

January 1st, 2027 AffirmedRx Choice Formulary Changes

Effective January 1, 2027

Beginning January 1, 2027, some medications covered under your pharmacy benefit will change. These updates may affect whether a medication is covered, the amount you pay, or the requirements that must be met before coverage is available.

What You Need to Know

- Some medications will move off the formulary, be added to the formulary, or no longer be covered.
- If it is a covered benefit for your plan, weight-loss GLP-1 fills by a non-CHL provider will be required to be monthly.
- Some medications will move to a different cost-sharing tier, which may change your out-of-pocket cost.
- Some medications will have new coverage requirements, such as prior authorization, step therapy, age limits, or quantity limits.

If Your Medication Is Listed

Do not stop or change your medication without speaking with your prescriber. Ask whether a covered alternative may be appropriate. If your prescriber believes your current medication is medically necessary, they may submit a coverage request for review. For the most current formulary and pharmacy benefit information, visit members.affirmedrx.com/purdue.



Medications Moving Off the Formulary

- These medications are moving off formulary. Covered alternatives may be available.
- What this means: Talk to your prescriber about a covered alternative. A coverage request may be submitted if your prescriber determines this specific medication is medically necessary for you.

Drug	Generic Name	Formulary Alternative
Oxycontin ER	Oxycodone	Xtampza ER
Insulin Delivery Devices: CeQur Simplicity 2U Device, InPen, NovoPen Echo	n/a	Insulin pens (Humalog KwikPen/Insulin lispro, Novolog/Insulin aspart), OmniPod

Medications Added to the Formulary

- These medications are being added to the formulary. Additional coverage requirements may apply.

Drug	Generic Name	New Tier
Ciclopirox Olamine Cream 0.77 % External	Ciclopirox	Tier 1
Eucrisa	Crisaborole	Tier 2
Xtampza ER 12 Hour Abuse- Deterrent	Oxycodone	Tier 2

Coverage Now Available Through Medical Review

- These medications are no longer excluded. Coverage may be available when medical necessity requirements are met.

Drug	Generic Name	Formulary Alternative
Auvi-Q 0.1 MG/0.1ML	Epinephrine	Epinephrine (generic Epi-Pen)

Medications No Longer Covered

- These medications will no longer be covered under your pharmacy benefit.

Drug	Generic Name	Drug Class
Diclofenac 2% topical solution	Diclofenac Sodium	Topical Pain Relievers
Rextovy Nasal Spray	Naloxone HCl	Over-the-Counter (OTC) Opioid Overdose Rescue Medication
Qlosi Solution	Pilocarpine HCl	Presbyopia Medications (eye drops for age-related blurry near vision)
Vizz Solution	Aceclidine HCl	
Vuity Solution	Pilocarpine HCl	
Yuvezzi Solution	Carbachol-Brimonidine Tartrate	

Note: Rextovy Nasal Spray (OTC) is available over the counter and is not covered under the prescription benefit.

New or Updated Coverage Requirements

- The medications below will have new or updated requirements before coverage is available.

Drug	Generic Name	Change
Nitrofurantoin Suspension 25 mg/5mL	Nitrofurantoin	Added Max Age Limit of 12 Years Added QL: 20mL per day
Nitrofurantoin Suspension 50 mg/5mL	Nitrofurantoin	Added Max Age Limit of 12 Years Added QL: 10mL per day
Voriconazole Suspension 40 mg/ML	Voriconazole	Added Max Age Limit of 12 Years
Calcitonin (Salmon) injection	Calcitonin (Salmon)	Prior authorization required
Flucytosine	Flucytosine	Prior authorization required
Posaconazole	Posaconazole	Prior authorization required
Soltamox	Tamoxifen Citrate	Prior authorization required
Cresemba 74.5 mg	Isavuconazonium	Prior authorization required; Updated QL: 128 capsules per 30 days
Cresemba 186 mg	Isavuconazonium	Prior authorization required; Updated QL: 64 capsules per 30 days
Santyl	Collagenase	Prior authorization required; Updated QL: 1 tube per 30 days
Disulfiram tablets	Disulfiram	Added QL: 1 tablet per day
Furoscix	Furosemide	Added QL: 10 kits per 90 days
Impavido	Miltefosine	Updated QL: 84 capsules per year
Journavx	Suzetrigine	Updated QL: 30 tablets per 30 days
OxyContin ER	Oxycodone	Updated QL: 2 tablets per day
Radiogardase capsules	Prussian Blue Insoluble Cap	Added QL: 18 capsules per day
Tembexa suspension	Brincidofovir	Added QL: 65 mL per 14 days
Tembexa tablets	Brincidofovir	Added QL: 4 tablets per 14 days
Desmopressin Acetate 0.01% Nasal Spray – Refrigerated solution	Desmopressin Acetate	Step therapy required through Desmopressin Acetate 0.01% Nasal Spray (non-refrigerated)
Dexcom products	Dexcom	History of Insulin use required
FreeStyle Libre products	FreeStyle Libre	History of Insulin use required

PA = Prior Authorization; QL = Quantity Limit

Additional Information:

- Information in this notice is subject to change.
- Not every change described in this notice may apply to your specific health plan.
- Review your plan documents for your costs and complete details about your benefits, exclusions, and coverage limitations. For the most current formulary and pharmacy benefit information, visit members.affirmedrx.com or contact Member Services using the number on your member ID card.