

**VIVA MEDICARE**  
**IMPORTANT 2020 5-T STANDARD FORMULARY UPDATES**

| <b>Drug Label Name</b> | <b>Tier</b> | <b>Description of Change</b> | <b>Requirements/Limits</b>   | <b>Effective Date</b> | <b>Alternative Drug</b> | <b>Alternative Drug Tier</b> |
|------------------------|-------------|------------------------------|--|-----------------------|-------------------------|------------------------------|
| DEFERASIROX TAB 360MG  | 5           | Added to 2020 Formulary      | Prior Authorization Required   | 2/1/2020              |                         |                              |
| DEFERASIROX TAB 90MG   | 5           | Added to 2020 Formulary      | Prior Authorization Required   | 2/1/2020              |                         |                              |
| DOCETAXEL INJ 160/8ML  | 5           | Added to 2020 Formulary      | B vs. D Prior Authorization Required   | 2/1/2020              |                         |                              |
| DRIZALMA CAP 20MG DR   | 4           | Added to 2020 Formulary      | New Start Prior Authorization Required;<br>Quantity Limit<br>(60 caps every 30 days) | 2/1/2020              |                         |                              |
| DRIZALMA CAP 30MG DR   | 4           | Added to 2020 Formulary      | New Start Prior Authorization Required;<br>Quantity Limit<br>(60 caps every 30 days) | 2/1/2020              |                         |                              |
| DRIZALMA CAP 40MG DR   | 4           | Added to 2020 Formulary      | New Start Prior Authorization Required;<br>Quantity Limit<br>(90 caps every 30 days) | 2/1/2020              |                         |                              |
| DRIZALMA CAP 60MG DR   | 4           | Added to 2020 Formulary      | New Start Prior Authorization Required;<br>Quantity Limit<br>(60 caps every 30 days) | 2/1/2020              |                         |                              |
| EVEROLIMUS TAB 2.5MG   | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required;<br>Quantity Limit<br>(30 tabs every 30 days) | 2/1/2020              |                         |                              |
| EVEROLIMUS TAB 5MG     | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required;<br>Quantity Limit<br>(30 tabs every 30 days) | 2/1/2020              |                         |                              |

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|------------------------------|-------------|------------------------------|--|-----------------------|-------------------------|------------------------------|
| EVEROLIMUS TAB 7.5MG         | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required;<br>Quantity Limit<br>(30 tabs every 30 days) | 2/1/2020              |                         |                              |
| LOKELMA PAK 10GM             | 3           | Added to 2020 Formulary      |  | 2/1/2020              |                         |                              |
| LOKELMA PAK 5GM              | 3           | Added to 2020 Formulary      |  | 2/1/2020              |                         |                              |
| NAYZILAM SPR 5MG             | 4           | Added to 2020 Formulary      |  | 2/1/2020              |                         |                              |
| NITISINONE CAP 10MG          | 5           | Added to 2020 Formulary      | Prior Authorization Required   | 2/1/2020              |                         |                              |
| NITISINONE CAP 2MG           | 5           | Added to 2020 Formulary      | Prior Authorization Required   | 2/1/2020              |                         |                              |
| NITISINONE CAP 5MG           | 5           | Added to 2020 Formulary      | Prior Authorization Required   | 2/1/2020              |                         |                              |
| OSPHENA TAB 60MG             | 3           | Added to 2020 Formulary      | Prior Authorization Required   | 2/1/2020              |                         |                              |
| PENTAMIDINE INH 300MG        | 2           | Added to 2020 Formulary      | B vs. D Prior Authorization Required   | 2/1/2020              |                         |                              |
| POSACONAZOLE TAB<br>100MG DR | 5           | Added to 2020 Formulary      | Quantity Limit<br>(93 tabs every 30 days)  | 2/1/2020              |                         |                              |
| ROZLYTREK CAP 100MG          | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required   | 2/1/2020              |                         |                              |
| ROZLYTREK CAP 200MG          | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required   | 2/1/2020              |                         |                              |
| TEMIXYS TAB 300-300          | 5           | Added to 2020 Formulary      |  | 2/1/2020              |                         |                              |
| TIADYLT ER CAP 360MG/24      | 2           | Added to 2020 Formulary      |  | 2/1/2020              |                         |                              |

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| Drug Label Name       | Tier | Description of Change        | Requirements/Limits                     | Effective Date | Alternative Drug              | Alternative Drug Tier |
|-----------------------|------|------------------------------|---|----------------|-------------------------------|-----------------------|
| D5W/NACL INJ 0.33%    | 2    | Removed from 2020 Formulary  |   | 2/1/2020       | D5W/NACL INJ 0.225%           | 2                     |
| DELYLA TAB 0.1-0.02   | 2    | Removed from 2020 Formulary  |   | 2/1/2020       | AVIANE TAB                    | 2                     |
| KCL/D5W/NACL INJ      | 2    | Removed from 2020 Formulary  |   | 2/1/2020       | KCL/D5W/NACL INJ .15-.45%     | 2                     |
| MORGIDOX CAP 1X50MG   | 2    | Removed from 2020 Formulary  |   | 2/1/2020       | DOXYCYCLINE HYCLATE CAP 50 MG | 2                     |
| NORLYROC TAB 0.35MG   | 2    | Removed from 2020 Formulary  |   | 2/1/2020       | CAMILA TAB 0.35MG             | 2                     |
| REBETOL SOL 40MG/ML   | 5    | Removed from 2020 Formulary  |   | 2/1/2020       | RIBAVIRIN TAB 200MG           | 2                     |
| RIBASPHERE CAP 200MG  | 2    | Removed from 2020 Formulary  |   | 2/1/2020       | RIBAVIRIN CAP 200MG           | 2                     |
| RIBASPHERE TAB 200MG  | 2    | Removed from 2020 Formulary  |   | 2/1/2020       | RIBAVIRIN TAB 200MG           | 2                     |
| RIBASPHERE TAB 600MG  | 5    | Removed from 2020 Formulary  |   | 2/1/2020       | RIBAVIRIN CAP 200MG           | 2                     |
| ZYKADIA CAP 150MG     | 5    | Removed from 2020 Formulary  | New Start Prior Authorization Required  | 2/1/2020       | ZYKADIA TAB 150MG             | 5                     |
| PRALUENT INJ 150MG/ML | 3    | Tier Change Tier 4 to Tier 3 | Prior Authorization Required            | 2/1/2020       |                               |                       |
| PRALUENT INJ 75MG/ML  | 3    | Tier Change Tier 4 to Tier 3 | Prior Authorization Required            | 2/1/2020       |                               |                       |
| RESTASIS EMU 0.05%    | 3    | Tier Change Tier 4 to Tier 3 | Quantity Limit (60 vials every 30 days) | 2/1/2020       |                               |                       |
| TRINTELLIX TAB 10MG   | 4    | Prior Authorization Removed  | Quantity Limit (60 tabs every 30 days)  | 2/1/2020       |                               |                       |

