

#### NOTIFICATION OF FORMULARY CHANGES\*

The following summary describes changes to the 2026 Presbyterian Senior Care (HMO) / (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:**



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



October 1 - March 31:

8 a.m. to 8 p.m., seven days a week (except holidays)

**April 1 - September 30:** 

8 a.m. to 8 p.m., Monday - Friday (except holidays)





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



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 DELETIONs)
1/1/2026	ABIGALE TABLET 0.5-0.1 MG, 1-0.5 MG ORAL	FORMULARY ADDITION	4	T4, PA	
1/1/2026	ABILIFY MAINTENA PREFILLED SYRINGE 400 MG INTRAMUSCULAR	TIER DECREASED	4	T4	
1/1/2026	ABILIFY MAINTENA SUSPENSION RECONSTITUTED ER 300 MG, 400 MG INTRAMUSCULAR	TIER DECREASED	4	T4, NDS	
1/1/2026	ABIRTEGA TABLET 250 MG ORAL	TIER DECREASED	2	T2, QL (4 PER 1 DAY)	
1/1/2026	ALBENDAZOLE TABLET 200 MG ORAL	TIER DECREASED	4	T4, NDS	
1/1/2026	ARIPIPRAZOLE TABLET DISPERSIBLE 10 MG, 15 MG ORAL	TIER DECREASED	4	T4, PA, QL (2 PER 1 DAY), NDS	
1/1/2026	AUGTYRO CAPSULE 160 MG ORAL	QL INCREASED	5	T5, PA, QL (2 PER 1 DAY), NDS	
1/1/2026	AZTREONAM SOLUTION RECONSTITUTED 2 GM INJECTION	TIER DECREASED	4	T4, NDS	
1/1/2026	BUCAPSOL CAPSULE 15 MG ORAL	FORMULARY ADDITION	4	T4	
1/1/2026	BUPRENORPHINE HCL TABLET SUBLINGUAL 2 MG, 8 MG SUBLINGUAL	QL INCREASED	2	T2, QL (4 PER 1 DAY)	
1/1/2026	BUPRENORPHINE HCL-NALOXONE FILM 12-3 MG SUBLINGUAL	QL INCREASED	4	T4, QL (3 PER 1 DAY), NDS	

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1/1/2026	BUPRENORPHINE FILM 2 MG, 4 MG, 8 MG SUBLINGUAL	QL INCREASED	4	T4, QL (4 PER 1 DAY)	
1/1/2026	BUPRENORPHINE HCL-NALOXONE TABLET SUBLINGUAL 2-0.5 MG, 8-2 MG SUBLINGUAL	QL INCREASED	2	T2, QL (4 PER 1 DAY)	
1/1/2026	CIBINQO TABLET 50 MG, 100 MG, 200 MG ORAL	FORMULARY ADDITION	5	T5, PA, QL (1 PER 1 DAY), NDS	
1/1/2026	CLINDAMYCIN PHOS-BENZOYL GEL 1.2-2.5% EXTERNAL	FORMULARY ADDITION	2	T2	
1/1/2026	COSENTYX (300 MG DOSE) SOLUTION PREFILLED SYRINGE 150 MG/ML SUBCUTANEOUS	FORMULARY ADDITION	5	T5, PA, QL (34 PER 365 DAYS), NDS	
1/1/2026	COSENTYX SENSOREADY (300 MG) SOLUTION AUTO-INJECTOR 150 MG/ML SUBCUTANEOUS	FORMULARY ADDITION	5	T5, PA, QL (34 PER 365 DAYS), NDS	
1/1/2026	COSENTYX SOLUTION PREFILLED SYRINGE 75 MG/0.5ML SUBCUTANEOUS	FORMULARY ADDITION	5	T5, PA, QL (9 PER 365 DAYS), NDS	
1/1/2026	COSENTYX UNOREADY SOLUTION AUTO-INJECTOR 300 MG/2ML SUBCUTANEOUS	FORMULARY ADDITION	5	T5, PA, QL (34 PER 365 DAYS), NDS	
1/1/2026	CRESEMBA CAPSULE 186 MG ORAL	FORMULARY ADDITION	5	T5, PA, QL (6 PER 1 DAY), NDS	
1/1/2026	CRESEMBA CAPSULE 74.5 MG ORAL	FORMULARY ADDITION	5	T5, PA, QL (15 PER 1 DAY), NDS	
1/1/2026	CYCLOBENZAPRINE HCL TABLET 5 MG, 7.5 MG, 10 MG ORAL	PA CRITERIA UPDATED	2	T2, PA, QL (3 PER 1 DAY)	
1/1/2026	DAPAGLIFLOZIN PROPANEDIOL TABLET 5 MG, 10 MG ORAL	GENERIC SUBSTITUTION	3	T3, QL (1 PER 1 DAY)	

