ISSUE 5 | VOLUME 18 | OCTOBER 2024

Written by: Tachanda Mensah, Pharm D, BCPS, CACP

Formulary Update

Formulary Additions

- Amlodipine/Benazepril Capsules (generic Lotrel)

Prior Authorization (QRM) Additions

- Alyglo (immune globulin, human)
- Amtagvi (lifileucel)
- Filsuvez (birch triterpenes)
- Fruzaqla (fruquintinib)
- Ohtuvayre (ensifentrine)
- Sohonos (palovarotene)

Prior Authorization (QRM) Updates

- Adalimumab products
- Augtyro (repotrectinib)
- Botox (botulinum toxins)
- Branded Stimulants
- Cabenuva/Vocabria (cabotegravir and rilpivirine/ cabotegravir)
- Cosentyx (secukinumab)
- Darzalex Faspro (daratumumab-hyaluronidase-fihj)
- Desoxyn (methamphetamine)
- GLP-1 RAs
- Hetlioz (tasimelteon)
- Hyaluronic Acid Injection Products
- Ilaris (canakinumab)
- Livmarli (maralixibat)
- Nitrofurantoin Oral Suspension
- RET Inhibitors
- Rinvoq (upadacitinib)
- SGLT-2 Inhibitors
- Skyrizi (risankizumab)
- Stelara (ustekinumab)
- Strensiq (asfotase alfa)
- Tirzepatide Products for Weight Loss
- Wakix (pitolisant)
- Zoryve (roflumilast)

Table of Contents	
1	Summary of Formulary Changes
2-3, 6	Formulary/ Floor Stock Updates
4-6	QRM Updates
7-8	Medicare Part D Updates
9-14	Summary of 2025 Commercial Formulary Changes

A PUBLICATION OF THE GEORGIA PHARMACY AND THERAPEUTICS (P&T) COMMITTEE. The Formulary Update contains information regarding formulary additions, deletions, exclusions, brief descriptions of products, and current drug related news. It also lists items to be discussed at upcoming P&T meetings. Please refer to the web pages: KP Georgia Formulary and Drug List OR Drug Formulary for Practitioners for all KPGA Drug Formularies.

Upcoming Formulary Items:

An important aspect of the formulary process is the involvement of all clinicians. Please contact your P&T Committee representative or your clinical department chief by November 12, if you wish to comment on any of the medications, class reviews, or other agenda items under consideration. To make formulary addition requests, you must submit a Formulary Additions/Deletions Form and Conflict of Interest Form to Drug Information Services or call (404) 439-4417.

Medication Class Review
December 2024

- Alternative Medicines
- Antacids
- Antidiarrheals/probiotic agents
- Antidotes
- Cardiotonics
- Chemicals
- Compounds
- Contraceptives, Oral
- Estrogens
- Laxatives
- Medical Devices
- Miscellaneous Therapeutic Classes
- Nutrients
- Oxytocics
- Progestins
- Ulcer drugs
- Vaginal Products

Commercial HMO/Closed Formulary Additions

The following medication will be ADDED to the Commercial Formulary effective November 6, 2024:

Note: Commercial Formulary additions may result in tier changes on the QHP (ACA)/Open Formulary.

Amlodipine/Benazepril Capsules (generic Lotrel)	Indicated for the management of hypertension

QHP-ACA/Open Formulary Step Therapy Additions

The following medications will have step therapy ADDED effective November 6, 2024:

Emverm (mebendazole)	Indicated for treatment of patients ≥2 years of age with GI infections caused by *Ancylostoma duodenale* or *Necator americanus* (hookworms), *Ascaris lumbricoides* (roundworms), *Enterobius vermicularis* (pinworms), and *Trichuris trichiura* (whipworms)

QHP-ACA/Open Formulary Tier Changes

The following medications will have a tier change effective November 6, 2024:

Drug	Previous Tier	New Tier
Granix (tbo-filgrastim) 300 MCG/0.5ML, 480 MCG/0.8ML Prefilled Syringe	Specialty Tier 5	Preferred Brand Tier 3
Granix (tbo-filgrastim) 300 MCG/ML, 480 MCG/1.6ML Solution	Specialty Tier 5	Preferred Brand Tier 3

Day Supply Additions

The following medication will have 30-day supply restrictions effective November 6, 2024:

Sohonos (palovarotene)	**30-day supply per 30 days**

Therapeutic Equivalent Substitution Authorization

Effective 11.6.2024, conversions from brand Somatuline Depot to Lanreotide Depot will take place for new and existing patients on brand Somatuline Depot

Somatuline Depot → **Lanreotide Depot**

Standing Order

Effective October 2024, KP Pharmacists are authorized to:

- Order and/or dispense naloxone HCl for overdose prevention
- Contact Kaiser Permanente members via letter or telephone informing them of the new prescription
- Educate Kaiser Permanente members on signs and symptoms of opioid overdose and the appropriate use of naloxone as directed by the manufacturer and the pharmacist

Approved Floor Stock List Changes

Medication	Department
Approved Floor Stock List Additions	
Gentamicin 80 mg/ 50 mL IVPB	Urogynecology Procedure Suite Pre-op Pyxis
Lidocaine 4% Gel	Women's Health
Sodium Bicarbonate 8.4% Injection	Women's Health
Approved Floor Stock List Removals	
Makena (hydroxyprogesterone caproate)	Women's Health

Approved Compounds List Changes

Compound	Approved Change
Approved Outpatient Compounds	
Magic Mouthwash - 3 components, 180 ml	Beyond use date (BUD) changed from 14 days to 35 days
Magic Mouthwash - Steroid-4 components, 240 ml	Beyond use date (BUD) changed from 14 days to 35 days

Information Concerning Coverage Determinations

Medicare Part D: Medicare Part D Plan Non Formulary and Prior Authorization criteria and coverage determination are made externally by the Pharmacy Benefit Manager Optum Rx.

Prescriber completes the .NFRequestForm when entering drug order. Your documentation is used by OptumRx to determine whether the prescribed drug is eligible for drug benefit coverage. No documentation = No coverage.

The KP Pharmacy Consult Service will send your documentation to OptumRx for their coverage determination decision within the labeled time frame (standard: 72 hours; urgent: 24 hours). If not received by the deadline, the PBM will deny the request. If OptumRx has further questions, you will be contacted for responses. You may phone OptumRx at 1-888-791-7255 to address any patient / drug coverage specific questions. To see the MPD Formulary, please visit: Medicare Part D Formulary.

Dual Choice: Dual Choice Plan Non Formulary and Prior Authorization criteria and coverage determination are made externally by the Pharmacy Benefit Manager MedImpact.

Prescriber completes the .NFRequestForm when entering drug order. Your documentation is used by MedImpact to determine whether the prescribed drug is eligible for drug benefit coverage. No documentation = No coverage.

