

VIVA MEDICARE

IMPORTANT 2020 5-T PERFORMANCE FORMULARY UPDATES

Drug Label Name	Tier	Description of Change	Requirements/Limits	Effective Date	Alternative Drug	Alternative Drug Tier
CLOCORTOLONE CRE 0.1%	2	Added to 2020 Formulary		2/1/2020		
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; Quantity Limit (60 caps every 30 days)	2/1/2020		
DRIZALMA CAP 30MG DR	4	Added to 2020 Formulary	New Start Prior Authorization Required; Quantity Limit (60 caps every 30 days)	2/1/2020		
DRIZALMA CAP 40MG DR	4	Added to 2020 Formulary	New Start Prior Authorization Required; Quantity Limit (90 caps every 30 days)	2/1/2020		
DRIZALMA CAP 60MG DR	4	Added to 2020 Formulary	New Start Prior Authorization Required; Quantity Limit (60 caps every 30 days)	2/1/2020		
EGRIFTA SV INJ 2MG	5	Added to 2020 Formulary	Prior Authorization Required	2/1/2020		

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Drug Label Name	Tier	Description of Change	Requirements/Limits	Effective Date	Alternative Drug	Alternative Drug Tier
EVEROLIMUS TAB 2.5MG	5	Added to 2020 Formulary	New Start Prior Authorization Required; Quantity Limit (30 tabs every 30 days)	2/1/2020		
EVEROLIMUS TAB 5MG	5	Added to 2020 Formulary	New Start Prior Authorization Required; Quantity Limit (30 tabs every 30 days)	2/1/2020		
EVEROLIMUS TAB 7.5MG	5	Added to 2020 Formulary	New Start Prior Authorization Required; Quantity Limit (30 tabs every 30 days)	2/1/2020		
FENTANYL CIT TAB 100MCG	5	Added to 2020 Formulary	Prior Authorization Required; Quantity Limit (120 tabs every 30 days)	2/1/2020		
HALCINONIDE CRE 0.1%	2	Added to 2020 Formulary	Quantity Limit (240 gm every 30 days)	2/1/2020		
KETODAN AER 2%	2	Added to 2020 Formulary	Quantity Limit (100 gm every 30 days)	2/1/2020		
MESALAMINE CAP 0.375GM	2	Added to 2020 Formulary		2/1/2020		
METRONIDAZOL INJ 5MG/ML	2	Added to 2020 Formulary		2/1/2020		
NAFTIFINE GEL 1%	2	Added to 2020 Formulary	Quantity Limit (90 gm every 30 days)	2/1/2020		
NAYZILAM SPR 5MG	4	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
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		
PENTAMIDINE INH 300MG	2	Added to 2020 Formulary	B vs. D Prior Authorization Required	2/1/2020		
POSACONAZOLE TAB 100MG DR	5	Added to 2020 Formulary	Quantity Limit (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		
SIKLOS TAB 1000MG	5	Added to 2020 Formulary		2/1/2020		
SIKLOS TAB 100MG	4	Added to 2020 Formulary		2/1/2020		
SUCRALFATE SUS 1GM/10ML	2	Added to 2020 Formulary		2/1/2020		
TEMIXYS TAB 300-300	5	Added to 2020 Formulary		2/1/2020		
TIADYL ER CAP 360MG/24	2	Added to 2020 Formulary		2/1/2020		
VANCOMYCIN SOL 250/5ML	4	Added to 2020 Formulary		2/1/2020		

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VYNDAMAX CAP 61MG	5	Added to 2020 Formulary	Prior Authorization Required; Quantity Limit (30 caps every 30 days)	2/1/2020		
ZELNORM TAB 6MG	4	Added to 2020 Formulary	Prior Authorization Required; Quantity Limit (60 tabs every 30 days)	2/1/2020		
AZELEX CRE 20%	4	Removed from 2020 Formulary		2/1/2020	AZELAIC ACID GEL 15%	2
BACTROBAN OIN NASAL 2%	4	Removed from 2020 Formulary		2/1/2020	MUPIROCIN OINT 2%	1
CLARINEX SYP 0.5MG/ML	4	Removed from 2020 Formulary		2/1/2020	CETIRIZINE SOL 1MG/ML	1
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
ESOMEPRAZOLE INJ 20MG	2	Removed from 2020 Formulary		2/1/2020	PANTOPRAZOLE INJ SOD 40MG	2
FENTORA TAB 100MCG	5	Removed from 2020 Formulary	Prior Authorization Required; Quantity Limit (120 tabs per 30 days)	2/1/2020	FENTANYL CITRATE BUCCAL TABLET 100 MCG	5
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