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1/1/2026	DARUNAVIR TABLET 600 MG ORAL	TIER DECREASED	4	T4, QL (2 PER 1 DAY), NDS	
1/1/2026	EDURANT PED TABLET SOLUBLE 2.5 MG ORAL	FORMULARY ADDITION	5	T5, NDS	
1/1/2026	EFAVIRENZ-EMTRICITAB-TENOFO DF TABLET 600 MG ORAL	TIER DECREASED	4	T4, QL (1 PER 1 DAY), NDS	
1/1/2026	ELTROMBOPAG OLAMINE PACKET 12.5 MG ORAL	QL INCREASED	5	T5, PA, QL (12 PER 1 DAY), NDS	
1/1/2026	ELTROMBOPAG OLAMINE PACKET 25 MG ORAL	QL INCREASED	5	T5, PA, QL (6 PER 1 DAY), NDS	
1/1/2026	ELTROMBOPAG OLAMINE TABLET 12.5 MG, 25 MG ORAL	AL UPDATED	5	T5, PA, QL (1 PER 1 DAY), NDS	
1/1/2026	EPRONTIA SOLUTION 25 MG/ML ORAL	FORMULARY ADDITION	4	T4, QL (16 PER 1 DAY), ST	
1/1/2026	ERAXIS SOLUTION RECONSTITUTED 50 MG INTRAVENOUS	TIER DECREASED	4	T4, NDS	
1/1/2026	ERZOFRI SUSPENSION PREFILLED SYRINGE 117 MG/0.75ML INTRAMUSCULAR	AL UPDATED	5	T5, PA, QL (1 PER 28 DAYS), NDS, AGE	
1/1/2026	EUCRISA OINTMENT 2 % EXTERNAL	FORMULARY ADDITION	4	T4	
1/1/2026	FANAPT TABLET 1 MG, 2 MG, 6 MG, 8 MG, 10 MG, 12 MG ORAL	PA CRITERIA UPDATED	5	T5, PA, QL (2 PER 1 DAY), NDS	
1/1/2026	FANAPT TABLET 4 MG ORAL	PA CRITERIA UPDATED	4	T4, PA, QL (2 PER 1 DAY)	
1/1/2026	IBTROZI CAPSULE 200 MG ORAL	FORMULARY ADDITION	5	T5, PA, NDS	
1/1/2026	IMATINIB MESYLATE TABLET 100 MG ORAL	TIER DECREASED	4	T4, PA, QL (2 PER 1 DAY), NDS	

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1/1/2026	JARDIANCE TABLET 10 MG ORAL	FORMULARY ADDITION	3	T3, QL (1 PER 1 DAY)	
1/1/2026	JARDIANCE TABLET 25 MG ORAL	FORMULARY ADDITION	3	Т3	
1/1/2026	KLOXXADO LIQUID 8 MG/0.1ML NASAL	FORMULARY ADDITION	4	T4	
1/1/2026	LEVEMIR FLEXPEN SOLUTION PEN- INJECTOR 100 UNIT/ML SUBCUTANEOUS	FORMULARY ADDITION	3	T3, QL (45 PER 30 DAYS)	
1/1/2026	LEVEMIR FLEXTOUCH SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS	FORMULARY ADDITION	3	T3, QL (45 PER 30 DAYS)	
1/1/2026	LEVEMIR SOLUTION 100 UNIT/ML SUBCUTANEOUS	FORMULARY ADDITION	3	T3, QL (50 PER 30 DAYS)	
1/1/2026	LUBIPROSTONE CAPSULE 8 MCG, 24 MCG ORAL	QL UPDATED	3	ТЗ	
1/1/2026	LURASIDONE HCL TABLET 20 MG, 40 MG, 60 MG, 120 MG ORAL	ST REMOVED	4	T4, QL (1 PER 1 DAY)	
1/1/2026	LURASIDONE HCL TABLET 80 MG ORAL	ST REMOVED	4	T4, QL (2 PER 1 DAY)	
1/1/2026	LUTRATE DEPOT INJECTABLE 22.5 MG INTRAMUSCULAR	NDS REMOVED	4	T4	
1/1/2026	MICAFUNGIN SODIUM SOLUTION RECONSTITUTED 100 MG INTRAVENOUS	FORMULARY ADDITION	4	T4	
1/1/2026	MIRABEGRON ER TABLET EXTENDED RELEASE 24 HOUR 25 MG, 50 MG ORAL	GENERIC SUBSTITUTION	3	T3, QL (1 PER 1 DAY)	
1/1/2026	NEXLETOL TABLET 180 MG ORAL	FORMULARY ADDITION	4	T4, PA, QL (1 PER 1 DAY)	

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1/1/2026	NILOTINIB HCL CAPSULE 50 MG, 150 MG, 200 MG ORAL	QL UPDATED	5	T5, PA, QL (4 PER 1 DAY), NDS	
1/1/2026	NOVOLOG PENFILL SOLUTION CARTRIDGE 100 UNIT/ML SUBCUTANEOUS	FORMULARY ADDITION	3	T3, QL (45 PER 30 DAYS)	
1/1/2026	NURTEC TABLET DISPERSIBLE 75 MG ORAL	FORMULARY ADDITION	5	T5, PA, QL (18 PER 30 DAYS), NDS	
1/1/2026	ORQUIDEA TABLET 0.35 MG ORAL	FORMULARY ADDITION	2	T2	
1/1/2026	OXYBUTYNIN CHLORIDE SOLUTION 5 MG/5ML ORAL	ST REMOVED	2	T2	
1/1/2026	OXYBUTYNIN CHLORIDE SYRUP 5 MG/5ML ORAL	ST REMOVED	2	T2	
1/1/2026	OXYBUTYNIN CHLORIDE TABLET 5 MG ORAL	ST REMOVED	2	T2	
1/1/2026	OXYBUTYNIN CHLORIDE TABLET EXTENDED RELEASE 24 HOUR 5 MG, 10 MG, 15 MG ORAL	ST REMOVED	2	T2	
1/1/2026	PENMENVY SUSPENSION RECONSTITUTED INTRAMUSCULAR	FORMULARY ADDITION	3	ТЗ	
1/1/2026	PERAMPANEL TABLET 2 MG ORAL	GENERIC SUBSTITUTION	4	T4, QL (1 PER 1 DAY), ST, NDS	
1/1/2026	PERAMPANEL TABLET 4 MG, 6 MG, 8 MG, 10 MG, 12 MG ORAL	GENERIC SUBSTITUTION	5	T5, QL (1 PER 1 DAY), ST, NDS	
1/1/2026	PERSERIS PREFILLED SYRINGE 90 MG, 120 MG SUBCUTANEOUS	PA CRITERIA UPDATED	5	T5, PA, NDS	
1/1/2026	PREDNISOLONE TABLET 5 MG ORAL	FORMULARY ADDITION	2	T2	
1/1/2026	QUETIAPINE FUMARATE TABLET EXTENDED RELEASE 24 HOUR 50	FORMULARY ADDITION	2	T2	

