prior Authorization removed		Tier 4	QL (30 per 30 days)
6/1/2023	CAPLYTA 21 MG CAP	Prior Authorization removed		Tier 4	QL (30 per 30 days)
6/1/2023	CAPLYTA 42 MG CAP	Prior Authorization removed		Tier 4	QL (30 per 30 days)
6/1/2023	DIGITEK 250 MCG TAB	Deletion - Manufacturer Discontinuation	DIGOXIN 250 MCG TAB	Tier 1	
6/1/2023	NORVIR 80 MG/ML SOLUTION	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		

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FREEDOM HEALTH

Formulary Changes- May 2023

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
5/1/2023	DUPIXENT 100 MG/0.67ML SOLN PRSYR	Formulary Addition		Tier 4	PA; QL (1.34 per 28 days)
5/1/2023	DUPIXENT 200 MG/1.14ML SOLN PRSYR	Formulary Addition		Tier 4	PA; QL (4.56 per 28 days)
5/1/2023	DUPIXENT 300 MG/2ML SOLN PEN	Formulary Addition		Tier 4	PA; QL (8 per 28 days)
5/1/2023	DUPIXENT 300 MG/2ML SOLN PRSYR	Formulary Addition		Tier 4	PA; QL (8 per 28 days)
5/1/2023	EPCLUSA 150-37.5 MG PACKET	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
5/1/2023	EPCLUSA 200-50 MG PACKET	Formulary Addition		Tier 4	PA; QL (60 per 30 days)
5/1/2023	EPCLUSA 200-50 MG TAB	Formulary Addition		Tier 4	PA; QL (60 per 30 days)
5/1/2023	EPCLUSA 400-100 MG TAB	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
5/1/2023	ERLEADA 240 MG TAB	Formulary Addition		Tier 4	PA
5/1/2023	GILENYA 0.25 MG CAP	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
5/1/2023	ICATIBANT ACETATE 30 MG/3ML SOLN PRSYR	Formulary Addition		Tier 4	PA

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Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
5/1/2023	JAYPIRCA 100 MG TAB	Formulary Addition		Tier 4	PA; QL (60 per 30 days)
5/1/2023	JAYPIRCA 50 MG TAB	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
5/1/2023	LUMAKRAS 320 MG TAB	Formulary Addition		Tier 4	PA; QL (90 per 30 days)
5/1/2023	LURASIDONE HCL 120 MG TAB	Formulary Addition		Tier 4	QL (30 per 30 days)
5/1/2023	LURASIDONE HCL 20 MG TAB	Formulary Addition		Tier 3	QL (30 per 30 days)
5/1/2023	LURASIDONE HCL 40 MG TAB	Formulary Addition		Tier 3	QL (30 per 30 days)
5/1/2023	LURASIDONE HCL 60 MG TAB	Formulary Addition		Tier 3	QL (30 per 30 days)
5/1/2023	LURASIDONE HCL 80 MG TAB	Formulary Addition		Tier 3	QL (60 per 30 days)
5/1/2023	ORSERDU 345 MG TAB	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
5/1/2023	ORSERDU 86 MG TAB	Formulary Addition		Tier 4	PA; QL (90 per 30 days)
5/1/2023	SUNLENCA 463.5 MG/1.5ML SOLUTION	Formulary Addition		Tier 4	QL (3 per 168 over time)
5/1/2023	BRIVIACT 10 MG TAB	PA removal		Tier 3	QL (60 per 30 days)

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Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
5/1/2023	BRIVIACT 10 MG/ML SOLUTION	PA removal		Tier 4	QL (600 per 30 days)
5/1/2023	BRIVIACT 100 MG TAB	PA removal		Tier 4	QL (60 per 30 days)
5/1/2023	BRIVIACT 25 MG TAB	PA removal		Tier 4	QL (60 per 30 days)
5/1/2023	BRIVIACT 50 MG TAB	PA removal		Tier 4	QL (60 per 30 days)
5/1/2023	BRIVIACT 75 MG TAB	PA removal		Tier 4	QL (60 per 30 days)
5/1/2023	SPRITAM 1000 MG TAB	PA removal		Tier 3	QL (60 per 30 days)
5/1/2023	SPRITAM 250 MG TAB	PA removal		Tier 3	QL (60 per 30 days)
5/1/2023	SPRITAM 500 MG TAB	PA removal		Tier 3	QL (60 per 30 days)
5/1/2023	SPRITAM 750 MG TAB	PA removal		Tier 3	QL (120 per 30 days)
5/1/2023	QUETIAPINE FUMARATE 150 MG TAB	Quantity Limit Increased		Tier 1	QL (150 per 30 days)
5/1/2023	CHATEAL 0.15-30 MG-MCG TAB	Deletion – No longer covered under Medicare Part D	LEVONORGESTREL/ETHINYL ESTRADIOL TAB	Tier 1	
5/1/2023	GIANVI 3-0.02 MG TAB	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		