The KP Pharmacy Consult Service will send your documentation to MedImpact for their coverage determination decision within the labeled time frame (standard: 72 hours; urgent: 24 hours). If not received by the deadline, the PBM will deny the request. If MedImpact has further questions, you will be contacted to provide responses. You may phone MedImpact at 1-888-336-2676 to address any patient / drug coverage specific questions. The Dual Choice formulary differs from the KPHC formulary (i.e. DOACs, ADHD, asthma). Please visit: Choice Formulary.

Additions to the QRM Prior Authorization Review List of Medications for the Commercial/HMO Closed Formularies & QHP-ACA/Open Formularies

Note: The updates below DO NOT APPLY to Medicare Part D or Dual Choice Prescription Benefit Plans. Optum and MedImpact are the external PBMs for each of these plans, respectively, externally administering all non-formulary or prior authorization criteria and coverage review.

The following medications will be ADDED to the QRM PA Review List effective October 6, 2024:

Alyglo (immune globulin, human)	Indicated for the treatment of primary humoral immunodeficiency (PI) in adults.
Amtagvi (lifileucel)	Indicated for the treatment of unresectable or metastatic melanoma in adults previously treated with a programmed cell death protein (PD-1) blocking antibody, and, if protooncogene B-raf (*BRAF)* V600 mutation positive, a BRAF inhibitor with or without a mitogen-activated protein kinase (MEK) inhibitor.
Filsuvez (birch triterpenes)	Indicated for the treatment of wounds associated with dystrophic and junctional epidermolysis bullosa (DEB and JEB) in adult and pediatric patients 6 months of age and older.
Fruzaqla (fruquintinib)	Indicated for the treatment of adult patients with metastatic colorectal cancer who have been previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy, an anti-vascular endothelial growth factor receptors (VEGF) therapy, and, if Rat sarcoma (RAS) wild-type and medically appropriate, an anti-epidermal growth factor receptor (EGFR) therapy.
Ohtuvayre (ensifentrine)	Indicated for the maintenance treatment of chronic obstructive pulmonary disease (COPD) in adults.
Sohonos (palovarotene)	Indicated for reduction in the volume of new heterotopic ossification in adults and children aged ≥8 years for females and ≥10 years for males with fibrodysplasia ossificans progressiva (FOP).

QRM Prior Authorization Review Criteria Updates

Note: The updates below DO NOT APPLY to Medicare Part D or Dual Choice Prescription Benefit Plans. Optum and MedImpact are the external PBMs for each of these plans, respectively, externally administering all non-formulary or prior authorization criteria and coverage review.

- **Adalimumab products:** Criteria updated to add the newly approved adalimumab biosimilars: unbranded Simlandi and unbranded Idacio to the list of non-preferred adalimumab products.
- **Augtyro (repotrectinib):** Criteria updated to (1) include the recent expanded approval for the treatment of adult and pediatric patients 12 years of age and older with solid tumors that have a neurotrophic tyrosine receptor kinase (NTRK) gene fusion and are locally advanced or metastatic or where surgical resection is likely to result in severe morbidity; have progressed following treatment; or have no satisfactory alternative therapy and (2) remove the requirement to document why Rozlytrek is not appropriate.
- **Botox (botulinum toxins):** Criteria for temporomandibular joint (TMJ) disorders updated to remove required trial of tricyclic antidepressants in patients < 65 years of age.
- **Branded Stimulants:** Criteria updated to require a trial of lisdexamfetamine (generic Vyvanse) prior to approval.
- **Cabenuva/Vocabria (cabotegravir and rilpivirine/ cabotegravir):** Criteria updated to (1) require every other month dosing and (2) require viral suppression for at least 6 months unless patient unable to take oral medications due to inability to swallow, digest, or absorb oral medications or there are severe, complicated mental health or socioeconomic factors making adherence to an oral drug regimen improbable.
- **Cosentyx (secukinumab):** Criteria updated to (1) require a trial of at least 1 anti-TNF agent, (2) remove required trial of oral agents, and (3) change continued approval criteria to allow either office or video visit and require follow-up every 24 months after the initial 12 month visit.
- **Darzalex Faspro (daratumumab-hyaluronidase-fihj):** Criteria updated to (1) include all FDA approved indications and (2) require administration in KPGA infusion centers.
- **Desoxyn (methamphetamine):** Criteria updated to require a trial of non-stimulant agents prior to approval for coverage.
- **GLP-1 RAs for Diabetes Indication:** Criteria updated to remove required failure of metformin under criteria for new members.
- **GLP-1 RAs for Weight Management Indication:** Criteria updated to (1) add TSPMG Internal Medicine and TSPMG Family Practice Department Clinicians to the list of prescribers and (2) require a trial of Contrave and Orlistat if patients have a contraindication to phentermine.
- **Hetlioz (tasimelteon):** Criteria updated to add the generic formulation as preferred.
- **Hyaluronic Acid Injection Products:** Criteria updated to (1) include Gel-one as non-preferred product and (2) add requirement that repeated courses of therapy are approved by the Chief of Service.
- **Ilaris (canakinumab):** Criteria updated to (1) highlight that Tyenne (tocilizumab-aazg) is preferred, (2) add criteria for the treatment of acute gout, (3) remove concurrent use of immunosuppressants as a reason for non-coverage, (4) remove age parameters from the list of reasons for non-coverage, and (5) change continued approval criteria to require follow-up appointment with a Specialist in the last 6 months.
- **Interferon Beta Products**: Criteria updated to (1) incorporate Betaseron and Extavia into the existing criteria as non-preferred products.
- **Livmarli (maralixibat):** Criteria was added for the treatment of cholestatic pruritis associated with progressive familial intrahepatic cholestasis (PFIC). The existing criteria for cholestatic pruritis associated with Alagille Syndrome (ALGS) was updated to (1) allow coverage for patients 3 to less than 18 years of age at initiation of therapy, (2) prescribing by pediatric hepatologist/gastroenterologist, (3) require genetic testing and evidence of cholestasis, (4) require trial and failure of treatment alternatives, (5) add decompensated hepatic events to the reasons for non-coverage, (6) change the initial approval period to 6 months, and (7) change the continued approval period to 12 months.
- **Nitrofurantoin Oral Suspension:** Criteria updated to (1) only require a trial of alternative oral antibiotics available in liquid form for infants less than 6 months of age and (2) allow continuation of therapy for infants less than 6 months of age.
- **RET Inhibitors- Gavreto (pralsetinib) and Retevmo (selpercatinib):** Criteria updated to (1) include the FDA expanded approval for Retevmo to treat certain pediatric patients 2 years of age and older and (2) require QRM Physician Director approval for initial and continued coverage.
- **Rinvoq (upadacitinib):** Criteria updated to (1) remove age parameters, (2) add pediatric rheumatologist to the list of prescribers, (3) reduce the number of required TNF-α biologics to one, and (3) revise continued approval criteria for existing members that previously met the full criteria to require a completed specialist follow-up visit.
- **SGLT-2 Inhibitors:** Criteria updated to (1) add the authorized generic for Farxiga (dapagliflozin) as preferred before Brenzavvy (bexagliflozin) under the list of non-preferred drugs and throughout the criteria, (2) remove Brenzavvy as preferred prior to Invokana under the list of non-preferred drugs and throughout the criteria, (3) remove requirement for documented failure of metformin, (4) replace branded Farxiga with authorized generic dapagliflozin throughout the criteria, and (5) add criteria to address request for branded Farxiga.

