

Changes to Neighborhood INTEGRITY's Formulary January 2023

Neighborhood INTEGRITY may immediately remove a brand name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Or, when adding the new generic drug, we may decide to keep the brand name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. We may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made. Also, if the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we may immediately remove the drug from our formulary and provide notice to members who take the drug.

Before we make other changes during the year to our Drug List that affect members currently taking a drug and that require us to provide advance notice, we will notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive a one-month supply of the drug.

If you are affected by a change in drug coverage or restriction, depending on the type of change, there may be different options to consider. For example:

You may be able to use another drug on our Drug List to treat your medical condition. Alternative drug(s) are provided below to help your prescriber to find a covered drug that might work for you. Ask your prescriber if one of the possible alternative drug(s) is right for you.

You, your prescriber, or your authorized representative may also ask for an exception. The notice we provide you will also include information on the steps to request an exception. To learn more about coverage decisions and how to ask for an exception, see your *Evidence of Coverage*, or call Customer Care at 1-844-812-6896 (TTY: 711), 8 am to 8 pm, Monday – Friday; 8 am to 12 pm on Saturday. On Saturday afternoons, Sundays and holidays, you may be asked to leave a message.

Name of Affected Drug	Description of Change	Alternative Drug(s) *	Effective Date
ABACAVIR/LAMIVUDINE/ZIDOVUDINE TAB	Generic Removed from Formulary	TRIZIVIR TAB	1/1/2023
ABRAXANE INJ 100MG	Brand Removed from Formulary	PACLITAXEL INJ 100MG (GENERIC OF ABRAXANE INJ)	1/1/2023
ADRIAMYCIN INJ 20MG	Removed from Formulary	DOXORUBICIN INJ 2MG/ML	1/1/2023
AFINITOR DIS TAB 2MG	Brand Removed from Formulary	EVEROLIMUS TAB 2 MG (GENERIC OF AFINITOR DIS TAB)	1/1/2023
AFINITOR DIS TAB 3MG	Brand Removed from Formulary	EVEROLIMUS TAB 3 MG (GENERIC OF AFINITOR DIS TAB)	1/1/2023
AFINITOR DIS TAB 5MG	Brand Removed from Formulary	EVEROLIMUS TAB 5 MG (GENERIC OF AFINITOR DIS TAB)	1/1/2023
AFINITOR TAB 10MG	Brand Removed from Formulary	EVEROLIMUS TAB 10MG (GENERIC OF AFINITOR TAB)	1/1/2023

