

Exclusion List Changes Coming January 1, 2025

This is not an all-inclusive list of exclusions for the Express Scripts National Preferred Formulary.

The excluded medications shown below are not covered on the Express Scripts National Preferred Formulary beginning January 1, 2025 unless otherwise noted. If there is a clinical reason, identified by your doctor, that requires you to continue taking your current medication, your doctor can request a coverage review by visiting the Express Scripts online portal at esrx.com/PA.

Single-Source Brand Exclusions

The following drug classes have new exclusions for January 1, 2025.

Drug Class	Excluded Medications	Preferred Alternatives
AUTONOMIC & CENTRAL NERVOUS SYSTEM Antimigraine Agents	TRUDHESA	dihydroergotamine nasal spray
Antipsychotics (Oral)	FANAPT~	aripiprazole, asenapine, lurasidone, olanzapine, quetiapine, risperidone, ziprasidone
DIABETES Insulins	U-100: ADMELOG*, APIDRA*, FIASP*, INSULIN ASPART*, NOVOLOG*, RELION NOVOLOG* Inhalation: AFREZZA*	U-100: HUMALOG VIAL#, HUMALOG (CARTRIDGE, KWIKPEN, JUNIOR KWIKPEN), HUMALOG TEMPO, INSULIN LISPRO, LYUMJEV KWIKPEN & VIAL, LYUMJEV TEMPO U-200: HUMALOG KWIKPEN, LYUMJEV KWIKPEN
	U-100: BASAGLAR, BASAGLAR TEMPO, INSULIN DEGLUDEC*, INSULIN GLARGINE*, LANTUS*, LEVEMIR*, REZVOGLAR* U-200: INSULIN DEGLUDEC* U-300: INSULIN GLARGINE*	U-100: INSULIN GLARGINE-YFGN*, SEMGLEE (YFGN), TRESIBA U-200: TRESIBA U-300: TOUJEO
Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors & Combinations	BRENZAVVY*, DAPAGLIFLOZIN*, INVOKANA*, STEGLATRO	FARXIGA, JARDIANCE
	DAPAGLIFLOZIN/METFORMIN ER*, INVOKAMET*, INVOKAMET XR*, SEGLUROMET	SYNJARDY, SYNJARDY XR, XIGDUO XR
GASTROINTESTINAL Antiemetics (Injectable)	CINVANTI, FOCINVEZ*	fosaprepitant injection
Constipation Agents	RELISTOR TABLETS	lubiprostone, MOVANTIK, SYMPROIC
OPHTHALMIC Antiglaucoma Agents (Ophthalmic Prostaglandins)	DURYSTA*, IDOSE TR*, IYUZEH*, LUMIGAN, VYZULTA, XELPROS*	bimatoprost drops, latanoprost drops, tafluprost drops, travoprost drops
OSTEOARTHRITIS Hyaluronic Acid Derivatives	DUROLANE*, EUFLEXXA, GEL-ONE*, GELSYN-3*, GENVISC 850*, HYALGAN*, HYMOVIS*, SUPARTZ FX*, SYNOJOYNT*, SYNVISIC*, SYNVISC-ONE*, TRILURON*, TRIVISC*, VISCO-3*	MONOVISC, ORTHOVISC
RESPIRATORY Alpha1 Proteinase Inhibitors for Emphysema	ARALAST NP, GLASSIA, ZEMAIRA	PROLASTIN C
Antihistamines (Oral)	CARBINOXAMINE ER 4 MG/5 ML SUSPENSION*, KARBINAL ER SUSPENSION	carbinoxamine, cetirizine, clemastine, desloratidine, diphenhydramine, fexofenadine, levocetirizine
MISCELLANEOUS AGENTS Weight Loss	SAXENDA	WEGOVY, ZEPBOUND

* Current 2024 exclusion in this class
~ Exclusion impacts new starts only
For current utilizers only

(continued)

Multi-Source Brand Exclusions

The generic equivalents of the following brand-name medications are covered on the National Preferred Formulary. FDA-approved generic medications meet strict standards and contain the same active ingredients as their corresponding brand-name medications, although they may have a different appearance.

DYMISTA	EMEND IV	FORTEO
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Excluded to Preferred

FABRAZYME	INSULIN GLARGINE-YFGN	YONSA
INCRUSE ELLIPTA	TRUQAP	

Excluded to Non-Preferred

RHOPRESSA	ROCKLATAN	TAVNEOS
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Non-Preferred to Preferred

HAEGARDA

* Current 2024 exclusion in this class
~ Exclusion impacts new starts only
For current utilizers only

Please note that formulary and product placement for treatment of Inflammatory and Atopic Conditions in the Inflammatory and Atopic Conditions Care Value (IACCV) Program are subject to change throughout the year based upon changes in market dynamics, new indications for existing products, biosimilar and new product launches.