QRM Prior Authorization Review Criteria Updates (continued)

Note: The updates below DO NOT APPLY to Medicare Part D or Dual Choice Prescription Benefit Plans. Optum and MedImpact are the external PBMs for each of these plans, respectively, externally administering all non-formulary or prior authorization criteria and coverage review.

- **Skyrizi (risankizumab):** Criteria updated to (1) align with the criteria for other drugs indicated for ulcerative colitis (UC) and Crohn's disease (CD), (2) add Rinvoq (upadacitinib) as a trial agent, and (3) add Velsipity (etrasimod) as a required trial agent to align with clinical practice.
- **Stelara (ustekinumab):** Criteria updated to remove Skyrizi (risankizumab) as a required trial agent prior to coverage.
- **Strensiq (asfotase alfa):** Criteria updated to allow coverage for patients with onset of clinical signs and symptoms for hypophosphatasia (HPP) prior to 18 years of age.
- **Tirzepatide Products for Weight Loss:** Criteria updated to align with the updated oral therapy requirements for GLP-1 RAs for weight loss.
- **Wakix (pitolisant):** Criteria updated to remove age restrictions to incorporate the expanded approval from the FDA for the treatment of excessive daytime sleepiness (EDS) in pediatric patients 6 years of age and older with narcolepsy.
- **Zoryve (roflumilast):** Criteria added for the treatment of atopic dermatitis.

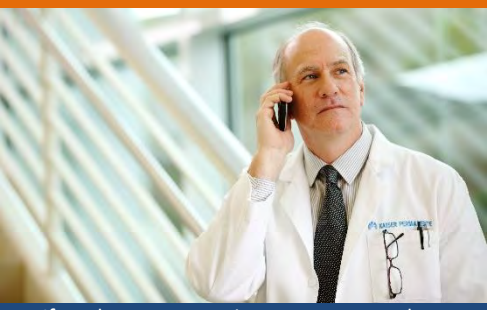
Medications Reviewed But Not Accepted to the Commercial HMO Formulary

Note: Medications that can be dispensed via the outpatient pharmacy benefit but are not accepted to the closed Commercial HMO formulary, will be placed on a tier for the QHP-ACA/ Open formularies.

Drug Name	Commercial HMO/Closed Formulary Status	QHP-ACA/ Open Formulary Status
Alyglo (immune globulin, human)	• Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage • Require QRM PA review	
Amtagvi (lifileucel)	• Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage • Require QRM PA review	
Defencath (taurolidine-heparin)	• Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage	
Filsuvez (birch triterpenes)	• Non-Formulary • Require QRM PA review	• Specialty Tier 5 • Require QRM PA review
Fruzaqla (fruquintinib)	• Non-Formulary • Require QRM PA review	• Specialty Tier 5 • Require QRM PA review
Ixchiq (chikungunya vaccine, live)	• Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage	
Libtayo (cemiplimab)	• Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage	
Ohtuvayre (ensifentrine)	• Non-Formulary • Require QRM PA review	• Specialty Tier 5 • Require QRM PA review
Sohonos (palovarotene)	• Non-Formulary • Require QRM PA review • 30-day supply limits	• Specialty Tier 5 • Require QRM PA review • 30-day supply limits
Voquezna (vonoprazan)	• Non-Formulary*	• Non-Preferred Tier 4*

* Pending approval to add QRM PA review

Questions and Concerns?



If you have any questions or concerns, please contact any of the following P&T Committee members and designated alternates:

P&T Committee Voting Members:

Debbi Baker, PharmD, BCPS
Clinical Pharmacy

Hector Clarke, PharmD, BCOP
Ambulatory Pharmacy

Halima Daboiko, MD
Obstetrics and Gynecology

Carole Gardner, MD
P&T Chair/Geriatrics

Pierson Gladney, MD
Hematology/Oncology

Ramin Haddad, MD
Adult Hospitalist

Larry Kang, MD
Adult Primary Care

Mary Kangoma, RN, MSN
Clinical Services

Craig Kaplan, MD
Adult Primary Care

Christine Kofman, MD
Pediatrics

Amy Levine, MD
Pediatrics

Sophie Lukashok, MD
Infectious Disease

Chad Madill, PharmD, MBA
Executive Director of Pharmacy Operations

Jennifer Marrast-Host, MD
Emergency Medicine/ ACC

Felecia Martin, PharmD
Pharmacy/Geriatrics

Shayne Mixon, PharmD
Pharmacy Operations

Jennifer Rodriguez, MD
Behavioral Health

P&T Committee Non-Voting Physician Members

Elizabeth Greco, MD
Physician Lead, Pharmacy Safety and Systems

Daniel Robitshek, MD
CDU/Hospital Services

Designated Alternates:

Jacqueline Anglade, MD
Obstetrics and Gynecology

Lesia Jackson, RN
Clinical Services

Satya Jayanthi, MD
Hospitalist

Medicare Part D Formulary Changes

Kaiser Permanente has a National Medicare Part D (MPD) Formulary. Each regional P&T Committee reviews drugs and decides on tier status. The National Medicare Part D Pharmacy and Therapeutics Committee is charged with reconciling regional differences in MPD Formulary recommendations through consensus building in order to maintain one National MPD Formulary for Kaiser Permanente.