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| <b>Drug Label Name</b>    | <b>Tier</b> | <b>Description of Change</b> | <b>Requirements/Limits</b>                 | <b>Effective Date</b> | <b>Alternative Drug</b> | <b>Alternative Drug Tier</b> |
|---------------------------|-------------|------------------------------|--|-----------------------|-------------------------|------------------------------|
| TRINTELLIX TAB 20MG       | 4           | Prior Authorization Removed  | Quantity Limit<br>(30 tabs every 30 days)  | 2/1/2020              |                         |                              |
| TRINTELLIX TAB 5MG        | 4           | Prior Authorization Removed  | Quantity Limit<br>(120 tabs every 30 days) | 2/1/2020              |                         |                              |
| VIIBRYD KIT STARTER       | 4           | Prior Authorization Removed  |  | 2/1/2020              |                         |                              |
| VIIBRYD TAB 10MG          | 4           | Prior Authorization Removed  | Quantity Limit<br>(30 tabs every 30 days)  | 2/1/2020              |                         |                              |
| VIIBRYD TAB 20MG          | 4           | Prior Authorization Removed  | Quantity Limit<br>(30 tabs every 30 days)  | 2/1/2020              |                         |                              |
| VIIBRYD TAB 40MG          | 4           | Prior Authorization Removed  | Quantity Limit<br>(30 tabs every 30 days)  | 2/1/2020              |                         |                              |
| BRUKINSA CAP 80MG         | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required     | 3/1/2020              |                         |                              |
| CLINISOL SF INJ 15%       | 2           | Added to 2020 Formulary      | B vs. D Prior Authorization Required       | 3/1/2020              |                         |                              |
| DOXEPIN TAB 3MG           | 2           | Added to 2020 Formulary      | Quantity Limit<br>(30 tabs every 30 days)  | 3/1/2020              |                         |                              |
| DOXEPIN TAB 6MG           | 2           | Added to 2020 Formulary      | Quantity Limit<br>(30 tabs every 30 days)  | 3/1/2020              |                         |                              |
| ELURYNG MIS               | 2           | Added to 2020 Formulary      |  | 3/1/2020              |                         |                              |
| ETONOGESTERE MIS ETHY EST | 2           | Added to 2020 Formulary      |  | 3/1/2020              |                         |                              |

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|------------------------|-------------|------------------------------|--|-----------------------|-------------------------|------------------------------|
| FIASP PENFIL INJ U-100 | 3           | Added to 2020 Formulary      |  | 3/1/2020              |                         |                              |
| HARVONI TAB 45-200MG   | 5           | Added to 2020 Formulary      | Prior Authorization Required           | 3/1/2020              |                         |                              |
| KANJINTI INJ 420MG     | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required | 3/1/2020              |                         |                              |
| KANJINTI SOL 150MG     | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required | 3/1/2020              |                         |                              |
| MVASI INJ 100MG        | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required | 3/1/2020              |                         |                              |
| MVASI INJ 400MG        | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required | 3/1/2020              |                         |                              |
| NOVOLIN N INJ 100 UNIT | 3           | Added to 2020 Formulary      |  | 3/1/2020              |                         |                              |
| NOVOLIN R INJ 100 UNIT | 3           | Added to 2020 Formulary      |  | 3/1/2020              |                         |                              |
| OGIVRI INJ 150MG       | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required | 3/1/2020              |                         |                              |
| OGIVRI INJ 420MG       | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required | 3/1/2020              |                         |                              |
| PENICILLAMIN TAB 250MG | 5           | Added to 2020 Formulary      |  | 3/1/2020              |                         |                              |
| PLENAMINE INJ 15%      | 2           | Added to 2020 Formulary      | B vs. D Prior Authorization Required   | 3/1/2020              |                         |                              |
| TRAVOPROST DRO 0.004%  | 2           | Added to 2020 Formulary      |  | 3/1/2020              |                         |                              |
| TRIKAFTA TAB           | 5           | Added to 2020 Formulary      | Prior Authorization Required           | 3/1/2020              |                         |                              |

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|---------------------------|-------------|------------------------------|--|-----------------------|--------------------------|------------------------------|
| ZOLEDRONIC INJ 4MG/100    | 2           | Added to 2020 Formulary      | B vs. D Prior Authorization Required   | 3/1/2020              |                          |                              |
| CIPROFLOXACIN SUS 500MG/5 | 2           | Removed from 2020 Formulary  |  | 3/1/2020              | CIPROFLOXACIN TAB 500MG  | 1                            |
| ISOSORB DIN TAB 40MG ER   | 2           | Removed from 2020 Formulary  |  | 3/1/2020              | ISOSORBIDE DINITRATE TAB | 2                            |
| AYVAKIT TAB 100MG         | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required;<br>Quantity Limit<br>(30 tabs per 30 days) | 4/1/2020              |                          |                              |
| AYVAKIT TAB 200MG         | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required;<br>Quantity Limit<br>(30 tabs per 30 days) | 4/1/2020              |                          |                              |
| AYVAKIT TAB 300MG         | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required;<br>Quantity Limit<br>(30 tabs per 30 days) | 4/1/2020              |                          |                              |
| CAPLYTA CAP 42MG          | 4           | Added to 2020 Formulary      | Quantity Limit<br>(30 caps per 30 days)  | 4/1/2020              |                          |                              |
| EUTHYROX TAB 100MCG       | 2           | Added to 2020 Formulary      |  | 4/1/2020              |                          |                              |
| EUTHYROX TAB 112MCG       | 2           | Added to 2020 Formulary      |  | 4/1/2020              |                          |                              |
| EUTHYROX TAB 125MCG       | 2           | Added to 2020 Formulary      |  | 4/1/2020              |                          |                              |
| EUTHYROX TAB 137MCG       | 2           | Added to 2020 Formulary      |  | 4/1/2020              |                          |                              |
| EUTHYROX TAB 150MCG       | 2           | Added to 2020 Formulary      |  | 4/1/2020              |                          |                              |