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	MG ORAL				
1/1/2026	REVCOVI SOLUTION 2.4 MG/1.5ML INTRAMUSCULAR	FORMULARY ADDITION	5	T5, PA, NDS	
1/1/2026	REZDIFFRA TABLET 60 MG, 80 MG, 100 MG ORAL	FORMULARY ADDITION	5	T5, PA, QL (1 PER 1 DAY), NDS	
1/1/2026	ROFLUMILAST TABLET 250 MCG ORAL	PA CRITERIA UPDATED	4	T4, QL (1 PER 1 DAY), NDS	
1/1/2026	ROFLUMILAST TABLET 500 MCG ORAL	PA CRITERIA UPDATED	4	T4, QL (1 PER 1 DAY)	
1/1/2026	SACUBITRIL-VALSARTAN TABLET 24 MG, 49 MG, 97 MG ORAL	GENERIC SUBSTITUTION	3	T3, QL (2 PER 1 DAY)	
1/1/2026	SIROLIMUS SOLUTION 1 MG/ML ORAL	TIER DECREASED	4	T4, PA, NDS	
1/1/2026	TERIPARATIDE SOLUTION PEN- INJECTOR 560 MCG/2.24ML SUBCUTANEOUS	PA CRITERIA UPDATED	5	T5, PA, QL (2 PER 28 DAYS), NDS	
1/1/2026	TERIPARATIDE SOLUTION PEN- INJECTOR 620 MCG/2.48ML SUBCUTANEOUS	PA CRITERIA UPDATED	5	T5, PA, QL (2 PER 28 DAYS), NDS	
1/1/2026	TETRABENAZINE TABLET 12.5 MG ORAL	TIER INCREASED	4	T4, PA, QL (3 PER 1 DAY), NDS	
1/1/2026	THALOMID CAPSULE 100 MG ORAL	QL INCREASED	5	T5, PA, QL (4 PER 1 DAY), NDS	
1/1/2026	THALOMID CAPSULE 50 MG ORAL	QL INCREASED	5	T5, PA, QL (8 PER 1 DAY), NDS	
1/1/2026	TICAGRELOR TABLET 60 MG ORAL	GENERIC SUBSTITUTION	3	T3, QL (2 PER 1 DAY)	
1/1/2026	TICAGRELOR TABLET 90 MG ORAL	GENERIC SUBSTITUTION	3	Т3	

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1/1/2026	TOLTERODINE TARTRATE CAPSULE EXTENDED RELEASE 24 HOUR 2 MG, 4 MG ORAL	ST REMOVED	4	T4, QL (1 PER 1 DAY)	
1/1/2026	TOLTERODINE TARTRATE TABLET 1 MG, 2 MG ORAL	ST REMOVED	2	T2	
1/1/2026	TOLVAPTAN TABLET 30 MG ORAL	FORMULARY ADDITION	5	T5, PA, QL (2 PER 1 DAY), NDS	
1/1/2026	TOLVAPTAN TABLET THERAPY PACK 15 MG, 3015 MG, 4515 MG, 6030 MG, 9030 MG ORAL	FORMULARY ADDITION	5	T5, PA, QL (2 PER 1 DAY), NDS	
1/1/2026	TOPIRAMATE SOLUTION 25 MG/ML ORAL	ST REMOVED	4	T4	
1/1/2026	TORPENZ TABLET 2.5 MG, 5 MG, 7.5 MG, 10 MG ORAL	FORMULARY ADDITION	5	T5, PA, NDS	
1/1/2026	TRIKAFTA TABLET THERAPY PACK 50 MG, 100 MG ORAL	FORMULARY ADDITION	5	T5, PA, QL (84 PER 28 DAYS), NDS	
1/1/2026	TRIKAFTA THERAPY PACK 80 MG, 100 MG ORAL	FORMULARY ADDITION	5	T5, PA, QL (56 PER 28 DAYS), NDS	
1/1/2026	TROSPIUM CHLORIDE CAPSULE EXTENDED RELEASE 24 HOUR 60 MG ORAL	ST REMOVED	4	T4, QL (1 PER 1 DAY)	
1/1/2026	TYENNE SOLUTION AUTO-INJECTOR 162 MG/0.9ML SUBCUTANEOUS	FORMULARY ADDITION	5	T5, PA, QL (4 PER 28 DAYS), NDS	
1/1/2026	TYENNE SOLUTION PREFILLED SYRINGE 162 MG/0.9ML SUBCUTANEOUS	FORMULARY ADDITION	5	T5, PA, QL (4 PER 28 DAYS), NDS	
1/1/2026	TYMLOS SOLUTION PEN-INJECTOR 3120 MCG/1.56ML SUBCUTANEOUS	PA CRITERIA UPDATED	5	T5, PA, QL (2 PER 30 DAYS), NDS	
1/1/2026	TYVASO DPI MAINTENANCE KIT POWDER 16 MCG, 16 & 32 & 48	FORMULARY ADDITION	5	T5, PA, NDS	

