


**NOTIFICATION OF FORMULARY CHANGES\***

**The following summary describes changes to the 2025 Presbyterian Senior Care (HMO) / (HMO-POS), Presbyterian UltraFlex (HMO-POS), and Presbyterian Dual Plus (HMO D-SNP) formularies.**


The formulary may change at any time. You will receive notice when required.

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.

**Presbyterian Senior Care (HMO)/(HMO-POS)  
and Presbyterian UltraFlex (HMO-POS):**




(505) 923-6060  
1-800-797-5343  
(TTY 711)



October 1 to March 31:  
8 a.m. to 8 p.m., seven days a week  
(except holidays)  
  
April 1 to September 30:  
8 a.m. to 8 p.m., Monday - Friday  
(except holidays)

**Presbyterian Dual Plus (HMO D-SNP):**



(505) 923-7675  
1-855-465-7737  
(TTY 711)



[www.phs.org/Medicare](http://www.phs.org/Medicare)

Positive and Neutral Formulary Changes

Effective Date of Change	Drug Name	Description of Change	Tier	Additional Information	Formulary Alternative(s) and Tier (if applicable for formulary removals)
01/01/2025	ARIKAYCE 590 MG/8.4ML INHALATION SUSPENSION	FORMULARY ADDITION	5	NDS	
01/01/2025	COLOCORT 100 MG/60ML RECTAL ENEMA	FORMULARY ADDITION	3		
01/01/2025	DICLOFENAC SODIUM 1.5 % EXTERNAL SOLUTION	FORMULARY ADDITION	4		
01/01/2025	FETZIMA TITRATION ER 24 HOUR THERAPY PACK 20 & 40 MG ORAL CAPSULE	FORMULARY ADDITION	4	ST; QL (56 EA per 365 days)	
01/01/2025	IMPAVIDO 50 MG ORAL CAPSULE	FORMULARY ADDITION	5	NDS	
01/01/2025	LIVTENCITY 200 MG ORAL TABLET	FORMULARY ADDITION	5	PA; QL (4 EA per 1 day); NDS	
01/01/2025	MIRENA (52 MG) 20 MCG/DAY INTRAUTERINE DEVICE	FORMULARY ADDITION	3		
01/01/2025	NEXPLANON 68 MG SUBCUTANEOUS IMPLANT	FORMULARY ADDITION	3		
01/01/2025	OPVEE 2.7 MG/0.1ML NASAL SOLUTION	FORMULARY ADDITION	3		
01/01/2025	PENICILLAMINE 250 MG ORAL CAPSULE	FORMULARY ADDITION	3		
01/01/2025	PIMECROLIMUS 1 % EXTERNAL CREAM	FORMULARY ADDITION	4		

01/01/2025	REBYOTA 150 ML RECTAL SUSPENSION	FORMULARY ADDITION	5	PA; NDS	
01/01/2025	TADALAFIL 5 MG ORAL TABLET	FORMULARY ADDITION	2	PA	
01/01/2025	TAVNEOS 10 MG ORAL CAPSULE	FORMULARY ADDITION	5	PA; LA; QL (6 EA per 1 day); NDS	
01/01/2025	TINIDAZOLE 250 MG, 500 MG ORAL TABLET	FORMULARY ADDITION	2		
01/01/2025	TOLVAPTAN 15 MG ORAL TABLET	FORMULARY ADDITION	4		
01/01/2025	TORPENZ 10 MG, 2.5 MG, 5 MG, 7.5 MG ORAL TABLET	FORMULARY ADDITION	5	PA; NDS	
01/01/2025	VELTASSA 16.8 GM, 25.2 GM, 8.4 GM ORAL PACKET	FORMULARY ADDITION	4	PA; QL (1 EA per 1 day)	
01/01/2025	VEOZAH 45 MG ORAL TABLET	FORMULARY ADDITION	4		
01/01/2025	VOWST ORAL CAPSULE	FORMULARY ADDITION	5	PA; NDS	
01/01/2025	XDEMVY 0.25 % OPHTHALMIC SOLUTION	FORMULARY ADDITION	5	QL (20 ML per 365 days); NDS	
01/01/2025	BUDESONIDE-FORMOTEROL FUMARATE 160-4.5 MCG/ACT, 80-4.5 MCG/ACT INHALATION AEROSOL	GENERIC SUBSTITUTION	3	QL (10.2 GM per 30 days)	
01/01/2025	L-GLUTAMINE 5 GM ORAL PACKET	GENERIC SUBSTITUTION	5	PA; QL (6 EA per 1 day); NDS	
01/01/2025	FEBUXOSTAT TABLET 40 MG ORAL, 80 MG ORAL	PA ADDITION	3	PA; QL (1 EA per 1 day)	
01/01/2025	HYDROXYZINE HCL TABLET 10 MG ORAL, 25 MG ORAL, 50 MG ORAL	PA ADDITION	4	PA	