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Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
5/1/2023	HEPATAMINE 8 % 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		
5/1/2023	PASER 4 GM PACKET	Deletion – No longer covered under Medicare Part D	Please talk to your health care provider about an alternative that may be right for you		
5/1/2023	ROSADAN 0.75 % CREAM	Deletion – No longer covered under Medicare Part D	METRONIDAZOLE CREAM 0.75%	Tier 2	
5/1/2023	TEKTURNA HCT 150-12.5 MG TAB	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		

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FREEDOM HEALTH

Formuary Changes- April 2023

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
4/1/2023	HEPLISAV-B 20 MCG/0.5ML SOLN PRSYR	Formulary Addition		Tier 2	B/D PA
4/1/2023	KRAZATI 200 MG TAB	Formulary Addition		Tier 4	PA; QL (180 per 30 days)
4/1/2023	LEUPROLIDE ACETATE 22.5 MG INJECTABLE	Formulary Addition		Tier 3	PA
4/1/2023	LEVEMIR FLEXPEN 100 UNIT/ML SOLN PEN	Formulary Addition		Tier 2	
4/1/2023	LYTGOBI (12 MG DAILY DOSE) 4 MG TAB THPK	Formulary Addition		Tier 4	PA
4/1/2023	LYTGOBI (16 MG DAILY DOSE) 4 MG TAB THPK	Formulary Addition		Tier 4	PA
4/1/2023	LYTGOBI (20 MG DAILY DOSE) 4 MG TAB THPK	Formulary Addition		Tier 4	PA
4/1/2023	REZLIDHIA 150 MG CAP	Formulary Addition		Tier 4	PA; QL (60 per 30 days)
4/1/2023	ROTARIX SUSPENSION	Formulary Addition		Tier 2	
4/1/2023	SUNLENCA 4 X 300 MG TAB THPK	Formulary Addition		Tier 3	

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Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
4/1/2023	SUNLENCA 5 X 300 MG TAB THPK	Formulary Addition		Tier 3	
4/1/2023	JYNNEOS 0.5 ML SUSPENSION	PA change		Tier 2	B/D PA
4/1/2023	AUBRA 0.1-20 MG-MCG TAB	Deletion - Manufacturer Discontinuation	LEVONORGESTREL/ETHINYL ESTRADIOL TABLET	Tier 1	
4/1/2023	BLEPHAMIDE S.O.P. 10-0.2 % OINTMENT	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
4/1/2023	CRIXIVAN 400 MG CAP	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		
4/1/2023	FLURAZEPAM HCL 15 MG CAP	Deletion - Manufacturer Discontinuation	Please talk to your health care provider about an alternative that may be right for you		

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FREEDOM HEALTH

Formulary Changes- March 2023

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
3/1/2023	AUVELITY 45-105 MG TAB ER	Formulary Addition		Tier 3	PA; QL (60 per 30 days)
3/1/2023	CALQUENCE 100 MG TAB	Formulary Addition		Tier 4	PA
3/1/2023	GLEOSTINE 10 MG CAP	Formulary Addition		Tier 3	PA
3/1/2023	GLEOSTINE 100 MG CAP	Formulary Addition		Tier 3	PA
3/1/2023	GLEOSTINE 40 MG CAP	Formulary Addition		Tier 3	PA
3/1/2023	MENEST 2.5 MG TAB	Formulary Addition		Tier 3	PA
3/1/2023	OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/3ML SOLN PEN	Formulary Addition		Tier 2	
3/1/2023	REVLIMID 10 MG CAP	Formulary Addition		Tier 4	PA; QL (60 per 30 days)
3/1/2023	REVLIMID 15 MG CAP	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
3/1/2023	REVLIMID 25 MG CAP	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
3/1/2023	REVLIMID 5 MG CAP	Formulary Addition		Tier 4	PA; QL (150 per 30 days)
3/1/2023	SKYRIZI 180 MG/1.2ML SOLN CART	Formulary Addition		Tier 4	PA; QL (1.2 per 56 days)
3/1/2023	TECVAYLI 153 MG/1.7ML SOLUTION	Formulary Addition		Tier 4	PA
3/1/2023	TECVAYLI 30 MG/3ML SOLUTION	Formulary Addition		Tier 4	PA

