PRESBYTERIAN

Presbyterian Health Plan, Inc.
Presbyterian Insurance Company, Inc.

NOTIFICATION OF FORMULARY CHANGES

The following summary describes changes to the Presbyterian Commercial Large Group Plans (Non-Metal Plans) Formularies effective 2025.

For the most recent list of drugs, information on obtaining a coverage determination or exception, or other questions, please contact the Presbyterian Customer Service Center at the number on the back or your Presbyterian member ID card. You can reach them [Monday through Friday from 7:00 a.m. to 6:00 p.m.]

TTY: 711
Online: **www.phs.org**

Effective Date of Change	Drug Name	Description of Change	Commercial 4-Tier Formulary Coverage	Federal Employees Formulary Coverage	Intel Connected Care Formulary Coverage	Commercial 4-Tier Formulary Alternative(s) and Tier (if applicable for formulary removals)	Federal Employees Formulary Alternative(s) and Tier (if applicable for formulary removals)	Intel Connected Care Formulary Alternative(s) and Tier (if applicable for formulary removals)
01/01/2025	**Aristada Initio®** (aripiprazole) 675 mg/2.4 mL prefilled syringe	Formulary Addition	T4, PA, QL, AL, SP	T4, PA, QL, AL, SP	T2, QL, AL, SP			
01/01/2025	**Abilify Maintena®** (aripiprazole) 300 mg, 400 mg prefilled syringe; 300 mg, 400 mg extended-release reconstituted suspension	PA Criteria Update	T4, PA, QL, AL, SP	T4, PA, QL, AL, SP	T3, PA, QL, AL, SP			
01/01/2025	asenapine (generic for **Saphris®**) 2.5 mg, 5 mg, 10 mg sublingual tablet	PA Removal	T3, QL, AL	T3, QL, AL	T3, QL, AL			

Effective Date of Change	Drug Name	Description of Change	Commercial 4-Tier Formulary Coverage	Federal Employees Formulary Coverage	Intel Connected Care Formulary Coverage	Commercial 4-Tier Formulary Alternative(s) and Tier (if applicable for formulary removals)	Federal Employees Formulary Alternative(s) and Tier (if applicable for formulary removals)	Intel Connected Care Formulary Alternative(s) and Tier (if applicable for formulary removals)
01/01/2025	**Caplyta®** (lumateperone tosylate) 10.5 mg, 21 mg, 42 mg capsule	PA Criteria Update	T4, PA, QL, AL	T4, PA, QL, AL	T3, PA, QL, AL			
01/01/2025	**Combipatch®** (estradiol-norethindrone acetate) 0.05-0.14 mg/day, 0.05-0.25 mg/day twice weekly transdermal patch	Tier Increased	T3, ST, QL	T3, ST, QL	T3, ST, QL			
01/01/2025	desvenlafaxine (generic for **Pristiq®**) 25 mg, 50 mg, 100 mg extended release tablet	Formulary Addition	T1, QL	T1, QL	T1, QL			
01/01/2025	**Farxiga®** (dapagliflozen) 5 mg, 10 mg tablet	PA Criteria Update	T2, ST	T2, ST	T2, ST			
01/01/2025	**Kevzara®** (sarilumab) 200 mg /1.14 mL prefilled syringe	PA Criteria Update	T4, PA	T4, PA	T3, PA			
01/01/2025	**Krazati®** (adagrasib) 600 mg tablet	Formulary Addition	T4, PA, QL	T4, PA, QL	T3, PA, QL			
01/01/2025	lamotrigine (generic for **Lamictal XR®**) 25 mg, 50 mg,100 mg, 200 mg, 250 mg, 300 mg extended- release 24-hour tablet	Tier Lowered	T1, QL	T1, QL	T1, QL			