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|------------------------|-------------|------------------------------|--|-----------------------|-------------------------|------------------------------|
| EUTHYROX TAB 175MCG    | 2           | Added to 2020 Formulary      |  | 4/1/2020              |                         |                              |
| EUTHYROX TAB 200MCG    | 2           | Added to 2020 Formulary      |  | 4/1/2020              |                         |                              |
| EUTHYROX TAB 25MCG     | 2           | Added to 2020 Formulary      |  | 4/1/2020              |                         |                              |
| EUTHYROX TAB 50MCG     | 2           | Added to 2020 Formulary      |  | 4/1/2020              |                         |                              |
| EUTHYROX TAB 75MCG     | 2           | Added to 2020 Formulary      |  | 4/1/2020              |                         |                              |
| EUTHYROX TAB 88MCG     | 2           | Added to 2020 Formulary      |  | 4/1/2020              |                         |                              |
| RUXIENCE INJ 100/10ML  | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required     | 4/1/2020              |                         |                              |
| RUXIENCE INJ 500/50ML  | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required     | 4/1/2020              |                         |                              |
| SECUADO DIS 3.8MG      | 4           | Added to 2020 Formulary      | Quantity Limit<br>(30 patches per 30 days) | 4/1/2020              |                         |                              |
| SECUADO DIS 5.7MG      | 4           | Added to 2020 Formulary      | Quantity Limit<br>(30 patches per 30 days) | 4/1/2020              |                         |                              |
| SECUADO DIS 7.6MG      | 4           | Added to 2020 Formulary      | Quantity Limit<br>(30 patches per 30 days) | 4/1/2020              |                         |                              |
| VALTOCO LIQ 15MG       | 4           | Added to 2020 Formulary      |  | 4/1/2020              |                         |                              |
| VALTOCO LIQ 20MG       | 4           | Added to 2020 Formulary      |  | 4/1/2020              |                         |                              |
| VALTOCO SPR 10MG       | 4           | Added to 2020 Formulary      |  | 4/1/2020              |                         |                              |

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|-----------------------------|-------------|------------------------------|--|-----------------------|---------------------------|------------------------------|
| VALTOCO SPR 5MG             | 4           | Added to 2020 Formulary      |  | 4/1/2020              |                           |                              |
| XELJANZ XR TAB 22MG         | 5           | Added to 2020 Formulary      | Prior Authorization Required;<br>Quantity Limit<br>(30 tabs per 30 days)     | 4/1/2020              |                           |                              |
| ZIRABEV INJ 100/4ML         | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required                                       | 4/1/2020              |                           |                              |
| ZIRABEV INJ 400/16ML        | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required                                       | 4/1/2020              |                           |                              |
| HUMIRA PEDIA INJ CROHNS     | 5           | Removed from 2020 Formulary  | Prior Authorization Required   | 4/1/2020              | HUMIRA KIT<br>40MG/0.8 ML | 5                            |
| SYLATRON KIT 600MCG         | 5           | Removed from 2020 Formulary  | New Start Prior Authorization Required                                       | 4/1/2020              | SYLATRON KIT<br>300MCG    | 5                            |
| CIPRO (10%) SUS 500MG/5     | 4           | Added to 2020 Formulary      |  | 5/1/2020              |                           |                              |
| ENBREL INJ 25/0.5ML         | 5           | Added to 2020 Formulary      | Prior Authorization Required;<br>Quantity Limit<br>(16 syringes per 28 days) | 5/1/2020              |                           |                              |
| ENBREL INJ 25MG             | 5           | Added to 2020 Formulary      | Prior Authorization Required;<br>Quantity Limit<br>(16 syringes per 28 days) | 5/1/2020              |                           |                              |
| ENBREL INJ 50MG/ML          | 5           | Added to 2020 Formulary      | Prior Authorization Required;<br>Quantity Limit<br>(8 syringes per 28 days)  | 5/1/2020              |                           |                              |
| ENBREL MINI INJ 50MG/ML     | 5           | Added to 2020 Formulary      | Prior Authorization Required;<br>Quantity Limit<br>(8 syringes per 28 days)  | 5/1/2020              |                           |                              |
| ENBREL SRCLK INJ<br>50MG/ML | 5           | Added to 2020 Formulary      | Prior Authorization Required;<br>Quantity Limit<br>(8 syringes per 28 days)  | 5/1/2020              |                           |                              |



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|------------------------|-------------|------------------------------|--|-----------------------|-------------------------|------------------------------|
| EVEROLIMUS TAB 0.25MG  | 2           | Added to 2020 Formulary      | B vs. D Prior Authorization Required                                       | 5/1/2020              |                         |                              |
| EVEROLIMUS TAB 0.5 MG  | 5           | Added to 2020 Formulary      | B vs. D Prior Authorization Required                                       | 5/1/2020              |                         |                              |
| EVEROLIMUS TAB 0.75MG  | 5           | Added to 2020 Formulary      | B vs. D Prior Authorization Required                                       | 5/1/2020              |                         |                              |
| MOXIFLOXACIN SOL 0.5%  | 2           | Added to 2020 Formulary      |  | 5/1/2020              |                         |                              |
| PHENOBARB INJ 65MG/ML  | 4           | Added to 2020 Formulary      | New Start Prior Authorization Required                                     | 5/1/2020              |                         |                              |
| RINVOQ TAB 15MG ER     | 5           | Added to 2020 Formulary      | Prior Authorization Required;<br>Quantity Limit<br>(30 tabs per 30 days)   | 5/1/2020              |                         |                              |
| SKYRIZI INJ 150DOSE    | 5           | Added to 2020 Formulary      | Prior Authorization Required;<br>Quantity Limit<br>(7 injections per year) | 5/1/2020              |                         |                              |
| TAZVERIK TAB 200MG     | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required                                     | 5/1/2020              |                         |                              |
| TIADYLT CAP 120MG/24   | 2           | Added to 2020 Formulary      |  | 5/1/2020              |                         |                              |
| TIADYLT CAP 180MG/24   | 2           | Added to 2020 Formulary      |  | 5/1/2020              |                         |                              |
| TIADYLT CAP 240MG/24   | 2           | Added to 2020 Formulary      |  | 5/1/2020              |                         |                              |
| TIADYLT CAP 300MG/24   | 2           | Added to 2020 Formulary      |  | 5/1/2020              |                         |                              |
| TIADYLT CAP 420MG/24   | 2           | Added to 2020 Formulary      |  | 5/1/2020              |                         |                              |
| TRAZIMERA INJ 420MG    | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required                                     | 5/1/2020              |                         |                              |