01/01/2025	HYDROXYZINE PAMOATE CAPSULE 100 MG ORAL, 25 MG ORAL, 50 MG ORAL	PA ADDITION	4	PA	
01/01/2025	CLOMIPRAMINE HCL CAPSULE 25 MG ORAL, 50 MG ORAL, 75 MG ORAL	PA REMOVAL	2		
01/01/2025	COMBIPATCH PATCH TWICE WEEKLY 0.05-0.14 MG/DAY TRANSDERMAL, PATCH TWICE WEEKLY 0.05-0.25 MG/DAY TRANSDERMAL	PA REMOVAL	4		
01/01/2025	DESIPRAMINE HCL TABLET 10 MG ORAL, 100 MG ORAL, 150 MG ORAL, 25 MG ORAL, 50 MG ORAL, 75 MG ORAL	PA REMOVAL	2		
01/01/2025	DOXEPIN HCL CAPSULE 10 MG ORAL, 100 MG ORAL, 150 MG ORAL, CAPSULE 25 MG ORAL, 50 MG ORAL, 75 MG ORAL	PA REMOVAL	4		
01/01/2025	IMIPRAMINE HCL TABLET 10 MG ORAL, 25 MG ORAL, 50 MG ORAL	PA REMOVAL	4		
01/01/2025	NORTRIPTYLINE HCL CAPSULE 10 MG ORAL, 25 MG ORAL, 50 MG ORAL, 75 MG ORAL, SOLUTION 10 MG/5ML ORAL	PA REMOVAL	1		
01/01/2025	NORTRIPTYLINE HCL SOLUTION 10 MG/5ML ORAL	PA REMOVAL	3		
01/01/2025	PAROXETINE HCL ER TABLET EXTENDED RELEASE 24 HOUR 12.5	PA REMOVAL	2		

	MG ORAL, 25 MG ORAL, 37.5 MG ORAL,				
01/01/2025	PROTRIPTYLINE HCL TABLET 10 MG ORAL, TABLET 5 MG ORAL	PA REMOVAL	2		
01/01/2025	TRIMIPRAMINE MALEATE CAPSULE 100 MG ORAL, 25 MG ORAL, 50 MG ORAL	PA REMOVAL	4		
01/01/2025	BISOPROLOL FUMARATE TABLET 10 MG ORAL	QL ADDITION	2	GC; QL (90 EA per 365 days)	
01/01/2025	AUSTEDO XR TABLET EXTENDED RELEASE 24 HOUR 6 MG ORAL	QL INCREASED	5	PA; QL (3 EA per 1 day); NDS	
01/01/2025	OJEMDA TABLET 100 MG ORAL (16 PACK)	QL INCREASED	5	PA; QL (24 EA per 28 days); NDS	
01/01/2025	ISENTRESS TABLET CHEWABLE 25 MG ORAL	TIER INCREASED	4	QL (6 EA per 1 day)	
01/01/2025	TIVICAY PD TABLET SOLUBLE 5 MG ORAL	TIER INCREASED	5		
01/01/2025	ALOSETRON HCL TABLET 0.5 MG ORAL	TIER LOWERED	4	PA; QL (2 EA per 1 day); NDS	
01/01/2025	ARIPIRAZOLE TABLET DISPERSIBLE 15 MG ORAL	TIER LOWERED	4	PA; QL (2 EA per 1 day); NDS	
01/01/2025	CLOZAPINE TABLET DISPERSIBLE 200 MG ORAL	TIER LOWERED	4	ST; NDS	
01/01/2025	DEFERASIROX TABLET 180 MG ORAL, 360 MG ORAL	TIER LOWERED	4	PA; NDS	
01/01/2025	EMTRICITABINE-TENOFOVIR DF TABLET 100-150 MG ORAL, 133-200 MG ORAL, 167-250 MG ORAL, 200-300 MG ORAL	TIER LOWERED	2	QL (1 EA per 1 day); NDS	