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NADOLOL/BEND TAB 40-5MG	2	Removed from 2020 Formulary		2/1/2020	BISOPROLOL & HYDROCHLOROTHIAZIDE TAB 2.5-6.25 MG	1
NORLYROC TAB 0.35MG	2	Removed from 2020 Formulary		2/1/2020	CAMILA TAB 0.35MG	2
PROMETHAZINE SUP 50MG	4	Removed from 2020 Formulary	Prior Authorization Required	2/1/2020	PROMETHEGAN SUP 50MG	4
REBETOL SOL 40MG/ML	5	Removed from 2020 Formulary		2/1/2020	RIBAVIRIN TAB 200MG	2
RIBAPAK PAK 1200/DAY	5	Removed from 2020 Formulary		2/1/2020	RIBAVIRIN TAB 200MG	2
RIBAPAK TAB 1000/DAY	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 TAB 200MG	2
SOLOXIDE TAB 150MG DR	2	Removed from 2020 Formulary		2/1/2020	DOXYCYCLINE HYCLATE TAB DR 150 MG	2
STRIANT MIS 30MG	4	Removed from 2020 Formulary	Prior Authorization Required; Quantity Limit (60 buccal systems per 30 days)	2/1/2020	TESTOSTERONE TD SOLN 30 MG/ACT	2
ZYKADIA CAP 150MG	5	Removed from 2020 Formulary	New Start Prior Authorization Required	2/1/2020	ZYKADIA TAB 150MG	5
LOKELMA PAK 10GM	3	Tier Change Tier 4 to Tier 3		2/1/2020		

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LOKELMA PAK 5GM	3	Tier Change Tier 4 to Tier 3		2/1/2020		
OSPHENA TAB 60MG	3	Tier Change Tier 4 to Tier 3	Prior Authorization Required	2/1/2020		
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		2/1/2020		
TRINTELLIX TAB 10MG	4	Prior Authorization Removed		2/1/2020		
TRINTELLIX TAB 20MG	4	Prior Authorization Removed		2/1/2020		
TRINTELLIX TAB 5MG	4	Prior Authorization Removed		2/1/2020		
VIIBRYD KIT STARTER	4	Prior Authorization Removed		2/1/2020		
VIIBRYD TAB 10MG	4	Prior Authorization Removed		2/1/2020		
VIIBRYD TAB 20MG	4	Prior Authorization Removed		2/1/2020		

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Drug Label Name	Tier	Description of Change	Requirements/Limits	Effective Date	Alternative Drug	Alternative Drug Tier
VIIBRYD TAB 40MG	4	Prior Authorization Removed		2/1/2020		
ABILIFY MYCI TAB 10MG	5	Added to 2020 Formulary	New Start Prior Authorization Required; Quantity Limit (30 tabs per 30 days)	3/1/2020		
ABILIFY MYCI TAB 15MG	5	Added to 2020 Formulary	New Start Prior Authorization Required; Quantity Limit (30 tabs per 30 days)	3/1/2020		
ABILIFY MYCI TAB 20MG	5	Added to 2020 Formulary	New Start Prior Authorization Required; Quantity Limit (30 tabs per 30 days)	3/1/2020		
ABILIFY MYCI TAB 2MG	5	Added to 2020 Formulary	New Start Prior Authorization Required; Quantity Limit (30 tabs per 30 days)	3/1/2020		
ABILIFY MYCI TAB 30MG	5	Added to 2020 Formulary	New Start Prior Authorization Required; Quantity Limit (30 tabs per 30 days)	3/1/2020		
ABILIFY MYCI TAB 5MG	5	Added to 2020 Formulary	New Start Prior Authorization Required; Quantity Limit (30 tabs per 30 days)	3/1/2020		