Name of Affected Drug	Description of Change	Alternative Drug(s) *	Effective Date
ALIMTA INJ 100MG	Brand Removed from Formulary	PEMETREXED INJ 100MG (GENERIC OF ALIMTA INJ 100MG)	1/1/2023
ALIMTA INJ 500MG	Brand Removed from Formulary	PEMETREXED INJ 500MG (GENERIC OF ALIMTA INJ 500MG)	1/1/2023
AMBISOME INJ 50MG	Brand Removed from Formulary	AMPHOTERICIN INJ 50MG (GENERIC OF AMBISOME INJ)	1/1/2023
AMLODIPINE-VALSARTAN-HCTZ TAB	Removed from Formulary	AMLODIPINE-VALSARTAN TAB plus HYDROCHLOROTHIAZIDE TAB; VALSARTAN-HYDROCHLOROTHIAZIDE TAB plus AMLODIPINE TAB	1/1/2023
AMLODIPINE-VALSARTAN-HCTZ TAB	Removed from Formulary	AMLODIPINE-VALSARTAN TAB plus HYDROCHLOROTHIAZIDE TAB; VALSARTAN-HYDROCHLOROTHIAZIDE TAB plus AMLODIPINE TAB	1/1/2023
AMLODIPINE-VALSARTAN-HCTZ TAB	Removed from Formulary	AMLODIPINE-VALSARTAN TAB plus HYDROCHLOROTHIAZIDE TAB; VALSARTAN-HYDROCHLOROTHIAZIDE TAB plus AMLODIPINE TAB	1/1/2023
AMLODIPINE-VALSARTAN-HCTZ TAB	Removed from Formulary	AMLODIPINE-VALSARTAN TAB plus HYDROCHLOROTHIAZIDE TAB; VALSARTAN-HYDROCHLOROTHIAZIDE TAB plus AMLODIPINE TAB	1/1/2023
AMLODIPINE-VALSARTAN-HCTZ TAB	Removed from Formulary	AMLODIPINE-VALSARTAN TAB plus HYDROCHLOROTHIAZIDE TAB; VALSARTAN-HYDROCHLOROTHIAZIDE TAB plus AMLODIPINE TAB	1/1/2023
ANDRODERM DIS 2MG/24HR	Removed from Formulary	TESTOSTERONE GEL 25MG/2.5GM, 50MG/5GM (generic of ANDROGEL); TESTOSTERONE GEL PUMP 1%; TESTOSTERONE GEL 1.62% (generic of ANDROGEL PUMP)	1/1/2023
ANDRODERM DIS 4MG/24HR	Removed from Formulary	TESTOSTERONE GEL 25MG/2.5GM, 50MG/5GM (generic of ANDROGEL); TESTOSTERONE GEL PUMP 1%; TESTOSTERONE GEL 1.62% (generic of ANDROGEL PUMP)	1/1/2023
AVASTIN INJ 100 MG/4ML	Removed from Formulary	MVASI INJ 100MG/4ML; ZIRABEV INJ 100/4ML	1/1/2023
AVASTIN INJ 400MG/16ML	Removed from Formulary	MVASI INJ 400MG/16ML; ZIRABEV INJ 400/16ML	1/1/2023
BEPOTASTINE DRO 1.5%	Removed from Formulary	CROMOLYN SOD SOL 4% OP; AZELASTINE DRO 0.05%; OLOPATADINE DRO 0.1%; ZERVIAE DRO 0.24%	1/1/2023
BEPREVE DRO 1.5%	Removed from Formulary	CROMOLYN SOD SOL 4% OP; AZELASTINE DRO 0.05%; OLOPATADINE DRO 0.1%; ZERVIAE DRO 0.24%	1/1/2023
BLEPHAMIDE OIN S.O.P.	Removed from Formulary	NEOMYCIN-POLYMYXIN-DEXAMETHASONE OIN 0.1% OP; SULFACETAMIDE SODIUM-PREDNISOLONE OPHTH SOLN 10-0.23%; TOBRADEX OIN 0.3-0.1%	1/1/2023
BROMFENAC SOL 0.09% OP	Removed from Formulary	DICLOFENAC SOL 0.1% OP; KETOROLAC SOL 0.5%; PROLENSA SOL 0.07%; BROMSITE DRO 0.075%; ILEVRO DRO 0.3% OP	1/1/2023
CARBAGLU TAB 200MG	Brand Removed from Formulary	CARGLUMIC TAB 200MG (GENERIC OF CARBAGLU TAB)	1/1/2023