01/01/2025	ETONOGESTREL-ETHINYL ESTRADIOL RING 0.12-0.015 MG/24HR VAGINAL	TIER LOWERED	3		
01/01/2025	ISENTRESS HD TABLET 600 MG	TIER LOWERED	3	QL (2 EA per 1 day); NDS	
01/01/2025	ISENTRESS PACKET 100 MG	TIER LOWERED	4	NDS	
01/01/2025	ISENTRESS TABLET 400 MG ORAL,	TIER LOWERED	3	QL (2 EA per 1 day); NDS	
01/01/2025	ISENTRESS CHEWABLE 100 MG ORAL	TIER LOWERED	4	QL (6 EA per 1 day); NDS	
01/01/2025	LEUPROLIDE ACETATE KIT 1 MG/0.2ML INJECTION	TIER LOWERED	4	NDS	
01/01/2025	LYLLANA 0.025 MG/24HR, 0.0375 MG/24HR, 0.05 MG/24HR, 0.075 MG/24HR, 0.1 MG/24HR TRANSDERMAL PATCH TWICE WEEKLY	TIER LOWERED	3	PA	
01/01/2025	MESALAMINE ER CAPSULE EXTENDED RELEASE 500 MG ORAL	TIER LOWERED	4	QL (8 EA per 1 day); NDS	
01/01/2025	NAYZILAM SOLUTION 5 MG/0.1ML NASAL	TIER LOWERED	4	QL (10 EA per 30 days); NDS	
01/01/2025	NORELGESTROMIN-ETH ESTRADIOL PATCH WEEKLY 150-35 MCG/24HR TRANSDERMAL	TIER LOWERED	3		
01/01/2025	OPSUMIT TABLET 10 MG ORAL	TIER LOWERED	4	PA; LA; QL (1 EA per 1 day); NDS	
01/01/2025	PYRIDOSTIGMINE BROMIDE SOLUTION 60 MG/5ML ORAL	TIER LOWERED	4	NDS	

01/01/2025	RISPERIDONE MICROSPHERES ER 25 MG INTRAMUSCULAR RECONSTITUTED SUSPENSION	TIER LOWERED	4	NDS	
01/01/2025	TADALAFIL (PAH) TABLET 20 MG ORAL	TIER LOWERED	2	PA; QL (2 EA per 1 day); NDS	
01/01/2025	TIVICAY TABLET 10 MG ORAL	TIER LOWERED	3		
01/01/2025	TRIUMEQ PD TABLET SOLUBLE 60-5-30 MG ORAL	TIER LOWERED	4	QL (6 EA per 1 day); NDS	
01/01/2025	XCOPRI TABLET 25 MG ORAL	TIER LOWERED	4	ST; QL (1 EA per 1 day); NDS	
01/01/2025	XULANE 150-35 MCG/24HR TRANSDERMAL PATCH WEEKLY	TIER LOWERED	3		
01/01/2025	ZAFEMY PATCH WEEKLY 150-35 MCG/24HR TRANSDERMAL, PATCH WEEKLY 150-35 MCG/24HR TRANSDERMAL, PATCH WEEKLY 150-35 MCG/24HR TRANSDERMAL, PATCH WEEKLY 150-35 MCG/24HR TRANSDERMAL	TIER LOWERED	3		
02/01/2025	AUGTYRO 160 MG CAPSULE	FORMULARY ADDITION	5	PA; QL (1 EA per 1 Day); NDS	
02/01/2025	COBENFY 50-20 MG CAPSULE	FORMULARY ADDITION	5	PA; QL (1 EA per 1 Day); NDS	
02/01/2025	COBENFY 100-20 MG CAPSULE, 125-30 MG CAPSULE	FORMULARY ADDITION	5	PA; QL (2 EA per 1 Day); NDS	
02/01/2025	COBENFY STARTER PACK 50-20 & 100-20 MG CAPSULE THERAPY PACK	FORMULARY ADDITION	5	PA; QL (112 CAPS per 365 Day); NDS	
02/01/2025	DASATINIB 20 MG TABLET, 50 MG TABLET, 70 MG TABLET, 100 MG	GENERIC SUBSTITUTION	5	PA; QL (1 EA per 1 Day); NDS	

