



## Molina Healthcare Marketplace

### Formulary Changes Effective April 1, 2026

| Drug Name                            | Description of Formulary Change  | Notes/Alternatives      |
|--------------------------------------|--|-------------------------|
| BESIFLOXACIN SUS 0.6%                | Adding to Formulary, Non-Preferred Generic Tier with Prior Authorization |                         |
| Beyfortus SOSY 100MG/ML              | Changed to Preventive Tier   |                         |
| Beyfortus SOSY 50MG/0.5ML            | Changed to Preventive Tier   |                         |
| COMIRNATY 5- INJ 11/25-26            | Adding to Formulary, Preventive Tier                                     | Age Limits Apply        |
| COMIRNATY INJ 30/.3ML                | Adding to Formulary, Preventive Tier                                     | Age Limits Apply        |
| CONJ ESTROGN TAB 0.3MG               | Adding to Formulary, Preferred Generic Tier                              | Quantity Limits Apply   |
| CONJ ESTROGN TAB 0.45MG              | Adding to Formulary, Preferred Generic Tier                              | Quantity Limits Apply   |
| CONJ ESTROGN TAB 0.625MG             | Adding to Formulary, Preferred Generic Tier                              | Quantity Limits Apply   |
| CONJ ESTROGN TAB 0.9MG               | Adding to Formulary, Preferred Generic Tier                              | Quantity Limits Apply   |
| CONJ ESTROGN TAB 1.25MG              | Adding to Formulary, Preferred Generic Tier                              | Quantity Limits Apply   |
| CVS PURELAX POW                      |  | Removed Quantity Limits |
| Daptacel SUSP 23-15-5                | Adding to Formulary, Preventive Tier                                     |                         |
| DOPTELET SPR CAP 10MG                | Adding to Formulary, Specialty Tier with Prior Authorization             | Quantity Limits Apply   |
| Eliquis (1.5 MG Pack) TBSO 3 x 0.5MG | Adding to Formulary, Preferred Brand Tier                                | Quantity Limits Apply   |
| Eliquis (2 MG Pack) TBSO 4 x 0.5MG   | Adding to Formulary, Preferred Brand Tier                                | Quantity Limits Apply   |
| Eliquis CPSP 0.15MG                  | Adding to Formulary, Preferred Brand Tier                                | Quantity Limits Apply   |
| Eliquis TBSO 0.5MG                   | Adding to Formulary, Preferred Brand Tier                                | Quantity Limits Apply   |
| Enflonsia SOSY 105MG/0.7ML           | Adding to Formulary, Preventive Tier                                     |                         |
| ESTRADIOL TAB 10MCG                  |  | Removed Quantity Limits |
| EVEXITHROID TAB 45MG                 | Adding to Formulary, Preferred Brand Tier                                |                         |
| EVEXITHROID TAB 75MG                 | Adding to Formulary, Preferred Brand Tier                                |                         |
| GAVILAX POW                          |  | Removed Quantity Limits |

**PA** = Prior Authorization **QL** = Quantity Limits **ST** = Step Therapy

| Drug Name   | Description of Formulary Change                    | Notes/Alternatives      |
|---|--|-------------------------|
| GENTLELAX POW   |  | Removed Quantity Limits |
| HEALTHYLAX POW  |  | Removed Quantity Limits |
| HM CLEARLAX POW   |  | Removed Quantity Limits |
| Imovax Rabies SUSR<br>2.5UNIT/ML                              | Adding to Formulary, Preventive Tier               | Quantity Limits Apply   |
| Infanrix SUSP 25-58-10  | Adding to Formulary, Preventive Tier               |                         |
| Lomustine CAPS 100MG  | Adding to Formulary, Specialty Tier                | Quantity Limits Apply   |
| Lomustine CAPS 10MG   | Adding to Formulary, Specialty Tier                | Quantity Limits Apply   |
| Lomustine CAPS 40MG   | Adding to Formulary, Specialty Tier                | Quantity Limits Apply   |
| Loteprednol-Tobramycin<br>SUSP 0.5-0.3%                       | Adding to Formulary, Non-Preferred Generic<br>Tier | Quantity Limits Apply   |
| NEXTSTELLIS TABS 3-<br>14.2MG                                 | Adding to Formulary, Preventive Tier               |                         |
| NUVAXOVID INJ 2025-26   | Adding to Formulary, Preventive Tier               | Age Limits Apply        |
| OTEZLA XR TAB 75MG  | Adding to Formulary, Specialty Tier                |                         |
| OTEZLA/XR TAB 28 DAY  | Adding to Formulary, Specialty Tier                |                         |
| Paxlovid (300/100 &<br>150/100) TBPK 6 x 150 MG<br>&5 x 100MG | Adding to Formulary, Preventive Tier               | Quantity Limits Apply   |
| PAZOPanib HCl TABS<br>400MG                                   | Adding to Formulary, Specialty Tier                | Quantity Limits Apply   |
| PHEXXI GEL 1.8-1-0.4%   | Adding to Formulary, Preventive Tier               |                         |
| POLYETH GLYC POW 3350<br>NF                                   |  | Removed Quantity Limits |
| POWDERLAX PAK 3350  |  | Removed Quantity Limits |
| Pyzchiva SOAJ 45MG/0.5ML                                      | Adding to Formulary, Specialty Tier                | Quantity Limits Apply   |
| Pyzchiva SOAJ 90MG/ML   | Adding to Formulary, Specialty Tier                | Quantity Limits Apply   |
| RabAvert SUSR   | Adding to Formulary, Preventive Tier               | Quantity Limits Apply   |
| Recombivax HB SUSP<br>40MCG/ML                                | Adding to Formulary, Preventive Tier               | Quantity Limits Apply   |
| Recombivax HB SUSY<br>10MCG/ML                                | Adding to Formulary, Preventive Tier               | Quantity Limits Apply   |
| Recombivax HB SUSY<br>5MCG/0.5ML                              | Adding to Formulary, Preventive Tier               | Quantity Limits Apply   |

| Drug Name                              | Description of Formulary Change  | Notes/Alternatives            |
|--|--|-------------------------------|
| Relistor SOLN 8MG/0.4ML                | Adding to Formulary, Non-Preferred Brand Tier with Prior Authorization |                               |
| Shingrix SUSY 50MCG/0.5ML              | Adding to Formulary, Preventive Tier                                   | Quantity and Age Limits Apply |
| SLYND TABS 4MG                         | Adding to Formulary, Preventive Tier                                   |                               |
| SM CLEARLAX POW                        |  | Removed Quantity Limits       |
| Tremfya-CD/UC Induction SOAJ 200MG/2ML | Adding to Formulary, Specialty Tier                                    |                               |
| TWIRLA PTWK 120-30MCG/24HR             | Adding to Formulary, Preventive Tier                                   |                               |
| VALTOCO LIQ 15MG                       |  | Changed Age Minimum 2 Years   |
| VALTOCO LIQ 20MG                       |  | Changed Age Minimum 2 Years   |
| VALTOCO SPR 10MG                       |  | Changed Age Minimum 2 Years   |
| VALTOCO SPR 5MG                        |  | Changed Age Minimum 2 Years   |
| Vraylar CAPS 0.5MG                     | Adding to Formulary, Preventive Tier                                   |                               |
| Vraylar CAPS 0.75MG                    | Adding to Formulary, Preventive Tier                                   |                               |
| YUVAFEM TAB 10MCG                      |  | Removed Quantity Limits       |



