November 25, 2025

Dear AmeriHealth Caritas Pennsylvania (PA)/AmeriHealth Caritas PA Community HealthChoices (CHC) Provider,

The Pennsylvania Department of Human Services (DHS) will implement changes to the statewide preferred drug list (PDL) on January 1, 2026 and January 5, 2026.

- **Effective January 1, 2026**:
  - Drugs containing a **GLP-1 receptor agonist for the treatment of overweight or obesity will no longer be covered** unless Members/Participants have a condition for which GLP-1 receptor agonist remains a covered prescription drug benefit. GLP-1 drugs impacted by this coverage change include:
    - Mounjaro (tirzepatide), Ozempic (semaglutide), Rybelsus (semaglutide), Saxenda (liraglutide), Trulicity (dulaglutide), Victoza (liraglutide), Wegovy (semaglutide), Zepbound (tirzepatide).
    - This pharmacy benefit change is authorized by 62 P.S. § 443.6(g), as amended by Act 2011-22, and 55 Pa. Code § 1121.54.
    - All Members/Participants receiving a GLP-1 receptor agonist will require a new prior authorization. Existing coverage will end on December 31, 2025, unless the provider requests a new prior authorization and the GLP-1 drug is authorized.
  - All Members/Participants receiving a **DPP-4 Inhibitor will require prior authorization**. Existing coverage will end on December 31, 2025, unless the provider requests a new prior authorization and the DPP-4 drug is authorized.
    - Please see **Appendix A**

- **Effective January 5, 2026:**
  - Please see **Appendix B** for a list of Statewide PDL drugs that will be changing formulary status for AmeriHealth Caritas PA and AmeriHealth Caritas PA CHC. Please keep in mind that up until January 5, 2026, the current version of the Statewide PDL is still in effect. AmeriHealth Caritas PA and AmeriHealth Caritas PA CHC will continue to use the same prior authorization guidelines as required by DHS for drugs included in the statewide PDL.

Reminder:

- AmeriHealth Caritas PA and AmeriHealth Caritas PA CHC will maintain a list of preferred and non-preferred drugs in classes that are not included in the statewide PDL. This is called the Supplemental Formulary.
- Medication classes that are not included in the statewide PDL are reviewed and approved by the AmeriHealth Caritas PA and AmeriHealth Caritas PA CHC Pharmacy and Therapeutics Committee.
- The process for obtaining prior authorization process remains the same. AmeriHealth Caritas PA and AmeriHealth Caritas PA CHC will continue to use the prior authorization guidelines as required by DHS for drugs included in the statewide PDL. For more information about prior authorization go to www.amerihealthcaritaspa.com → Pharmacy or www.amerihealthcaritaschc.com → Providers → Pharmacy Services.

Prior Authorization Request by:	AmeriHealth Caritas PA	AmeriHealth Caritas PA CHC
Phone	1-866-610-2774	1-888-674-8720
Fax	1-888-981-5202	1-855-851-4058
Online	www.amerihealthcaritaspa.com	www.amerihealthcaritaschc.com

Where can I see the changes?
The current PDL and 2026 PDL are available on DHS's Pharmacy website and at: https://papdl.com/. Additional resources including our plan Supplemental formularies are available on the Formulary page www.amerihealthcaritaspa.com → Pharmacy or www.amerihealthcaritaschc.com → Providers → Pharmacy Services.

If you have any questions regarding this change, please contact AmeriHealth Caritas PA Pharmacy Services at **1-866-610-2774** or AmeriHealth Caritas PA CHC Pharmacy Services at **1-888-674-8720**.

Appendix A: Statewide PDL Drug Class changes **effective January 1, 2026***

HYPOGLYCEMICS DPP-4 INHIBITORS
Preferred Agents: PRIOR AUTHORIZATION REQUIRED Janumet Tablet, Janumet XR Tablet, Januvia Tablet, Jentadueto Tablet, Jentadueto XR Tablet, Tradjenta Tablet

Appendix B Statewide PDL drugs changing from Preferred to Non-preferred **effective January 5, 2026***

Drug	Preferred alternative options*
ANGIOTENSIN MODULATORS	
Quinapril HCTZ Oral Tablet 10-12.5 MG, 20-12.5 MG	Quinapril tablet (separate products), HCTZ tablet (separate products), Enalapril-Hydrochlorothiazide Tablet, Lisinopril-Hydrochlorothiazide Tablet
ANTICOAGULANTS	
Pradaxa Oral Capsule 150 MG	Dabigatran Capsule (generic)
ANTIEMETICS/ANTIVERTIGO AGENTS	
Diclegis Oral Tablet Delayed Release 10-10 MG	Doxylamine Succinate-Pyridoxine DR Tablet (generic)
Meclizine HCl Oral Tablet 50 MG	Meclizine 12.5 mg, 25 mg Tablet and Chewable Tablet
Trimethobenzamide HCl Oral Capsule 300 MG	Ondansetron ODT/tablet, Prochlorperazine Tablet, Aprepitant Capsule
ANTIFUNGALS, TOPICAL	
Trimazole External Cream 1 %	Clotrimazole Cream (generic)
CYTOKINE AND CAM ANTAGONISTS	
• Adalimumab-adbm(CF) 100 mg/ml Pen and Syringe (Boehringer Ingelheim [00597] labeler only) • Adalimumab-adaz Subcutaneous Solution Auto-injector 40 MG/0.4ML, 80 MG/0.8ML • Amjevita Subcutaneous Solution Auto-Injector 40 MG/0.4ML, 80 MG/0.8ML • Amjevita Subcutaneous Solution Prefilled Syringe 40 MG/0.4ML • Hadlima PushTouch Subcutaneous Solution Auto-injector and Prefilled Syringe 40 MG/0.4ML • Humira (2 Pen) Subcutaneous Auto-injector Kit 40 MG/0.4ML, 80MG/0.8ML • Humira (2 Syringe) Subcutaneous Prefilled Syringe Kit 10 MG/0.1ML, 20 MG/0.2ML, 40 MG/0.4ML • Humira-CD/UC/HS Starter Subcutaneous Auto-injector Kit 80 MG/0.8ML	• Adalimumab-aaty(CF) 100 mg/mL Autoinjector & Syringe • Simlandi(CF) (adalimumab-ryvk) 100 mg/mL Autoinjector & Syringe