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|------------------------|-------------|------------------------------|--|-----------------------|---------------------------|------------------------------|
| TRUXIMA INJ 100/10ML   | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required   | 5/1/2020              |                           |                              |
| TRUXIMA INJ 500/50ML   | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required   | 5/1/2020              |                           |                              |
| ZIPRASIDONE INJ 20MG   | 2           | Added to 2020 Formulary      | Quantity Limit<br>(6 injections per 3 days)  | 5/1/2020              |                           |                              |
| AFINITOR TAB 2.5MG     | 5           | Removed from 2020 Formulary  | New Start Prior Authorization Required;<br>Quantity Limit<br>(30 tabs per 30 days) | 5/1/2020              | EVEROLIMUS TAB<br>2.5MG   | 5                            |
| AFINITOR TAB 5MG       | 5           | Removed from 2020 Formulary  | New Start Prior Authorization Required;<br>Quantity Limit<br>(30 tabs per 30 days) | 5/1/2020              | EVEROLIMUS TAB<br>5MG     | 5                            |
| AFINITOR TAB 7.5MG     | 5           | Removed from 2020 Formulary  | New Start Prior Authorization Required;<br>Quantity Limit<br>(30 tabs per 30 days) | 5/1/2020              | EVEROLIMUS TAB<br>7.5MG   | 5                            |
| DEPEN TITRA TAB 250MG  | 5           | Removed from 2020 Formulary  |  | 5/1/2020              | PENICILLAMIN TAB<br>250MG | 5                            |
| FARYDAK CAP 15MG       | 5           | Removed from 2020 Formulary  | New Start Prior Authorization Required   | 5/1/2020              | FARYDAK CAP 20MG          | 5                            |
| FLURBIPROFEN TAB 50MG  | 2           | Removed from 2020 Formulary  |  | 5/1/2020              | FLURBIPROFEN TAB<br>100MG | 2                            |
| IONOSOL-MB INJ D5W     | 4           | Removed from 2020 Formulary  |  | 5/1/2020              | NORMOSOL -M INJ<br>/D5W   | 4                            |
| JADENU TAB 360MG       | 5           | Removed from 2020 Formulary  | Prior Authorization Required   | 5/1/2020              | DEFERASIROX TAB<br>360MG  | 5                            |
| JADENU TAB 90MG        | 5           | Removed from 2020 Formulary  | Prior Authorization Required   | 5/1/2020              | DEFERASIROX TAB<br>90MG   | 5                            |

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|-----------------------|------|-----------------------------|--------------------------------------|----------------|---|-----------------------|
| NEBUPENT INH 300MG    | 4    | Removed from 2020 Formulary | B vs. D Prior Authorization          | 5/1/2020       | PENTAMIDINE INH 300MG                   | 2                     |
| NOXAFIL TAB 100MG     | 5    | Removed from 2020 Formulary | Quantity Limit (93 tabs per 30 days) | 5/1/2020       | POSACONAZOLE TAB 100MG DR               | 5                     |
| NUVARING MIS          | 4    | Removed from 2020 Formulary |                                      | 5/1/2020       | ELURYNG MIS                             | 2                     |
| PENTAM 300 INJ 300MG  | 4    | Removed from 2020 Formulary |                                      | 5/1/2020       | PENTAMIDINE ISETHIONATE FOR SOLN 300 MG | 2                     |
| SILENOR TAB 3MG       | 3    | Removed from 2020 Formulary | Quantity Limit (30 tabs per 30 days) | 5/1/2020       | DOXEPIN TAB                             | 2                     |
| SILENOR TAB 6MG       | 3    | Removed from 2020 Formulary | Quantity Limit (30 tabs per 30 days) | 5/1/2020       | DOXEPIN TAB                             | 2                     |
| TRAVATAN Z DRO 0.004% | 4    | Removed from 2020 Formulary |                                      | 5/1/2020       | TRAVOPROST DROPS 0.004%                 | 2                     |
| BELSOMRA TAB 10MG     | 4    | Added to 2020 Formulary     | Quantity Limit (30 tabs per 30 days) | 6/1/2020       |   |                       |
| BELSOMRA TAB 15MG     | 4    | Added to 2020 Formulary     | Quantity Limit (30 tabs per 30 days) | 6/1/2020       |   |                       |
| BELSOMRA TAB 20MG     | 4    | Added to 2020 Formulary     | Quantity Limit (30 tabs per 30 days) | 6/1/2020       |   |                       |
| BELSOMRA TAB 5MG      | 4    | Added to 2020 Formulary     | Quantity Limit (30 tabs per 30 days) | 6/1/2020       |   |                       |
| CLOVIQUE CAP 250MG    | 5    | Added to 2020 Formulary     | Prior Authorization Required         | 6/1/2020       |   |                       |
| DIAZOXIDE SUS 50MG/ML | 2    | Added to 2020 Formulary     |                                      | 6/1/2020       |   |                       |
| FASENRA INJ 30MG/ML   | 5    | Added to 2020 Formulary     | Prior Authorization Required         | 6/1/2020       |   |                       |