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Drug Label Name	Tier	Description of Change	Requirements/Limits	Effective Date	Alternative Drug	Alternative Drug Tier
AKLIEF CRE 0.005%	4	Added to 2020 Formulary	Prior Authorization Required; Quantity Limit (45 grams per 30 days)	3/1/2020		
AZELEX CRE 20%	4	Added to 2020 Formulary		3/1/2020		
BRUKINSA CAP 80MG	5	Added to 2020 Formulary	New Start Prior Authorization Required	3/1/2020		
DAPSONE GEL 7.5%	2	Added to 2020 Formulary	Quantity Limit (90 grams per 30 days)	3/1/2020		
DOXEPIN TAB 3MG	2	Added to 2020 Formulary	Quantity Limit (30 tabs per 30 days)	3/1/2020		
DOXEPIN TAB 6MG	2	Added to 2020 Formulary	Quantity Limit (30 tabs per 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		
EZALLOR SPR CAP 10MG	4	Added to 2020 Formulary		3/1/2020		
EZALLOR SPR CAP 20MG	4	Added to 2020 Formulary		3/1/2020		
EZALLOR SPR CAP 40MG	4	Added to 2020 Formulary		3/1/2020		
EZALLOR SPR CAP 5MG	4	Added to 2020 Formulary		3/1/2020		
FIASP PENFIL INJ U-100	3	Added to 2020 Formulary		3/1/2020		

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HARVONI TAB 45-200MG	5	Added to 2020 Formulary	Prior Authorization Required	3/1/2020		
HEPARIN SOD INJ 5000/ML	4	Added to 2020 Formulary	B vs. D 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		
NOURIANZ TAB 20MG	5	Added to 2020 Formulary	Quantity Limit (30 tabs per 30 days)	3/1/2020		
NOURIANZ TAB 40MG	5	Added to 2020 Formulary	Quantity Limit (30 tabs per 30 days)	3/1/2020		
NOVOLIN N INJ 100 UNIT	4	Added to 2020 Formulary		3/1/2020		
NOVOLIN N INJ 100 UNIT	3	Added to 2020 Formulary		3/1/2020		
NOVOLIN R INJ 100 UNIT	4	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		

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Drug Label Name	Tier	Description of Change	Requirements/Limits	Effective Date	Alternative Drug	Alternative Drug Tier
PENICILLAMIN TAB 250MG	5	Added to 2020 Formulary		3/1/2020		
PRETOMANID TAB 200MG	4	Added to 2020 Formulary		3/1/2020		
SUNOSI TAB 150MG	4	Added to 2020 Formulary	Prior Authorization Required; Quantity Limit (30 tabs per 30 days)	3/1/2020		
SUNOSI TAB 75MG	4	Added to 2020 Formulary	Prior Authorization Required; Quantity Limit (30 tabs per 30 days)	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		
VANCOMYCIN INJ 1.5/300	4	Added to 2020 Formulary		3/1/2020		
VANCOMYCIN INJ 1GM/200M	4	Added to 2020 Formulary		3/1/2020		
VANCOMYCIN INJ 500MG	4	Added to 2020 Formulary		3/1/2020		
VANCOMYCIN SOL 2G/400ML	4	Added to 2020 Formulary		3/1/2020		
XENLETA INJ 150/15ML	5	Added to 2020 Formulary		3/1/2020		
XENLETA TAB 600MG	5	Added to 2020 Formulary		3/1/2020		

