PROACT PHARMACY BENEFIT MANAGEMENT

JANUARY 2025 Advantage Formulary Changes

The excluded medications shown below are not covered. In most cases, if you fill a prescription for one of these drugs you will pay the full retail price. If you're currently using one of the excluded medications, please ask your doctor to consider writing you a new prescription for one of the preferred alternatives. Additional covered alternatives may be available so please consult with your doctor. As prescription plans vary, not all drugs listed as alternatives may be covered by your plan. Grandfathering will not be provided for any excluded medications.

For the most current listing of covered medications or if you have questions, please visit **www.proactrx.com** or call the ProAct Help Desk at **1-877-635-9545**.

Non-Preferred to Preferred

DRUG CLASS	DRUG NAME	PREFERRED ALTERNATIVES
Hematological Agents	HAEGARDA 2,000 UNIT VIAL	
	HAEGARDA 3,000 UNIT VIAL	

Non-Covered to Non-Preferred

DRUG CLASS	DRUG NAME	PREFERRED ALTERNATIVES
Hematological Agents	TAVNEOS 10 MG CAPSULE	AZATHIOPRINE, METHOTREXATEMYCOPHENOLATE MOFETIL, RUXIENCE
Ophthalmic Agents	RHOPRESSA 0.02% OPHTH SOLUTION	BETAXOLOL HCL, BIMATOPROST, DORZOLAMIDE-TIMOLOL, LATANOPROST, LEVOBUNOLOL HCL, TIMOLOL MALEATE, TRAVOPROST
	ROCKLATAN 0.02%-0.005% EYE DRP	

Non-Covered to Preferred

DRUG CLASS	DRUG NAME	PREFERRED ALTERNATIVES
Antineoplastics	TRUQAP 160 MG TABLET	
	TRUQAP 200 MG TABLET	
	YONSA 125 MG TABLET	
Endocrine and Metabolic Agents	FABRAZYME 35 MG VIAL	
	FABRAZYME 5 MG VIAL	
Inhaled Long Acting Muscarinic Antagonists	INCRUSE ELLIPTA 62.5 MCG INH	
Insulin - Basal	INSULIN GLARGINE-YFGN U100 PEN	
	INSULIN GLARGINE-YFGN U100 VL	

Non-Preferred to Not Covered

DRUG CLASS	DRUG NAME	PREFERRED ALTERNATIVES
Antiemetics	EMEND 150 MG VIAL	FOSAPREPITANT DIMEGLUMINE
Antihistamines	KARBINAL ER 4 MG/ 5 ML SUSP	CARBINOXAMINE, CETIRIZINE HCL, CLEMASTINE FUMARATE, DESLORATADINE, DIPHENHYDRAMINE HCL, FEXOFENADINE HCL, LEVOCETIRIZINE DIHYDROCHLORIDE
Insulin - Basal	BASAGLAR 100 UNIT/ML KWIKPEN	INSULIN GLARGINE YFGN, SEMGLEE (YFGN) PEN, TOUJEO SOLOSTAR, TRESIBA FLEXTOUCH U-100
	BASAGLAR TEMPO PEN 100 UNIT/ML	
Migraine Products	TRUDHESA NASAL SPRAY	DIHYDROERGOTAMINE MESYLATE
Nasal Agents - Systemic and Topical	DYMISTA NASAL SPRAY	AZELASTINE-FLUTICASONE
Novel Psychotropics	FANAPT 1 MG TABLET	ARIPIPRAZOLE, ASENAPINE MALEATE, LURASIDONE HCL, OLANZAPINE, QUETIAPINE, FUMARATE, RISPERIDONE, ZIPRASIDONE HCL
	FANAPT 10 MG TABLET	
	FANAPT 12 MG TABLET	
	FANAPT 2 MG TABLET	
	FANAPT 4 MG TABLET	
	FANAPT 6 MG TABLET	
	FANAPT 8 MG TABLET	
	FANAPT TITRATION PACK	
Ophthalmic Prostaglandins	LUMIGAN 0.01% EYE DROPS	BIMATOPROST, LATANOPROST, TAFLUPROST, TRAVOPROST
	VYZULTA 0.024% OPHTH SOLUTION	
Weight Loss	SAXENDA 18 MG/3 ML PEN	WEGOVY, ZEPBOUND