## Molina Healthcare Marketplace

### Formulary Changes Effective January 1, 2026

| Drug Name                       | Description of Formulary Change                              | Notes/Alternatives            |
|---------------------------------|--|-------------------------------|
| ACNE MEDICAT LOT 10%            | Adding to Formulary, Generic Tier                            |                               |
| ACNE MEDICAT LOT 5%             | Adding to Formulary, Generic Tier                            |                               |
| ALOG/PIOGLIT TAB 12.5-15        | Removing from Formulary                                      |                               |
| ALOG/PIOGLIT TAB 12.5-30        | Removing from Formulary                                      |                               |
| ALOG/PIOGLIT TAB 12.5-45        | Removing from Formulary                                      |                               |
| ALOG/PIOGLIT TAB 25-15MG        | Removing from Formulary                                      |                               |
| ALOG/PIOGLIT TAB 25-30MG        | Removing from Formulary                                      |                               |
| ALOG/PIOGLIT TAB 25-45MG        | Removing from Formulary                                      |                               |
| Alogliptin Benzoate TABS 12.5MG | Changing from Preferred Brand Tier to Preferred Generic Tier |                               |
| Alogliptin Benzoate TABS 25MG   | Changing from Preferred Brand Tier to Preferred Generic Tier |                               |
| Alogliptin Benzoate TABS 6.25MG | Changing from Preferred Brand Tier to Preferred Generic Tier |                               |
| AMLOD/OLMESA TAB 10-20MG        | Changing from Preferred Brand Tier to Preferred Generic Tier |                               |
| AMLOD/OLMESA TAB 10-40MG        | Changing from Preferred Brand Tier to Preferred Generic Tier |                               |
| AMLOD/OLMESA TAB 5-20MG         | Changing from Preferred Brand Tier to Preferred Generic Tier |                               |
| AMLOD/OLMESA TAB 5-40MG         | Changing from Preferred Brand Tier to Preferred Generic Tier |                               |
| AMPHETAMINE TAB 10MG            | Adding to Formulary, Preventative Tier                       | Quantity and Age Limits Apply |
| AMPHETAMINE TAB 5MG             | Adding to Formulary, Preventative Tier                       | Quantity and Age Limits Apply |
| ARALAST NP INJ 1000MG           | Removing from Formulary                                      |                               |
| ARANESP INJ 100MCG              | Changing from Specialty Tier to Non-Preferred Tier           |                               |
| ARANESP INJ 10MCG               | Changing from Specialty Tier to Non-Preferred Tier           |                               |
| ARANESP INJ 150MCG              | Changing from Specialty Tier to Non-Preferred Tier           |                               |

| Drug Name                             | Description of Formulary Change                              | Notes/Alternatives    |
|---------------------------------------|--|-----------------------|
| ARANESP INJ 200MCG                    | Changing from Specialty Tier to Non-Preferred Tier           |                       |
| ARANESP INJ 25MCG                     | Changing from Specialty Tier to Non-Preferred Tier           |                       |
| ARANESP INJ 300MCG                    | Changing from Specialty Tier to Non-Preferred Tier           |                       |
| ARANESP INJ 40MCG                     | Changing from Specialty Tier to Non-Preferred Tier           |                       |
| ARANESP INJ 500MCG                    | Changing from Specialty Tier to Non-Preferred Tier           |                       |
| ARANESP INJ 60MCG                     | Changing from Specialty Tier to Non-Preferred Tier           |                       |
| ATROVENT HFA AER 17MCG                | Removing from Formulary                                      |                       |
| AVITA CRE 0.025%                      | Removing from Formulary                                      |                       |
| AVITA GEL 0.025%                      | Removing from Formulary                                      |                       |
| Azelaic Acid GEL 15%                  | Adding to Formulary, Preferred Generic Tier                  | Quantity Limits Apply |
| BETAINE POWD                          | Changing from Specialty Tier to Non-Preferred Tier           |                       |
| BEYFORTUS INJ 100MG/ML                | Adding to Formulary, Specialty Tier with Prior Authorization | Age Limits Apply      |
| BEYFORTUS INJ 50/0.5ML                | Adding to Formulary, Specialty Tier with Prior Authorization | Age Limits Apply      |
| BISMTH/METR/ CAP TETRACY              | Adding to Formulary, Preferred Brand Tier                    | Quantity Limits Apply |
| Briviact SOLN 10MG/ML                 | Adding to Formulary, Preventative Tier                       | Age Limits Apply      |
| Briviact TABS 100MG                   | Adding to Formulary, Preventative Tier                       |                       |
| Briviact TABS 10MG                    | Adding to Formulary, Preventative Tier                       |                       |
| Briviact TABS 25MG                    | Adding to Formulary, Preventative Tier                       |                       |
| Briviact TABS 50MG                    | Adding to Formulary, Preventative Tier                       |                       |
| Briviact TABS 75MG                    | Adding to Formulary, Preventative Tier                       |                       |
| CABOMETYX TAB 20MG                    | Adding to Formulary, Specialty Tier                          | Quantity Limits Apply |
| CABOMETYX TAB 40MG                    | Adding to Formulary, Specialty Tier                          | Quantity Limits Apply |
| CABOMETYX TAB 60MG                    | Adding to Formulary, Specialty Tier                          | Quantity Limits Apply |
| Calcipotriene CREA 0.005 %            | Adding to Formulary, Preferred Generic Tier                  | Quantity Limits Apply |
| CALCIPOTRIENE OINT 0.005%             | Changing from Preferred Brand Tier to Preferred Generic Tier | Quantity Limits Apply |
| CALCIPOTRIENE SOLN 0.005% (50 MCG/ML) | Changing from Preferred Brand Tier to Preferred Generic Tier | Quantity Limits Apply |

