Changes to Wellcare Meridian Dual Align (HMO D-SNP)'s List of Covered Drugs (Formulary)

The table below outlines changes to our List of Covered Drugs (Formulary) that may impact you.

Name of Affected Drug	Description of Change	Reason for Change	Alternative Drug(s) *	Alternative Drug(s) Tier	Effective Date
PROLIA 60 MG/ML SYRINGE (ML)	Deletion Of Drug From Formulary	Biosimilar Available	BOMYNTRA 120 mg/1.7 mL (70 mg/mL) Syringe and Vial; osenvelt 120 mg/1.7 mL (70 mg/mL) solution	Tier 5	02/01/2026
XGEVA 120 MG/ 1.7 VIAL (ML)	Deletion Of Drug From Formulary	Biosimilar Available	osenvelt 120 mg/1.7 mL (70 mg/mL) solution and vial; BOMYNTRA 120 mg/1.7 mL (70 mg/mL) Solution	Tier 5	02/01/2026
GLEOSTINE 10 MG CAPSULE	Deletion Of Drug From Formulary	Generic Available	lomustine 10 mg capsule	Tier 4	02/01/2026
GLEOSTINE 100 MG CAPSULE	Deletion Of Drug From Formulary	Generic Available	lomustine 100 mg capsule	Tier 5	02/01/2026
GLEOSTINE 40 MG CAPSULE	Deletion Of Drug From Formulary	Generic Available	lomustine 40 mg capsule	Tier 5	02/01/2026
DIFICID 200 MG TABLET	Deletion Of Drug From Formulary	Generic Available	fidaxomicin 200 mg tablet	Tier 5	02/01/2026
FYCOMPA	Deletion of drug from Formulary	Generic Available	perampanel 0.5mg/ml suspension, oral (Final Dose Form)	Tier 5	04/01/2026
VYNDAQEL	Deletion Of Drug from Formulary	Market Removal	Consult Your Health Care Provider	N/A	05/01/2026

Name of Affected Drug	Description of Change	Reason for Change	Alternative Drug(s) *	Alternative Drug(s) Tier	Effective Date
POMALYST	Deletion of Drug from Formulary	Generic Available	POMALIDOMIDE 1MG, 2MG, 3MG, 4MG CAPSULE	Tier 5	05/01/2026
BRIVIACT TABLET	Deletion of drug from Formulary	Generic Available	brivaracetam 10mg, 25mg, 50mg, 75mg, 100mg tablet	Tier 5	06/01/2026
BRIVIACT ORAL SOLUTION	Deletion of drug from Formulary	Generic Available	brivaracetam 10mg/ml oral solution	Tier 5	06/01/2026
XIGDUO XR	Deletion of drug from Formulary	Generic Available	dapagliflozin-metformin ER 5mg-1000mg, 10mg-1000mg tablet Immediate and Extended Rel Biphase 24hr	Tier 3	06/01/2026
STELARA	Deletion of drug from Formulary	Biosimilar Available	ustekinumab-TTWE 45mg/0.5ml vial	Tier 3	06/01/2026
ustekinumab	Deletion of drug from Formulary	Biosimilar Available	ustekinumab-TTWE 45mg/0.5ml vial	Tier 3	06/01/2026
OFEV	Deletion Of Drug From Formulary	Generic Available	NINTEDANIB ESYLATE 100 MG, 150 MG CAPSULE	Tier 5	09/01/2026
FARXIGA	Deletion Of Drug From Formulary	Generic Available	DAPAGLIFLOZIN 5 MG, 10 MG TABLET	Tier 3	09/01/2026
XIGDUO XR	Deletion Of Drug From Formulary	Generic Available	DAPAGLIFLOZIN/METFORMIN 5 MG-500MG , 10MG-500MG TABLET, IMMED AND EXTEND REL BIPHASE 24HR	Tier 3	09/01/2026
SAVELLA	Deletion Of Drug From Formulary	Generic Available	MILNACIPRAN HCL 12.5 MG, 25 MG, 50 MG, 100 MG TABLET	Tier 3	09/01/2026