Preferred to Not Covered

DRUG CLASS	DRUG NAME	PREFERRED ALTERNATIVES
Antiemetics	CINVANTI 130 MG/18 ML VIAL	FOSAPREPITANT DIMEGLUMINE
Gastrointestinal Agents	RELISTOR 150 MG TABLET	LUBIPROSTONE, MOVANTIK, SYMPROIC
Hyaluronic Acid Derivatives	EUFLEXXA 1% 20 MG/2 ML SYRINGE	MONOVISC, ORTHOVISC
Inflammatory Conditions	HUMIRA* 40 MG/0.8 ML SYRINGE	ADALIMUMAB-ADAZ(CF), ADALIMUMAB-ADBM(CF), ADALIMUMAB-RYVK(CF) AUTOINJECTCYLTEZO(CF), SIMLANDI(CF) AUTOINJECTOR
	HUMIRA PEN* 40 MG/0.8 ML	ADALIMUMAB-ADAZ(CF) PEN, ADALIMUMAB-ADBM(CF) PEN, ADALIMUMAB-RYVK(CF) AUTOINJECT, CYLTEZO(CF) PEN, SIMLANDI(CF) AUTOINJECTOR
	HUMIRA PEN CROHN-UC-HS* 40 MG	
	HUMIRA PEN PS-UV-ADOL HS* 40 MG	
	HUMIRA(CF)* 10 MG/0.1 ML SYRINGE	ADALIMUMAB-ADAZ(CF), ADALIMUMAB-ADBM(CF), ADALIMUMAB-RYVK(CF) AUTOINJECTCYLTEZO(CF), SIMLANDI(CF) AUTOINJECTOR
	HUMIRA(CF)* 10 MG/0.1 ML SYRINGE	
	HUMIRA(CF)* 40 MG/0.4 ML SYRINGE	
	HUMIRA(CF) PEDI CROHN* 80-40 MG	ADALIMUMAB-ADAZ(CF) PEN, ADALIMUMAB-ADBM(CF) PEN, ADALIMUMAB-RYVK(CF) AUTOINJECT, CYLTEZO(CF) PEN, SIMLANDI(CF) AUTOINJECTOR
	HUMIRA(CF) PEDI CROHN* 80MG/0.8	ADALIMUMAB-ADAZ(CF), ADALIMUMAB-ADBM(CF), ADALIMUMAB-RYVK(CF) AUTOINJECTCYLTEZO(CF), SIMLANDI(CF) AUTOINJECTOR
	HUMIRA(CF) PEN* 40 MG/0.4 ML	ADALIMUMAB-ADAZ(CF) PEN, ADALIMUMAB-ADBM(CF) PEN, ADALIMUMAB-RYVK(CF) AUTOINJECT, CYLTEZO(CF) PEN, SIMLANDI(CF) AUTOINJECTOR
	HUMIRA(CF) PEN* 80 MG/0.8 ML	
	HUMIRA(CF) PEN CRHN-UC-HS* 80MG	
	HUMIRA(CF) PEN PEDI UC* 80 MG	
	HUMIRA(CF) PEN PS-UV-AHS* 80-40	

Preferred to Not Covered Cont.

DRUG CLASS	DRUG NAME	PREFERRED ALTERNATIVES
Inflammatory Conditions Cont.	HYRIMOZ(CF) 10 MG/0.1 ML SYRNGE	ADALIMUMAB-ADAZ(CF), ADALIMUMAB-ADBM(CF), ADALIMUMAB-RYVK(CF) AUTOINJECTCYLTEZO(CF), SIMLANDI(CF) AUTOINJECTOR
	HYRIMOZ(CF) 20 MG/0.2 ML SYRNGE	
	HYRIMOZ(CF) 40 MG/0.4 ML SYRNGE	
	HYRIMOZ(CF) PEDI CROHN 80 MG	
	HYRIMOZ(CF) PEDI CROHN 80-40MG	
	HYRIMOZ(CF) PEN 40 MG/0.4 ML	ADALIMUMAB-ADAZ(CF) PEN, ADALIMUMAB-ADBM(CF) PEN, ADALIMUMAB-RYVK(CF) AUTOINJECT, CYLTEZO(CF) PEN, SIMLANDI(CF) AUTOINJECTOR
	HYRIMOZ(CF) PEN 80 MG/0.8 ML	
	HYRIMOZ(CF) PEN CROHN-UC 80 MG	
	HYRIMOZ(CF) PEN PSORIA 80-40MG	
Insulin - Rapid Acting	HUMALOG 100 UNIT/ML VIAL	INSULIN LISPRO
Osteoporosis - Parathyroid Hormone Agents	FORTEO 600 MCG/2.4 ML PEN INJ	TERIPARATIDE
Respiratory Agents	ARALAST NP 1,000 MG VIAL	PROLASTIN C
	ARALAST NP 500 MG VIAL	
	GLASSIA 1 GM/50 ML VIAL	
	ZEMAIRA 1,000 MG VIAL	
	ZEMAIRA 4,000 MG VIAL	
	ZEMAIRA 5,000 MG VIAL	
SGLT2 Inhibitors	SEGLUROMET 2.5-1,000 MG TABLET	SYNJARDY, SYNJARDY XR, XIGDUO XR
	SEGLUROMET 2.5-500 MG TABLET	
	SEGLUROMET 7.5-1,000 MG TABLET	
	SEGLUROMET 7.5-500 MG TABLET	
	STEGLATRO 15 MG TABLET	FARXIGA, JARDIANCE
	STEGLATRO 5 MG TABLET	

** Advantage formulary preferred to excluded changes effective January 1, 2025 for Humira patients new to therapy. The phased approach to prefer innovative ADALIMUMAB biosimilar products to HUMIRA® takes into consideration formulary placement, clinical efficacy, and interchangeability while giving members adequate time to transition therapies to low-cost biosimilar alternatives. Advantage formulary preferred to excluded changes effective July 1, 2025 for all Humira patients.*

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