| Drug Name                                     | Description of Formulary Change                              | Notes/Alternatives                   |
|---|--|--------------------------------------|
| Candesartan Cilexetil TABS 16MG               | Changing from Preferred Brand Tier to Preferred Generic Tier | Quantity Limits Apply                |
| Candesartan Cilexetil TABS 32MG               | Changing from Preferred Brand Tier to Preferred Generic Tier | Quantity Limits Apply                |
| Candesartan Cilexetil TABS 4MG                | Changing from Preferred Brand Tier to Preferred Generic Tier | Quantity Limits Apply                |
| Candesartan Cilexetil TABS 8MG                | Changing from Preferred Brand Tier to Preferred Generic Tier | Quantity Limits Apply                |
| CAPTOPR/HCTZ TAB 25-15MG                      | Removing from Formulary                                      |                                      |
| CAPTOPR/HCTZ TAB 25-25MG                      | Removing from Formulary                                      |                                      |
| CAPTOPR/HCTZ TAB 50-15MG                      | Removing from Formulary                                      |                                      |
| CAPTOPR/HCTZ TAB 50-25MG                      | Removing from Formulary                                      |                                      |
| CINACALCET TAB 30MG                           | Changing from Preferred Brand Tier to Specialty Tier         |                                      |
| CINACALCET TAB 60MG                           | Changing from Preferred Brand Tier to Specialty Tier         |                                      |
| CINACALCET TAB 90MG                           | Changing from Preferred Brand Tier to Specialty Tier         |                                      |
| Ciprofloxacin-Fluocinolone PF SOLN 0.3-0.025% | Adding to Formulary, Preferred Brand Tier                    | Quantity Limits and Age Limits Apply |
| CLINDAMY/BEN GEL 1.2-5%                       | Changing from Preferred Brand Tier to Preferred Generic Tier |                                      |
| CLINDAMYCIN LOT 10MG/ML                       | Changing from Preferred Brand Tier to Preferred Generic Tier | Quantity Limits Apply                |
| COMETRIQ KIT 100MG                            | Adding to Formulary, Specialty Tier with Prior Authorization | Quantity Limits Apply                |
| COMETRIQ KIT 140MG                            | Adding to Formulary, Specialty Tier with Prior Authorization | Quantity Limits Apply                |
| COMETRIQ KIT 60MG                             | Adding to Formulary, Specialty Tier with Prior Authorization | Quantity Limits Apply                |
| CYCLOPHOSPH CAP 25MG                          | Changing from Specialty Tier to Non-Preferred Tier           |                                      |
| CYCLOPHOSPH CAP 50MG                          | Changing from Specialty Tier to Non-Preferred Tier           |                                      |

| Drug Name                  | Description of Formulary Change                      | Notes/Alternatives    |
|----------------------------|--|-----------------------|
| DABIGATRAN CAP 110MG       | Adding to Formulary, Generic Tier                    | Quantity Limits Apply |
| DABIGATRAN CAP 150MG       | Adding to Formulary, Generic Tier                    | Quantity Limits Apply |
| DABIGATRAN CAP 75MG        | Adding to Formulary, Generic Tier                    | Quantity Limits Apply |
| DEXMETHYLPH CAP 10MG<br>ER | Adding to Formulary, Preventative Tier               |                       |
| DEXMETHYLPH CAP 15MG<br>ER | Adding to Formulary, Preventative Tier               |                       |
| DEXMETHYLPH CAP 20MG<br>ER | Adding to Formulary, Preventative Tier               |                       |
| DEXMETHYLPH CAP 25MG<br>ER | Adding to Formulary, Preventative Tier               |                       |
| DEXMETHYLPH CAP 30MG<br>ER | Adding to Formulary, Preventative Tier               |                       |
| DEXMETHYLPH CAP 35MG<br>ER | Adding to Formulary, Preventative Tier               |                       |
| DEXMETHYLPH CAP 40MG<br>ER | Adding to Formulary, Preventative Tier               |                       |
| DEXMETHYLPHE CAP 5MG<br>ER | Adding to Formulary, Preventative Tier               |                       |
| DIACOMIT CAP 250MG         | Changing from Non-Preferred Tier to Specialty Tier   |                       |
| DIACOMIT CAP 500MG         | Changing from Non-Preferred Tier to Specialty Tier   |                       |
| DIACOMIT PAK 250MG         | Changing from Non-Preferred Tier to Specialty Tier   |                       |
| DIACOMIT PAK 500MG         | Changing from Non-Preferred Tier to Specialty Tier   |                       |
| DIFFERIN LOT 0.1%          | Removing from Formulary                              |                       |
| DOFETILIDE CAP 125MCG      | Changing from Preferred Brand Tier to Specialty Tier |                       |
| DOFETILIDE CAP 250MCG      | Changing from Preferred Brand Tier to Specialty Tier |                       |
| DOFETILIDE CAP 500MCG      | Changing from Preferred Brand Tier to Specialty Tier |                       |
| EMCYT CAP 140MG            | Changing from Specialty Tier to Non-Preferred Tier   |                       |

| Drug Name              | Description of Formulary Change                              | Notes/Alternatives         |
|------------------------|--|----------------------------|
| EPOGEN INJ 10000/ML    | Changing from Specialty Tier to Non-Preferred Tier           |                            |
| EPOGEN INJ 2000/ML     | Changing from Specialty Tier to Non-Preferred Tier           |                            |
| EPOGEN INJ 20000/ML    | Changing from Specialty Tier to Non-Preferred Tier           |                            |
| EPOGEN INJ 3000/ML     | Changing from Specialty Tier to Non-Preferred Tier           |                            |
| EPOGEN INJ 4000/ML     | Changing from Specialty Tier to Non-Preferred Tier           |                            |
| EPROSART MES TAB 600MG | Removing from Formulary                                      |                            |
| ETOPOSIDE CAP 50MG     | Changing from Specialty Tier to Non-Preferred Tier           |                            |
| EUFLEXXA INJ 10MG/ML   | Changing from Specialty Tier to Non-Preferred Tier           |                            |
| EVEROLIMUS TAB 0.25MG  | Changing from Specialty Tier to Non-Preferred Tier           |                            |
| EVEROLIMUS TAB 0.5 MG  | Changing from Specialty Tier to Non-Preferred Tier           |                            |
| EVEROLIMUS TAB 0.75MG  | Changing from Specialty Tier to Non-Preferred Tier           |                            |
| EVEROLIMUS TAB 1MG     | Changing from Specialty Tier to Non-Preferred Tier           |                            |
| FANAPT PAK             | Removing from Formulary                                      | Adding Rexulti and Vraylar |
| FANAPT TAB 10MG        | Removing from Formulary                                      | Adding Rexulti and Vraylar |
| FANAPT TAB 12MG        | Removing from Formulary                                      | Adding Rexulti and Vraylar |
| FANAPT TAB 1MG         | Removing from Formulary                                      | Adding Rexulti and Vraylar |
| FANAPT TAB 2MG         | Removing from Formulary                                      | Adding Rexulti and Vraylar |
| FANAPT TAB 4MG         | Removing from Formulary                                      | Adding Rexulti and Vraylar |
| FANAPT TAB 6MG         | Removing from Formulary                                      | Adding Rexulti and Vraylar |
| FANAPT TAB 8MG         | Removing from Formulary                                      | Adding Rexulti and Vraylar |
| Farydak CAPS 10MG      | Adding to Formulary, Specialty Tier                          | Quantity Limits Apply      |
| Farydak CAPS 15MG      | Adding to Formulary, Specialty Tier                          | Quantity Limits Apply      |
| Farydak CAPS 20MG      | Adding to Formulary, Specialty Tier                          | Quantity Limits Apply      |
| FENOFIBRATE CAP 134MG  | Changing from Preferred Brand Tier to Preferred Generic Tier | Quantity Limits Apply      |

