

Formulary ID: 24085



ATRIO Choice Rx (PPO)
ATRIO Select Rx (PPO)
ATRIO Prime Rx (PPO)
ATRIO Select Rx (HMO)

ATRIO Health Plans 2024 PPO Plans Monthly Formulary Change Notice

ATRIO Health Plans may remove drugs from our formulary (list of covered drugs) or add rules about whether and when certain drugs are covered during the year. The chart below contains upcoming changes to the ATRIO Health Plans formulary. **You may not be taking these drugs now. We provide you with these updates so that you know about future changes to our drug list.** Please see Section 4 of your *Explanation of Benefits* for specific changes to drugs that you are currently taking.

Effective Date	Drug Name	Change Description	Reason Description	Alternate Drugs**
2/1/2024	VOTRIENT 200 MG ORAL TABLET	BRAND DELETION, ADD FRF GENERIC	REMOVAL OF BRAND NAME DRUG FROM FORMULARY DUE TO ADDITION OF NEW GENERIC EQUIVALENT	PAZOPANIB HCL 200 MG ORAL TABLET-5
2/1/2024	ALPHAGAN P 0.1 % OPHTHALMIC DROPS	BRAND DELETION, ADD FRF GENERIC	REMOVAL OF BRAND NAME DRUG FROM FORMULARY DUE TO ADDITION OF NEW GENERIC EQUIVALENT	BRIMONIDINE TARTRATE 0.1 % OPHTHALMIC DROPS-3
04/01/2024	FORTEO 20MCG/DOSE SUBCUTANE. PEN INJCTR	BRAND DELETION, ADD FRF GENERIC	REMOVAL OF BRAND NAME DRUG FROM FORMULARY DUE TO ADDITION OF NEW GENERIC EQUIVALENT	TERIPARATIDE 20MCG/DOSE SUBCUTANE. PEN INJCTR-3
04/01/2024	TRACLEER 125 MG ORAL TABLET	BRAND DELETION, ADD FRF GENERIC	REMOVAL OF BRAND NAME DRUG FROM FORMULARY DUE TO ADDITION OF NEW GENERIC EQUIVALENT	BOSENTAN 125 MG ORAL TABLET-5
04/01/2024	TRACLEER 62.5 MG ORAL TABLET	BRAND DELETION, ADD FRF GENERIC	REMOVAL OF BRAND NAME DRUG FROM FORMULARY DUE TO ADDITION OF NEW GENERIC EQUIVALENT	BOSENTAN 62.5 MG ORAL TABLET-5
04/01/2024	RISPERDAL CONSTA 25 MG/2 ML INTRAMUSC. VIAL	BRAND DELETION, ADD FRF GENERIC	REMOVAL OF BRAND NAME DRUG FROM FORMULARY DUE TO ADDITION OF NEW GENERIC EQUIVALENT	RISPERIDONE ER 25 MG/2 ML INTRAMUSC. VIAL-1