Name of Affected Drug	Description of Change	Alternative Drug(s) *	Effective Date
CHANTIX PAK 0.5& 1MG	Brand Removed from Formulary	VARENICLINE PAK 0.5X1MG (GENERIC OF CHANTIX PAK)	1/1/2023
CYSTADANE POW	Brand Removed from Formulary	BETAINE ANHY POW (GENERIC OF CYSTADANE POW)	1/1/2023
DEXLANSOPRAZ CAP 30MG DR	Removed from Formulary	OMEPRAZOLE CAP; PANTOPRAZOLE TAB; LANSOPRAZOLE CAP	1/1/2023
DEXLANSOPRAZ CAP 60MG DR	Removed from Formulary	OMEPRAZOLE CAP; PANTOPRAZOLE TAB; LANSOPRAZOLE CAP	1/1/2023
DIGITEK TAB 0.125MG	Removed from Formulary	DIGOXIN TAB 0.125MG	1/1/2023
DIGITEK TAB 0.25MG	Removed from Formulary	DIGOXIN TAB 0.25MG	1/1/2023
EPIRUBICIN INJ 200MG	Removed from Formulary	ELLENCE INJ 2MG/ML	1/1/2023
EPIRUBICIN INJ 50/25ML	Removed from Formulary	ELLENCE INJ 2MG/ML	1/1/2023
ESBRIET TAB 267MG	Brand Removed from Formulary	PIRFENIDONE TAB 267MG (GENERIC OF ESBRIET TAB 267MG)	1/1/2023
ESBRIET TAB 801MG	Brand Removed from Formulary	PIRFENIDONE TAB 801MG (GENERIC OF ESBRIET TAB 801MG)	1/1/2023
FLUTAMIDE CAP 125MG	Generic Removed from Formulary	EULEXIN CAP 125MG; NILUTAMIDE TAB 150MG; BICALUTAMIDE TAB 50MG; ABIRATERONE TAB	1/1/2023
GAVILYTE-N SOL FLAV PK	Removed from Formulary	PEG 3350-KCL-SOD BICARB-NACL FOR SOLN 420 GM	1/1/2023
INTRON A INJ 18MU (6000000 UNIT/ML)	Removed from Formulary	INTRON A INJ 10MU, 18MU, 50MU	1/1/2023
INTRON A INJ 25MU (10000000 UNIT/ML)	Removed from Formulary	INTRON A INJ 10MU, 18MU, 50MU	1/1/2023
INVEGA TRINZ INJ 273MG	Removed from Formulary	INVEGA SUSTENNA INJ; PERSERIS INJ; ABILIFY MAINTENA INJ; ARISTADA INJ, ARISTADA INITIO INJ	1/1/2023
INVEGA TRINZ INJ 410MG	Removed from Formulary	INVEGA SUSTENNA INJ; PERSERIS INJ; ABILIFY MAINTENA INJ; ARISTADA INJ, ARISTADA INITIO INJ	1/1/2023
INVEGA TRINZ INJ 546MG	Removed from Formulary	INVEGA SUSTENNA INJ; PERSERIS INJ; ABILIFY MAINTENA INJ; ARISTADA INJ, ARISTADA INITIO INJ	1/1/2023
INVEGA TRINZ INJ 819MG	Removed from Formulary	INVEGA SUSTENNA INJ; PERSERIS INJ; ABILIFY MAINTENA INJ; ARISTADA INJ, ARISTADA INITIO INJ	1/1/2023

Name of Affected Drug	Description of Change	Alternative Drug(s) *	Effective Date
INVIRASE TAB 500MG	Removed from Formulary	ATAZANAVIR CAP; PREZISTA TAB	1/1/2023
LASTACFT SOL 0.25%	Removed from Formulary	CROMOLYN SOD SOL 4% OP; AZELASTINE DRO 0.05%; OLOPATADINE DRO 0.1%; ZERVIAE DRO 0.24%	1/1/2023
LITHIUM SOL 8MEQ/5ML	Removed from Formulary	LITHIUM CARBONATE CAP, TAB	1/1/2023
NULYTELY SOL LMN/LIME	Brand Removed from Formulary	PEG 3350-KCL-SOD BICARB-NACL FOR SOLN 420 GM (GENERIC OF NULYTELY SOL LMN/LIME)	1/1/2023
ONDANSETRON TAB 24MG	Removed from Formulary	ONDANSETRON TAB 4MG, 8MG; GRANISETRON TAB 1MG	1/1/2023
ORSYTHIA TAB	Removed from Formulary	LEVONORGESTREL-ETHINYL ESTRADIOL TAB 0.1 MG-20 MCG	1/1/2023
OZEMPIC INJ 2/1.5ML (1 MG/DOSE)	Removed from Formulary	OZEMPIC INJ 4MG/3ML (1 MG/DOSE)	1/1/2023
PAMIDRONATE INJ 30MG	Removed from Formulary	PAMIDRONATE INJ 30MG/10ML	1/1/2023
PAMIDRONATE INJ 90MG	Removed from Formulary	PAMIDRONATE INJ 90MG/10ML	1/1/2023
PAXIL SUS 10MG/5ML	Brand Removed from Formulary	PAROXETINE SUS 10MG/5ML (GENERIC OF PAXIL SUS)	1/1/2023
PREGABALIN ER TAB 165MG	Removed from Formulary	GABAPENTIN TAB, CAP; DULOXETINE CAP 20MG, 30MG, 60MG; PREGABALIN CAP	1/1/2023
PREGABALIN ER TAB 330MG	Removed from Formulary	GABAPENTIN TAB, CAP; DULOXETINE CAP 20MG, 30MG, 60MG; PREGABALIN CAP	1/1/2023
PREGABALIN ER TAB 82.5MG	Removed from Formulary	GABAPENTIN TAB, CAP; DULOXETINE CAP 20MG, 30MG, 60MG; PREGABALIN CAP	1/1/2023
RIABNI SOL 100MG/10ML	Removed from Formulary	TRUXIMA INJ 100MG/10ML	1/1/2023
RIABNI SOL 500MG/50ML	Removed from Formulary	TRUXIMA INJ 500MG/50ML	1/1/2023
RISPERDAL INJ 12.5MG	Removed from Formulary	PERSERIS INJ; INVEGA SUSTENNA INJ; ABILIFY MAINTENA INJ; ARISTADA INJ, ARISTADA INITIO INJ	1/1/2023
RISPERDAL INJ 25MG	Removed from Formulary	PERSERIS INJ; INVEGA SUSTENNA INJ; ABILIFY MAINTENA INJ; ARISTADA INJ, ARISTADA INITIO INJ	1/1/2023
RISPERDAL INJ 37.5MG	Removed from Formulary	PERSERIS INJ; INVEGA SUSTENNA INJ; ABILIFY MAINTENA INJ; ARISTADA INJ, ARISTADA INITIO INJ	1/1/2023