| <b>Drug Name</b>                         | <b>Description of Formulary Change</b>                       | <b>Notes/Alternatives</b> |
|--|--|---------------------------|
| FENOFIBRATE CAP 200MG                    | Changing from Preferred Brand Tier to Preferred Generic Tier | Quantity Limits Apply     |
| FENOFIBRATE CAP 43MG                     | Changing from Preferred Brand Tier to Preferred Generic Tier | Quantity Limits Apply     |
| FENOFIBRATE CAP 67MG                     | Changing from Preferred Brand Tier to Preferred Generic Tier | Quantity Limits Apply     |
| FULPHILA SOSY 6MG/0.6ML                  | Removing from Formulary                                      |                           |
| Glassia SOLN<br>1000MG/50ML              | Removing from Formulary                                      |                           |
| Glassia SOLN 4GM/200ML                   | Removing from Formulary                                      |                           |
| Glassia SOLN 5GM/250ML                   | Removing from Formulary                                      |                           |
| GLUCAGON KIT 1MG                         | Changing from Generic Tier to Preventative Tier              | Quantity Limits Apply     |
| HYALGAN INJ 20MG/2ML                     | Changing from Specialty Tier to Non-Preferred Tier           |                           |
| Imbruvica CAP 70MG                       | Adding to Formulary, Specialty Tier with Prior Authorization | Quantity Limits Apply     |
| Imbruvica TABS 140MG                     | Adding to Formulary, Specialty Tier with Prior Authorization | Quantity Limits Apply     |
| Imbruvica TABS 280MG                     | Adding to Formulary, Specialty Tier with Prior Authorization | Quantity Limits Apply     |
| Imbruvica TABS 420MG                     | Adding to Formulary, Specialty Tier with Prior Authorization | Quantity Limits Apply     |
| Imbruvica TABS 560MG                     | Adding to Formulary, Specialty Tier with Prior Authorization | Quantity Limits Apply     |
| INLYTA TAB 1MG                           | Adding to Formulary, Specialty Tier with Prior Authorization | Quantity Limits Apply     |
| INLYTA TAB 5MG                           | Adding to Formulary, Specialty Tier with Prior Authorization | Quantity Limits Apply     |
| Insulin Glargine-yfgn SOLN<br>100UNIT/ML | Adding to Formulary, Preferred Brand Tier                    | Quantity Limits Apply     |
| Insulin Glargine-yfgn SOPN<br>100UNIT/ML | Adding to Formulary, Preferred Brand Tier                    | Quantity Limits Apply     |
| Lagevrio CAPS 200MG                      | Adding to Formulary, Preventative Tier                       | Quantity Limits Apply     |
| LANSOPR/AMOX MIS<br>/CLARITH             | Removing from Formulary                                      |                           |

| Drug Name                             | Description of Formulary Change                              | Notes/Alternatives                  |
|---------------------------------------|--|-------------------------------------|
| LEUKERAN TAB 2MG                      | Changing from Specialty Tier to Non-Preferred Tier           |                                     |
| LEVALBUTEROL INH HFA 200              | Adding to Formulary, Preferred Brand Tier                    | Quantity Limits Apply               |
| MELPHALAN TAB 2MG                     | Changing from Specialty Tier to Non-Preferred Tier           |                                     |
| MENEST TAB 2.5MG                      | Adding to Formulary, Preferred Brand Tier                    | Quantity Limits Apply               |
| MESALAMINE TAB 1.2GM DR               | Adding to Formulary, Preferred Brand Tier                    |                                     |
| MESALAMINE TAB 800MG DR               | Removing from Formulary                                      |                                     |
| METHITEST TAB 10MG                    | Changing from Specialty Tier to Non-Preferred Tier           |                                     |
| METHOTREXATE INJ 250/10ML             | Changing from Generic Tier to Specialty Tier                 | Quantity Limits Apply               |
| METHOTREXATE INJ 25MG/ML              | Changing from Generic Tier to Specialty Tier                 | Quantity Limits Apply               |
| METHOTREXATE INJ 50MG/2ML             | Changing from Generic Tier to Specialty Tier                 | Quantity Limits Apply               |
| METHYLTESTOS CAP 10MG                 | Changing from Specialty Tier to Non-Preferred Tier           |                                     |
| METHYLTESTOSTERONE ORAL TAB 10 MG     | Changing from Specialty Tier to Non-Preferred Tier           |                                     |
| Miconazole 3 SUPP 200MG               | Adding to Formulary, Preferred Generic Tier                  | Quantity Limits Apply               |
| MONOCLATE-P KIT 1000 UNIT INTRAVENOUS | Changing from Specialty Tier to Non-Preferred Tier           |                                     |
| NEUAC GEL 1.2-5%                      | Changing from Preferred Brand Tier to Preferred Generic Tier |                                     |
| Niacin ER TBCR 1000MG                 | Adding to Formulary, Generic Tier                            | Quantity Limits Apply<br>**OTC Only |
| NITISINONE CAP 10MG                   | Changing from Specialty Tier to Non-Preferred Tier           |                                     |
| NITISINONE CAP 20 MG                  | Changing from Specialty Tier to Non-Preferred Tier           |                                     |
| NITISINONE CAP 2MG                    | Changing from Specialty Tier to Non-Preferred Tier           |                                     |

