

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

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Date of		Change	4-Tier	Employees	Connected	Formulary Alternative(s) and	Formulary	Formulary
Change			Formulary Coverage	Formulary Coverage	Care Formulary	Tier (if applicable for formulary removals)	Alternative(s) and Tier (if applicable for	Alternative(s) and Tier (if applicable for
			Coverage	Coverage	Coverage	Torinulary Ternovals)	formulary removals)	formulary removals)
01/01/2025	Caplyta® (lumateperone	PA Criteria	T4, PA, QL,	T4, PA, QL,	T3, PA, QL,			101110101 (10110 (1010)
	tosylate)	Update	AL	AL	AL			
	10.5 mg, 21 mg, 42 mg capsule							
01/01/2025	Combipatch® (estradiol-	Tier Increased	T3, ST, QL	T3, ST, QL	T3, ST, QL			
	norethindrone acetate)							
	0.05-0.14 mg/day, 0.05-0.25 mg/day twice weekly							
	transdermal patch							
01/01/2025	desvenlafaxine (generic for	Formulary	T1, QL	T1, QL	T1, QL			
	Pristiq®)	Addition						
	25 mg, 50 mg, 100 mg							
01/01/2025	extended release tablet Farxiga® (dapagliflozen)	PA Criteria	T2, ST	T2, ST	T2, ST			
01/01/2023	5 mg, 10 mg tablet	Update	12, 51	12, 51	12, 51			
01/01/2025	Kevzara® (sarilumab)	PA Criteria	T4, PA	T4, PA	T3, PA			
	200 mg /1.14 mL prefilled	Update	,	,	,			
	syringe							
01/01/2025	Krazati® (adagrasib)	Formulary	T4, PA, QL	T4, PA, QL	T3, PA, QL			
01/01/2025	600 mg tablet	Addition	T1 OI	T1 OI	T1 OI			
01/01/2025	lamotrigine (generic for Lamictal XR®)	Tier Lowered	T1, QL	T1, QL	T1, QL			
	25 mg, 50 mg,100 mg, 200							
	mg, 250 mg, 300 mg							
	extended- release 24-hour							
	tablet							

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Date of	C	Change	4-Tier	Employees	Connected	Formulary Alternative(s) and	Formulary	Formulary
Change		-	Formulary	Formulary	Care	Tier (if applicable for	Alternative(s) and	Alternative(s) and
			Coverage	Coverage	Formulary	formulary removals)	Tier (if applicable for	Tier (if applicable for
					Coverage		formulary removals)	formulary removals)
01/01/2025	lurasidone (generic for	Tier Lowered	T3, QL, AL	T3, QL, AL	T3, QL, AL			
	Latuda®)							
	20 mg, 40 mg, 60 mg, 80							
01/01/2025	mg, 120 mg tablet	Г 1					D	D
01/01/2025	Menest® (esterified	Formulary				Premarin tablets (T2),	Premarin tablets	Premarin tablets
	estrogens estradiol)	Removal				Premarin Cream (T2),	(T2), Premarin	(T2), Premarin
	0.3 mg, 0.625 mg, 1.25 mg tablets					Premphase, Prempro, and	Cream (T2),	Cream (T2),
	tablets					Combipatch (T3, QL, ST	Premphase, Prempro,	Premphase, Prempro,
						required)	and Combipatch (T3,	and Combipatch (T3,
							QL, ST required)	QL, ST required)
01/01/2025	Menostar® (estradiol)	Formulary				Premarin tablets (T2),	Premarin tablets	Premarin tablets
	14 mcg/24 hour transdermal	Removal				Premarin Cream (T2),	(T2), Premarin	(T2), Premarin
	weekly patches					Premphase, Prempro, and	Cream (T2),	Cream (T2),
						Combipatch (T3, QL, ST	Premphase, Prempro,	Premphase, Prempro,
						required)	and Combipatch (T3,	and Combipatch (T3,
						1 /	QL, ST required)	QL, ST required)
01/01/2025	quetiapine (generic for	Tier Decreased	T1, QL, BH	T1, QL, BH	T1, QL, BH			
01/01/2020	Seroquel®)		· · · , (_, _ · · · ·	,,				
	50 mg, 150 mg, 200 mg, 300							
	mg, 400 mg extended-release							
	tablet							
01/01/2025	quetiapine (generic for	Formulary	T1, QL, AL	T1, QL, AL	T1, QL, AL			
	Seroquel®)	Addition						
	150 mg immediate-release							
	tablet							