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Drug Label Name	Tier	Description of Change	Requirements/Limits	Effective Date	Alternative Drug	Alternative Drug Tier
ZOLEDRONIC INJ 4MG/100	2	Added to 2020 Formulary	B vs. D Prior Authorization Required	3/1/2020		
ABSTRAL SUB 300MCG	5	Removed from 2020 Formulary	Prior Authorization Required; Quantity Limit (120 tabs per 30 days)	3/1/2020	FENTANYL OT LOZ	5
ABSTRAL SUB 400MCG	5	Removed from 2020 Formulary	Prior Authorization Required; Quantity Limit (120 tabs per 30 days)	3/1/2020	FENTANYL OT LOZ	5
ABSTRAL SUB 600MCG	5	Removed from 2020 Formulary	Prior Authorization Required; Quantity Limit (120 tabs per 30 days)	3/1/2020	FENTANYL OT LOZ	5
ABSTRAL SUB 800MCG	5	Removed from 2020 Formulary	Prior Authorization Required; Quantity Limit (120 tabs per 30 days)	3/1/2020	FENTANYL OT LOZ	5
CIPROFLOXACN SUS 500MG/5	2	Removed from 2020 Formulary		3/1/2020	CIPROFLOXACIN TAB 500MG	1
KCL/D5W/LACT INJ 40MEQ/L	4	Removed from 2020 Formulary		3/1/2020	KCL/D5W/LACT INJ 20MEQ/L	4
MAXIPIME INJ 2GM	4	Removed from 2020 Formulary		3/1/2020	CEFEPIME INJ 1GM	2
REPAGLINIDE TAB 1-500MG	1	Removed from 2020 Formulary	Quantity Limit (150 tabs per 30 days)	3/1/2020	REPAGLINIDE TAB 1MG	1
REPAGLINIDE TAB 2-500MG	1	Removed from 2020 Formulary	Quantity Limit (150 tabs per 30 days)	3/1/2020	REPAGLINIDE TAB 2MG	1

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TOLMETIN SOD TAB 200MG	2	Removed from 2020 Formulary		3/1/2020	MELOXICAM TAB	1
AMPHETAMI ER SUS 1.25/ML	2	Added to 2020 Formulary	Quantity Limit (450 mL per 30 days)	4/1/2020		
AYVAKIT TAB 100MG	5	Added to 2020 Formulary	New Start Prior Authorization Required; Quantity Limit (30 tabs per 30 days)	4/1/2020		
AYVAKIT TAB 200MG	5	Added to 2020 Formulary	New Start Prior Authorization Required; Quantity Limit (30 tabs per 30 days)	4/1/2020		
AYVAKIT TAB 300MG	5	Added to 2020 Formulary	New Start Prior Authorization Required; Quantity Limit (30 tabs per 30 days)	4/1/2020		
CALCIP/BETAM SUS	5	Added to 2020 Formulary	Prior Authorization Required; Quantity Limit (400 gms per 30 days)	4/1/2020		
CAPLYTA CAP 42MG	4	Added to 2020 Formulary	Quantity Limit (30 caps per 30 days)	4/1/2020		
CIPRO/FLUOC DRO PF	2	Added to 2020 Formulary		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		

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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		
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		
GVOKE PFS INJ	3	Added to 2020 Formulary		4/1/2020		
HYDROCODONE CAP 10MG ER	2	Added to 2020 Formulary	Prior Authorization Required; Quantity Limit (60 caps per 30 days)	4/1/2020		
HYDROCODONE CAP 15MG ER	2	Added to 2020 Formulary	Prior Authorization Required; Quantity Limit (60 caps per 30 days)	4/1/2020		

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Drug Label Name	Tier	Description of Change	Requirements/Limits	Effective Date	Alternative Drug	Alternative Drug Tier
HYDROCODONE CAP 20MG ER	2	Added to 2020 Formulary	Prior Authorization Required; Quantity Limit (60 caps per 30 days)	4/1/2020		
HYDROCODONE CAP 30MG ER	2	Added to 2020 Formulary	Prior Authorization Required; Quantity Limit (60 caps per 30 days)	4/1/2020		
HYDROCODONE CAP 40MG ER	2	Added to 2020 Formulary	Prior Authorization Required; Quantity Limit (60 caps per 30 days)	4/1/2020		
HYDROCODONE CAP 50MG ER	2	Added to 2020 Formulary	Prior Authorization Required; Quantity Limit (60 caps per 30 days)	4/1/2020		
INS ASP PROT INJ FLEXPEN	4	Added to 2020 Formulary		4/1/2020		
INSULIN ASPA INJ 100/ML	4	Added to 2020 Formulary		4/1/2020		
INSULIN ASPA INJ 70/30	4	Added to 2020 Formulary		4/1/2020		
INSULIN ASPA INJ FLEXPEN	4	Added to 2020 Formulary		4/1/2020		
INSULIN ASPA INJ PENFILL	4	Added to 2020 Formulary		4/1/2020		
PROAIR DIGIH AER 108MCG	4	Added to 2020 Formulary	Quantity Limit (2 inhalers per 30 days)	4/1/2020		