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|----------------------------|-------------|------------------------------|--|-----------------------|-------------------------|------------------------------|
| FASENRA PEN INJ<br>30MG/ML | 5           | Added to 2020 Formulary      | Prior Authorization Required   | 6/1/2020              |                         |                              |
| GLYXAMBI TAB 10-5 MG       | 3           | Added to 2020 Formulary      | Quantity Limit<br>(30 tabs per 30 days)  | 6/1/2020              |                         |                              |
| GLYXAMBI TAB 25-5 MG       | 3           | Added to 2020 Formulary      | Quantity Limit<br>(30 tabs per 30 days)  | 6/1/2020              |                         |                              |
| GVOKE PFS INJ              | 3           | Added to 2020 Formulary      |  | 6/1/2020              |                         |                              |
| IBRANCE TAB 100MG          | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required;<br>Quantity Limit<br>(21 tabs per 28 days) | 6/1/2020              |                         |                              |
| IBRANCE TAB 125MG          | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required;<br>Quantity Limit<br>(21 tabs per 28 days) | 6/1/2020              |                         |                              |
| IBRANCE TAB 75MG           | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required;<br>Quantity Limit<br>(21 tabs per 28 days) | 6/1/2020              |                         |                              |
| IRINOTECAN INJ 300/15ML    | 2           | Added to 2020 Formulary      | B vs. D Prior Authorization  | 6/1/2020              |                         |                              |
| NIZATIDINE CAP 150MG       | 2           | Added to 2020 Formulary      |  | 6/1/2020              |                         |                              |
| NIZATIDINE CAP 300MG       | 2           | Added to 2020 Formulary      |  | 6/1/2020              |                         |                              |
| VELTASSA POW 16.8GM        | 4           | Added to 2020 Formulary      | Prior Authorization Required   | 6/1/2020              |                         |                              |
| VELTASSA POW 25.2GM        | 4           | Added to 2020 Formulary      | Prior Authorization Required   | 6/1/2020              |                         |                              |

**VIVA MEDICARE**  
**IMPORTANT 2020 5-T STANDARD FORMULARY UPDATES**

| <b>Drug Label Name</b>    | <b>Tier</b> | <b>Description of Change</b> | <b>Requirements/Limits</b>             | <b>Effective Date</b> | <b>Alternative Drug</b> | <b>Alternative Drug Tier</b> |
|---------------------------|-------------|------------------------------|--|-----------------------|-------------------------|------------------------------|
| VELTASSA POW 8.4GM        | 4           | Added to 2020 Formulary      | Prior Authorization Required           | 6/1/2020              |                         |                              |
| RANITIDINE INJ 150/6ML    | 2           | Removed from 2020 Formulary  |  | 6/1/2020              | FAMOTIDINE INJ          | 2                            |
| RANITIDINE INJ 50MG/2ML   | 2           | Removed from 2020 Formulary  |  | 6/1/2020              | FAMOTIDINE INJ          | 2                            |
| RANITIDINE SYP 75MG/5ML   | 2           | Removed from 2020 Formulary  |  | 6/1/2020              | FAMOTIDINE SUS 40MG/5ML | 2                            |
| RANITIDINE TAB 150MG      | 1           | Removed from 2020 Formulary  |  | 6/1/2020              | FAMOTIDINE TAB          | 1                            |
| RANITIDINE TAB 300MG      | 1           | Removed from 2020 Formulary  |  | 6/1/2020              | FAMOTIDINE TAB          | 1                            |
| RESCRIPTOR TAB 200MG      | 4           | Removed from 2020 Formulary  |  | 6/1/2020              | EFAVIRENZ TAB 600MG     | 5                            |
| DEFERASIROX TAB 180MG     | 5           | Added to 2020 Formulary      | Prior Authorization Required           | 7/1/2020              |                         |                              |
| FLAREX SUS 0.1% OP        | 4           | Added to 2020 Formulary      |  | 7/1/2020              |                         |                              |
| GVOKE HYPO 2 INJ .5/.1ML  | 3           | Added to 2020 Formulary      |  | 7/1/2020              |                         |                              |
| GVOKE HYPO 2 INJ 1MG/.2ML | 3           | Added to 2020 Formulary      |  | 7/1/2020              |                         |                              |
| HALOPER DEC INJ 50MG/ML   | 2           | Added to 2020 Formulary      |  | 7/1/2020              |                         |                              |
| HERZUMA INJ 150MG         | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required | 7/1/2020              |                         |                              |
| HERZUMA INJ 420MG         | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required | 7/1/2020              |                         |                              |

**VIVA MEDICARE**  
**IMPORTANT 2020 5-T STANDARD FORMULARY UPDATES**

| <b>Drug Label Name</b>          | <b>Tier</b> | <b>Description of Change</b> | <b>Requirements/Limits</b>   | <b>Effective Date</b> | <b>Alternative Drug</b> | <b>Alternative Drug Tier</b> |
|---------------------------------|-------------|------------------------------|--|-----------------------|-------------------------|------------------------------|
| INGREZZA CAP 40-80MG            | 5           | Added to 2020 Formulary      | Prior Authorization Required;<br>Quantity Limit<br>(28 caps per 28 days)     | 7/1/2020              |                         |                              |
| INGREZZA CAP 40MG               | 5           | Added to 2020 Formulary      | Prior Authorization Required;<br>Quantity Limit<br>(30 caps per 30 days)     | 7/1/2020              |                         |                              |
| INGREZZA CAP 80MG               | 5           | Added to 2020 Formulary      | Prior Authorization Required;<br>Quantity Limit<br>(30 caps per 30 days)     | 7/1/2020              |                         |                              |
| ONTRUZANT INJ 150MG             | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required                                       | 7/1/2020              |                         |                              |
| ONTRUZANT INJ 420MG             | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required                                       | 7/1/2020              |                         |                              |
| PEMAZYRE TAB 13.5MG             | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required                                       | 7/1/2020              |                         |                              |
| PEMAZYRE TAB 4.5MG              | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required                                       | 7/1/2020              |                         |                              |
| PEMAZYRE TAB 9MG                | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required                                       | 7/1/2020              |                         |                              |
| PROMACTA PAK 25MG               | 5           | Added to 2020 Formulary      | Prior Authorization Required;<br>Quantity Limit<br>(180 packets per 30 days) | 7/1/2020              |                         |                              |
| RYBELSUS TAB 14MG               | 3           | Added to 2020 Formulary      | Quantity Limit<br>(30 tabs per 30 days)                                      | 7/1/2020              |                         |                              |
| RYBELSUS TAB 3MG                | 3           | Added to 2020 Formulary      | Quantity Limit<br>(30 tabs per 30 days)                                      | 7/1/2020              |                         |                              |
| RYBELSUS TAB 7MG                | 3           | Added to 2020 Formulary      | Quantity Limit<br>(30 tabs per 30 days)                                      | 7/1/2020              |                         |                              |
| TRIJARDY XR TAB 12.5-2.5-1000MG | 3           | Added to 2020 Formulary      | Quantity Limit<br>(60 tabs per 30 days)                                      | 7/1/2020              |                         |                              |