	TABLET, 140 MG TABLET				
02/01/2025	FINTEPLA 2.2 MG/ML ORAL SOLUTION	FORMULARY ADDITION	5	QL (12 ML per 1 Day); LA	
02/01/2025	ITOVEBI 3 MG TABLET	FORMULARY ADDITION	5	PA; QL (2 EA per 1 Day); NDS	
02/01/2025	ITOVEBI 9 MG TABLET	FORMULARY ADDITION	5	PA; QL (1 EA per 1 Day); NDS	
02/01/2025	LAZCLUZE 80 MG TABLET	FORMULARY ADDITION	5	PA; QL (2 EA per 1 Day); NDS	
02/01/2025	LAZCLUZE 240 MG TABLET	FORMULARY ADDITION	5	PA; QL (1 EA per 1 Day); NDS	
02/01/2025	LUMAKRAS 240 MG TABLET	FORMULARY ADDITION	5	PA; QL (2 EA per 1 Day); NDS; LD	
02/01/2025	VORANIGO 10 MG TABLET	FORMULARY ADDITION	5	PA; QL (2 EA per 1 Day); NDS	
02/01/2025	VORANIGO 40 MG TABLET	FORMULARY ADDITION	5	PA; QL (1 EA per 1 Day); NDS	
03/01/2025	BREYNA 160-4.5 MCG/ACT, 80-4.5 MCG/ACT INHALATION	FORMULARY ADDITION	3	QL (10.3 GM per 30 Days);	
03/01/2025	DANZITEN 71 MG, 95 MG TABLET	FORMULARY ADDITION	5	PA; QL (4 EA per 1 Day); NDS	
03/01/2025	IMKELDI 80 MG/ML ORAL SOLUTION	FORMULARY ADDITION	5	PA; QL (10 ML per 1 Day); NDS	
03/01/2025	PROCTOFOAM HC 1-1% EXTERNAL FOAM	FORMULARY ADDITION	3		
03/01/2025	REVUFORJ 110 MG, 160 MG TABLET	FORMULARY ADDITION	5	PA; QL (4 EA per 1 Day); NDS	
04/01/2025	MESNA 400 MG TABLET	FORMULARY ADDITION	5	NDS	



04/01/2025	MINZOYA 0.1-20 MG-MCG TABLET	FORMULARY ADDITION	3		
04/01/2025	BISOPROLOL FUMARATE 10 MG TABLET	QL REMOVAL	2		
05/01/2025	FEIRZA 1.5-30 MG-MCG, 1-20 MG-MCG TABLET	FORMULARY ADDITION	3		
05/01/2025	XARAH FE 1-20/1-30/1-35 MG-MCG TABLET	FORMULARY ADDITION	3		
06/01/2025	ABIRTEGA 250 MG TABLET	FORMULARY ADDITION	5	QL (4 EA per 1 day); NDS	
06/01/2025	AURANOFIN 3 MG CAPSULE	FORMULARY ADDITION	5	NDS	
06/01/2025	EULEXIN 125 MG CAPSULE	FORMULARY ADDITION	5	NDS	
06/01/2025	GOMEKLI 1 MG CAPSULE	FORMULARY ADDITION	5	PA; QL (2 EA per 1 day); NDS	
06/01/2025	GOMEKLI 2 MG CAPSULE	FORMULARY ADDITION	5	PA; QL (4 EA per 1 day); NDS	
06/01/2025	GOMEKLI 1 MG TABLET SOLUBLE	FORMULARY ADDITION	5	PA; QL (8 EA per 1 day); NDS	
06/01/2025	LACTULOSE 20 GM PACKET	FORMULARY ADDITION	4		
06/01/2025	MERCAPTOPURINE 2000 MG/100ML SUSPENSION	FORMULARY ADDITION	5	PA; NDS	
06/01/2025	REVUFORJ 25 MG TABLET	FORMULARY ADDITION	5	PA; QL (8 EA per 1 day); NDS	
06/01/2025	ROMVIMZA 14 MG, 20 MG, 30MG CAPSULE	FORMULARY ADDITION	5	PA; QL (8 EA per 28 days); NDS	
06/01/2025	XPOVIO (40 MG ONCE WEEKLY) 10 MG TABLET THERAPY PACK	FORMULARY ADDITION	5	PA; QL (4 EA per 28 days); NDS	