Name of Affected Drug	Description of Change	Reason for Change	Alternative Drug(s) *	Alternative Drug(s) Tier	Effective Date
WIDE SEAL DIAPHRAGM 60MM, 65MM, 70MM, 75MM, 80MM, 85MM, 90MM, 95MM	Deletion Of Drug From Formulary	Medicaid Will No Longer Cover	CAYA CONTOURED DIAPHRAGM	N/A	09/01/2026
TOLNAFTATE 1% POWDER	Deletion Of Drug From Formulary	Medicaid Will No Longer Cover	TOLNAFTATE 1% CREAM	N/A	09/01/2026
QUFLORA FE PED 0.25 MG/ML DROP	Deletion Of Drug From Formulary	Medicaid Will No Longer Cover	POLY-VI-FLOR-IRON 0.5-10MG CHW, POLY-VI-FLOR-IRON 0.25 MG/ML, MULTIVIT-FLUOR-IRON 0.25 MG/ML	N/A	09/01/2026
PEDIAVENT 2 MG/5 ML SYRUP	Deletion Of Drug From Formulary	Medicaid Will No Longer Cover	ALA-HIST IR 2 MG TABLET	N/A	09/01/2026
QUFLORA FE 0.25 MG CHEW TABLET	Deletion Of Drug From Formulary	Medicaid Will No Longer Cover	STROVITE FORTE CAPLET, STROVITE ONE CAPLET, BACMIN CAPLET, DIALYVITE SUPREME D TABLET, CORVITA TABLET, CORVITE TABLET	N/A	09/01/2026
FLORAFOL FE PEDI 0.25MG/ML DRP	Deletion Of Drug From Formulary	Medicaid Will No Longer Cover	MULTIVIT-FLUOR-IRON 0.25 MG/ML	N/A	09/01/2026
TRUE VITAMIN D3 250 MCG CAP	Deletion Of Drug From Formulary	Medicaid Will No Longer Cover	VITAMIN D2 1.25MG (50,000 UNIT)	N/A	09/01/2026
XELJANZ XR	Deletion Of Drug From Formulary	Generic Available	TOFACITINIB CITRATE ER 11 MG TABLET, 22 MG TABLET EXTENDED RELEASE 24 HR	Tier 5	09/01/2026
BOSULIF	Deletion Of Drug From Formulary	Generic Available	BOSUTINIB 400MG TABLET	Tier 5	09/01/2026
JANUMET	Deletion Of Drug From Formulary	Generic Available	SITAGLIPTIN PHOS/METFORMIN HCL 50MG-500MG, 50-1000 MG	Tier 3	10/01/2026

Name of Affected Drug	Description of Change	Reason for Change	Alternative Drug(s) *	Alternative Drug(s) Tier	Effective Date
ZEPBOUND 2.5 MG/ 0.5 ML VIAL	Deletion Of Drug From Formulary	Medicaid Will No Longer Cover	ZEPBOUND 2.5 MG/0.5 ML PEN, ZEPBOUND 2.5MG DOSE KWIKPEN	N/A	10/01/2026
ZEPBOUND 5 MG/ 0.5 ML VIAL	Deletion Of Drug From Formulary	Medicaid Will No Longer Cover	ZEPBOUND 5 MG/0.5 ML PEN, ZEPBOUND 5MG DOSE KWIKPEN	N/A	10/01/2026
ZEPBOUND 7.5 MG/ 0.5 ML VIAL	Deletion Of Drug From Formulary	Medicaid Will No Longer Cover	ZEPBOUND 7.5 MG/0.5 ML PEN, ZEPBOUND 7.5MG DOSE KWIKPEN	N/A	10/01/2026
ZEPBOUND 10 MG/ 0.5 ML VIAL	Deletion Of Drug From Formulary	Medicaid Will No Longer Cover	ZEPBOUND 10 MG/0.5 ML PEN, ZEPBOUND 10MG DOSE KWIKPEN	N/A	10/01/2026
ACNE MEDICATION 10% LOTION	Deletion Of Drug From Formulary	Medicaid Will No Longer Cover	ACNE MEDICATION 10% GEL, BENZOYL PEROXIDE 10% GEL	N/A	10/01/2026
POLY-VI-FLOR-IRON 0.25 MG/ML	Deletion Of Drug From Formulary	Medicaid Will No Longer Cover	POLY-VI-FLOR-IRON 0.5-10MG CHW, MULTIVIT-FLUOR-IRON 0.25 MG/ML	N/A	10/01/2026
NUEDEXTA 20 MG-10MG CAPSULE	Deletion Of Drug From Formulary	Generic Available	DEXTROMETHORPHAN HBR/ QUINIDINE 20 MG-10MG CAPSULE	Tier 3	11/01/2026
JANUMET XR 50MG-500MG, 50-1000 MG , 100-1000MG TABLET, EXTENDED RELEASE MULTIPHASE 24 HR	Deletion Of Drug From Formulary	Generic Available	SITAGLIPTIN PHOS/METFORMIN HCL 50MG-500 MG, 50-1000 MG, 100-1000MG TABLET, EXTENDED RELEASE MULTIPHASE 24 HR	Tier 3	11/01/2026
NOVOLOG FLEXPEN 100/ ML (3) INSULIN PEN (ML)	Deletion Of Drug From Formulary	New Biosimilar	KIRSTY PEN 100/ML (3) INSULIN PEN (ML)	Tier 3	11/01/2026
NOVOLOG 100/ML VIAL (ML)	Deletion Of Drug From Formulary	New Biosimilar	KIRSTY 100/ML VIAL (ML)	Tier 3	11/01/2026

*Alternative drug(s) are drugs that you could consider with your prescriber. Only your prescriber can determine alternative drugs that are appropriate for you given the individualized nature of drug therapy. Please consult your prescriber to confirm if this is an appropriate drug for you.