**VIVA MEDICARE**  
**IMPORTANT 2020 5-T STANDARD FORMULARY UPDATES**

| Drug Label Name              | Tier | Description of Change       | Requirements/Limits                       | Effective Date | Alternative Drug             | Alternative Drug Tier |
|------------------------------|------|-----------------------------|---|----------------|------------------------------|-----------------------|
| TRIJARDY XR TAB 5-2.5-1000MG | 3    | Added to 2020 Formulary     | Quantity Limit<br>(60 tabs per 30 days)   | 7/1/2020       |                              |                       |
| TRIJARDY XR TAB 25-5-1000MG  | 3    | Added to 2020 Formulary     | Quantity Limit<br>(30 tabs per 30 days)   | 7/1/2020       |                              |                       |
| TRIJARDY XR TAB 10-5-1000MG  | 3    | Added to 2020 Formulary     | Quantity Limit<br>(30 tabs per 30 days)   | 7/1/2020       |                              |                       |
| ZERVIATE DRO 0.24%           | 4    | Added to 2020 Formulary     |   | 7/1/2020       |                              |                       |
| ADRUCIL INJ 2.5/50ML         | 2    | Removed from 2020 Formulary | B vs. D Prior Authorization               | 7/1/2020       | FLUOROURACIL INJ<br>2.5/50ML | 2                     |
| ADRUCIL INJ 500/10ML         | 2    | Removed from 2020 Formulary | B vs. D Prior Authorization               | 7/1/2020       | FLUOROURACIL INJ<br>500/10ML | 2                     |
| VIDEX EC CAP 125MG           | 4    | Removed from 2020 Formulary |   | 7/1/2020       | DIDANOSINE CAP<br>250MG      | 2                     |
| VIDEX SOL 2GM                | 4    | Removed from 2020 Formulary |   | 7/1/2020       | DIDANOSINE CAP<br>200MG      | 2                     |
| HARVONI PAK                  | 5    | Added to 2020 Formulary     | Prior Authorization Required              | 8/1/2020       |                              |                       |
| HARVONI PAK 45-200MG         | 5    | Added to 2020 Formulary     | Prior Authorization Required              | 8/1/2020       |                              |                       |
| MICAFUNGIN INJ 100MG         | 5    | Added to 2020 Formulary     |   | 8/1/2020       |                              |                       |
| MICAFUNGIN INJ 50MG          | 5    | Added to 2020 Formulary     |   | 8/1/2020       |                              |                       |
| NYMALIZE SOL                 | 5    | Added to 2020 Formulary     |   | 8/1/2020       |                              |                       |
| TUKYSA TAB 150MG             | 5    | Added to 2020 Formulary     | New Start Prior Authorization<br>Required | 8/1/2020       |                              |                       |

**VIVA MEDICARE**  
**IMPORTANT 2020 5-T STANDARD FORMULARY UPDATES**

| <b>Drug Label Name</b> | <b>Tier</b> | <b>Description of Change</b> | <b>Requirements/Limits</b>              | <b>Effective Date</b> | <b>Alternative Drug</b> | <b>Alternative Drug Tier</b> |
|------------------------|-------------|------------------------------|---|-----------------------|-------------------------|------------------------------|
| TUKYSA TAB 50MG        | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required  | 8/1/2020              |                         |                              |
| XCOPRI PAK 12.5-25     | 4           | Added to 2020 Formulary      | Quantity Limit<br>(28 tabs per 28 days) | 8/1/2020              |                         |                              |
| XCOPRI PAK 150-200     | 5           | Added to 2020 Formulary      | Quantity Limit<br>(56 tabs per 28 days) | 8/1/2020              |                         |                              |
| XCOPRI PAK 50-100MG    | 5           | Added to 2020 Formulary      | Quantity Limit<br>(28 tabs per 28 days) | 8/1/2020              |                         |                              |
| XCOPRI TAB 100MG       | 5           | Added to 2020 Formulary      | Quantity Limit<br>(60 tabs per 28 days) | 8/1/2020              |                         |                              |
| XCOPRI TAB 150MG       | 5           | Added to 2020 Formulary      | Quantity Limit<br>(60 tabs per 28 days) | 8/1/2020              |                         |                              |
| XCOPRI TAB 200MG       | 5           | Added to 2020 Formulary      | Quantity Limit<br>(60 tabs per 28 days) | 8/1/2020              |                         |                              |
| XCOPRI TAB 50-200MG    | 5           | Added to 2020 Formulary      | Quantity Limit<br>(56 tabs per 28 days) | 8/1/2020              |                         |                              |
| XCOPRI TAB 50MG        | 5           | Added to 2020 Formulary      | Quantity Limit<br>(90 tabs per 28 days) | 8/1/2020              |                         |                              |
| AMINOSYN-PF INJ 10%    | 4           | Removed from 2020 Formulary  | B vs. D Prior Authorization             | 8/1/2020              | AMINOSYN II INJ 10%     | 4                            |
| EC-NAPROXEN TAB 375MG  | 2           | Added to 2020 Formulary      |   | 9/1/2020              |                         |                              |
| EC-NAPROXEN TAB 500MG  | 2           | Added to 2020 Formulary      |   | 9/1/2020              |                         |                              |
| ONE VITE TAB 1MG PLUS  | 3           | Added to 2020 Formulary      |   | 9/1/2020              |                         |                              |
| QINLOCK TAB 50MG       | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required  | 9/1/2020              |                         |                              |