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	MCG, 32 MCG, 48 MCG, 64 MCG				
	INHALATION				
1/1/2026	TYVASO DPI TITRATION KIT	FORMULARY	5	T5, PA, NDS	
	POWDER 16 MCG, 16 & 32 & 48	ADDITION			
	MCG, 32 MCG, 48 MCG, 64 MCG				
	INHALATION				
1/1/2026	USTEKINUMAB SOLUTION 45	FORMULARY	5	T5, PA, NDS	
	MG/0.5ML SUBCUTANEOUS	ADDITION			
1/1/2026	USTEKINUMAB SOLUTION	FORMULARY	5	T5, PA, NDS	
	PREFILLED SYRINGE 45 MG/0.5ML	ADDITION			
	SUBCUTANEOUS				
1/1/2026	USTEKINUMAB SOLUTION	FORMULARY	5	T5, PA, NDS	
	PREFILLED SYRINGE 90 MG/ML	ADDITION			
	SUBCUTANEOUS				
1/1/2026	VIMKUNYA SUSPENSION PREFILLED	FORMULARY	3	Т3	
	SYRINGE 40 MCG/0.8ML	ADDITION			
	INTRAMUSCULAR				
1/1/2026	VIVOTIF CAPSULE DELAYED RELEASE	FORMULARY	3	Т3	
	ORAL	ADDITION			
1/1/2026	WINREVAIR KIT 2 X 45 MG, 2 X 60	FORMULARY	5	T5, PA, NDS	
	MG, 45 MG, 60 MG	ADDITION			
	SUBCUTANEOUS				
1/1/2026	XPOVIO TABLET THERAPY PACK 10	QL UPDATED	5	T5, PA, QL (16 PER 28 DAYS), NDS	
	MG, 20 MG ORAL				
1/1/2026	ZTALMY SUSPENSION 50 MG/ML	PA CRITERIA	5	T5, NDS	
	ORAL	UPDATED			
1/1/2026	ZYMFENTRA AUTO-INJECTOR KIT	FORMULARY	5	T5, PA, QL (1 PER 28 DAYS), NDS	
	120 MG/ML SUBCUTANEOUS	ADDITION			
1/1/2026	ZYMFENTRA PREFILLED SYRINGE KIT	FORMULARY	5	T5, PA, QL (1 PER 28 DAYS), NDS	
	120 MG/ML SUBCUTANEOUS	ADDITION			

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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 DELETIONs)	Member Notification
1/1/2026	ACETAMINOPHEN-CODEINE #2 TABLET 300-15 MG ORAL	TIER INCREASED	3	T3, QL (6 PER 1 DAY), NDS		Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	ACETAMINOPHEN-CODEINE #3 TABLET 300-15 MG ORAL	TIER INCREASED	3	T3, QL (6 PER 1 DAY), NDS		Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	ACETAMINOPHEN-CODEINE #4 TABLET 300-15 MG ORAL	TIER INCREASED	3	T3, QL (6 PER 1 DAY), NDS		Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	ACETAMINOPHEN-CODEINE SOLUTION 120 MG/5ML ORAL	TIER INCREASED	3	T3, NDS		Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	ACETAMINOPHEN-CODEINE SOLUTION 300-15 MG/12.5ML ORAL	TIER INCREASED	3	T3, NDS		Members were sent advanced general notice of new plan year formulary changes in their

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						Evidence of Coverage (EOC).
1/1/2026	ACETAMINOPHEN-CODEINE TABLET 300-30 MG ORAL	TIER INCREASED	3	T3, QL (6 PER 1 DAY), NDS		Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	ACTEMRA ACTPEN SOLUTION AUTO-INJECTOR 162 MG/0.9ML SUBCUTANEOUS	GENERIC SUBSTITUTION			T5: TYENNE SOLUTION AUTO- INJECTOR 162 MG/0.9ML SUBCUTANEOUS	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	ACTEMRA SOLUTION PREFILLED SYRINGE 162 MG/0.9ML SUBCUTANEOUS	GENERIC SUBSTITUTION			T5: TYENNE SOLUTION PREFILLED SYRINGE 162 MG/0.9ML SUBCUTANEOUS	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	AVMAPKI FAKZYNJA CO-PACK THERAPY PACK 0.8 & 200 MG ORAL	QL DECREASED	5	T5, PA, QL (66 PER 28 DAYS), NDS		Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	BRILINTA TABLET 60 MG, 90 MG ORAL	GENERIC SUBSTITUTION			T3: TICAGRELOR TABLET 60 MG, 90 MG ORAL	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	BUPROPION HCL TABLET EXTENDED RELEASE 24 HOUR 450 MG ORAL	FORMULARY DELETION				Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	ENTRESTO TABLET 24 MG, 49 MG, 97 MG ORAL	GENERIC SUBSTITUTION			T3: SACUBITRIL-VALSARTAN TABLET 24 MG, 49 MG, 97 MG ORAL	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