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RECARBRIO INJ 1.25GM	5	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 (30 patches per 30 days)	4/1/2020		
SECUADO DIS 5.7MG	4	Added to 2020 Formulary	Quantity Limit (30 patches per 30 days)	4/1/2020		
SECUADO DIS 7.6MG	4	Added to 2020 Formulary	Quantity Limit (30 patches per 30 days)	4/1/2020		
TOSYMRA SOL 10MG	4	Added to 2020 Formulary	Quantity Limit (18 nasal units 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		
VALTOCO SPR 5MG	4	Added to 2020 Formulary		4/1/2020		
XELJANZ XR TAB 22MG	5	Added to 2020 Formulary	Prior Authorization Required; Quantity Limit (30 tabs per 30 days)	4/1/2020		

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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		
ABSTRAL SUB 100MCG	5	Removed from 2020 Formulary	Prior Authorization Required; Quantity Limit (120 tabs per 30 days)	4/1/2020	FENTANYL CITRATE BUCCAL TAB 100MCG	5
ABSTRAL SUB 200MCG	5	Removed from 2020 Formulary	Prior Authorization Required; Quantity Limit (120 tabs per 30 days)	4/1/2020	FENTANYL CITRATE BUCCAL TAB 200MCG	5
ACZONE GEL 7.5%	4	Removed from 2020 Formulary	Quantity Limit (90 gms per 30 days)	4/1/2020	DAPSONE GEL 7.5%	2
AKTIPAK GEL 5-3%	4	Removed from 2020 Formulary		4/1/2020	BENZOYL PEROXIDE-ERYTHROMYCIN GEL 5-3%	2
AUGMENTIN SUS 125/5ML	5	Removed from 2020 Formulary		4/1/2020	AMOXICILLIN & K CLAVULANATE FOR SUSP 250/5ML	2
CESAMET CAP 1MG	5	Removed from 2020 Formulary	B vs. D Prior Authorization; Quantity Limit (60 caps per 30 days)	4/1/2020	DRONABINOL CAP	2
EURAX CRE 10%	4	Removed from 2020 Formulary		4/1/2020	CROTAN LOTION 10%	2
FENOFIBRIC TAB 105MG	2	Removed from 2020 Formulary		4/1/2020	FENOFIBRATE TAB	2

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FENOFIBRIC TAB 35MG	2	Removed from 2020 Formulary		4/1/2020	FENOFIBRATE TAB	2
HUMIRA PEDIA INJ CROHNS	5	Removed from 2020 Formulary	Prior Authorization Required	4/1/2020	HUMIRA KIT 40MG/0.8 ML	5
MAXIPIME INJ 1GM	4	Removed from 2020 Formulary		4/1/2020	CEFEPIME INJ 1GM	2
MICORT-HC CRE 2.5%	4	Removed from 2020 Formulary		4/1/2020	HYDROCORT CREAM 2.5%	1
NORETH/ETHIN TAB FE 1/20	2	Removed from 2020 Formulary		4/1/2020	JUNEL FE 24 TAB 1/20	2
PREPOPIK PAK	4	Removed from 2020 Formulary		4/1/2020	CLENPIQ SOL	4
SYLATRON KIT 600MCG	5	Removed from 2020 Formulary	New Start Prior Authorization Required	4/1/2020	SYLATRON KIT 300MCG	5