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**IMPORTANT 2020 5-T STANDARD FORMULARY UPDATES**

| <b>Drug Label Name</b>  | <b>Tier</b> | <b>Description of Change</b> | <b>Requirements/Limits</b>             | <b>Effective Date</b> | <b>Alternative Drug</b>                | <b>Alternative Drug Tier</b> |
|-------------------------|-------------|------------------------------|--|-----------------------|--|------------------------------|
| RETEVMO CAP 40MG        | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required | 9/1/2020              |  |                              |
| RETEVMO CAP 80MG        | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required | 9/1/2020              |  |                              |
| TABRECTA TAB 150MG      | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required | 9/1/2020              |  |                              |
| TABRECTA TAB 200MG      | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required | 9/1/2020              |  |                              |
| TIVICAY PD TAB 5MG      | 3           | Added to 2020 Formulary      |  | 9/1/2020              |  |                              |
| XPOVIO PAK 40MG         | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required | 9/1/2020              |  |                              |
| XPOVIO PAK 60MG         | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required | 9/1/2020              |  |                              |
| E.E.S. 400 TAB 400MG    | 2           | Removed from 2020 Formulary  |  | 9/1/2020              | ERYTHROMYCIN ETHYLSUCCINATE TAB 400 MG | 2                            |
| POT CHL/D5W INJ 40MEQ/L | 2           | Removed from 2020 Formulary  |  | 9/1/2020              | POTASSIUM CHLORIDE/D5W INJ 20MEQ/L     | 2                            |
| RIFATER TAB             | 4           | Removed from 2020 Formulary  |  | 9/1/2020              | ISONIAZID TAB                          | 1                            |
| DEFERASIROX GRA 180MG   | 5           | Added to 2020 Formulary      | Prior Authorization Required           | 10/1/2020             |  |                              |
| DEFERASIROX GRA 360MG   | 5           | Added to 2020 Formulary      | Prior Authorization Required           | 10/1/2020             |  |                              |
| DEFERASIROX GRA 90MG    | 5           | Added to 2020 Formulary      | Prior Authorization Required           | 10/1/2020             |  |                              |

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| <b>Drug Label Name</b>    | <b>Tier</b> | <b>Description of Change</b> | <b>Requirements/Limits</b>   | <b>Effective Date</b> | <b>Alternative Drug</b> | <b>Alternative Drug Tier</b> |
|---------------------------|-------------|------------------------------|--|-----------------------|-------------------------|------------------------------|
| FINTEPLA SOL 2.2MG/ML     | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required;<br>Quantity Limit<br>(360mL per 30 days) | 10/1/2020             |                         |                              |
| FLEBOGAMMA INJ 10/100ML   | 5           | Added to 2020 Formulary      | Prior Authorization Required   | 10/1/2020             |                         |                              |
| FLEBOGAMMA INJ 10/200ML   | 5           | Added to 2020 Formulary      | Prior Authorization Required   | 10/1/2020             |                         |                              |
| FLEBOGAMMA INJ 20/400ML   | 5           | Added to 2020 Formulary      | Prior Authorization Required   | 10/1/2020             |                         |                              |
| FLEBOGAMMA INJ 5GM/50ML   | 5           | Added to 2020 Formulary      | Prior Authorization Required   | 10/1/2020             |                         |                              |
| FLEBOGAMMA INJ DIF 5%     | 5           | Added to 2020 Formulary      | Prior Authorization Required   | 10/1/2020             |                         |                              |
| METYROSINE CAP 250MG      | 5           | Added to 2020 Formulary      | Prior Authorization Required   | 10/1/2020             |                         |                              |
| PHESGO SOL                | 5           | Added to 2020 Formulary      | New Start Prior Authorization Required   | 10/1/2020             |                         |                              |
| RUKOBIA TAB 600MG ER      | 5           | Added to 2020 Formulary      |  | 10/1/2020             |                         |                              |
| SIRTURO TAB 20MG          | 5           | Added to 2020 Formulary      | Prior Authorization Required   | 10/1/2020             |                         |                              |
| D5W/NACL INJ 0.225%       | 2           | Removed from 2020 Formulary  |  | 10/1/2020             | D5W/NACL INJ 0.2%       | 2                            |
| DESO/ETHINYL TAB ESTRADIO | 2           | Removed from 2020 Formulary  |  | 10/1/2020             | APRI TAB                | 2                            |
| NORMOSOL -R INJ /D5W      | 4           | Removed from 2020 Formulary  |  | 10/1/2020             | ISOLYTE-S INJ           | 4                            |
| CIPRO/DEXA SUS 0.3-0.1%   | 2           | Added to 2020 Formulary      |  | 11/1/2020             |                         |                              |

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| <b>Drug Label Name</b>      | <b>Tier</b> | <b>Description of Change</b> | <b>Requirements/Limits</b>   | <b>Effective Date</b> | <b>Alternative Drug</b>             | <b>Alternative Drug Tier</b> |
|-----------------------------|-------------|------------------------------|--|-----------------------|-------------------------------------|------------------------------|
| CYCLOPHOSPH INJ 1GM         | 5           | Added to 2020 Formulary      | B vs. D Prior Authorization  | 11/1/2020             |                                     |                              |
| CYCLOPHOSPHA INJ 500MG      | 5           | Added to 2020 Formulary      | B vs. D Prior Authorization  | 11/1/2020             |                                     |                              |
| EFAVIR/LAMIV TAB<br>TENOFVI | 5           | Added to 2020 Formulary      |  | 11/1/2020             |                                     |                              |
| EMTRICITABIN CAP 200MG      | 2           | Added to 2020 Formulary      |  | 11/1/2020             |                                     |                              |
| ENBREL INJ 25MG             | 5           | Added to 2020 Formulary      | Prior Authorization Required;<br>Quantity Limit<br>(8 vials per 28 days) | 11/1/2020             |                                     |                              |
| INQOVI TAB 35-100MG         | 5           | Added to 2020 Formulary      | New Start Prior Authorization  | 11/1/2020             |                                     |                              |
| TRULICITY INJ               | 3           | Added to 2020 Formulary      | Quantity Limit<br>(4 pens per 28 days)                                   | 11/1/2020             |                                     |                              |
| ADRUCIL INJ 5/100ML         | 2           | Removed from 2020 Formulary  | B vs. D Prior Authorization  | 11/1/2020             | FLUOROURACIL INJ<br>5GM/100M        | 2                            |
| COLOCORT ENE 100MG          | 2           | Removed from 2020 Formulary  |  | 11/1/2020             | HYDROCORTISONE<br>ENEMA 100 MG/60ML | 2                            |
| COUMADIN TAB 10MG           | 3           | Removed from 2020 Formulary  |  | 11/1/2020             | WARFARIN TAB                        | 1                            |
| COUMADIN TAB 2.5MG          | 3           | Removed from 2020 Formulary  |  | 11/1/2020             | WARFARIN TAB                        | 1                            |
| COUMADIN TAB 2MG            | 3           | Removed from 2020 Formulary  |  | 11/1/2020             | WARFARIN TAB                        | 1                            |
| COUMADIN TAB 3MG            | 3           | Removed from 2020 Formulary  |  | 11/1/2020             | WARFARIN TAB                        | 1                            |
| COUMADIN TAB 4MG            | 3           | Removed from 2020 Formulary  |  | 11/1/2020             | WARFARIN TAB                        | 1                            |