| Drug Name                      | Description of Formulary Change  | Notes/Alternatives    |
|--------------------------------|--|-----------------------|
| NITISINONE CAP 5MG             | Changing from Specialty Tier to Non-Preferred Tier                     |                       |
| NORVIR POW 100MG               | Adding to Formulary, Preferred Brand Tier                              | Quantity Limits Apply |
| OLM MED/HCTZ TAB 20-12.5       | Changing from Preferred Brand Tier to Preferred Generic Tier           | Quantity Limits Apply |
| OLM MED/HCTZ TAB 40-12.5       | Changing from Preferred Brand Tier to Preferred Generic Tier           | Quantity Limits Apply |
| OLM MED/HCTZ TAB 40-25MG       | Changing from Preferred Brand Tier to Preferred Generic Tier           | Quantity Limits Apply |
| Olmesartan Medoxomil TABS 20MG | Changing from Preferred Brand Tier to Preferred Generic Tier           | Quantity Limits Apply |
| Olmesartan Medoxomil TABS 40MG | Changing from Preferred Brand Tier to Preferred Generic Tier           | Quantity Limits Apply |
| Olmesartan Medoxomil TABS 5MG  | Changing from Preferred Brand Tier to Preferred Generic Tier           | Quantity Limits Apply |
| OXYCODONE TAB 10MG ER          | Adding to Formulary, Non-Preferred Brand Tier with Prior Authorization |                       |
| OXYCODONE TAB 15MG ER          | Adding to Formulary, Non-Preferred Brand Tier with Prior Authorization |                       |
| OXYCODONE TAB 20MG ER          | Adding to Formulary, Non-Preferred Brand Tier with Prior Authorization |                       |
| OXYCODONE TAB 30MG ER          | Adding to Formulary, Non-Preferred Brand Tier with Prior Authorization |                       |
| OXYCODONE TAB 40MG ER          | Adding to Formulary, Non-Preferred Brand Tier with Prior Authorization |                       |
| OXYCODONE TAB 60MG ER          | Adding to Formulary, Non-Preferred Brand Tier with Prior Authorization |                       |
| OXYCODONE TAB 80MG ER          | Adding to Formulary, Non-Preferred Brand Tier with Prior Authorization |                       |
| PANRETIN GEL 0.1%              | Changing from Specialty Tier to Non-Preferred Tier                     |                       |
| PHENADOZ SUP 12.5MG            | Removing from Formulary  |                       |
| PHENADOZ SUP 25MG              | Removing from Formulary  |                       |
| PHENOXYBENZA CAP 10MG          | Changing from Specialty Tier to Non-Preferred Tier                     |                       |
| Poly-Vi-Flor SUSP 0.25MG/ML    | Removing from Formulary  |                       |

| Drug Name                 | Description of Formulary Change                    | Notes/Alternatives |
|---------------------------|--|--------------------|
| PROCRIT INJ 10000/ML      | Changing from Specialty Tier to Non-Preferred Tier |                    |
| PROCRIT INJ 2000/ML       | Changing from Specialty Tier to Non-Preferred Tier |                    |
| PROCRIT INJ 20000/ML      | Changing from Specialty Tier to Non-Preferred Tier |                    |
| PROCRIT INJ 3000/ML       | Changing from Specialty Tier to Non-Preferred Tier |                    |
| PROCRIT INJ 4000/ML       | Changing from Specialty Tier to Non-Preferred Tier |                    |
| PROCRIT INJ 40000/ML      | Changing from Specialty Tier to Non-Preferred Tier |                    |
| PROLASTIN-C INJ 1000MG    | Removing from Formulary                            |                    |
| PROLIA SOL 60MG/ML        | Removing from Formulary                            |                    |
| PROMETHAZINE SUP 12.5MG   | Removing from Formulary                            |                    |
| PROMETHAZINE SUP 25MG     | Removing from Formulary                            |                    |
| PROMETHEGAN SUP 12.5MG    | Removing from Formulary                            |                    |
| PROMETHEGAN SUP 25MG      | Removing from Formulary                            |                    |
| PYRIME/LEUCO CAP 12.5/2.5 | Removing from Formulary                            |                    |
| PYRIME/LEUCO CAP 25/10MG  | Removing from Formulary                            |                    |
| PYRIME/LEUCO CAP 25/5MG   | Removing from Formulary                            |                    |
| PYRIME/LEUCO CAP 50/10MG  | Removing from Formulary                            |                    |
| PYRIME/LEUCO CAP 50/20MG  | Removing from Formulary                            |                    |
| PYRIME/LEUCO CAP 50/25MG  | Removing from Formulary                            |                    |
| PYRIME/LEUCO CAP 75/25MG  | Removing from Formulary                            |                    |
| QUINTABS TAB              | Adding to Formulary, Generic Tier                  |                    |
| RELISTOR INJ 12/0.6ML     | Changing from Specialty Tier to Non-Preferred Tier |                    |

| Drug Name   | Description of Formulary Change                        | Notes/Alternatives                           |
|---|--|--|
| RELISTOR INJ 12/0.6ML                                     | Changing from Specialty Tier to Non-Preferred Tier     |  |
| RELISTOR TAB 150MG  | Changing from Specialty Tier to Non-Preferred Tier     |  |
| REPATHA INJ 140MG/ML                                      | Changing from Specialty Tier to Non-Preferred Tier     |  |
| REPATHA PUSH INJ 420/3.5                                  | Changing from Specialty Tier to Non-Preferred Tier     |  |
| REPATHA SURE INJ 140MG/ML                                 | Changing from Specialty Tier to Non-Preferred Tier     |  |
| RETACRIT INJ 10000UNT                                     | Changing from Specialty Tier to Non-Preferred Tier     |  |
| RETACRIT INJ 20000UNI                                     | Changing from Specialty Tier to Non-Preferred Tier     |  |
| RETACRIT INJ 2000UNIT                                     | Changing from Specialty Tier to Non-Preferred Tier     |  |
| RETACRIT INJ 3000UNIT                                     | Changing from Specialty Tier to Non-Preferred Tier     |  |
| RETACRIT INJ 40000UNT                                     | Changing from Specialty Tier to Non-Preferred Tier     |  |
| RETACRIT INJ 4000UNIT                                     | Changing from Specialty Tier to Non-Preferred Tier     |  |
| REYVOW TABS 100MG   | Removing from Formulary                                |  |
| REYVOW TABS 50MG  | Removing from Formulary                                |  |
| RHO D IMMUNE GLOBULIN IM SOLN PREF SYR 1500 UNIT (300MCG) | Changing from Preferred Brand Tier to Specialty Tier   |  |
| RIBAVIRIN CAP 200MG                                       | Changing from Preferred Generic Tier to Specialty Tier |  |
| RIBAVIRIN TAB 200MG                                       | Changing from Preferred Generic Tier to Specialty Tier |  |
| RINVOQ LQ SOL 1MG/ML                                      | Adding to Formulary, Specialty Tier                    | Age Limits Apply                             |
| SIMLANDI 1PN INJ 40/0.4ML                                 | Removing from Formulary                                | Hadlima is covered on Specialty Tier with PA |
| SIMLANDI 2PN INJ 40/0.4ML                                 | Removing from Formulary                                | Hadlima is covered on Specialty Tier with PA |