Name of Affected Drug	Description of Change	Alternative Drug(s) *	Effective Date
RISPERDAL INJ 50MG	Removed from Formulary	PERSERIS INJ; INVEGA SUSTENNA INJ; ABILIFY MAINTENA INJ; ARISTADA INJ, ARISTADA INITIO INJ	1/1/2023
RITUXAN INJ 100MG	Removed from Formulary	TRUXIMA INJ 100MG/10ML	1/1/2023
RITUXAN INJ 500MG	Removed from Formulary	TRUXIMA INJ 500MG/50ML	1/1/2023
RITUXAN INJ HYCELA	Removed from Formulary	TRUXIMA INJ; CONSULT YOUR HEALTH CARE PROVIDER	1/1/2023
RITUXAN INJ HYCELA	Removed from Formulary	TRUXIMA INJ; CONSULT YOUR HEALTH CARE PROVIDER	1/1/2023
RUXIENCE INJ 100MG/10ML	Removed from Formulary	TRUXIMA INJ 100MG/10ML	1/1/2023
RUXIENCE INJ 500MG/50ML	Removed from Formulary	TRUXIMA INJ 500MG/50ML	1/1/2023
SELZENTRY TAB 150MG	Brand Removed from Formulary	MARAVIROC TAB 150MG (GENERIC OF SELZENTRY TAB)	1/1/2023
SELZENTRY TAB 300MG	Brand Removed from Formulary	MARAVIROC TAB 300MG (GENERIC OF SELZENTRY TAB)	1/1/2023
STELARA INJ 45MG/0.5	Removed from Formulary	SKYRIZI INJ; HUMIRA INJ; ENBREL INJ; TALTZ INJ; OTEZLA TAB; XELJANZ TAB, XELJANZ XR TAB ER; RINVOQ TAB	1/1/2023
STELARA INJ 45MG/0.5	Removed from Formulary	SKYRIZI INJ; HUMIRA INJ; ENBREL INJ; TALTZ INJ; OTEZLA TAB; XELJANZ TAB, XELJANZ XR TAB ER; RINVOQ TAB	1/1/2023
STELARA INJ 90MG/ML	Removed from Formulary	SKYRIZI INJ; HUMIRA INJ; ENBREL INJ; TALTZ INJ; OTEZLA TAB; XELJANZ TAB, XELJANZ XR TAB ER; RINVOQ TAB	1/1/2023
TARGRETIN GEL 1%	Brand Removed from Formulary	BEXAROTENE GEL 1% (GENERIC OF TARGRETIN GEL 1%)	1/1/2023