Medicare Part D Initial Tier Placement

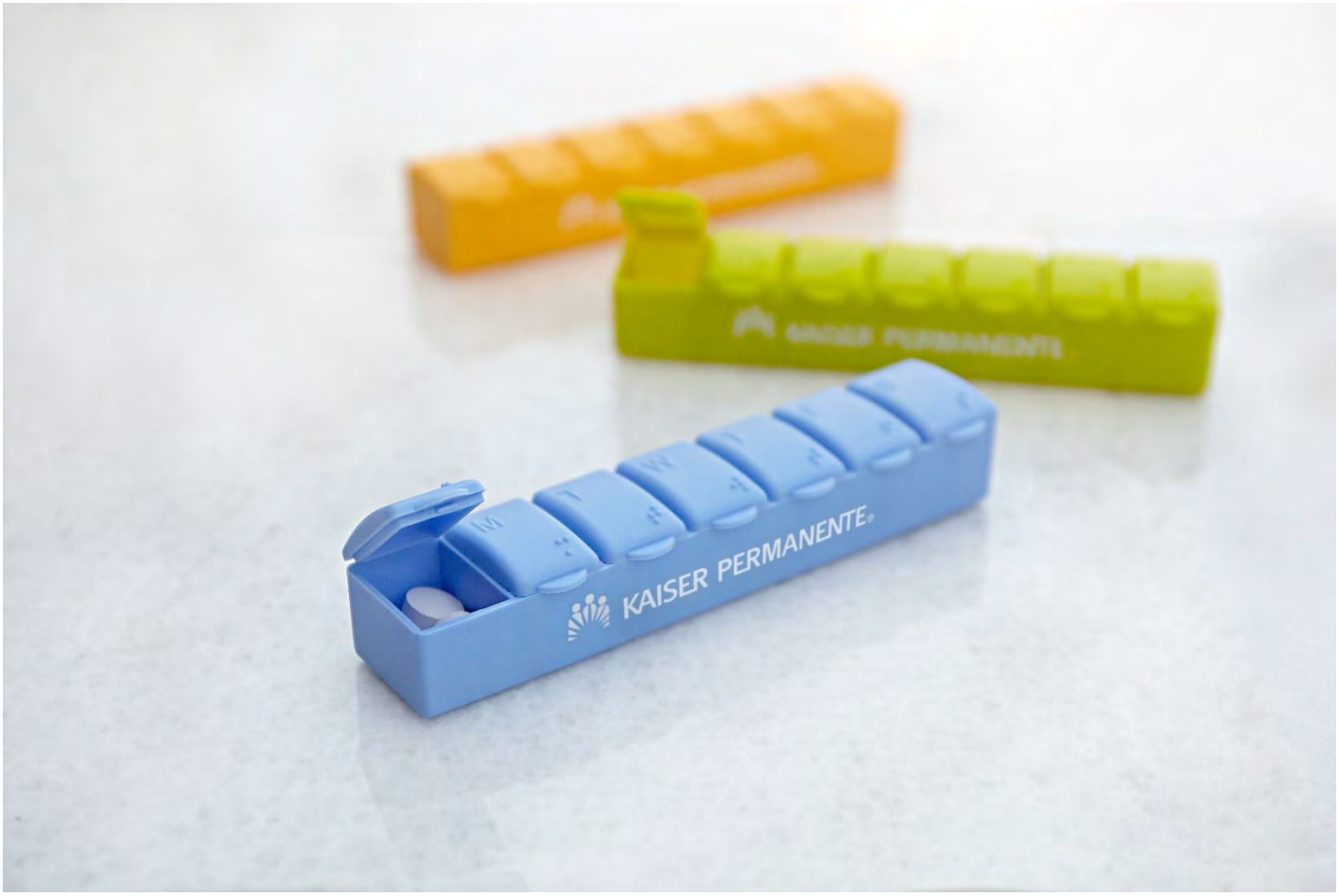
Initial tier placements for recently launched and approved medications

#	Drug Name	Tier Status	Implementation Date
1	guselkumab 200 mg/2 mL, 200 mg/20 mL injection; 200 mg/2 mL prefill injection (Tremfya)	Specialty Tier 5	9/19/2024
2	atezolixumab-hyaluronidase 1875 mg-30000 mg/15 mL injection (Tecentriq)	Specialty Tier 5	9/18/2024
3	lebrikizumab-lbkz 250 mg/2 mL injection (Ebglyss)	Specialty Tier 5	9/17/2024
4	palopegteriparatide 168 mcg/0.56 mL, 294 mcg/0.98 mL, 420 mcg/1.4 mL	Specialty Tier 5	9/5/2024
5	dasatinib 20 mg, 50 mg, 70 mg 80 mg, 100 mg, 140 mg tablets (generic)	Specialty Tier 5	9/3/2024
6	faricimab-svoa 6 mg/0.05 mL injection (Vabysmo)	Specialty Tier 5	8/28/2024
7	lofexidine HCL 0.18 mg tablets (generic)	Specialty Tier 5	8/26/2024
8	lazertinib mesylate 80 mg, 240 mg tablets (Lazcluze)	Specialty Tier 5	8/23/2024
9	tislelizumab-jsgr 100 mg/10 mL injection (Tevimbra)	Specialty Tier 5	8/23/2024
10	seladelpar lysine 10 mg capsules (Livdelzi)	Specialty Tier 5	8/16/2024
11	nemolizumab-ilto 30 mg injection (Nemluvio)	Specialty Tier 5	8/14/2024
12	vorasidenib 10 mg, 40 mg tablets (Voranigo)	Specialty Tier 5	8/12/2024
13	selpercatinib 40 mg, 80 mg, 120 mg, 160 mg tablets (Retevmo)	Specialty Tier 5	8/6/2024
14	vigabatrin 100 mg/mL injection (Vigafyde)	Specialty Tier 5	8/6/2024
15	apremilast 20 mg tablets; 4 x 10 mg, 51 x 20 mg starter therapy pack (Otezla)	Specialty Tier 5	8/1/2024
16	methocarbamol 100 mg tablets (Tanlor)	Specialty Tier 5	7/31/2024
17	maralixibat chloride 19 mg/mL oral solution (Livmarli)	Specialty Tier 5	7/31/2024
18	ixekizumab 20 mg/0.25 mL, 40 mg/0.5 mL injection (Taltz)	Specialty Tier 5	7/30/2024
19	cyclophosphamide 1 g/2 mL injection, 2 g/4 mL injection (generic)	Specialty Tier 5	7/26/2024
20	tiopronin 100 mg, 300 mg delayed-release tablets (generic)	Specialty Tier 5	7/24/2024
21	oxycodone HCl 15 mg abuse-deterrent tablets (generic)	Specialty Tier 5	7/23/2024
22	adalimumab-ryvk 40 mg/0.4 mL prefilled syringe kit (Simlandi)	Specialty Tier 5	7/22/2024
23	vadadustat 300 mg tablets (Vafseo)	Specialty Tier 5	7/18/2024
24	crovalimab-akkz 340 mg/2 mL injection (Piasky)	Specialty Tier 5	7/17/2024
25	glutamine 5 g powder packs (L-Glutamine)	Specialty Tier 5	7/15/2024
26	edaravone 30 mg/100 mL injection (generic)	Specialty Tier 5	7/11/2024
27	deutetrabenazine 18 mg 24 hour extended-release tablets (Austedo XR); 12 mg, 18 mg, 24 mg, 30 mg extended-release tablets titration pack (Austedo XR tablets titration kit)	Specialty Tier 5	7/8/2024
28	corticotropin 40 unit/0.5 mL; 80 unit/mL subcutaneous auto-injection (Acthar Gel)	Specialty Tier 5	7/8/2024
29	pegunigalsidase alfa-iwxj 5 mg/2.5 ml injection (Elfabrio)	Specialty Tier 5	7/5/2024

Medicare Part D Formulary Removal of Brand Drugs

During the year, Kaiser Permanente may make changes to our Medicare Part D Formulary (Drug List). The list below is intended to inform you of these changes. The following table lists all products recently removed from the Medicare Part D Formulary to be replaced with the generic.