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1/1/2026	FORTEO SOLUTION 600 MCG/2.4ML SUBCUTANEOUS	GENERIC SUBSTITUTION			T5: TERIPARATIDE SOLUTION PEN- INJECTOR 560 MCG/2.24ML SUBCUTANEOUS	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	FORTEO SOLUTION SOLUTION PEN-INJECTOR 620 MCG/2.48ML SUBCUTANEOUS	GENERIC SUBSTITUTION			T5: TERIPARATIDE SOLUTION PEN- INJECTOR 620 MCG/2.48ML SUBCUTANEOUS	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	FYCOMPA TABLET 2 MG, 4 MG, 6 MG, 8 MG, 10 MG, 12 MG ORAL	GENERIC SUBSTITUTION			T5: PERAMPANEL TABLET 2 MG, 4 MG, 6 MG, 8 MG, 10 MG, 12 MG ORAL	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	HUMALOG KWIKPEN SOLUTION PEN-INJECTOR 100 UNIT/ML SUBCUTANEOUS	QL UPDATED	3	T3, QL (45 PER 30 DAYS)		Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	HUMALOG MIX SUSPENSION 75 UNIT/ML SUBCUTANEOUS	QL UPDATED	3	T3, QL (50 PER 30 DAYS)		Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	HUMALOG MIX SUSPENSION PEN-INJECTOR 75 UNIT/ML SUBCUTANEOUS	QL UPDATED	3	T3, QL (45 PER 30 DAYS)		Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	HUMALOG SOLUTION 100 UNIT/ML INJECTION	QL UPDATED	3	T3, QL (50 PER 30 DAYS)		Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	HYDROCODONE- ACETAMINOPHEN TABLET 5-325 MG, 7.5-325 MG, 10-325 MG ORAL	TIER INCREASED	3	T3, QL (6 PER 1 DAY), NDS		Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

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1/1/2026	HYDROCODONE-IBUPROFEN	TIER INCREASED	3	T3, QL (6 PER 1 DAY), NDS	Members were sent advanced
	TABLET 7.5 MG-200 MG ORAL				general notice of new plan year
					formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	HYDROMORPHONE HCL TABLET	TIER INCREASED	3	T3, QL (6 PER 1 DAY), NDS	Members were sent advanced
	2 MG, 4 MG ORAL				general notice of new plan year
					formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	HYDROMORPHONE HCL TABLET	TIER INCREASED	3	T3, QL (3 PER 1 DAY), NDS	Members were sent advanced
	8 MG ORAL				general notice of new plan year
					formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	INSULIN LISPRO SOLUTION 100	QL UPDATED	3	T3, QL (50 PER 30 DAYS)	Members were sent advanced
	UNIT/ML INJECTION				general notice of new plan year
					formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	INSULIN LISPRO SOLUTION PEN-	QL UPDATED	3	T3, QL (45 PER 30 DAYS)	Members were sent advanced
	INJECTOR 100 UNIT/ML				general notice of new plan year
	SUBCUTANEOUS				formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	INVEGA HAFYERA SUSPENSION	PA CRITERIA	5	T5, PA, QL (4.0 PER 180 DAYS),	Members were sent advanced
	PREFILLED SYRINGE 1092	UPDATED		NDS	general notice of new plan year
	MG/3.5ML INTRAMUSCULAR				formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	INVEGA HAFYERA SUSPENSION	PA CRITERIA	5	T5, PA, QL (5 PER 180 DAYS),	Members were sent advanced
	PREFILLED SYRINGE 1560	UPDATED		NDS	general notice of new plan year
	MG/5ML INTRAMUSCULAR				formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	INVEGA SUSTENNA	PA CRITERIA	5	T5, PA, NDS	Members were sent advanced
	SUSPENSION 117 MG/0.75ML	UPDATED			general notice of new plan year
	INTRAMUSCULAR				formulary changes in their
					Evidence of Coverage (EOC).

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1/1/2026	INVEGA SUSTENNA	PA CRITERIA	5	T5, PA, NDS	Members were sent advanced
	SUSPENSION 156 MG/ML	UPDATED			general notice of new plan year
	INTRAMUSCULAR				formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	INVEGA SUSTENNA	PA CRITERIA	5	T5, PA, NDS	Members were sent advanced
	SUSPENSION 234 MG/1.5ML	UPDATED			general notice of new plan year
	INTRAMUSCULAR				formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	INVEGA SUSTENNA	PA CRITERIA	4	T4, PA	Members were sent advanced
	SUSPENSION 39 MG/0.25ML	UPDATED			general notice of new plan year
	INTRAMUSCULAR				formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	INVEGA SUSTENNA	PA CRITERIA	5	T5, PA, NDS	Members were sent advanced
	SUSPENSION 78 MG/0.5ML	UPDATED			general notice of new plan year
	INTRAMUSCULAR				formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	INVEGA SUSTENNA	PA CRITERIA	5	T5, PA, NDS	Members were sent advanced
	SUSPENSION PREFILLED	UPDATED			general notice of new plan year
	SYRINGE 117 MG/0.75ML				formulary changes in their
	INTRAMUSCULAR				Evidence of Coverage (EOC).
1/1/2026	INVEGA SUSTENNA	PA CRITERIA	5	T5, PA, NDS	Members were sent advanced
	SUSPENSION PREFILLED	UPDATED			general notice of new plan year
	SYRINGE 156 MG/ML				formulary changes in their
	INTRAMUSCULAR				Evidence of Coverage (EOC).
1/1/2026	INVEGA SUSTENNA	PA CRITERIA	5	T5, PA, NDS	Members were sent advanced
	SUSPENSION PREFILLED	UPDATED			general notice of new plan year
	SYRINGE 234 MG/1.5ML				formulary changes in their
	INTRAMUSCULAR				Evidence of Coverage (EOC).
1/1/2026	INVEGA SUSTENNA	PA CRITERIA	4	T4, PA	Members were sent advanced
- ·	SUSPENSION PREFILLED	UPDATED			general notice of new plan year
	SYRINGE 39 MG/0.25ML				formulary changes in their
	,				Evidence of Coverage (EOC).