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

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Date of	C	Change	4-Tier	Employees	Connected	Formulary Alternative(s) and	Formulary	Formulary
Change		_	Formulary	Formulary	Care	Tier (if applicable for	Alternative(s) and	Alternative(s) and
_			Coverage	Coverage	Formulary	formulary removals)	Tier (if applicable for	Tier (if applicable for
					Coverage		formulary removals)	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)	PA Criteria	T4, PA, SP	T4, PA, SP	T3, PA, SP			
	200 mg vial kit and Prefilled	Update						
	syringe: 200 mg/mL (2							
	syringes) and Cimzia starter							
	6 X 200 mg/mL							
03/01/2025	Tecentriq Hybreza®	Formulary	MB, PA	MB, PA	MB, PA			
	(atezolizumab/hyaluronidate-	Addition						
	tqjs)							
	1,875 mg atezolizumab and							
	30,000 units hyaluronidase							
	per 15mL Single dose vial							
03/01/2025	dasatinib (generic for	Formulary	T4, PA, SP	T4, PA, SP	T3, PA, SP			
	Sprycel®)	Addition						
	20 mg, 50 mg, 70 mg, 80							
	mg, 100 mg, 140 mg Oral							
	Tablet	D 1						
03/01/2025	octreotide LAR (generic for	Formulary	MB	MB	MB			
	Sandostatin LAR®)	Addition						
	20 mg, 30 mg intramuscular							
02/01/2025	kit	F 1						
03/01/2025	Retevmo® (selpercatinib)	Formulary	T4, PA, QL	T4, PA, QL	T3, PA, QL			
		Addition						

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Change			Formulary	Formulary	Care	Tier (if applicable for	Alternative(s) and	Alternative(s) and
			Coverage	Coverage	Formulary	formulary removals)	Tier (if applicable for	Tier (if applicable for
	40 m = 80 m = 120 m = 160				Coverage		formulary removals)	formulary removals)
	40 mg, 80 mg, 120 mg, 160 mg Oral Tablet							
03/01/2025	Veozah® (fezolinetant)	Formulary	T3, PA, QL,	T3, PA, QL,	T3, PA, QL,			
	45 mg Oral Tablet	Addition	AL	AL	AL			
03/01/2025	Thyrogen® (thyrotropin	PA Removal	MB, QL	MB, QL	MB, QL			
	alfa)							
	0.9 mg IM injection							
03/01/2025	Pavblu® (alibercept-ayyh)	Formulary	MB, SP	MB, SP	MB, SP			
	2 MG/0.05ML Intravitreal	Addition						
	Solution Prefilled Syringe							
06/01/2025	acamprosate (generic for	Tier Lowered	T1	T1	T1, QL			
	Campral®)							
	333 mg Delayed Release							
	Tablet							
06/01/2025	clobazam (generic for Onfi	Formulary	T3, QL, ST	T3, QL, ST	T3, QL, ST			
	(R)	Addition						
	2.5 mg/mL Oral Suspension							
06/01/2025	clobazam (generic for Onfi	Formulary	T3, QL, ST	T3, QL, ST	T3, QL, ST			
	(R)	Addition						
	10 mg, 20mg Tablet							
06/01/2025	mesalamine (generic for	ST Removal	Т3	Т3	Т3			
	Delzicol®)							
	400 mg Delayed Release							
	Capsule							
06/01/2025	mesalamine (generic for	ST Removal	T3, QL	T3, QL	T3, QL			
	Apriso®)							

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Change			Formulary	Formulary	Care	Tier (if applicable for	Alternative(s) and	Alternative(s) and
			Coverage	Coverage	Formulary	formulary removals)	Tier (if applicable for	Tier (if applicable for
	0.275 C Freter 1.1 D days				Coverage		formulary removals)	formulary removals)
	0.375 G Extended Release							
06/01/2025	Capsule	ST Removal						
06/01/2025	mesalamine (generic for	SI Removal	T3, QL	T3, QL	T3, QL			
	Lialda®)							
	1.2 G Delayed Release							
06/01/2025	Tablet	DA D	T4 OL ST	T4 OL CT				
06/01/2025	Nayzilam® (midazolam)	PA Removal	T4, QL, ST	T4, QL, ST	T3, QL, ST			
06/01/2025	5 mg/0.1 mL Nasal Solution	ST Added						
06/01/2025	Opdivo Qvantig ®	Formulary	MB, PA	MB, PA	MB, PA			
	(nivolumab and	Addition						
	hyaluronidase)							
	600 mg-10,000 Units Per 5 mL Subcutaneous Solution							
06/01/2025		PA Removal	T4 OI ST	T4 OL ST	T2 OL ST			
06/01/2025	Valtoco® (diazepam)		T4, QL, ST	T4, QL, ST	T3, QL, ST			
	10 mg/ 0.1 mL, 5 mg/0.1 mL Nasal Solution	ST Added						
0(/01/2025		PA Removal	T4 CT	T4 CT				
06/01/2025	Valtoco® (diazepam)		T4, ST	T4, ST	T3, ST			
	15 mg Dose 2 X 7.5 mg/0.1	ST Added						
	mL, 2 X 10 mg/0.1 mL, Nasal Solution							
08/01/2025		OL Undated	т1	T1 OI	T1 OI			
08/01/2025	Accu-Chek Test Strips and Lancets	QL Updated	T1, QL	T1, QL	T1, QL			
08/01/2025		Removed from	<u> </u>	NF	NF	Specialty Tier:		
00/01/2023		Formulary	INΓ	INГ	INF	Tyenne (tocilizumab-aazg)		
	162 mg/0.9 mL prefilled syringe and auto-injector,	ronnulary				162 mg/0.9 mL prefilled syring	ra and auto injector	
						80 mg/4 mL, 200 mg/10 mL, 4		
	80 mg/4 mL, 200 mg/10 mL,					80 mg/4 mL, 200 mg/10 mL, 4	oo mg/20 mL solution	
	400 mg/20 mL solution							