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04/01/2024	PROLENSA 0.07 % OPHTHALMIC DROPS	BRAND DELETION, ADD FRF GENERIC	REMOVAL OF BRAND NAME DRUG FROM FORMULARY DUE TO ADDITION OF NEW GENERIC EQUIVALENT	BROMFENAC SODIUM 0.07 % OPHTHALMIC DROPS-1
04/01/2024	RISPERDAL CONSTA 12.5MG/2ML INTRAMUSC. VIAL	BRAND DELETION, ADD FRF GENERIC	REMOVAL OF BRAND NAME DRUG FROM FORMULARY DUE TO ADDITION OF NEW GENERIC EQUIVALENT	RISPERIDONE ER 12.5MG/2ML INTRAMUSC. VIAL-1
04/01/2024	RISPERDAL CONSTA 50 MG/2 ML INTRAMUSC. VIAL	BRAND DELETION, ADD FRF GENERIC	REMOVAL OF BRAND NAME DRUG FROM FORMULARY DUE TO ADDITION OF NEW GENERIC EQUIVALENT	RISPERIDONE ER 50 MG/2 ML INTRAMUSC. VIAL-1
04/01/2024	RISPERDAL CONSTA 37.5MG/2ML INTRAMUSC. VIAL	BRAND DELETION, ADD FRF GENERIC	REMOVAL OF BRAND NAME DRUG FROM FORMULARY DUE TO ADDITION OF NEW GENERIC EQUIVALENT	RISPERIDONE ER 37.5MG/2ML INTRAMUSC. VIAL-1
05/01/2024	LEVONORG-ETH ESTRAD-FE BISGLYC 0.1-0.02MG ORAL TABLET	DELETION OF DRUG FROM FORMULARY	NOT A PART D COVERED DRUG	
06/01/2024	RECTIV 0.4% (W/W) RECTAL OINT. (G)	BRAND DELETION, ADD FRF GENERIC	REMOVAL OF BRAND NAME DRUG FROM FORMULARY DUE TO ADDITION OF NEW GENERIC EQUIVALENT	NITROGLYCERIN 0.4% (W/W) RECTAL OINT. (G)-3
07/01/2024	MITIGARE 0.6 MG ORAL CAPSULE	FORMULARY DELETION	FORMULARY DELETION	
07/01/2024	AZOPT 1 % OPHTHALMIC DROPS SUSP	FORMULARY DELETION	FORMULARY DELETION	
8/1/2024	TRUSELTIQ 100 MG/DAY ORAL CAPSULE	FDA WITHDRAWAL		
8/1/2024	TRUSELTIQ 50 MG/DAY ORAL CAPSULE	FDA WITHDRAWAL		
8/1/2024	TRUSELTIQ 75 MG/DAY ORAL CAPSULE	FDA WITHDRAWAL		
8/1/2024	FARYDAK 15 MG ORAL CAPSULE	DELETION OF DRUG FROM FORMULARY	PRODUCT WITHDRAWN FROM MARKET	
8/1/2024	TRUSELTIQ 125 MG/DAY ORAL CAPSULE	FDA WITHDRAWAL		

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8/1/2024	FARYDAK 10 MG ORAL CAPSULE	DELETION OF DRUG FROM FORMULARY	PRODUCT WITHDRAWN FROM MARKET	
8/1/2024	FARYDAK 20 MG ORAL CAPSULE	DELETION OF DRUG FROM FORMULARY	PRODUCT WITHDRAWN FROM MARKET	
10/1/2024	MOUNJARO 12.5MG/0.5 SUBCUTANE. PEN INJCTR	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		
10/1/2024	MOUNJARO 15MG/0.5ML SUBCUTANE. PEN INJCTR	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		
10/1/2024	MOUNJARO 2.5 MG/0.5 SUBCUTANE. PEN INJCTR	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		
10/1/2024	MOUNJARO 10MG/0.5ML SUBCUTANE. PEN INJCTR	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		
10/1/2024	OZEMPIC 2MG/0.75ML SUBCUTANE. PEN INJCTR	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		
10/1/2024	TRULICITY 0.75MG/0.5 SUBCUTANE. PEN INJCTR	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		
10/1/2024	MOUNJARO 7.5 MG/0.5 SUBCUTANE. PEN INJCTR	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		

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10/1/2024	MOUNJARO 5 MG/0.5ML SUBCUTANE. PEN INJCTR	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		
10/1/2024	RYBELSUS 14 MG ORAL TABLET	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		
10/1/2024	TRULICITY 1.5 MG/0.5 SUBCUTANE. PEN INJCTR	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		
10/1/2024	TRULICITY 3 MG/0.5ML SUBCUTANE. PEN INJCTR	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		
10/1/2024	OZEMPIC 0.25 OR .5 SUBCUTANE. PEN INJCTR	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		
10/1/2024	OZEMPIC 1/0.75 (3) SUBCUTANE. PEN INJCTR	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		
10/1/2024	RYBELSUS 7 MG ORAL TABLET	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		
10/1/2024	TRULICITY 4.5 MG/0.5 SUBCUTANE. PEN INJCTR	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		
10/1/2024	RYBELSUS 3 MG ORAL TABLET	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		

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10/1/2024	OZEMPIC .25 OR 0.5 SUBCUTANE. PEN INJCTR	PAYMENT DETERMINATION ADDED TO PRIOR AUTHORIZATION		

** These drugs are on our drug list (formulary). Please talk with your doctor to find out if these drugs are right for you.

Note: The amount you will pay for these drugs depends on your plan and which coverage period you are in. To find out how much you will pay for these drugs, please refer to your plan benefit documents, or call Customer Service at **1-877-672-8620** (TTY 711), daily from 8 a.m. to 8 p.m. local time.