07/01/2025	ABIRATERONE ACETATE 250 MG TABLET	TIER LOWERED	3	QL (4 PER 1 day)	
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Negative Formulary Changes

Effective Date of Change	Drug Name	Description of Change	Tier	Additional Information	Formulary Alternative(s) and Tier (if applicable for formulary removals)	Member Notification
01/01/2025	AMJEVITA 40 MG/0.8ML, 80 MG/0.8ML SOLUTION AUTO-INJECTOR; AMJEVITA-PED 10KG TO <15KG 10 MG/0.2ML, 15KG TO <30KG 20 MG/0.2ML, 15KG TO <30KG 20 MG/0.4ML PREFILLED SYRINGE	FORMULARY DELETION			<ul style="list-style-type: none"><li>AMJEVITA 40 MG/0.4ML T5</li></ul>	–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2025	CALCIUM ACETATE 667 MG ORAL CAPSULE	FORMULARY DELETION		Must be billed in a bundle with dialysis treatment.		–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2025	COSENTYX (300 MG DOSE) 150 MG/ML PREFILLED SYRINGE; COSENTYX SENSOREADY (300 MG) 150 MG/ML, 150 MG/ML AUTO-INJECTOR; COSENTYX 75 MG/0.5ML PREFILLED SYRINGE; COSENTYX UNOREADY 300 MG/2ML AUTO-INJECTOR	FORMULARY DELETION			<ul style="list-style-type: none"><li>AMJEVITA 40 MG/0.4ML T5</li><li>ENBREL 25 MG/0.5ML, 50 MG/ML T5</li><li>HADLIMA 40 MG/0.4ML T5</li><li>XELJANZ ORAL TABLETS T5</li></ul>	–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

01/01/2025	DIMETHYL FUMARATE 120 MG ORAL, 240 MG CAPSULE	FORMULARY DELETION			<ul style="list-style-type: none"><li>FINGOLIMOD 0.5 MG ORAL CAPS T4</li><li>TERIFLUNOMIDE 7 MG, 14 MG OTAL TABLETS T2</li></ul>	– Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2025	EXKIVITY 40 MG CAPSULE	FORMULARY DELETION			REMOVED FROM MARKET	–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2025	EXTAVIA KIT 0.3 MG SUBCUTANEOUS KIT	FORMULARY DELETION			<ul style="list-style-type: none"><li>FINGOLIMOD 0.5 MG ORAL CAPS T4</li><li>TERIFLUNOMIDE 7 MG, 14 MG OTAL TABLETS T2</li></ul>	– Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2025	FINTEPLA 2.2 MG/ML ORAL SOLUTION	FORMULARY DELETION			<ul style="list-style-type: none"><li>VALPROIC ACID 250 MG CAPSULES T2</li><li>LAMOTRIGINE 25 MG, 100 MG, 150 MG, 200 MG TABLETS T2</li><li>RUFINAMIDE 200 MG, 400 MG TABS, 40 MG/ML SOLUTION T5</li><li>TOPIRAMATE 15 MG, 25 MG CAPSULES, 25 MG, 50 MG, 100 MG, 200 MG TABLETS T2</li><li>CLOBAZAM 10 MG, 20 MG TABS, 2.5 MG/ML SOLUTION T4</li><li>FELBAMATE 400 MG, 600 MG TABS, 600 MG/5ML SOLUTION T3</li></ul>	–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2025	HADLIMA PUSHTOUCH 40 MG/0.8ML AUTO-	FORMULARY DELETION			<ul style="list-style-type: none"><li>HADLIMA 40 MG/0.4ML T5</li></ul>	–Members were sent advanced general notice of new plan year