Effective Date of Change	Drug Name	Description of Change	Commercial 4-Tier Formulary Coverage	Federal Employees Formulary Coverage	Intel Connected Care Formulary Coverage	Commercial 4-Tier Formulary Alternative(s) and Tier (if applicable for formulary removals)	Federal Employees Formulary Alternative(s) and Tier (if applicable for formulary removals)	Intel Connected Care Formulary Alternative(s) and Tier (if applicable for formulary removals)
01/01/2025	lurasidone (generic for **Latuda®**) 20 mg, 40 mg, 60 mg, 80 mg, 120 mg tablet	Tier Lowered	T3, QL, AL	T3, QL, AL	T3, QL, AL			
01/01/2025	**Menest®** (esterified estrogens estradiol) 0.3 mg, 0.625 mg, 1.25 mg tablets	Formulary Removal				Premarin tablets (T2), Premarin Cream (T2), Premphase, Prempro, and Combipatch (T3, QL, ST required)	Premarin tablets (T2), Premarin Cream (T2), Premphase, Prempro, and Combipatch (T3, QL, ST required)	Premarin tablets (T2), Premarin Cream (T2), Premphase, Prempro, and Combipatch (T3, QL, ST required)
01/01/2025	**Menostar®** (estradiol) 14 mcg/24 hour transdermal weekly patches	Formulary Removal				Premarin tablets (T2), Premarin Cream (T2), Premphase, Prempro, and Combipatch (T3, QL, ST required)	Premarin tablets (T2), Premarin Cream (T2), Premphase, Prempro, and Combipatch (T3, QL, ST required)	Premarin tablets (T2), Premarin Cream (T2), Premphase, Prempro, and Combipatch (T3, QL, ST required)
01/01/2025	quetiapine (generic for **Seroquel®**) 50 mg, 150 mg, 200 mg, 300 mg, 400 mg extended-release tablet	Tier Decreased	T1, QL, BH	T1, QL, BH	T1, QL, BH			
01/01/2025	quetiapine (generic for **Seroquel®**) 150 mg immediate-release tablet	Formulary Addition	T1, QL, AL	T1, QL, AL	T1, QL, AL			

Effective Date of Change	Drug Name	Description of Change	Commercial 4-Tier Formulary Coverage	Federal Employees Formulary Coverage	Intel Connected Care Formulary Coverage	Commercial 4-Tier Formulary Alternative(s) and Tier (if applicable for formulary removals)	Federal Employees Formulary Alternative(s) and Tier (if applicable for formulary removals)	Intel Connected Care Formulary Alternative(s) and Tier (if applicable for formulary removals)
01/01/2025	risperidone (generic for **Risperdal®**) 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg, 4 mg orally dispersible tablet	PA Criteria Removal	T3, QL, AL	T3, QL, AL	T3, QL, AL			
01/01/2025	**Secuado®** (asenapine) 3.8 mg/24-hour, 5.7 mg/24-hour and 7.6 mg/24-hour transdermal patch	PA Criteria Update	T4, PA, QL, AL	T4, PA, QL, AL	T3, PA, QL, AL			
01/01/2025	vilazodone (generic for **Viibryd®**) 10 mg, 20 mg, 40 mg tablet	PA Criteria Removal	T3, QL	T3, QL	T3, QL			
01/01/2025	**Vraylar®** (cariprazine) 1.5 & 3 mg therapy pack; 1.5 mg, 3 mg, 4.5 mg, 6 mg capsule	PA Criteria Update	T4, PA, QL, AL	T4, PA, QL, AL	T3, PA, QL, AL			
01/01/2025	**Wakix®** (pitolisant) 4.45 mg, 17.8 mg tablet	AL Update	T4, PA, AL, QL	T4, PA, AL, QL	T3, PA, AL, QL			
03/01/2025	**Cobenfy ®** (xanomeline and trospium hydrochloride) 50 mg/20 mg,100 mg/20 mg, 125 mg/30 mg oral capsules	Formulary Addition	T4, PA, AL, QL	T4, PA, AL, QL	T3, PA, AL, QL			
03/01/2025	**Itovebi ®** (inavolisib) 3mg, 9mg Oral Capsules	Formulary Addition	T4, PA, QL, SP	T4, PA, QL, SP	T3, PA, QL, SP			
03/01/2025	**Dupixent ®** (dupilumab)	PA Criteria Update	T4, PA, SP	T4, PA, SP	T3, PA, SP			