Brand Medication	Brand Drug Current Tier	Generic Alternative	Generic Drug Tier	Effective Date
CORLANOR TABS 5 MG	Tier 4	IVABRADINE HCL TABS 5 MG	Tier 4	10/1/2024
CORLANOR TABS 7.5 MG	Tier 4	IVABRADINE HCL TABS 7.5 MG	Tier 4	10/1/2024
THIOLA EC TBEC 100 MG	Tier 5	TIOPRONIN TBEC 100 MG	Tier 5	10/1/2024
THIOLA EC TBEC 300 MG	Tier 5	TIOPRONIN TBEC 300 MG	Tier 5	10/1/2024



2025 KPGA Commercial HMO/Closed Formulary & QHP-ACA Open Formulary Changes

Note: The updates below DO NOT APPLY to Medicare Part D or Dual Choice Prescription Benefit Plans.

QRM Prior Authorization Additions

Product Description			
ABRILADA AJKT 40 MG/0.8ML	GILOTRIF TABS 40 MG	MEKTOVI TABS 15 MG	TRUQAP TABS 200 MG
ABRILADA PSKT 20 MG/0.4ML	HADLIMA PUSHTOUCH SOAJ 40 MG/0.4ML	NERLYNX TABS 40 MG	TURALIO CAPS 125 MG
ABRILADA PSKT 40 MG/0.8ML	HADLIMA PUSHTOUCH SOAJ 40 MG/0.8ML	NEULASTA ONPRO PSKT 6 MG/0.6ML	UDENYCA AUTOINJECTOR
ADALIMUMAB-AACF AJKT 40 MG/0.8ML	HADLIMA SOSY 40 MG/0.4ML	NEULASTA SOSY 6 MG/0.6ML	UDENYCA ONBODY SOSY 6 MG/0.6ML
ADALIMUMAB-ADAZ SOAJ 40 MG/0.4ML	HADLIMA SOSY 40 MG/0.8ML	NEUPOGEN SOLN 300 MCG/ML	VANFLYTA TABS 17.7 MG
ADALIMUMAB-ADAZ SOSY 40 MG/0.4ML	HIZENTRA SOLN 10 GM/50ML	NEUPOGEN SOLN 480 MCG/1.6ML	VANFLYTA TABS 26.5 MG
ADEMPAS TABS 0.5 MG	HULIO AJKT 40 MG/0.8ML	NEUPOGEN SOSY 300 MCG/0.5ML	VELSIPITY TABS 2 MG
ADEMPAS TABS 1 MG	HULIO PSKT 20 MG/0.4ML	NEUPOGEN SOSY 480 MCG/0.8ML	VENCLEXTA STARTING PACK TBPK 10 & 50 & 100 MG
ADEMPAS TABS 1.5 MG	HULIO PSKT 40 MG/0.8ML	NGENLA SOPN 24 MG/1.2ML	VENCLEXTA TABS 10 MG
ADEMPAS TABS 2 MG	HYRIMOZ SOAJ 40 MG/0.4ML	NGENLA SOPN 60 MG/1.2ML	VENCLEXTA TABS 100 MG
ADEMPAS TABS 2.5 MG	HYRIMOZ SOAJ 40 MG/0.8ML	NITISINONE CAPS 10 MG	VENCLEXTA TABS 50 MG
AKEEGA TABS 100-500 MG	HYRIMOZ SOAJ 80 MG/0.8ML	NITISINONE CAPS 2 MG	VEOZAH TABS 45 MG
AKEEGA TABS 50-500 MG	HYRIMOZ SOSY 10 MG/0.1 ML	NITISINONE CAPS 5 MG	VERZENIO TABS 100 MG
ALUNBRIG TABS 180 MG	HYRIMOZ SOSY 20 MG/0.2ML	NITROFURANTOIN SUSP 50 MG/5ML	VERZENIO TABS 150 MG
ALUNBRIG TABS 30 MG	HYRIMOZ SOSY 40 MG/0.4ML	NITYR TABS 10 MG	VERZENIO TABS 200 MG
ALUNBRIG TABS 90 MG	HYRIMOZ SOSY 40 MG/0.8ML	NITYR TABS 2 MG	VERZENIO TABS 50 MG
ALUNBRIG TBPK 90 & 180 MG	HYRIMOZ-PED CROHNS STARTER SOSY 80 MG/0.8ML	NITYR TABS 5 MG	VIZIMPRO TABS 15 MG
AUGTYRO CAPS 40 MG	HYRIMOZ-PED CROHNS STARTER SOSY 80 MG/0.8ML & 40MG/0.4ML	ODOMZO CAPS 200 MG	VIZIMPRO TABS 30 MG
AUSTEDO XR PATIENT TITRATION TEPK 6 & 12 & 24 MG	HYRIMOZ-PLAQUE PSORIASIS START SOAJ 80 MG/0.8ML & 40MG/0.4ML	OGSIVEO TABS 50 MG	VIZIMPRO TABS 45 MG
AUSTEDO XR TB24 12 MG	IBRANCE CAPS 100 MG	OJJAARA TABS 100 MG	VOWST CAPS
AUSTEDO XR TB24 24 MG	IBRANCE CAPS 125 MG	OJJAARA TABS 150 MG	VYJUVEK GEL 5000000000 PFU/2.5ML
AUSTEDO XR TB24 6 MG	IBRANCE CAPS 75 MG	OJJAARA TABS 200 MG	VYVGART HYTRULO SOLN 180-2000 MG-UNIT/ML
AYVAKIT TABS 100 MG	IBRANCE TABS 100 MG	OMVOH SOAJ 100 MG/ML	XALKORI CAPS 200 MG
AYVAKIT TABS 200 MG	IBRANCE TABS 125 MG	OPFOLDA CAPS 65 MG	XALKORI CAPS 250 MG
AYVAKIT TABS 25 MG	IBRANCE TABS 75 MG	ORSERDU TABS 345 MG	XALKORI CPSP 150 MG
AYVAKIT TABS 300 MG	ICOSAPENT ETHYL CAPS 0.5 GM	ORSERDU TABS 86 MG	XALKORI CPSP 20 MG
AYVAKIT TABS 50 MG	IDACIO AJKT 40 MG/0.8ML	OXBRYTA TABS 300 MG	XALKORI CPSP 50 MG
BETASERON KIT 0.3 MG	IDACIO PSKT 40 MG/0.8ML	OZEMPIC (0.25 OR 0.5 MG/DOSE) SOPN 2 MG/3ML	XDEMVY SOLN 0.25 %
BIMZELX SOAJ 160 MG/ML	INPEFA 400 MG	PEMAZYRE TABS 13.5 MG	XOSPATA TABS 40 MG
BIMZELX SOSY 160 MG/ML	INPEFA TABS 200 MG	PEMAZYRE TABS 4.5 MG	XPHOZAH 20 MG
BRAFTOVI CAPS 75 MG	INREBIC CAPS 100 MG	PEMAZYRE TABS 9 MG	XPHOZAH 30 MG
BRENZAVVY TABS 20 MG	JADENU SPRINKLE PACK 180 MG	QINLOCK TABS 50 MG	XTANDI CAPS 40 MG
CLINDAMYCIN PHOS-BENZOYL PEROX GEL 1.2-3.75 %	JADENU SPRINKLE PACK 360 MG	ROLVEDON SOSY 13.2 MG/0.6ML	XTANDI TABS 40 MG
COPIKTRA CAPS 15 MG	JADENU SPRINKLE PACK 90 MG	ROZLYTREK PACK 50 MG	XTANDI TABS 80 MG
COPIKTRA CAPS 25 MG	JADENU TABS 180 MG	RYDAPT CAPS 25 MG	YUFLYMA 2-SYRINGE KIT PSKT 40 MG/0.4ML
COSENTYX SOAJ 300 MG/2ML	JADENU TABS 360 MG	SAXAGLIPTIN-METFORMIN ER TB24 2.5-1000 MG	YUFLYMA AJKT 40 MG/0.4ML