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	INTRAMUSCULAR				
1/1/2026	INVEGA SUSTENNA SUSPENSION PREFILLED SYRINGE 78 MG/0.5ML INTRAMUSCULAR	PA CRITERIA UPDATED	5	T5, PA, NDS	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	INVEGA TRINZA SUSPENSION 273 MG/0.875ML INTRAMUSCULAR	PA CRITERIA UPDATED	5	T5, PA, NDS	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	INVEGA TRINZA SUSPENSION 410 MG/1.315ML INTRAMUSCULAR	PA CRITERIA UPDATED	5	T5, PA, NDS	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	INVEGA TRINZA SUSPENSION 546 MG/1.75ML INTRAMUSCULAR	PA CRITERIA UPDATED	5	T5, PA, NDS	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	INVEGA TRINZA SUSPENSION 819 MG/2.625ML INTRAMUSCULAR	PA CRITERIA UPDATED	5	T5, PA, NDS	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 273 MG/0.875ML INTRAMUSCULAR	PA CRITERIA UPDATED	5	T5, NDS	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	INVEGA TRINZA SUSPENSION PREFILLED SYRINGE 273 MG/0.88ML INTRAMUSCULAR	PA CRITERIA UPDATED	5	T5, PA, NDS	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

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1/1/2026	INVEGA TRINZA SUSPENSION	PA CRITERIA	5	T5, PA, NDS	Members were sent advanced
	PREFILLED SYRINGE 410	UPDATED			general notice of new plan year
	MG/1.315ML INTRAMUSCULAR				formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	INVEGA TRINZA SUSPENSION	PA CRITERIA	5	T5, PA, NDS	Members were sent advanced
	PREFILLED SYRINGE 410	UPDATED			general notice of new plan year
	MG/1.32ML INTRAMUSCULAR				formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	INVEGA TRINZA SUSPENSION	PA CRITERIA	5	T5, PA, NDS	Members were sent advanced
	PREFILLED SYRINGE 546	UPDATED			general notice of new plan year
	MG/1.75ML INTRAMUSCULAR				formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	INVEGA TRINZA SUSPENSION	PA CRITERIA	5	T5, PA, NDS	Members were sent advanced
	PREFILLED SYRINGE 819	UPDATED			general notice of new plan year
	MG/2.625ML INTRAMUSCULAR				formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	INVEGA TRINZA SUSPENSION	PA CRITERIA	5	T5, PA, NDS	Members were sent advanced
	PREFILLED SYRINGE 819	UPDATED			general notice of new plan year
	MG/2.63ML INTRAMUSCULAR				formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	INVOKANA TABLET 100 MG, 300	FORMULARY			Members were sent advanced
	MG ORAL	DELETION			general notice of new plan year
					formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	LANTUS SOLOSTAR SOLUTION	QL UPDATED	3	T3, QL (45 PER 30 DAYS)	Members were sent advanced
	PEN-INJECTOR 100 UNIT/ML				general notice of new plan year
	SUBCUTANEOUS				formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	LANTUS SOLUTION 100	QL UPDATED	3	T3, QL (50 PER 30 DAYS)	Members were sent advanced
	UNIT/ML SUBCUTANEOUS				general notice of new plan year
					formulary changes in their
					Evidence of Coverage (EOC).

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1/1/2026	METHADONE HCL TABLET 10	TIER INCREASED	3	T3, QL (4 PER 1 DAY), NDS	Members were sent advanced
	MG ORAL				general notice of new plan year
					formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	METHADONE HCL TABLET 5 MG	TIER INCREASED	3	T3, QL (6 PER 1 DAY), NDS	Members were sent advanced
	ORAL				general notice of new plan year
					formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	MORPHINE SULFATE TABLET	TIER INCREASED	3	T3, QL (3 PER 1 DAY), NDS	Members were sent advanced
	EXTENDED RELEASE 15 MG, 30				general notice of new plan year
	MG ORAL				formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	MORPHINE SULFATE TABLET	TIER INCREASED	3	T3, QL (2 PER 1 DAY), NDS	Members were sent advanced
	EXTENDED RELEASE 60 MG, 100				general notice of new plan year
	MG, 200 MG ORAL				formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	ORPHENADRINE CITRATE	PA CRITERIA	2	T2, PA	Members were sent advanced
	TABLET EXTENDED RELEASE 12	UPDATED			general notice of new plan year
	HOUR 100 MG ORAL				formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	OXYCODONE HCL TABLET 15	TIER INCREASED	3	T3, QL (5 PER 1 DAY), NDS	Members were sent advanced
	MG ORAL				general notice of new plan year
					formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	OXYCODONE HCL TABLET 20	TIER INCREASED	3	T3, QL (4 PER 1 DAY), NDS	Members were sent advanced
	MG ORAL				general notice of new plan year
					formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	OXYCODONE HCL TABLET 30	TIER INCREASED	3	T3, QL (2 PER 1 DAY), NDS	Members were sent advanced
	MG ORAL				general notice of new plan year
					formulary changes in their
					Evidence of Coverage (EOC).