	INJECTOR; HADLIMA 40 MG/0.8ML PREFILLED SYRINGE					formulary changes in their Evidence of Coverage (EOC).
01/01/2025	JYLAMVO 2 MG/ML ORAL SOLUTION	FORMULARY DELETION			<ul style="list-style-type: none"><li>METHOTREXATE 2.5 MG TABLETS T1</li></ul>	–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2025	LANTHANUM 500 MG, 750 MG, 1000 MG CHEWABLE TABLET	FORMULARY DELETION		Must be billed in a bundle with dialysis treatment.		–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2025	LEXIVA 50 MG/ML ORAL SUSPENSION	FORMULARY DELETION			<ul style="list-style-type: none"><li>FOSAMPRENAVIR 700 MG TABS T5</li></ul>	–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2025	OZEMPIC (0.25 OR 0.5 MG/DOSE) 2 MG/1.5ML, (0.25 OR 0.5 MG/DOSE) 2 MG/3ML, (1 MG/DOSE) 4 MG/3ML, (2 MG/DOSE) 8 MG/3ML PEN-INJECTOR	FORMULARY DELETION			<ul style="list-style-type: none"><li>MOUNJARO 2.5 MG, 5 MG, 7.5 MG, 10 MG, 12.5 MG, 15 MG</li><li>TRULICITY 0.75 MG, 1.5 MG, 3 MG, 4.5 MG</li></ul>	–Members were sent individual 90-day notices.
01/01/2025	PREFEST 1/1-0.09 MG (15/15) ORAL TABLET	FORMULARY DELETION			Please refer to posted formulary and review the Estrogens class.	–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2025	REBIF REBIDOSE 22 MCG/0.5ML, 44	FORMULARY DELETION			<ul style="list-style-type: none"><li>FINGOLIMOD 0.5 MG ORAL CAPS</li></ul>	–Members were sent advanced general notice of new plan year

	MCG/0.5ML AUTO-INJECTOR; REBIF 22 MCG/0.5ML, 44 MCG/0.5ML PREFILLED SYRINGE; REBIF 6X8.8 & 6X22 MCG PREFILLED SYRINGE TITRATION PACK				<ul style="list-style-type: none"><li>• TERIFLUNOMIDE 7 MG, 14 MG TABS</li></ul>	formulary changes in their Evidence of Coverage (EOC).
01/01/2025	RINVOQ LQ 1 MG/ML ORAL SOLUTION; RINVOQ EXTENDED RELEASE 24 HOUR 15 MG, EXTENDED RELEASE 24 HOUR 30 MG ORAL, EXTENDED RELEASE 24 HOUR 45 MG ORAL TABLET	FORMULARY DELETION			<ul style="list-style-type: none"><li>• AMJEVITA 40 MG/0.4ML T5</li><li>• ENBREL 25 MG/0.5ML, 50 MG/ML T5</li><li>• HADLIMA 40 MG/0.4ML T5</li><li>• XELJANZ ORAL TABLETS T5</li></ul>	–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2025	RYBELSUS 14 MG, 3 MG, 7 MG ORAL TABLET	FORMULARY DELETION			<ul style="list-style-type: none"><li>• MOUNJARO 2.5 MG, 5 MG, 7.5 MG, 10 MG, 12.5 MG, 15 MG T3</li><li>• TRULICITY 0.75 MG, 1.5 MG, 3 MG, 4.5 MG T3</li></ul>	–Members were sent individual 90-day notices.
01/01/2025	SEVELAMIR 0.8 GM, 2.4 GM ORAL PACKET; 800 MG ORAL TABLET	FORMULARY DELETION		Must be billed in a bundle with dialysis treatment.		–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2025	SKYRIZI (150 MG DOSE) 75 MG/0.83ML PREFILLED SYRINGE KIT; 150 MG/ML PEN SOLUTION AUTO-INJECTOR; 180 MG/1.2ML CARTRIDGE, 360 MG/2.4ML CARTRIDGE;	FORMULARY DELETION			<ul style="list-style-type: none"><li>• AMJEVITA 40 MG/0.4ML T5</li><li>• ENBREL 25 MG/0.5ML, 50 MG/ML T5</li><li>• HADLIMA 40 MG/0.4ML T5</li><li>• XELJANZ ORAL TABLETS T5</li></ul>	–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