| Drug Name               | Description of Formulary Change                              | Notes/Alternatives   |
|-------------------------|--|--|
| SIRTURO TAB 100MG       | Changing from Non-Preferred Tier to Specialty Tier           |  |
| SIRTURO TAB 20MG        | Changing from Non-Preferred Tier to Specialty Tier           |  |
| SOMAVERT INJ 25MG       | Adding to Formulary, Specialty Tier with Prior Authorization |  |
| Somavert SOLR 30MG      | Adding to Formulary, Specialty Tier with Prior Authorization |  |
| Sprycel TABS 100MG      | Removing from Formulary                                      |  |
| Sprycel TABS 140MG      | Removing from Formulary                                      |  |
| Sprycel TABS 20MG       | Removing from Formulary                                      |  |
| Sprycel TABS 50MG       | Removing from Formulary                                      |  |
| Sprycel TABS 70MG       | Removing from Formulary                                      |  |
| Sprycel TABS 80MG       | Removing from Formulary                                      |  |
| Stelara SOLN 130MG/26ML | Removing from Formulary                                      | Pyzchiva and Yesintek are covered on Specialty Tier with PA      |
| Stelara SOLN 45MG/0.5ML | Removing from Formulary                                      | Pyzchiva and Yesintek are covered on Specialty Tier with PA      |
| Stelara SOSY 90MG/ML    | Removing from Formulary                                      | Pyzchiva and Yesintek are covered on Specialty Tier with PA      |
| SUPARTZ FX INJ 25/2.5ML | Changing from Specialty Tier to Non-Preferred Tier           |  |
| SYNAGIS INJ 100MG/ML    | Removing from Formulary                                      | Beyfortus Covered with Prior Authorization at Specialty Pharmacy |
| SYNAGIS INJ 50/0.5ML    | Removing from Formulary                                      | Beyfortus Covered with Prior Authorization at Specialty Pharmacy |
| SYNAREL SOL 2MG/ML      | Changing from Specialty Tier to Non-Preferred Tier           |  |
| TABLOID TAB 40MG        | Changing from Specialty Tier to Non-Preferred Tier           |  |
| TASIGNA CAP 150MG       | Removing from Formulary                                      | Generic Nilotinib available on Specialty Tier                    |
| TASIGNA CAP 200MG       | Removing from Formulary                                      | Generic Nilotinib available on Specialty Tier                    |
| TASIGNA CAP 50MG        | Removing from Formulary                                      | Generic Nilotinib available on Specialty Tier                    |

| Drug Name                                      | Description of Formulary Change   | Notes/Alternatives  |
|--|---|---|
| TAVABOROLE SOLN 5%                             | Prior Authorization Added   | Quantity Limits Added                                     |
| TAZAROTENE CRE 0.05%                           | Changing from Preferred Brand Tier to Preferred Generic Tier with Prior Authorization | Quantity Limits Apply                                     |
| TAZAROTENE CRE 0.1%                            | Changing from Preferred Brand Tier to Preferred Generic Tier with Prior Authorization | Quantity Limits Apply                                     |
| TAZAROTENE GEL 0.05%                           | Changing from Preferred Brand Tier to Preferred Generic Tier with Prior Authorization | Quantity Limits Apply                                     |
| TAZAROTENE GEL 0.1%                            | Changing from Preferred Brand Tier to Preferred Generic Tier with Prior Authorization | Quantity Limits Added                                     |
| TECHLITE INSULIN SYRINGE MISC 30G X 1/2"0.3 ML | Adding to Formulary, DME Tier (takes Durable Medical Equipment Cost Sharing)          | Quantity Limits Apply                                     |
| Telmisartan TABS 20MG                          | Changing from Preferred Brand Tier to Preferred Generic Tier                          | Remove Step Therapy, Quantity Limits Apply                |
| Telmisartan TABS 40MG                          | Changing from Preferred Brand Tier to Preferred Generic Tier                          | Remove Step Therapy, Quantity Limits Apply                |
| Telmisartan TABS 80MG                          | Changing from Preferred Brand Tier to Preferred Generic Tier                          | Remove Step Therapy, Quantity Limits Apply                |
| TERBUTALINE TAB 2.5MG                          | Changing from Preferred Brand Tier to Preferred Generic Tier                          | Quantity Limits Apply                                     |
| TERBUTALINE TAB 5MG                            | Changing from Preferred Brand Tier to Preferred Generic Tier                          | Quantity Limits Apply                                     |
| Teriparatide SOPN 560MCG/2.24ML                | Removing from Formulary   |   |
| TRETINOIN CAP 10MG                             | Changing from Specialty Tier to Non-Preferred Tier                                    |   |
| TRETINOIN CRE 0.025%                           | Changing from Preferred Brand Tier to Preferred Generic Tier                          | Remove Step Therapy, Quantity Limits and Age Limits Apply |
| TRETINOIN CRE 0.05%                            | Changing from Preferred Brand Tier to Preferred Generic Tier                          | Remove Step Therapy, Quantity Limits and Age Limits Apply |
| TRETINOIN CRE 0.1%                             | Changing from Preferred Brand Tier to Preferred Generic Tier                          | Remove Step Therapy, Quantity Limits and Age Limits Apply |
| TRETINOIN GEL 0.01%                            | Changing from Preferred Brand Tier to Preferred Generic Tier                          | Remove Step Therapy, Quantity Limits and Age Limits Apply |
| TRETINOIN GEL 0.025%                           | Changing from Preferred Brand Tier to Preferred Generic Tier                          | Remove Step Therapy, Quantity Limits and Age Limits Apply |