Effective Date of Change	Drug Name	Description of Change	Commercial 4-Tier Formulary Coverage	Federal Employees Formulary Coverage	Intel Connected Care Formulary Coverage	Commercial 4-Tier Formulary Alternative(s) and Tier (if applicable for formulary removals)	Federal Employees Formulary Alternative(s) and Tier (if applicable for formulary removals)	Intel Connected Care Formulary Alternative(s) and Tier (if applicable for formulary removals)
	200 mg/1.14mL, 300 mg/2mL autoinjector; 100 mg/0.67mL, 200 mg/1.14ml, and 300 mg/2mL prefilled syringe							
03/01/2025	**Cimzia®** (certolizumab) 200 mg vial kit and Prefilled syringe: 200 mg/mL (2 syringes) and Cimzia starter 6 X 200 mg/mL	PA Criteria Update	T4, PA, SP	T4, PA, SP	T3, PA, SP			
03/01/2025	**Tecentriq Hybreza®** (atezolizumab/hyaluronidate-tqjs) 1,875 mg atezolizumab and 30,000 units hyaluronidase per 15mL Single dose vial	Formulary Addition	MB, PA	MB, PA	MB, PA			
03/01/2025	dasatinib (generic for **Sprycel®**) 20 mg, 50 mg, 70 mg, 80 mg, 100 mg, 140 mg Oral Tablet	Formulary Addition	T4, PA, SP	T4, PA, SP	T3, PA, SP			
03/01/2025	octreotide LAR (generic for **Sandostatin LAR®**) 20 mg, 30 mg intramuscular kit	Formulary Addition	MB	MB	MB			
03/01/2025	**Retevmo®** (selpercatinib)	Formulary Addition	T4, PA, QL	T4, PA, QL	T3, PA, QL			

Effective Date of Change	Drug Name	Description of Change	Commercial 4-Tier Formulary Coverage	Federal Employees Formulary Coverage	Intel Connected Care Formulary Coverage	Commercial 4-Tier Formulary Alternative(s) and Tier (if applicable for formulary removals)	Federal Employees Formulary Alternative(s) and Tier (if applicable for formulary removals)	Intel Connected Care Formulary Alternative(s) and Tier (if applicable for formulary removals)
	40 mg, 80 mg, 120 mg, 160 mg Oral Tablet							
03/01/2025	**Veozah®** (fezolinetant) 45 mg Oral Tablet	Formulary Addition	T3, PA, QL, AL	T3, PA, QL, AL	T3, PA, QL, AL			
03/01/2025	**Thyrogen®** (thyrotropin alfa) 0.9 mg IM injection	PA Removal	MB, QL	MB, QL	MB, QL			
03/01/2025	**Pavblu®** (aflibercept-ayyh) 2 MG/0.05ML Intravitreal Solution Prefilled Syringe	Formulary Addition	MB, SP	MB, SP	MB, SP			
06/01/2025	acamprosate (generic for **Campral®**) 333 mg Delayed Release Tablet	Tier Lowered	T1	T1	T1, QL			
06/01/2025	clobazam (generic for **Onfi ®**) 2.5 mg/mL Oral Suspension	Formulary Addition	T3, QL, ST	T3, QL, ST	T3, QL, ST			
06/01/2025	clobazam (generic for **Onfi ®**) 10 mg, 20mg Tablet	Formulary Addition	T3, QL, ST	T3, QL, ST	T3, QL, ST			
06/01/2025	mesalamine (generic for **Delzicol®**) 400 mg Delayed Release Capsule	ST Removal	T3	T3	T3			
06/01/2025	mesalamine (generic for **Apriso®**)	ST Removal	T3, QL	T3, QL	T3, QL			

Effective Date of Change	Drug Name	Description of Change	Commercial 4-Tier Formulary Coverage	Federal Employees Formulary Coverage	Intel Connected Care Formulary Coverage	Commercial 4-Tier Formulary Alternative(s) and Tier (if applicable for formulary removals)	Federal Employees Formulary Alternative(s) and Tier (if applicable for formulary removals)	Intel Connected Care Formulary Alternative(s) and Tier (if applicable for formulary removals)
	0.375 G Extended Release Capsule							
06/01/2025	mesalamine (generic for **Lialda®**) 1.2 G Delayed Release Tablet	ST Removal	T3, QL	T3, QL	T3, QL			
06/01/2025	**Nayzilam®** (midazolam) 5 mg/0.1 mL Nasal Solution	PA Removal ST Added	T4, QL, ST	T4, QL, ST	T3, QL, ST			
06/01/2025	**Opdivo Qvantig ®** (nivolumab and hyaluronidase) 600 mg-10,000 Units Per 5 mL Subcutaneous Solution	Formulary Addition	MB, PA	MB, PA	MB, PA			
06/01/2025	**Valtoco®** (diazepam) 10 mg/ 0.1 mL, 5 mg/0.1 mL Nasal Solution	PA Removal ST Added	T4, QL, ST	T4, QL, ST	T3, QL, ST			
06/01/2025	**Valtoco®** (diazepam) 15 mg Dose 2 X 7.5 mg/0.1 mL, 2 X 10 mg/0.1 mL, Nasal Solution	PA Removal ST Added	T4, ST	T4, ST	T3, ST			
08/01/2025	**Accu-Chek** Test Strips and Lancets	QL Updated	T1, QL	T1, QL	T1, QL			
08/01/2025	**Actemra ®** (tocilizumab) 162 mg/0.9 mL prefilled syringe and auto-injector, 80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL solution	Removed from Formulary	NF	NF	NF	Specialty Tier: **Tyenne ®** (tocilizumab-aazg) 162 mg/0.9 mL prefilled syringe and auto-injector, 80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL solution		