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Date of Change		Change	4-Tier Formulary	Employees Formulary	Connected Care	Formulary Alternative(s) and Tier (if applicable for	Formulary Alternative(s) and	Formulary Alternative(s) and
Change			Coverage	Coverage	Formulary	formulary removals)	Tier (if applicable for	Tier (if applicable for
			coverage	coverage	Coverage		formulary removals)	formulary removals)
08/01/2025	Tyenne ® (tocilizumab-	Formulary	T4, PA, QL,	T4, PA, QL,	T3, PA, QL,			, , ,
	aazg)	Addition	SP	SP	SP			
	162 mg/0.9 mL prefilled							
	syringe and auto-injector,							
	80 mg/4 mL, 200 mg/10 mL, 400 mg/20 mL solution							
08/01/2025	Eylea ® (aflibercept)	Formulary	NF	NF	NF	MB:		
00/01/2025	2 mg/0.05 mL solution and	Removal			111	Pavblu ® (aflibercept-ayyh)		
	prefilled syringe					2 mg/0.05 mL solution and pre	filled syringe	
08/01/2025	Pavblu ® (aflibercept-	Formulary	MB	MB	MB			
	ayyh)	Addition						
	2 mg/0.05 mL solution and							
08/01/2025	prefilled syringe	E a marca la mar	NF	NE	NF	MB:		
08/01/2025	Prolia ® (denosumab) 60 mg/mL prefilled syringe	Formulary Removal	INF	NF	INF	Jubbonti® (denosumab-bbdz)		
	bo mg/mL prenned syringe	Removal				60 mg/mL prefilled syringe		
08/01/2025	Jubbonti® (denosumab-	Formulary	MB	MB	MB			
00/01/2025	bbdz)	Addition	1112	THE STATE	in D			
	60 mg/mL prefilled syringe							
08/01/2025	Xgeva® (denosumab)	Formulary	NF	NF	NF	MB:		
	120 mg/1.7 mL	Removal				Wyost® (denosumab-bbdz)		
	subcutaneous solution					120 mg/1.7 mL subcutaneous s	solution	
08/01/2025	Wyost® (denosumab-bbdz)	Formulary	MB	MB	MB			
	120 mg/1.7 mL	Addition						
	subcutaneous solution							

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Date of	C .	Change	4-Tier	Employees	Connected	Formulary Alternative(s) and	Formulary	Formulary
Change			Formulary	Formulary	Care	Tier (if applicable for	Alternative(s) and	Alternative(s) and
			Coverage	Coverage	Formulary	formulary removals)	Tier (if applicable for	Tier (if applicable for
					Coverage		formulary removals)	formulary removals)
08/01/2025	Stelara® (ustekinumab)	Formulary	NF	NF	NF	Specialty Tier:		
	45 mg/0.5mL, 90 mg/mL	Removal				Imuldosa® (ustekinumab-srlf)		
	solution prefilled syringe					45 mg/0.5mL, 90 mg/mL solut	ion prefilled syringe	
						Steqeyma® (ustekinumab-stba		
						45 mg/0.5mL, 90 mg/mL solut	ion prefilled syringe	
						Yesintek® (ustekinumab-kfce)		
						45 mg/0.5mL, 90 mg/mL solut	ion prefilled syringe	
08/01/2025	Imuldosa [®] (ustekinumab-	Formulary	T4, PA, QL,	T4, PA, QL,	T3, PA, QL,			
	srlf)	Addition	SP	SP	SP			
	45 mg/0.5mL, 90 mg/mL							
0.0 /0.1 /0.0 0.5	solution prefilled syringe							
08/01/2025	Steqeyma® (ustekinumab-	Formulary	T4, PA, QL,	T4, PA, QL,	T3, PA, QL,			
	stba)	Addition	SP	SP	SP			
	45 mg/0.5mL, 90 mg/mL							
	solution prefilled syringe							
09/01/2025	Variatela (antelaine 1	F						
08/01/2025	× ×	Formulary	T4, PA, QL,	T4, PA, QL,	T3, PA, QL,			
	kfce) $45 \text{ mg/}0.5 \text{mJ} = 00 \text{ mg/}\text{mJ}$	Addition	SP	SP	SP			
	45 mg/0.5mL, 90 mg/mL							
	solution prefilled syringe						1	

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.