QRM Prior Authorization Additions (continued)

Product Description			
CRESEMBA CAPS 74.5 MG	JADENU TABS 90 MG	SAXAGLIPTIN-METFORMIN ER TB24 5-1000 MG	YUFLYMA(CF) AI CROHN'S-UC-HS 80 MG/0.8 ML
CYLTEZO PSKT 10 MG/0.2ML	JAKAFI TABS 10 MG	SAXAGLIPTIN-METFORMIN ER TB24 5-500 MG	YUSIMRY(CF) PEN
CYLTEZO PSKT 20 MG/0.4M	JAKAFI TABS 15 MG	SOGROYA SOPN 10 MG/1.5ML	ZAVZPRET SOLN 10 MG/ACT
CYLTEZO PSKT 40 MG/0.8ML	JAKAFI TABS 20 MG	SOGROYA SOPN 15 MG/1.5ML	ZEJULA TABS 100 MG
CYLTEZO-CD/UC/HS STARTER AJKT 40 MG/0.8ML	JAKAFI TABS 25 MG	SOGROYA SOPN 5 MG/1.5ML	ZEJULA TABS 200 MG
DAURISMO TABS 100 MG	JAKAFI TABS 5 MG	SOHONOS CAPS 1 MG	ZEJULA TABS 300 MG
DAURISMO TABS 25 MG	JAYPIRCA TABS 100 MG	SOHONOS CAPS 1.5 MG	ZEPBOUND 10 mg/0.5 ML
ENTYVIO SOPN 108 MG/0.68ML	JAYPIRCA TABS 50 MG	SOHONOS CAPS 10 MG	ZEPBOUND 12.5 mg/0.5 ML
ERIVEDGE CAPS 150 MG	JESDUVROQ TABS 1 MG	SOHONOS CAPS 2.5 MG	ZEPBOUND 15 mg/0.5 ML
ERLEADA TABS 240 MG	JESDUVROQ TABS 2 MG	SOHONOS CAPS 5 MG	ZEPBOUND 2.5 mg/0.5 ML
ERLEADA TABS 60 MG	JESDUVROQ TABS 4 MG	SOMATULINE DEPOT SOLN 120 MG/0.5ML	ZEPBOUND 5 mg/0.5 ML
EXJADE TBSO 125 MG	JESDUVROQ TABS 6 MG	SOMATULINE DEPOT SOLN 60 MG/0.2ML	ZEPBOUND 7.5 mg/0.5 ML
EXJADE TBSO 250 MG	JESDUVROQ TABS 8 MG	SOMATULINE DEPOT SOLN 90 MG/0.3ML	ZEPOSIA STARTER KIT CPPK 0.23MG &0.46MG 0.92MG(21)
EXJADE TBSO 500 MG	KALYDECO 5.8 MG	TAFINLAR CAPS 50 MG	ZITUVIO TABS 100 MG
EXTAVIA 0.3 MG	KALYDECO PACK 13.4 MG	TAFINLAR CAPS 75 MG	ZITUVIO TABS 25 MG
FERRIPROX SOLN 100 MG/ML	LODOCO TABS 0.5 MG	TAFINLAR TBSO 10 MG	ZITUVIO TABS 50 MG
FERRIPROX TABS 500 MG	LORBRENA TABS 100 MG	TALZENNA CAPS 0.1 MG	ZORYVE FOAM 0.3 %
FERRIPROX TWICE-A-DAY TABS 1000 MG	LORBRENA TABS 25 MG	TALZENNA CAPS 0.35 MG	ZURZUVAE CAPS 20 MG
FIASP PUMPCART SOCT 100 UNIT/ML	LUMRYZ PACK 4.5 GM	TASIMELTEON CAPS 20 MG	ZURZUVAE CAPS 25 MG
FILSPARI TABS 200 MG	LUMRYZ PACK 6 GM	TAZVERIK TABS 200 MG	ZURZUVAE CAPS 30 MG
FILSPARI TABS 400 MG	LUMRYZ PACK 7.5 GM	TERIPARATIDE (RECOMBINANT) SOPN 600 MCG/2.4ML	ZYDELIG TABS 100 MG
FRUZAQLA 1 MG	LUMRYZ PACK 9 GM	TRIENTINE HCL CAPS 500 MG	ZYDELIG TABS 150 MG
FRUZAQLA 5 MG	MEKINIST SOLR 0.05 MG/ML	TRIKAFTA THPK 100-50-75 & 75 MG	ZYKADIA TABS 150 MG
GILOTRIF TABS 20 MG	MEKINIST TABS 0.5 MG	TRIKAFTA THPK 80-40-60 & 59.5 MG	
GILOTRIF TABS 30 MG	MEKINIST TABS 2 MG	TRUQAP TABS 160 MG	