Name of Affected Drug	Description of Change	Alternative Drug(s) *	Effective Date
TEMIXYS TAB 300-300	Removed from Formulary	CIMDUO TAB; DESCOVY TAB; EMTRICITABINE-TENOFOVIR DISOPROXIL FUMARATE TAB; ABACAVIR SULFATE-LAMIVUDINE TAB	1/1/2023
TIMOLOL MALEATE SOL 0.5%	Removed from Formulary	TIMOLOL MALEATE SOL OP (GENERIC OF TIMOPTIC); TIMOLOL MALEATE GEL SOL OP; CARTEOLOL SOL OP; LEVOBUNOLOL SOL OP; BETOPTIC-S SUS OP	1/1/2023
TOVIAZ TAB 4MG	Brand Removed from Formulary	FESOTERODINE TAB 4MG ER (GENERIC OF TOVIAZ TAB 4MG)	1/1/2023
TOVIAZ TAB 8MG	Brand Removed from Formulary	FESOTERODINE TAB 8MG ER (GENERIC OF TOVIAZ TAB 8MG)	1/1/2023
TRELSTAR MIX INJ 11.25MG	Removed from Formulary	ELIGARD INJ; ORGOVYX TAB	1/1/2023
TRELSTAR MIX INJ 3.75MG	Removed from Formulary	ELIGARD INJ; ORGOVYX TAB	1/1/2023
TRIDERM CRE 0.5%	Removed from Formulary	TRIAMCINOLONE CRE 0.5%	1/1/2023
UBRELVY TAB 100MG	Removed from Formulary	NURTEC TAB ODT; SUMATRIPTAN TAB; RIZATRIPTAN TAB	1/1/2023
UBRELVY TAB 50MG	Removed from Formulary	NURTEC TAB ODT; SUMATRIPTAN TAB; RIZATRIPTAN TAB	1/1/2023
VANDAZOLE GEL 0.75%	Removed from Formulary	METRONIDAZOLE VAG GEL 0.75%	1/1/2023
VELCADE INJ 3.5MG	Brand Removed from Formulary	BORTEZOMIB INJ 3.5MG (GENERIC OF VELCADE INJ)	1/1/2023
VIIBRYD TAB 10MG	Brand Removed from Formulary	VILAZODONE TAB 10MG (GENERIC OF VIIBRYD TAB 10MG)	1/1/2023
VIIBRYD TAB 20MG	Brand Removed from Formulary	VILAZODONE TAB 20MG (GENERIC OF VIIBRYD TAB 20MG)	1/1/2023
VIIBRYD TAB 40MG	Brand Removed from Formulary	VILAZODONE TAB 40MG (GENERIC OF VIIBRYD TAB 40MG)	1/1/2023
VIMPAT INJ 200MG/20	Brand Removed from Formulary	LACOSAMIDE SOL 200MG/20 (GENERIC OF VIMPAT INJ)	1/1/2023
XPOVIO PAK 100MG	Removed from Formulary	XPOVIO PAK 50MG (100MG ONCE WEEKLY)	1/1/2023
XPOVIO PAK 40MG	Removed from Formulary	XPOVIO PAK 40MG (40MG ONCE WEEKLY)	1/1/2023
XPOVIO PAK 40MG	Removed from Formulary	XPOVIO PAK 40MG (40MG TWICE WEEKLY)	1/1/2023
XPOVIO PAK 60MG	Removed from Formulary	XPOVIO PAK 60MG (60MG ONCE WEEKLY)	1/1/2023
XPOVIO PAK 80MG	Removed from Formulary	XPOVIO PAK 40MG (80MG ONCE WEEKLY)	1/1/2023
ZORTRESS TAB 1MG	Brand Removed from Formulary	EVEROLIMUS TAB 1MG (GENERIC OF ZORTRESS TAB)	1/1/2023