Effective Date of Change	Drug Name	Description of Change	Commercial 4-Tier Formulary Coverage	Federal Employees Formulary Coverage	Intel Connected Care Formulary Coverage	Commercial 4-Tier Formulary Alternative(s) and Tier (if applicable for formulary removals)	Federal Employees Formulary Alternative(s) and Tier (if applicable for formulary removals)	Intel Connected Care Formulary Alternative(s) and Tier (if applicable for formulary removals)
08/01/2025	**Tyenne ®** (tocilizumab-aazg) 162 mg/0.9 mL prefilled syringe and auto-injector, 80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL solution	Formulary Addition	T4, PA, QL, SP	T4, PA, QL, SP	T3, PA, QL, SP			
08/01/2025	**Eylea ®** (aflibercept) 2 mg/0.05 mL solution and prefilled syringe	Formulary Removal	NF	NF	NF	MB: **Pavblu ®** (aflibercept-ayyh) 2 mg/0.05 mL solution and prefilled syringe		
08/01/2025	**Pavblu ®** (aflibercept-ayyh) 2 mg/0.05 mL solution and prefilled syringe	Formulary Addition	MB	MB	MB			
08/01/2025	**Prolia®** (denosumab) 60 mg/mL prefilled syringe	Formulary Removal	NF	NF	NF	MB: **Jubbonti®** (denosumab-bbdz) 60 mg/mL prefilled syringe		
08/01/2025	**Jubbonti®** (denosumab-bbdz) 60 mg/mL prefilled syringe	Formulary Addition	MB	MB	MB			
08/01/2025	**Xgeva®** (denosumab) 120 mg/1.7 mL subcutaneous solution	Formulary Removal	NF	NF	NF	MB: **Wyost®** (denosumab-bbdz) 120 mg/1.7 mL subcutaneous solution		
08/01/2025	**Wyost®** (denosumab-bbdz) 120 mg/1.7 mL subcutaneous solution	Formulary Addition	MB	MB	MB			

Effective Date of Change	Drug Name	Description of Change	Commercial 4-Tier Formulary Coverage	Federal Employees Formulary Coverage	Intel Connected Care Formulary Coverage	Commercial 4-Tier Formulary Alternative(s) and Tier (if applicable for formulary removals)	Federal Employees Formulary Alternative(s) and Tier (if applicable for formulary removals)	Intel Connected Care Formulary Alternative(s) and Tier (if applicable for formulary removals)
08/01/2025	**Stelara®** (ustekinumab) 45 mg/0.5mL, 90 mg/mL solution prefilled syringe	Formulary Removal	NF	NF	NF	Specialty Tier: **Imuldosa®** (ustekinumab-srlf) 45 mg/0.5mL, 90 mg/mL solution prefilled syringe **Steqeyma®** (ustekinumab-stba) 45 mg/0.5mL, 90 mg/mL solution prefilled syringe **Yesintek®** (ustekinumab-kfce) 45 mg/0.5mL, 90 mg/mL solution prefilled syringe		
08/01/2025	**Imuldosa®** (ustekinumab-srlf) 45 mg/0.5mL, 90 mg/mL solution prefilled syringe	Formulary Addition	T4, PA, QL, SP	T4, PA, QL, SP	T3, PA, QL, SP			
08/01/2025	**Steqeyma®** (ustekinumab-stba) 45 mg/0.5mL, 90 mg/mL solution prefilled syringe	Formulary Addition	T4, PA, QL, SP	T4, PA, QL, SP	T3, PA, QL, SP			
08/01/2025	**Yesintek®** (ustekinumab-kfce) 45 mg/0.5mL, 90 mg/mL solution prefilled syringe	Formulary Addition	T4, PA, QL, SP	T4, PA, QL, SP	T3, PA, QL, SP			

MB= Medical Benefit**, PA** = Prior Authorization required, **QL** = Quantity Limit, **SP** = Specialty Pharmacy required, **ST** = Step Therapy, **AL**=Age Limit

Learn more about Presbyterian's Nondiscrimination Notice and Interpreter Services at **https://www.phs.org/nondiscrimination.**