Step Therapy Additions

Product Description			
ACTEMRA ACTPEN SOAJ 162 MG/0.9ML	FC2 FEMALE CONDOM MISC	METHSUXIMIDE CAPS 300 MG	PROVIGIL TABS 100 MG
ACTEMRA SOSY 162 MG/0.9ML	FENTANYL PT72 37.5 MCG/HR	METHYLDOPA TABS 250 MG	PROVIGIL TABS 200 MG
ADMELOG SOLN 100 UNIT/ML	FENTANYL PT72 62.5 MCG/HR	METHYLDOPA TABS 500 MG	RAGWITEK SUBL 12 AMB A 1-U
ALPRAZOLAM ER TB24 1 MG	FENTANYL PT72 87.5 MCG/HR	METHYLDOPA-HYDROCHLOROTHIAZIDE TABS 250-15 MG	RAYOS TBEC 1 MG
ALPRAZOLAM ER TB24 2 MG	FLUOROURACIL CREA 0.5 %	METHYLDOPA-HYDROCHLOROTHIAZIDE TABS 250-25 MG	RESTORIL CAPS 15 MG
ALPRAZOLAM ER TB24 3 MG	FLUOXETINE HCL TABS 10 MG	METHYLTESTOSTERONE CAPS 10 MG	RESTORIL CAPS 30 MG
ALPRAZOLAM INTENSOL CONC 1 MG/ML	FLUOXETINE HCL TABS 20 MG	METOPROLOL-HYDROCHLOROTHIAZIDE TABS 100-50 MG	RETIN-A MICRO PUMP GEL 0.08 %
ALPRAZOLAM XR TB24 0.5 MG	GLYNASE TABS 1.5 MG	METRONIDAZOLE GEL 0.75 %	RILUTEK TABS 50 MG
AMCINONIDE OINT 0.1 %	GLYNASE TABS 3 MG	MICONAZOLE 3 SUPP 200 MG	RITALIN 10 MG TABLET
AMETHYST TABS 90-20 MCG	GLYNASE TABS 6 MG	MOZOBIL SOLN 24 MG/1.2ML	RITALIN 20 MG TABLET
AMLODIPINE-ATORVASTATIN TABS 10-10 MG	GRALISE TABS 450 MG	NAYZILAM SOLN 5 MG/0.1ML	RITALIN 5 MG TABLET
AMLODIPINE-ATORVASTATIN TABS 10-20 MG	GRALISE TABS 750 MG	NEFAZODONE HCL TABS 100 MG	SERTRALINE HCL CAPS 150 MG
AMLODIPINE-ATORVASTATIN TABS 10-40 MG	GRALISE TABS 900 MG	NEFAZODONE HCL TABS 150 MG	SERTRALINE HCL CAPS 200 MG
AMLODIPINE-ATORVASTATIN TABS 10-80 MG	GRASTEK SUBL 2800 BAU	NEFAZODONE HCL TABS 200 MG	SPIRONOLACTONE 25 MG/5 ML
AMLODIPINE-ATORVASTATIN TABS 2.5-10 MG	GVOKE HYPOPEN 1-PACK SOAJ 0.5 MG/0.1ML	NEFAZODONE HCL TABS 250 MG	SUFLAVE SOLR 178.7 GM
AMLODIPINE-ATORVASTATIN TABS 2.5-20 MG	GVOKE HYPOPEN 1-PACK SOAJ 1 MG/0.2ML	NEFAZODONE HCL TABS 50 MG	SYMBICORT AERO 160-4.5 MCG/ACT
AMLODIPINE-ATORVASTATIN TABS 2.5-40 MG	GVOKE PFS SOSY 0.5 MG/0.1ML	NORTRIPTYLINE HCL SOLN 10 MG/5ML	SYMBICORT AERO 80-4.5 MCG/ACT
AMLODIPINE-ATORVASTATIN TABS 5-10 MG	GVOKE PFS SOSY 1 MG/0.2ML	Nymalize Oral Solution 6MG/ML	TADLIQ SUSP 20 MG/5ML
AMLODIPINE-ATORVASTATIN TABS 5-20 MG	HUMALOG MIX 50/50 SUSP (50-50) 100 UNIT/ML	OPTIONS GYNOL II CONTRACEPTIVE GEL 3 %	TARGRETIN CAP 75MG
AMLODIPINE-ATORVASTATIN TABS 5-40 MG	HUMULIN N KWIKPEN SUPN 100 UNIT/ML	OXANDROLONE TABS 10 MG	TESTOSTERONE GEL 25 MG/2.5GM (1%)
AMLODIPINE-ATORVASTATIN TABS 5-80 MG	HUMULIN N SUSP 100 UNIT/ML	OXANDROLONE TABS 2.5 MG	TESTOSTERONE GEL 25 MG/2.5GM (1%)
Atorvaliq: 20 mg/5 mL	HYDROXYZINE HCL SYRP 10 MG/5ML	OXYBUTYNIN CHLORIDE TABS 2.5 MG	TIOPRONIN TABS 100 MG
AVAR CLEANSER 10-5 % LIQD	IMIPRAMINE PAMOATE CAPS 100 MG	OXYCODONE-ACETAMINOPHEN TABS 2.5-300 MG	TIOTROPIUM BROMIDE MONOHYDRATE CAPS 18 MCG
BETOPTIC-S SUSP 0.25 %	IMIPRAMINE PAMOATE CAPS 125 MG	OZOBAX DS SOLN 10 MG/5ML	TODAY SPONGE MISC 1000 MG
BIJUVA CAPS 0.5-100 MG	IMIPRAMINE PAMOATE CAPS 150 MG	OZOBAX DS SOLN 10 MG/5ML	TOPIRAMATE ER CS24 100 MG
BREO ELLIPTA AEPB 50-25 MCG/INH	IMIPRAMINE PAMOATE CAPS 75 MG	PAZOPANIB HCL TABS 200 MG	TOPIRAMATE ER CS24 25 MG
BRIMONIDINE TARTRATE SOLN 0.1 %	IMITREX 100 MG TAB	PENCICLOVIR CREA 1 %	TOPIRAMATE ER CS24 50 MG
CABTREO GEL 0.15-3.1-1.2 %	IMITREX 25 MG TAB	PENTAZOCINE-NALOXONE HCL TABS 50-0.5 MG	TRETINOIN 0.08% GEL

Step Therapy Additions (continued)