| Drug Name                                    | Description of Formulary Change                              | Notes/Alternatives    |
|--|--|-----------------------|
| TRILURON INJ 20MG/2ML                        | Changing from Specialty Tier to Non-Preferred Tier           |                       |
| TRIZIVIR TABS 300-150-300MG                  | Removing from Formulary                                      |                       |
| VALGANCICLOV SOL 50MG/ML                     | Changing from Specialty Tier to Non-Preferred Tier           |                       |
| VALGANCICLOV TAB 450MG                       | Changing from Specialty Tier to Non-Preferred Tier           |                       |
| Venclexta Starting Pack TBPK 10 & 50 & 100MG | Adding to Formulary, Specialty Tier                          | Quantity Limits Apply |
| Venclexta TABS 100MG                         | Adding to Formulary, Specialty Tier                          | Quantity Limits Apply |
| Venclexta TABS 10MG                          | Adding to Formulary, Specialty Tier                          | Quantity Limits Apply |
| Venclexta TABS 50MG                          | Adding to Formulary, Specialty Tier                          | Quantity Limits Apply |
| Viread POWD 40MG/GM                          | Adding to Formulary, Preferred Brand Tier                    | Quantity Limits Apply |
| VIREAD TAB 150MG                             | Adding to Formulary, Preferred Brand Tier                    | Quantity Limits Apply |
| VIREAD TAB 200MG                             | Adding to Formulary, Preferred Brand Tier                    | Quantity Limits Apply |
| VIREAD TAB 250MG                             | Adding to Formulary, Preferred Brand Tier                    | Quantity Limits Apply |
| VIREAD TAB 300MG                             | Adding to Formulary, Preferred Brand Tier                    | Quantity Limits Apply |
| VISCO-3 SOSY 25MG/2.5ML                      | Changing from Specialty Tier to Non-Preferred Tier           |                       |
| Vraylar CPPK 1.5 & 3MG                       | Adding to Formulary, Preventative Tier                       |                       |
| XARELTO SUS 1MG/ML                           | Removing from Formulary                                      |                       |
| XARELTO TAB 2.5MG                            | Removing from Formulary                                      | Remove Brand          |
| XIFAXAN TAB 200MG                            | Changing from Specialty Tier to Non-Preferred Tier           |                       |
| XIFAXAN TAB 550MG                            | Changing from Specialty Tier to Non-Preferred Tier           |                       |
| XOFLUZA TAB 20MG                             | Removing from Formulary                                      |                       |
| XOFLUZA TAB 40MG                             | Changing from Preferred Brand Tier to Specialty Tier         | Quantity Limits Apply |
| XOFLUZA TAB 80MG                             | Changing from Preferred Brand Tier to Specialty Tier         | Quantity Limits Apply |
| ZARXIO SOSY 300MCG/0.5ML                     | Removing from Formulary                                      |                       |
| ZARXIO SOSY 480MCG/0.8ML                     | Removing from Formulary                                      |                       |
| ZEJULA TAB 100MG                             | Adding to Formulary, Specialty Tier with Prior Authorization | Quantity Limits Apply |



| <b>Drug Name</b>             | <b>Description of Formulary Change</b>                       | <b>Notes/Alternatives</b> |
|------------------------------|--|---------------------------|
| ZEJULA TAB 200MG             | Adding to Formulary, Specialty Tier with Prior Authorization | Quantity Limits Apply     |
| ZEJULA TAB 300MG             | Adding to Formulary, Specialty Tier with Prior Authorization | Quantity Limits Apply     |
| ZEMAIRA INJ 1000MG           | Removing from Formulary                                      |                           |
| Zenpep CPEP 60000-189600UNIT | Adding to Formulary, Preferred Brand Tier                    |                           |

**PA** = Prior Authorization **QL** = Quantity Limits **ST** = Step Therapy

The medications listed below are available on the pharmacy benefit without a Prior Authorization:

Los medicamentos que se enumeran a continuación están disponibles en el beneficio de farmacia sin autorización previa.

|                                       |                                   |
|---------------------------------------|-----------------------------------|
| ABIRATERONE TAB 500MG                 | EVEROLIMUS TAB 2MG                |
| ABIRATERONE TAB 250MG                 | EVEROLIMUS TAB 3MG                |
| ACTEMRA INJ 162/0.9                   | EVEROLIMUS TAB 5MG                |
| ACTEMRA INJ 200/10ML                  | EVEROLIMUS TAB 5MG                |
| ACTEMRA INJ 400/20ML                  | EVEROLIMUS TAB 7.5MG              |
| ACTEMRA INJ 80MG/4ML                  | FARYDAK CAP 10MG                  |
| ACTEMRA INJ ACTPEN                    | FARYDAK CAP 15MG                  |
| ACTIMMUNE INJ 2MU/0.5                 | FARYDAK CAP 20MG                  |
| ALECENSA CAP 150MG                    | FLEBOGAMMA INJ 20/200ML           |
| ARCALYST INJ 220MG                    | FLEBOGAMMA INJ DIF 5%             |
| BEXAROTENE CAP 75MG                   | FLEBOGAMMA INJ DIF 5%             |
| CAPECITABINE TAB 150MG                | GAMMAGARD INJ 1GM/10ML            |
| CAPECITABINE TAB 500MG                | GAMMAGARD SD INJ 10GM HU          |
| CAPRELSA TAB 100MG                    | GAMMAKED INJ 1GM/10ML             |
| CAPRELSA TAB 300MG                    | GAMMAPLEX INJ 10%                 |
| CIMZIA KIT                            | GAMMAPLEX INJ 5%                  |
| CIMZIA PREFL KIT 200MG/ML             | GAMUNEX-C INJ 1GM/10ML            |
| Cosentyx Sensoready Pen SOAJ 150MG/ML | GILOTRIF TAB 20MG                 |
| Cosentyx SOSY 150MG/ML                | GILOTRIF TAB 30MG                 |
| Cosentyx SOSY 75MG/0.5ML              | GILOTRIF TAB 40MG                 |
| Cosentyx UnoReady SOAJ 300MG/2ML      | GLEOSTINE CAP 100MG               |
| CUVITRU INJ 2GM/10ML                  | GLEOSTINE CAP 10MG                |
| CYCLOPHOSPH CAP 25MG                  | GLEOSTINE CAP 40MG                |
| CYCLOPHOSPH CAP 50MG                  | Hadlima PushTouch SOAJ 40MG/0.4ML |
| EMCYT CAP 140MG                       | Hadlima PushTouch SOAJ 40MG/0.8ML |
| ENBREL INJ 25/0.5ML                   | Hadlima SOSY 40MG/0.4ML           |
| ENBREL INJ 50MG/ML                    | Hadlima SOSY 40MG/0.8ML           |
| Enbrel SOLN 25MG/0.5ML                | HIZENTRA INJ 1GM/5ML              |
| ENBREL SRCLK INJ 50MG/ML              | HIZENTRA INJ 2GM/10ML             |
| ERIVEDGE CAP 150MG                    | HIZENTRA 1 GM/5ML                 |
| ERLOTINIB TAB 100MG                   | HIZENTRA 10 GM/50ML               |
| ERLOTINIB TAB 150MG                   | HIZENTRA 4 GM/20ML                |
| ERLOTINIB TAB 25MG                    | HIZENTRA INJ 2GM/10ML             |
| ETOPOSIDE CAP 50MG                    | HIZENTRA SOL 20% SOLN PR          |
| EVEROLIMUS TAB 10MG                   | HUMIRA PSKT 40MG/0.8ML            |
| EVEROLIMUS TAB 2.5MG                  | HUMIRA PEN PNKT 40MG/0.8ML        |