Drug	Preferred alternative options*
• Humira-Psoriasis/Uveit Starter Subcutaneous Auto-injector Kit 80 MG/0.8ML & 40MG/0.4ML	
• Adalimumab-aacf (2 Pen) Subcutaneous Auto-injector Kit 40 MG/0.8ML • Humira (2 Pen) Subcutaneous Auto-injector Kit 40 MG/0.4ML • Humira (2 Syringe) Subcutaneous Prefilled Syringe 40 MG/0.4ML, 40MG/0.8ML • Humira-Psoriasis/Uveit Starter Subcutaneous Auto-injector Kit 80 MG/0.8ML & 40MG/0.4ML • Yusimry Subcutaneous Solution Auto-injector 40 MG/0.8ML	• Adalimumab-fkjp(CF) 50 mg/mL Pen & Syringe • Hadlima (adalimumab-bwwd) 50 mg/mL Pushtouch & Syringe
• Otulfi Subcutaneous Solution Prefilled Syringe 45 MG/0.5ML and 90 MG/ML • Selarsdi Subcutaneous Solution Prefilled Syringe 90 MG/ML • Steqeyma Subcutaneous Solution Prefilled Syringe 45 MG/0.5ML and 90 MG/ML • Yesintek Intravenous Solution **and** Prefilled Syringe 45 MG/0.5ML, 130 MG/26ML	Pyzchiva (ustekinumab-ttwe) Syringe & Vial
Pyzchiva Intravenous Solution **and** Prefilled Syringe 45MG/0.5ML, 90MG/ML 130 MG/26ML	Ustekinumab-Ttwe Subcutaneous Solution & Prefilled Syringe
EPINEPHRINE, SELF-ADMINISTERED	
Auvi-Q Injection Solution Auto-injector 0.3 MG/0.3ML	Auvi-Q 0.1 mg/0.1 mL Autoinjector, Epinephrine Autoinjector (Mylan [49502] labeler only)
HEREDITARY ANGIOEDEMA (HAE) AGENTS	
Sajazir Subcutaneous Solution Prefilled Syringe 30 MG/3ML	Icatibant Acetate Solution Prefilled Syringe 30 MG/3ML Subcutaneous
HISTAMINE 2 RECEPTOR BLOCKERS	
Nizatidine Oral Capsule 150 MG	Cimetidine Tablet, Famotidine Tablet, Acid Reducer Complete (famotidine-calcium carbonate-magnesium hydroxide chewable) Tablet Chew
HYPOGLYCEMICS, SGLT2 INHIBITORS	
Invokana Oral Tablet 100 MG, 300 MG	Farxiga Tablet, Jardiance Tablet
Invokamet Oral Tablet 50-500 MG, 50-1000 MG, 150-500 MG, 150-1000 MG	Farxiga Tablet, Jardiance Tablet, Synjardy Tablet/XR Tablet, Xigduo XR Tablet
NSAIDs	

Drug	Preferred alternative options*
Naproxen Oral Suspension 125 MG/5ML	Ibuprofen Suspension and Chewable Tablet, Naproxen 250 mg, 375 mg, 500 mg Tablet
ONCOLOGY AGENTS, ORAL	
Sprycel Oral Tablet 20 MG, 50 MG, 70 MG, 80 MG, 100 MG, 140 MG	Dasatinib Tablet (generic)
Tasigna Oral Capsule 150 MG	Nilotinib HCl Capsule (generic)
OPHTHALMICS, ANTI-INFLAMMATORIES	
Ilevro Ophthalmic Suspension 0.3 % Nevanac Ophthalmic Suspension 0.1 %	Bromfenac, Ketorolac Drop, Flurbiprofen Drop, Maxidex Drop
POTASSIUM REMOVING AGENTS	
Lokelma (sodium zirconium cyclosilicate) Powder Packet (NDCs 00310110501, 00310111001)	Lokelma (sodium zirconium cyclosilicate) Powder Packet (NDCs 00310111030, 00310110530, 00310110539, 00310111039)
Veltassa (patiromer) Powder Packet (NDCs 53436025230, 53436025201, 53436008404)	Veltassa (patiromer) Powder Packet (NDCs 53436001060, 53436001001, 53436016830, 53436016801, 53436008430, 53436008401)

***Not an all-inclusive list, and some drugs may be subject to additional limits and/or specifications.**

For a complete list of Preferred and Non-preferred drugs to be included in the 2026 Statewide PDL, as well as any limits associated with these drugs, please visit https://papdl.com.