**Changes to the HealthSun Formulary**

The table below outlines formulary changes for the HealthSun Formulary.

| Effective Date | Drug Name | Reason | Alternative Drug* | Drug Copay** | Restrictions*** |
|---|---|---|---|---|---|
| 10/1/2023 | BYDUREON BCISE 2 MG/0.85ML AUTO-INJ | Prior Authorization needed for members starting on drug | | Tier 3 | PA; QL (4 per 28 days) |
| 10/1/2023 | OZEMPIC 2 MG/1.5ML SOLN PEN | Prior Authorization needed for members starting on drug | | Tier 3 | PA |
| 10/1/2023 | OZEMPIC 2 MG/3ML SOLN PEN | Prior Authorization needed for members starting on drug | | Tier 3 | PA |
| 10/1/2023 | OZEMPIC 4 MG/3ML SOLN PEN | Prior Authorization needed for members starting on drug | | Tier 3 | PA |
| 10/1/2023 | OZEMPIC 8 MG/3ML SOLN PEN | Prior Authorization needed for members starting on drug | | Tier 3 | PA |
| 10/1/2023 | RYBELSUS 7 MG TAB | Prior Authorization needed for members starting on drug | | Tier 3 | PA; QL (30 per 30 days) |
| 10/1/2023 | RYBELSUS 3 MG TAB | Prior Authorization needed for members starting on drug | | Tier 3 | PA; QL (60 per 365 days) |
| 10/1/2023 | RYBELSUS 14 MG TAB | Prior Authorization needed for members starting on drug | | Tier 3 | PA; QL (30 per 30 days) |



*Alternative drugs are drugs in the same therapeutic category/class or cost sharing tier as the affected drug. Only your health care provider can determine if the alternative(s) listed here is appropriate for you given the individualized nature of drug therapy.
**Please refer to the description of your plan for copay/coinsurance amounts.
***Prior Authorization (PA), Quantity Limits (QL), or Step Therapy (ST) restrictions may apply.

| Effective Date | Drug Name | Reason | Alternative Drug* | Drug Copay** | Restrictions*** |
|---|---|---|---|---|---|
| 10/1/2023 | TRULICITY 3 MG/0.5ML SOLN PEN | Prior Authorization needed for members starting on drug | | Tier 3 | PA; QL (2 per 28 days) |
| 10/1/2023 | TRULICITY 4.5 MG/0.5ML SOLN PEN | Prior Authorization needed for members starting on drug | | Tier 3 | PA; QL (2 per 28 days) |
| 10/1/2023 | TRULICITY 1.5 MG/0.5ML SOLN PEN | Prior Authorization needed for members starting on drug | | Tier 3 | PA; QL (2 per 28 days) |
| 10/1/2023 | TRULICITY 0.75 MG/0.5ML SOLN PEN | Prior Authorization needed for members starting on drug | | Tier 3 | PA; QL (2 per 28 days) |
| 10/1/2023 | VICTOZA 18 MG/3ML SOLN PEN | Prior Authorization needed for members starting on drug | | Tier 3 | PA; QL (9 per 30 days) |



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**Please refer to the description of your plan for copay/coinsurance amounts.
***Prior Authorization (PA), Quantity Limits (QL), or Step Therapy (ST) restrictions may apply.