Name of Affected Drug	Description of Change	Effective Date
APTiom TAB 200MG	Quantity Limit Decreased	1/1/2023
APTiom TAB 400MG	Quantity Limit Decreased	1/1/2023
ARMODAFINIL TAB 50MG	Quantity Limit Decreased	1/1/2023
BOSENTAN TAB 62.5MG	Quantity Limit Decreased	1/1/2023
BUDESONIDE CAP 3MG DR	Quantity Limit Requirement Added	1/1/2023
BUDESONIDE TAB ER 9MG	Quantity Limit Requirement Added	1/1/2023
CELECOXIB CAP 100MG	Quantity Limit Decreased	1/1/2023
CELECOXIB CAP 50MG	Quantity Limit Decreased	1/1/2023
CINACALCET TAB 30MG	Quantity Limit Decreased	1/1/2023
CLOZAPINE TAB 200/ODT	Quantity Limit Decreased	1/1/2023
CLOZAPINE TAB 200MG	Quantity Limit Decreased	1/1/2023
DESCOVY TAB 200/25MG	Quantity Limit Requirement Added	1/1/2023
EPRONTIA SOL 25MG/ML	Quantity Limit Requirement Added; Prior Authorization Requirement Added	1/1/2023
FYCOMPA TAB 4MG	Quantity Limit Decreased	1/1/2023
FYCOMPA TAB 6MG	Quantity Limit Decreased	1/1/2023
GABAPENTIN CAP 100MG	Quantity Limit Decreased	1/1/2023
GABAPENTIN CAP 300MG	Quantity Limit Decreased	1/1/2023
GABAPENTIN CAP 400MG	Quantity Limit Decreased	1/1/2023
ICLUSIG TAB 10MG	Quantity Limit Decreased	1/1/2023
IVERMECTIN TAB 3MG	Quantity Limit Requirement Added; Prior Authorization Type Changed	1/1/2023
LEVALBUTEROL AER 45/ACT	Step Therapy Requirement Added	1/1/2023
MOVANTIK TAB 12.5MG	Quantity Limit Decreased	1/1/2023
POMALYST CAP 1MG	Quantity Limit Decreased	1/1/2023
POMALYST CAP 2MG	Quantity Limit Decreased	1/1/2023
RASAGILINE TAB 0.5MG	Quantity Limit Decreased	1/1/2023

Name of Affected Drug	Description of Change	Effective Date
RIVASTIGMINE CAP 1.5MG	Quantity Limit Decreased	1/1/2023
RIVASTIGMINE CAP 3MG	Quantity Limit Decreased	1/1/2023
RUFINAMIDE SUS 40MG/ML	Quantity Limit Decreased	1/1/2023
SKYRIZI INJ 150MG/ML	Quantity Limit Decreased	1/1/2023
SKYRIZI PEN INJ 150MG/ML	Quantity Limit Decreased	1/1/2023
SOLQUA INJ 100/33	Quantity Limit Decreased	1/1/2023
TRIMIPRAMINE CAP 25MG	Quantity Limit Decreased	1/1/2023
TRINTELLIX TAB 10MG	Quantity Limit Decreased	1/1/2023
TRINTELLIX TAB 5MG	Quantity Limit Decreased	1/1/2023
XCOPRI TAB 100MG	Quantity Limit Decreased	1/1/2023
XCOPRI TAB 50MG	Quantity Limit Decreased	1/1/2023
XOFLUZA TAB 40MG	Quantity Limit Decreased	1/1/2023
XPOVIO PAK 40MG	Quantity Limit Requirement Added	1/1/2023
XPOVIO PAK 40MG	Quantity Limit Requirement Added	1/1/2023
XPOVIO PAK 40MG	Quantity Limit Requirement Added	1/1/2023
XPOVIO PAK 50MG	Quantity Limit Requirement Added	1/1/2023
XPOVIO PAK 60MG	Quantity Limit Requirement Added	1/1/2023
XPOVIO PAK 60MG	Quantity Limit Requirement Added	1/1/2023
XPOVIO PAK 80MG	Quantity Limit Requirement Added	1/1/2023
ZALEPLON CAP 5MG	Quantity Limit Decreased	1/1/2023

*Alternative drug(s) are drugs that you could consider with your prescriber. Only your prescriber can determine alternative drugs that are appropriate for you given the individualized nature of drug therapy. Please consult your prescriber to confirm if this is an appropriate drug for you.

**Applies to new starts