	150 MG/ML PREFILLED SYRINGE					
01/01/2025	STELARA 130 MG/26ML INTRAVENOUS SOLUTION	FORMULARY DELETION			<ul style="list-style-type: none"><li>• AMJEVITA 40 MG/0.4ML T5</li><li>• ENBREL 25 MG/0.5ML, 50 MG/ML T5</li><li>• HADLIMA 40 MG/0.4ML T5</li><li>• XELJANZ ORAL TABLETS T5</li></ul>	–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2025	SUBLOCADE 100 MG/0.5ML, 300 MG/1.5ML PREFILLED SYRINGE	FORMULARY DELETION			Part B benefit	–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2025	TEMOZOLOMIDE 100 MG, 140 MG, 180 MG, 20 MG ORAL, 250 MG, 5 MG ORAL CAPSULE	FORMULARY DELETION			Part B benefit	–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2025	THEOPHYLLINE EXTENDED RELEASE 12 HOUR 100 MG ORAL TABLET	FORMULARY DELETION			<ul style="list-style-type: none"><li>• THEOPHYLLINE 300 MG, 450 MG TABLETS</li></ul>	–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
01/01/2025	VENTAVIS 10 MCG/ML, 20 MCG/ML INHALATION SOLUTION	FORMULARY DELETION			<ul style="list-style-type: none"><li>• ADEMPAS 0.5 MG, 1 MG, 1.5 MG, 2 MG, 2.5 MG TABLETS T5</li><li>• ALYQ 20 MG TABLETS T5</li><li>• AMBRISENTAN 5 MG, 10 MG TABLETS T5</li><li>• BOSENTAN 62.5 MG, 125 MG TABLETS</li></ul>	–Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

					<ul style="list-style-type: none"><li>• OPSUMIT 10 TABLETS T5</li><li>• SILDENAFIL 20 MG TABLETS T2</li><li>• TADALAFIL 20 MG TABLETS T2</li></ul>	
01/01/2025	VICTOZA 18 MG/3ML PEN-INJECTOR	FORMULARY DELETION			<ul style="list-style-type: none"><li>• MOUNJARO 2.5 MG, 5 MG, 7.5 MG, 10 MG, 12.5 MG, 15 MG T3</li><li>• TRULICITY 0.75 MG, 1.5 MG, 3 MG, 4.5 MG T3</li></ul>	–Members were sent individual 90-day notices.
02/01/2025	SPRYCEL 20 MG TABLET, 50 MG TABLET, 70 MG TABLET, 100 MG TABLET, 140 MG TABLET	FORMULARY DELETION			<ul style="list-style-type: none"><li>• DASATINIB 20 MG TABLET, 50 MG TABLET, 70 MG TABLET, 100 MG TABLET, 140 MG TABLET T5</li></ul>	
06/01/2025	PURIXAN 2000 MG/100 ML ORAL SUSPENSION	FORMULARY DELETION			<ul style="list-style-type: none"><li>• MERCAPTOPURINE 2000 MG/100ML SUSPENSION T5</li></ul>	

**B/D** = This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination, **NDS** = Drug is limited to a one-month supply, **PA** = Prior Authorization required, **QL** = Quantity Limit, **SP** = Specialty Pharmacy required, **ST** = Step Therapy. The benefit information provided is a brief summary, not a complete description of benefits. For more information, contact the plan.

Limitations, copayments, and restrictions may apply.

Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change on January 1 of each year.

**Learn more about Presbyterian’s Nondiscrimination Notice and Interpreter Services.**