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1/1/2026	OXYCODONE HCL TABLET 5 MG, 10 MG ORAL	TIER INCREASED	3	T3, QL (6 PER 1 DAY), NDS	Members were sent advanced general notice of new plan year formulary changes in their
					Evidence of Coverage (EOC).
1/1/2026	OXYCODONE HCL TABLET ABUSE-DETERRENT 15 MG ORAL	TIER INCREASED	3	T3, QL (5 PER 1 DAY), NDS	Members were sent advanced general notice of new plan year formulary changes in their
1/1/2026	OXYCODONE-ACETAMINOPHEN TABLET 2.5-325 MG, 5-325 MG, 7.5-325 MG, 10-325 MG ORAL	TIER INCREASED	3	T3, QL (6 PER 1 DAY), NDS	Evidence of Coverage (EOC). Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	PAXLOVID (150/100) TABLET THERAPY PACK 10 X 100MG ORAL	QL UPDATED	3	T3, QL (60 PER 365 DAYS)	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	PAXLOVID (300/100) TABLET THERAPY PACK 10 X 100MG ORAL	QL UPDATED	3	T3, QL (90 PER 365 DAYS)	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	REGRANEX GEL 0.01 % EXTERNAL	FORMULARY DELETION			Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	RISPERIDONE MICROSPHERES SUSPENSION RECONSTITUTED ER 50 MG INTRAMUSCULAR	PA CRITERIA UPDATED	5	T5, PA, NDS	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	UPTRAVI TABLET 200 MCG, 400 MCG, 600 MCG, 800 MCG, 1000 MCG, 1200 MCG, 1400 MCG, 1600 MCG ORAL	FORMULARY DELETION			Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

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1/1/2026	UPTRAVI TITRATION TABLET THERAPY PACK 200 & 800 MCG ORAL	FORMULARY DELETION			Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	XDEMVY SOLUTION 0.25 % OPHTHALMIC	PA CRITERIA UPDATED	5	T5, PA, QL (30 PER 365 DAYS), NDS	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	ZYPREXA RELPREVV SUSPENSION RECONSTITUTED 210 MG INTRAMUSCULAR	PA CRITERIA UPDATED	4	T4, PA	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).
1/1/2026	ZYPREXA RELPREVV SUSPENSION RECONSTITUTED 300 MG, 405 MG INTRAMUSCULAR	PA CRITERIA UPDATED	5	T5, PA, NDS	Members were sent advanced general notice of new plan year formulary changes in their Evidence of Coverage (EOC).

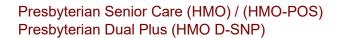
**B/D** = This drug may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination, **NDS** = Drug is limited to a one-month supply, **PA** = Prior Authorization required, **QL** = Quantity 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.

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Based on a Model of Care review, Presbyterian Dual Plus (HMO D-SNP) has been approved by the National Committee for Quality Assurance (NCQA) to operate a Special Needs Plan (SNP) through 2028.

# **Notice of Availability**

English	ATTENTION: If you speak English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-855-592-7737 (TTY: 711) or speak to your provider.
Spanish Español	ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. También están disponibles de forma gratuita ayuda y servicios auxiliares apropiados para proporcionar información en formatos accesibles. Llame al 1-855-592-7737 (TTY: 711) o hable con su proveedor.
Navajo Diné	SHOOH: Diné bee yániłti'gogo, saad bee aná'awo' bee áka'anída'awo'ít'áá jiik'eh ná hóló. Bee ahił hane'go bee nida'anishí t'áá ákodaat'éhígíí dóó bee áka'anída'wo'í áko bee baa hane'í bee hadadilyaa bich'į' ahoot'i'ígíí éí t'áá jiik'eh hóló. Kohjį' 1-855-592-7737 (TTY: 711) hodíilnih doodago nika'análwo'í bich'į' hanidziih.
Vietnamese Việt	LƯU Ý: Nếu bạn nói tiếng Việt, chúng tôi cung cấp miễn phí các dịch vụ hỗ trợ ngôn ngữ. Các hỗ trợ dịch vụ phù hợp để cung cấp thông tin theo các định dạng dễ tiếp cận cũng được cung cấp miễn phí. Vui lòng gọi theo số 1-855-592-7737 (Người khuyết tật: TTY: 711) hoặc trao đổi với người cung cấp dịch vụ của bạn.
German Deutsch	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Entsprechende Hilfsmittel und Dienste zur Bereitstellung von Informationen in barrierefreien Formaten stehen ebenfalls kostenlos zur Verfügung. Rufen Sie 1-855-592-7737 (TTY: 711) an oder sprechen Sie mit Ihrem Provider.
Chinese Simplified 简体中文	注意:如果您使用简体中文,我们将免费为您提供语言协助服务。我们还免费提供适当的辅助工具和服务,以提供无障碍格式版信息。请拨打 1-855-592-7737 (TTY: 711) 或咨询您的服务提供者。
Chinese Traditional 繁體中文	注意:如果您使用繁體中文,我們將免費為您提供語言協助服務。我們還免費提供適當的輔助工具和服務,以提供無障礙格式版資訊。請致電 1-855-592-7737 (TTY:711) 或諮詢您的服務提供者。
Japanese 日本語	注:日本語を話される場合、無料の言語支援サービスをご利用いただけます。アクセシブル (誰もが利用できるよう配慮された)な形式で情報を提供するための適切な補助支援やサー ビスも無料でご利用いただけます。1-855-592-7737 (TTY:711)までお電話ください。または、 ご利用の事業者にご相談ください。
Filipino	ATTENTION: Kung marunong kang magsalita ng Filipino, makakagamit ka ng mga libreng serbisyo sa tulong sa wika. Ang mga angkop na karagdagang tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format ay magagamit din nang libre. Tumawag sa 1-855-592-7737 (TTY: 711) o makipag-usap sa iyong provider.
Korean 한국어	주의: 한국어를 사용하는 경우 무료 언어 지원 서비스를 이용하실 수 있습니다. 접근 가능한 형식으로 정보를 제공하기 위한 적절한 보조 도구 및 서비스도 무료로 제공됩니다. 1-855-592-7737(TTY: 711)로 전화하거나 서비스 제공업체에 문의하세요.