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| <b>Drug Label Name</b>      | <b>Tier</b> | <b>Description of Change</b>    | <b>Requirements/Limits</b>                 | <b>Effective Date</b> | <b>Alternative Drug</b>                         | <b>Alternative Drug Tier</b> |
|-----------------------------|-------------|---------------------------------|--|-----------------------|---|------------------------------|
| COUMADIN TAB 5MG            | 3           | Removed from 2020 Formulary     |  | 11/1/2020             | WARFARIN TAB                                    | 1                            |
| COUMADIN TAB 6MG            | 3           | Removed from 2020 Formulary     |  | 11/1/2020             | WARFARIN TAB                                    | 1                            |
| COUMADIN TAB 7.5MG          | 3           | Removed from 2020 Formulary     |  | 11/1/2020             | WARFARIN TAB                                    | 1                            |
| LORCET HD TAB 10-325MG      | 2           | Removed from 2020 Formulary     | Quantity Limit<br>(180 tabs per 30 days)   | 11/1/2020             | HYDROCODONE-<br>ACETAMINOPHEN TAB<br>10-325 MG  | 2                            |
| LORCET PLUS TAB 7.5-325     | 2           | Removed from 2020 Formulary     | Quantity Limit<br>(180 tabs per 30 days)   | 11/1/2020             | HYDROCODONE-<br>ACETAMINOPHEN TAB<br>7.5-325 MG | 2                            |
| LORCET TAB 5-325MG          | 2           | Removed from 2020 Formulary     | Quantity Limit<br>(240 tabs per 30 days)   | 11/1/2020             | HYDROCODONE-<br>ACETAMINOPHEN TAB<br>5-325 MG   | 2                            |
| NORMOSOL-R INJ PH 7.4       | 4           | Removed from 2020 Formulary     |  | 11/1/2020             | ISOLYTE-S INJ                                   | 4                            |
| ONE VITE TAB 1MG PLUS       | 3           | Removed from 2020 Formulary     |  | 11/1/2020             | PRENATAL TAB 27-<br>1MG                         | 3                            |
| CHLORPROMAZ INJ<br>25MG/ML  | 2           | Tier change<br>Tier 4 to Tier 2 |  | 11/1/2020             |   |                              |
| CHLORPROMAZ INJ<br>50MG/2ML | 2           | Tier change<br>Tier 4 to Tier 2 |  | 11/1/2020             |   |                              |
| BREZTRI AERO AER SPHERE     | 3           | Added to 2020<br>Formulary      | Quantity Limit<br>(4 inhalers per 28 days) | 12/1/2020             |   |                              |
| BREZTRI AERO AER SPHERE     | 3           | Added to 2020<br>Formulary      | Quantity Limit<br>(1 inhaler per 30 days)  | 12/1/2020             |   |                              |
| EFAVIR/EMTRI TAB<br>TENOFVI | 5           | Added to 2020<br>Formulary      |  | 12/1/2020             |   |                              |

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|                          |   |                             |   |           |                   |   |
|--------------------------|---|-----------------------------|---|-----------|-------------------|---|
| EMTR/TENOFOV TAB 200-300 | 5 | Added to 2020 Formulary     | Quantity Limit<br>(30 tabs per 30 days)     | 12/1/2020 |                   |   |
| EPCLUSA TAB 200-50MG     | 5 | Added to 2020 Formulary     | Prior Authorization Required                | 12/1/2020 |                   |   |
| GAVRETO CAP 100MG        | 5 | Added to 2020 Formulary     | New Start Prior Authorization Required      | 12/1/2020 |                   |   |
| LAPATINIB TAB 250MG      | 5 | Added to 2020 Formulary     | New Start Prior Authorization Required      | 12/1/2020 |                   |   |
| MENQUADFI INJ            | 3 | Added to 2020 Formulary     |   | 12/1/2020 |                   |   |
| ONUREG TAB 200MG         | 5 | Added to 2020 Formulary     | New Start Prior Authorization Required      | 12/1/2020 |                   |   |
| ONUREG TAB 300MG         | 5 | Added to 2020 Formulary     | New Start Prior Authorization Required      | 12/1/2020 |                   |   |
| SAPROPTERIN POW 100MG    | 5 | Added to 2020 Formulary     | Prior Authorization Required                | 12/1/2020 |                   |   |
| SAPROPTERIN POW 500MG    | 5 | Added to 2020 Formulary     | Prior Authorization Required                | 12/1/2020 |                   |   |
| SAPROPTERIN TAB 100MG    | 5 | Added to 2020 Formulary     | Prior Authorization Required                | 12/1/2020 |                   |   |
| TRELEGY AER ELLIPTA      | 3 | Added to 2020 Formulary     | Quantity Limit<br>(60 blisters per 30 days) | 12/1/2020 |                   |   |
| TRIDERM CRE 0.5%         | 1 | Added to 2020 Formulary     |   | 12/1/2020 |                   |   |
| COUMADIN TAB 1MG         | 3 | Removed from 2020 Formulary |   | 12/1/2020 | WARFARIN TAB      | 1 |
| JUXTAPID CAP 40MG        | 5 | Removed from 2020 Formulary | Prior Authorization Required                | 12/1/2020 | JUXTAPID CAP 20MG | 5 |
| JUXTAPID CAP 60MG        | 5 | Removed from 2020 Formulary | Prior Authorization Required                | 12/1/2020 | JUXTAPID CAP 20MG | 5 |