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Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
3/1/2023	TURALIO 125 MG CAP	Formulary Addition		Tier 4	PA; QL (120 per 30 days)
3/1/2023	PRIORIX RECON SUSP	Drug Moved to Lower Tier		Tier 2	
3/1/2023	UBRELVY 50 MG TAB	Quantity Limit Increased		Tier 4	PA; QL (20 per 30 days)
3/1/2023	AFEDITAB CR 60 MG TAB ER 24H	Deletion – No longer covered under Medicare Part D	NIFEDIPINE XR TABLET	Tier 1	
3/1/2023	APO-VARENICLINE 0.5 MG TAB	Deletion – No longer covered under Medicare Part D	VARENICLINE TABLET	Tier 3	
3/1/2023	APO-VARENICLINE 1 MG TAB	Deletion – No longer covered under Medicare Part D	VARENICLINE TABLET	Tier 3	
3/1/2023	CRIXIVAN 200 MG CAP	Deletion – No longer covered under Medicare Part D	Please talk to your health care provider about an alternative that may be right for you		
3/1/2023	DIGITEK 125 MCG TAB	Deletion – No longer covered under Medicare Part D	DIGOXIN TABLET	Tier 1	

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FREEDOM HEALTH

Formulary Changes- February 2023

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

Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
2/1/2023	BESREMI 500 MCG/ML SOLN PRSYR	Formulary Addition		Tier 4	PA
2/1/2023	FINGOLIMOD HCL 0.5 MG CAP	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
2/1/2023	HALOETTE 0.12-0.015 MG/24HR RING	Formulary Addition		Tier 3	
2/1/2023	IMBRUVICA 70 MG/ML SUSPENSION	Formulary Addition		Tier 4	PA; QL (216 per 27 days)
2/1/2023	JAVYGTOR 100 MG TAB	Formulary Addition		Tier 4	PA
2/1/2023	JAVYGTOR 500 MG PACKET	Formulary Addition		Tier 4	PA
2/1/2023	JYNNEOS 0.5 ML SUSPENSION	Formulary Addition		Tier 2	
2/1/2023	KETOPROFEN 50 MG CAP	Formulary Addition		Tier 1	
2/1/2023	LENALIDOMIDE 2.5 MG CAP	Formulary Addition		Tier 4	PA; QL (30 per 30 days)
2/1/2023	LENALIDOMIDE 20 MG CAP	Formulary Addition		Tier 4	PA; QL (30 per 30 days)

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Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
2/1/2023	MENVEO SOLUTION	Formulary Addition		Tier 2	
2/1/2023	MYRBETRIQ 8 MG/ML SRER	Formulary Addition		Tier 3	QL (300 per 30 days)
2/1/2023	ORKAMBI 75-94 MG PACKET	Formulary Addition		Tier 4	PA; QL (60 per 30 days)
2/1/2023	PENCICLOVIR 1 % CREAM	Formulary Addition		Tier 3	QL (5 per 30 days)
2/1/2023	POTASSIUM CHLORIDE IN DEXTROSE 10-5 MEQ/L-% SOLUTION	Formulary Addition		Tier 2	
2/1/2023	PREMPRO 0.3-1.5 MG TAB	Formulary Addition		Tier 3	PA
2/1/2023	RECOMBIVAX HB 10 MCG/ML SUSP PRSYR	Formulary Addition		Tier 2	B/D PA
2/1/2023	RECOMBIVAX HB 5 MCG/0.5ML SUSP PRSYR	Formulary Addition		Tier 2	B/D PA

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Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
2/1/2023	ROFLUMILAST 500 MCG TAB	Formulary Addition		Tier 2	PA; QL (30 per 30 days)
2/1/2023	TAZAROTENE 0.05 % GEL	Formulary Addition		Tier 3	PA
2/1/2023	TAZAROTENE 0.1 % GEL	Formulary Addition		Tier 3	PA
2/1/2023	VENLAFAXINE BESYLATE ER 112.5 MG TAB ER 24H	Formulary Addition		Tier 3	
2/1/2023	XARELTO 1 MG/ML RECON SUSP	Formulary Addition		Tier 2	QL (600 per 30 days)
2/1/2023	ZONISADE 100 MG/5ML SUSPENSION	Formulary Addition		Tier 3	
2/1/2023	DABIGATRAN ETEXILATE MESYLATE 150 MG CAP	Drug Moved to Lower Tier		Tier 2	QL (60 per 30 days)
2/1/2023	DABIGATRAN ETEXILATE MESYLATE 75 MG CAP	Drug Moved to Lower Tier		Tier 2	QL (60 per 30 days)

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Effective Date	Drug Name	Reason	Alternative Drug*	Drug Copay**	Restrictions***
2/1/2023	CAZIANT 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	
2/1/2023	ROSADAN 0.75 % GEL	Deletion – No longer covered under Medicare Part D	METRONIDAZOLE GEL 0.75%	Tier 2	
2/1/2023	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		

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