



**VNS Health EasyCare Plus (HMO D-SNP)
&
VNS Health Total (HMO D-SNP)
Future Formulary Changes (Updated on 08/21/24)**

The brand name drugs listed below will be removed from the Formulary and will no longer be covered. These drugs can be replaced by alternate or generic drugs. Please refer to the list below for more information.

If you have any questions, please call us at 1-866-783-1444 (TTY: 711), 7 days a week, 8 am – 8 pm (Oct. – Mar.) and weekdays, 8 am – 8 pm (Apr. – Sept.).

Effective Date	Brand Name Drugs that are no longer covered	Alternate or Generic Drugs that will be covered and tier information
2/1/2024	VOTRIENT 200 MG ORAL TABLET	PAZOPANIB HCL 200 MG ORAL TABLET-1
2/1/2024	CAROSPIR 25 MG/5 ML ORAL ORAL SUSP	SPIRONOLACTONE 25 MG/5 ML ORAL ORAL SUSP-1
2/1/2024	ALPHAGAN P 0.1 % OPHTHALMIC DROPS	BRIMONIDINE TARTRATE 0.1 % OPHTHALMIC DROPS-1
4/1/2024	FORTEO 20MCG/DOSE SUBCUTANE. PEN INJCTR	TERIPARATIDE 20MCG/DOSE SUBCUTANE. PEN INJCTR-1
4/1/2024	TRACLEER 125 MG ORAL TABLET	BOSENTAN 125 MG ORAL TABLET-1
4/1/2024	TRACLEER 62.5 MG ORAL TABLET	BOSENTAN 62.5 MG ORAL TABLET-1
4/1/2024	RISPERDAL CONSTA 37.5MG/2ML INTRAMUSC. VIAL	RISPERIDONE ER 37.5MG/2ML INTRAMUSC. VIAL-1
4/1/2024	PROLENSA 0.07 % OPHTHALMIC DROPS	BROMFENAC SODIUM 0.07 % OPHTHALMIC DROPS-1

Effective Date	Brand Name Drugs that are no longer covered	Alternate or Generic Drugs that will be covered and tier information
4/1/2024	RISPERDAL CONSTA 12.5MG/2ML INTRAMUSC. VIAL	RISPERIDONE ER 12.5MG/2ML INTRAMUSC. VIAL-1
4/1/2024	RISPERDAL CONSTA 50 MG/2 ML INTRAMUSC. VIAL	RISPERIDONE ER 50 MG/2 ML INTRAMUSC. VIAL-1
4/1/2024	RISPERDAL CONSTA 25 MG/2 ML INTRAMUSC. VIAL	RISPERIDONE ER 25 MG/2 ML INTRAMUSC. VIAL-1
5/1/2024	LEVONORG-ETH ESTRAD-FE BISGLYC 0.1-0.02MG ORAL TABLET	N/A
5/1/2024	KORLYM 300 MG ORAL TABLET	MIFEPRISTONE 300 MG ORAL TABLET-1
5/1/2024	BROMSITE 0.075 % OPHTHALMIC DROPS	BROMFENAC SODIUM 0.075 % OPHTHALMIC DROPS-1
5/1/2024	ALREX 0.2 % OPHTHALMIC DROPS SUSP	LOTEPREDNOL ETABONATE 0.2 % OPHTHALMIC DROPS SUSP-1
6/1/2024	RECTIV 0.4% (W/W) RECTAL OINT. (G)	NITROGLYCERIN 0.4% (W/W) RECTAL OINT. (G)-1
7/1/2024	MITIGARE 0.6 MG ORAL CAPSULE	N/A
7/1/2024	AZOPT 1 % OPHTHALMIC DROPS SUSP	N/A
8/1/2024	FARYDAK 15 MG ORAL CAPSULE	N/A
8/1/2024	TRUSELTIQ 50 MG/DAY ORAL CAPSULE	N/A
8/1/2024	FARYDAK 20 MG ORAL CAPSULE	N/A

Effective Date	Brand Name Drugs that are no longer covered	Alternate or Generic Drugs that will be covered and tier information
8/1/2024	TRUSELTIQ 100 MG/DAY ORAL CAPSULE	N/A
8/1/2024	TRUSELTIQ 125 MG/DAY ORAL CAPSULE	N/A
8/1/2024	TRUSELTIQ 75 MG/DAY ORAL CAPSULE	N/A
8/1/2024	FARYDAK 10 MG ORAL CAPSULE	N/A
10/1/2024	MOUNJARO 12.5MG/0.5 SUBCUTANE. PEN INJCTR	N/A
10/1/2024	RYBELSUS 3 MG ORAL TABLET	N/A
10/1/2024	RYBELSUS 7 MG ORAL TABLET	N/A
10/1/2024	MOUNJARO 10MG/0.5ML SUBCUTANE. PEN INJCTR	N/A
10/1/2024	OZEMPIC 0.25 OR .5 SUBCUTANE. PEN INJCTR	N/A
10/1/2024	TRULICITY 1.5 MG/0.5 SUBCUTANE. PEN INJCTR	N/A
10/1/2024	MOUNJARO 15MG/0.5ML SUBCUTANE. PEN INJCTR	N/A
10/1/2024	TRULICITY 0.75MG/0.5 SUBCUTANE. PEN INJCTR	N/A
10/1/2024	TRULICITY 4.5 MG/0.5 SUBCUTANE. PEN INJCTR	N/A

Effective Date	Brand Name Drugs that are no longer covered	Alternate or Generic Drugs that will be covered and tier information
10/1/2024	MOUNJARO 2.5 MG/0.5 SUBCUTANE. PEN INJCTR	N/A
10/1/2024	MOUNJARO 5 MG/0.5ML SUBCUTANE. PEN INJCTR	N/A
10/1/2024	OZEMPIC .25 OR 0.5 SUBCUTANE. PEN INJCTR	N/A
10/1/2024	RYBELSUS 14 MG ORAL TABLET	N/A
10/1/2024	TRULICITY 3 MG/0.5ML SUBCUTANE. PEN INJCTR	N/A
10/1/2024	MOUNJARO 7.5 MG/0.5 SUBCUTANE. PEN INJCTR	N/A
10/1/2024	OZEMPIC 2MG/0.75ML SUBCUTANE. PEN INJCTR	N/A
10/1/2024	OZEMPIC 1/0.75 (3) SUBCUTANE. PEN INJCTR	N/A