Product Description			
CARBATROL CP12 100 MG	IMITREX 50 MG TAB	PIOGLITAZONE HCL-GLIMEPIRIDE TABS 30-2 MG	TRETINOIN 0.08% GEL
CARBATROL CP12 200 MG	INDOMETHACIN SUPP 50 MG	PIOGLITAZONE HCL-GLIMEPIRIDE TABS 30-4 MG	TRIAMTERENE 100mg
CARBATROL CP12 300 MG	IRESSA TABS 250 MG	PIOGLITAZONE HCL-METFORMIN HCL TABS 15-500 MG	TRIAMTERENE 50mg
CAYA DPRH	IYUZEH	PIOGLITAZONE HCL-METFORMIN HCL TABS 15-850 MG	TRIMIPRAMINE MALEATE CAPS 100 MG
CELONTIN 300 MG CAP	JYLAMVO SOLN 2 MG/ML	PLAQUENIL 200 MG	UROCIT-K 15 TBCR 15 MEQ (1620 MG)
CLEOCIN SUPP 100 MG	KETO-DIASTIX STRP	POKONZA PACK 10 MEQ	UROXATRAL TB24 10 MG
COMPRO SUPP 25 MG	KETOSTIX STRP	POTASSIUM CHLORIDE ER CPCR 8 MEQ	VECTICAL OINT 3 MCG/GM
COXANTO CAPS 300 MG	KLOR-CON TBCR 8 MEQ	POTASSIUM CHLORIDE ER TBCR 8 MEQ	VEVYE SOLN 0.1 %
DEMECLOCYCLINE HCL TABS 150 MG	LAMICTAL TABS 100 MG	POTASSIUM CITRATE ER TBCR 15 MEQ (1620 MG)	VISTOGARD PACK 10 GM
DEMECLOCYCLINE HCL TABS 300 MG	LAMICTAL TABS 150 MG	PREZISTA TABS 600 MG	VOTRIENT TABS 200 MG
DIASTIX STRP	LAMICTAL TABS 200 MG	PREZISTA TABS 800 MG	VYTORIN TABS 10-10 MG
DROXIDOPA CAPS 100 MG	LIALDIA 1.2GM TABLETS DR	PRIMIDONE TABS 125 MG	VYTORIN TABS 10-20 MG
DROXIDOPA CAPS 200 MG	LIKMEZ SUSP 500 MG/5ML	PROMACTA PACK 12.5 MG	VYTORIN TABS 10-40 MG
DROXIDOPA CAPS 300 MG	MAXALT 10 MG ODT	PROMACTA PACK 25 MG	VYTORIN TABS 10-80 MG
DSUVIA SUBL 30 MCG	MAXALT 10 MG TAB	PROMACTA TABS 12.5 MG	XELJANZ SOLN 1 MG/ML
DUOBRII LOTN 0.01-0.045 %	MELOXICAM SUSP 7.5 MG/5ML	PROMACTA TABS 25 MG	XELJANZ XR TB24 22 MG
EFFER-K TBEF 25 MEQ	MEPROBAMATE TABS 400 MG	PROMACTA TABS 50 MG	XURIDEN PACK 2 GM
EMEND TRI-PACK CAPS 80 & 125 MG	MESTINON 180 MG ER TAB	PROMACTA TABS 75 MG	ZOLPIDEM TARTRATE CAPS 7.5 MG
ESTRACE CREA 0.1 MG/GM	MESTINON 60 MG TAB	PROMETHAZINE VC SYRP 6.25-5 MG/5ML	
EVOXAC CAPS 30 MG	METHITEST TABS 10 MG	PROTRIPTYLINE HCL TABS 10 MG	

QHP- ACA/ Open Formulary Tier Changes

Note: These tier changes may result in tier changes on the Commercial HMO/2-Tier Formulary.

Drug Name	2024 Tier Level	2025 Tier Level
ACTEMRA SOSY 162 MG/0.9ML	3	5
ALENDRONATE SODIUM 70 MG TAB	1	2
ALENDRONATE SODIUM TABS 10 MG	1	2
ALENDRONATE SODIUM TABS 35 MG	1	2
BELBUCA FILM 750 MCG	4	5
BELBUCA FILM 900 MCG	4	5
BETASERON KIT 0.3 MG	2	5
BETOPTIC-S SUSP 0.25 %	3	4
BUSPIRONE HCL TABS 15 MG	1	2
BUSPIRONE HCL TABS 30 MG	1	4
BUSPIRONE HCL TABS 7.5 MG	1	4
DEFERASIROX TABS 180 MG	5	2
DEFERASIROX TABS 360 MG	5	2
DEFERASIROX TABS 90 MG	5	2
DEFERASIROX TBSO 125 MG	5	2
DEFERASIROX TBSO 250 MG	5	2
DEFERASIROX TBSO 500 MG	5	2
DROXIDOPA CAPS 100 MG	5	4
DROXIDOPA CAPS 200 MG	5	4
DROXIDOPA CAPS 300 MG	5	4
EMEND TRI-PACK CAPS 80 & 125 MG	4	5
ENTRESTO TABS 24-26 MG	3	4
ENVARSUS XR TB24 4 MG	4	5
ESTRACE CREA 0.1 MG/GM	3	4
EXTAVIA 0.3 MG	2	5
FC2 FEMALE CONDOM MISC	3	4
GLIPIZIDE-METFORMIN HCL TABS 2.5-250 MG	1	4
GLIPIZIDE-METFORMIN HCL TABS 2.5-500 MG	1	4
GLIPIZIDE-METFORMIN HCL TABS 5-500 MG	1	4
GVOKE HYPOPEN 1-PACK SOAJ 0.5 MG/0.1ML	3	4
GVOKE HYPOPEN 1-PACK SOAJ 1 MG/0.2ML	3	4
GVOKE PFS SOSY 0.5 MG/0.1ML	3	4
GVOKE PFS SOSY 1 MG/0.2ML	3	4
HUMATIN CAPS 250 MG	2	5
HYDROXYZINE HCL SYRP 10 MG/5ML	2	4
IPRATROPIUM BR 0.02% SOLN	1	2
KETO-DIASTIX STRP	3	4
KETOSTIX STRP	3	4
METHITEST TABS 10 MG	2	5
METHSUXIMIDE CAPS 300 MG	2	4
METHYLDOPA TABS 250 MG	2	4
METHYLDOPA TABS 500 MG	2	4
METHYLTESTOSTERONE CAPS 10 MG	2	5
MONTELUKAST SOD 4 MG TAB CHEW	1	2
MONTELUKAST SOD 5 MG TAB CHEW	1	2
NAYZILAM SOLN 5 MG/0.1ML	5	4
NYMALIZE SOLN 6 MG/ML	4	5
PAROXETINE HCL TABS 40 MG	1	2
PERCOCET TABS 7.5-325 MG	4	5
PIOGLITAZONE HCL 45 MG TABLET	1	2
RAYOS TBEC 1 MG	4	5
SYMBICORT AERO 160-4.5 MCG/ACT	3	4
SYMBICORT AERO 80-4.5 MCG/ACT	3	4
THIOLA EC TBEC 100 MG	4	5
THIOLA EC TBEC 300 MG	4	5
THIOLA TABS 100 MG	4	5
TODAY SPONGE MISC 1000 MG	3	4

QHP- ACA/ Open Formulary Tier Changes (continued)

Note: These tier changes may result in tier changes on the Commercial HMO/2-Tier Formulary.

Drug Name	2024 Tier Level	2025 Tier Level
TRAZODONE 100 MG TABLET	1	2
TRAZODONE HCL TABS 150 MG	1	2
VALTOCO 10 MG DOSE LIQD 10 MG/0.1ML	5	4
VALTOCO 15 MG DOSE LQPK 7.5 MG/0.1ML	5	4
VALTOCO 20 MG DOSE LQPK 10 MG/0.1ML	5	4
VALTOCO 5 MG DOSE LIQD 5 MG/0.1ML	5	4
VECTICAL OINT 3 MCG/GM	2	4
XCOPRI TABS 100 MG	4	5
XCOPRI TABS 150 MG	4	5
XCOPRI TABS 50 MG	4	5