HUMIRA PEN-CD/UC/HS STARTER PNKT  
40MG/0.8ML  
HUMIRA PEN-PS/UV/ADOL HS START PNKT  
40MG/0.8ML  
HUMIRA PSKT 40MG/0.4ML  
HUMIRA PEDIATRIC CROHNS START PSKT 80  
MG/0.8ML &40MG/0.4ML  
HUMIRA PEN PNKT 40MG/0.4ML  
HUMIRA PEDIATRIC CROHNS START PSKT  
80MG/0.8ML  
HUMIRA PSKT 10MG/0.1ML  
HUMIRA PSKT 20MG/0.2ML  
HUMIRA PEN PNKT 80MG/0.8ML  
HUMIRA PEN-CD/UC/HS STARTER PNKT  
80MG/0.8ML  
HUMIRA PEN-PEDIATRIC UC START PNKT  
80MG/0.8ML  
HUMIRA PEN-PSOR/UEIT STARTER PNKT 80  
MG/0.8ML &40MG/0.4ML  
HYQVIA INJ 10-800  
HYQVIA INJ 2.5-200  
HYQVIA INJ 20-1600  
HYQVIA INJ 30-2400  
HYQVIA INJ 5-400  
Hyrimoz SOAJ 40MG/0.4ML  
Hyrimoz SOAJ 40MG/0.8ML  
Hyrimoz SOAJ 80MG/0.8ML  
Hyrimoz-Plaque Psoriasis Start SOAJ 80  
MG/0.8ML &40MG/0.4ML  
Hyrimoz SOSY 20MG/0.2ML  
Hyrimoz SOSY 40MG/0.4ML  
Hyrimoz SOSY 40MG/0.8ML  
IBRANCE CAP 100MG  
IBRANCE CAP 125MG  
IBRANCE CAP 75MG  
Ibrance TABS 100MG  
Ibrance TABS 125MG  
Ibrance TABS 75MG  
ICLUSIG TAB 10MG  
ICLUSIG TAB 15MG  
ICLUSIG TAB 30MG  
ICLUSIG TAB 45MG  
IMATINIB MES TAB 100MG  
IMATINIB MES TAB 400MG

IMBRUVICA CAP 140MG  
JAKAFI TAB 10MG  
JAKAFI TAB 15MG  
JAKAFI TAB 20MG  
JAKAFI TAB 25MG  
JAKAFI TAB 5MG  
KEVZARA INJ 150/1.14  
KEVZARA INJ 150/1.14  
KEVZARA INJ 200/1.14  
KEVZARA INJ 200/1.14  
KINERET INJ  
LAPATINIB TAB 250MG  
LENALIDOMIDE CAP 10 MG  
LENALIDOMIDE CAP 15 MG  
LENALIDOMIDE CAP 20 MG  
LENALIDOMIDE CAP 25 MG  
LENALIDOMIDE CAP 5 MG  
LENALIDOMIDE CAPS 2.5 MG  
LENVIMA CAP 10 MG  
LENVIMA CAP 12MG  
LENVIMA CAP 14 MG  
LENVIMA CAP 18 MG  
LENVIMA CAP 20 MG  
LENVIMA CAP 24 MG  
LENVIMA CAP 4MG  
LENVIMA CAP 8 MG  
LEUKERAN TAB 2MG  
LEUPROLIDE INJ 1MG/0.2  
LYNPARZA TAB 100MG  
LYNPARZA TAB 150MG  
LYSODREN TAB 500MG  
MATULANE CAP 50MG  
MEKINIST TAB 0.5MG  
MEKINIST TAB 2MG  
MELPHALAN TAB 2MG  
NILUTAMIDE TAB 150MG  
OCTAGAM INJ 20/200ML  
OCTAGAM INJ 5GM  
ODOMZO CAP 200MG  
ORENCIA CLCK INJ 125MG/ML  
ORENCIA INJ 125MG/ML  
ORENCIA INJ 250MG  
ORENCIA INJ 50/0.4  
ORENCIA INJ 87.5/0.7

OTEZLA TAB 10/20/30  
OTEZLA TAB 30MG  
PAZOPanib HCI TABS 200MG  
POMALYST CAP 1MG  
POMALYST CAP 2MG  
POMALYST CAP 3MG  
POMALYST CAP 4MG  
PRIVIGEN INJ 20GRAMS  
Rinvoq TB24 15MG  
Rinvoq TB24 30MG  
Rinvoq TB24 45MG  
RUBRACA TAB 200 MG  
RUBRACA TAB 250 MG  
RUBRACA TAB 300 MG  
Simlandi (2 Pen) AJKT 40MG/0.4ML  
Simlandi (1 Pen) AJKT 40MG/0.4ML  
SIMPONI INJ 100MG/ML  
SIMPONI INJ 100MG/ML  
SIMPONI INJ 50/0.5ML  
SIMPONI INJ 50/0.5ML  
Skyrizi (150 MG Dose) PSKT 75MG/0.83ML  
Skyrizi Pen SOAJ 150MG/ML  
Skyrizi SOCT 180MG/1.2ML  
Skyrizi SOCT 360MG/2.4ML  
Skyrizi SOLN 600MG/10ML  
Skyrizi SOSY 150MG/ML  
SORAfenib Tosylate TABS 200MG  
Stelara SOLN 130MG/26ML  
Stelara SOLN 45MG/0.5ML  
Stelara SOSY 45MG/0.5ML  
Stelara SOSY 90MG/ML  
STIVARGA TAB 40MG  
SUNItinib Malate CAPS 12.5MG  
SUNItinib Malate CAPS 25MG  
SUNItinib Malate CAPS 37.5MG  
SUNItinib Malate CAPS 50MG  
TABLOID TAB 40MG  
TAFINLAR CAP 50MG  
TAFINLAR CAP 75MG  
Tagrisso TABS 40MG  
Tagrisso TABS 80MG  
TASIGNA CAP 150MG  
TASIGNA CAP 200MG  
TASIGNA CAP 50MG  
TEMOZOLOMIDE CAP 100MG  
TEMOZOLOMIDE CAP 140MG  
TEMOZOLOMIDE CAP 180MG  
TEMOZOLOMIDE CAP 20MG  
TEMOZOLOMIDE CAP 250MG  
TEMOZOLOMIDE CAP 5MG  
THALOMID CAP 100MG  
THALOMID CAP 150MG  
THALOMID CAP 200MG  
THALOMID CAP 50MG  
TOREMIFENE TAB 60MG  
Tremfya SOPN 100MG/ML  
Tremfya SOSY 100MG/ML  
TRETINOIN CAP 10MG  
Verzenio TABS 100MG  
Verzenio TABS 150MG  
Verzenio TABS 200MG  
Verzenio TABS 50MG  
XALKORI CAP 200MG  
XALKORI CAP 250MG  
Xeljanz SOLN 1MG/ML  
XELJANZ TAB 10MG  
XELJANZ TAB 5MG  
XELJANZ XR TAB 22MG  
XELJANZ XR TAB 11MG  
Xtandi CAPS 40MG  
Xtandi TABS 40MG  
Xtandi TABS 80MG  
ZEJULA CAP 100MG  
ZOLINZA CAP 100MG  
ZYDELIG TAB 100MG  
ZYDELIG TAB 150MG