French Français	ATTENTION : Si vous parlez Français, des services d'assistance linguistique gratuits sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-855-592-7737 (TTY : 711) ou parlez à votre fournisseur.
Tagalog	PAALALA: Kung nagsasalita ka ng Tagalog, magagamit mo ang mga libreng serbisyong tulong sa wika. Magagamit din nang libre ang mga naaangkop na auxiliary na tulong at serbisyo upang magbigay ng impormasyon sa mga naa-access na format. Tumawag sa 1-855-592-7737 (TTY: 711) o makipag-usap sa iyong provider.
Russian РУССКИЙ	ВНИМАНИЕ: Если вы говорите на русский, вам доступны бесплатные услуги языковой поддержки. Соответствующие вспомогательные средства и услуги по предоставлению информации в доступных форматах также предоставляются бесплатно. Позвоните по телефону 1-855-592-7737 (ТТҮ: 711) или обратитесь к своему поставщику услуг.
Urdu اردو	توجہ دیں: اگر آپ ار دو بولتے ہیں تو، مفت لسانی اعانت کی خدمات آپ کے لیے دستیاب ہیں۔ مناسب ضمنی امداد اور خدمات بھی قابل رسائی فارمیٹس میں معلومات فراہم کرنے کے لیے بلا معاوضہ دستیاب ہیں۔ (TTY: 711) 592-592-592 پر کال کریں یا اپنے فراہم کنندہ سے بات کریں۔
Nepali नेपाली	ध्यान दिनुहोस्: तपाईं नेपाली बोल्नुहुन्छ भने तपाईंका लागि नि:शुल्क भाषा सहायता सेवाहरू उपलब्ध छन्। पहुँचयोग्य ढाँचाहरूमा जानकारी प्रदान गर्न उपयुक्त सहायक सहायताहरू र सेवाहरू पनि नि:शुल्क उपलब्ध छन्। 1-855-592-7737 (TTY: 711) मा फोन गर्नुहोस् वा आफ्नो प्रदायकसँग कुरा गर्नुहोस्।
Bengali বাংলা	মনোযোগ দিন: আপনি যদি বাংলায় কথা বলেন, তাহলে বিনামূল্যে ভাষা সহায়তা পরিষেবা আপনার জন্য উপলব্ধ। অ্যাক্সেসযোগ্য ফর্ম্যাটে তথ্য প্রদানের জন্য উপযুক্ত সহায়ক সহায়তা এবং পরিষেবাগুলিও বিনামূল্যে পাওয়া যায়। 1-855-592-7737 (TTY: 711) নম্বরে কল করুন অথবা আপনার প্রদানকারীর সাথে কথা বলুন।
Hindi हिंदी	ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए निःशुल्क भाषा सहायता सेवाएँ उपलब्ध हैं। सुलभ प्रारूपों में जानकारी प्रदान करने के लिए उपयुक्त सहायक सहायताएँ और सेवाएँ भी निःशुल्क उपलब्ध हैं। 1-855-592-7737 (TTY: 711) पर कॉल करें या अपने प्रदाता से बात करें।
Arabic اللغة العربية	تنبيه: إذا كنت تتحدث العربية، فمتاح لك خدمات لغوية بالمجان. ومتاح بالمجان أيضًا مساعدات وخدمات إضافية مناسبة لتقديم المعلومات بتنسيقات يسهل الحصول عليها. اتصل بالرقم (711: 711) 7737-592-185-1 (خدمة الهاتف النصيي) أو تحدث إلى مزود الخدمة المعني بك.
Turkish Türkçe	DiKKATİNİZE: Türkçe biliyorsanız, ücretsiz dil destek hizmetlerinden faydalanabilirsiniz. Ayrıca ücretsiz olarak, uygun yardımcı araçlarla ve hizmetlerle erişilebilir formatlarda bilgi de sağlanmaktadır. 1-855-592-7737 (TTY (İşitme ve Konuşma Engelli Destek Hattı): 711) numaralı telefondan bize ulaşabilir veya hizmet sağlayıcınız ile görüşebilirsiniz.