Notice of Availability of Language Assistance Services and Auxiliary Aids and Services

ATTENTION: If you speak a language other than English, free language assistance services are available to you. Appropriate auxiliary aids and services to provide information in accessible formats are also available free of charge. Call 1-844-536-2168 (TTY: 711).

Español ATENCIÓN: Contamos con servicios de asistencia lingüística que se encuentran disponibles para usted de manera gratuita. También se encuentran disponibles de manera gratuita ayudas y servicios auxiliares adecuados para proporcionar información en formatos accesibles. Llame al 1-844-536-2168 (TTY: 711).

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Deutsch ACHTUNG: Sprachdienstleistungen stehen Ihnen kostenlos zur Verfügung. Geeignete zusätzliche Unterstützung und Dienstleistungen für Informationen in zugänglichen Formaten stehen Ihnen ebenfalls kostenlos zur Verfügung. Rufen Sie folgende Nummer an: 1-844-536-2168 (TTY: 711).

አማርኛ ይነበብ፦ ነጻ የቋንቋ እገዛ አገልግሎቶች ለእርስዎ ይገኛሉ። በተጨማሪም አግባብነት ያላቸው ለእርስዎ ተደራሽ በሆኑ ቅርጸቶች መረጃ የሚያቀርቡልዎ አጋዥ መሳሪያዎች እና አገልግሎቶችን ከክፍያ ነጻ ያገኛሉ። ወደ **1-844-536-2168 (TTY: 711)** ይደውሉ።

Soomaali DIGNIIN: Adeegyada kaalmada luqadda bilaashka ah ayaa kuu diyaar ah. Sidoo kale, qalab iyo adeegyo kaabayaal ku habboon ayaa diyaar ah si macluumaadka loogu helo qaabab sahlan oo la heli karo, iyadoo aan wax kharash ah lagaaga qaadin. Wac 1-844-536-2168 (TTY: 711).

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বাংলা খেয়াল করুন: আপনার জন্য বিনামূল্যে ভাষা পরিষেবার সুবিধা রয়েছে। বিনামূল্যে অ্যাক্সেসযোগ্য ফর্ম্যাটে তথ্য দিতে উপযুক্ত সহায়ক উপকরণ এবং পরিষেবাও উপলব্ধ রয়েছে। এখানে কল করুন 1-844-536-2168 (TTY: 711) l

Français REMARQUE : des services d'assistance linguistique gratuits sont à votre disposition. Des services et aides pour obtenir des informations dans des formats accessibles sont également disponibles gratuitement. Appelez le 1-844-536-2168 (TTY : 711).

Français cadien COMMUNIQUE: Des services d'aide linguistique sans frais sont à votre disposition. Des aides et services auxiliaires appropriés pour fournir des informations en formats accessibles sont également proposés sans frais. Composez le 1-844-536-2168 (TTY : 711).

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తెలుగు గమనిక: మీకు ఉచిత భాష సంబంధ సహాయక సేవలు అందుబాటులో ఉన్నాయి. యాక్సెస్ చేయదగిన ఫార్మాట్‌లలో సమాచారాన్ని అందించడానికి తగిన సహాయక టూల్‌లు, సేవలు కూడా ఉచితంగా అందుబాటులో ఉన్నాయి. 1-844-536-2168 (TTY: 711) నంబర్‌కి కాల్ చేయండి.

Tiếng Việt LƯU Ý: Chúng tôi có cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí. Các dịch vụ và trợ giúp bổ trợ phù hợp để cung cấp thông tin ở các định dạng có thể truy cập cũng được cung cấp miễn phí. Gọi **1-844-536-2168 (TTY: 711).**

ייִדיש אויפֿמערקזאַמקייט: פרייע שפּראַך הילף סערוויסעס זענען פֿאַר אײַך פֿאַראַן. פֿאַסיקע הילפסמיטלען און סערוויסעס צו צושטעלן אינפֿאָרמאַציע אין צוגענגלעכע פֿאָרמאַטן זענען אויך פֿאַראַן פריי פֿון אָפּצאָל. רופֿט 1-844-536-2168 (TTY: 711).

Pennsylvania Deitsch GEB ACHT: Schprooch Helfe sin meeglich mitaus Koscht. Rechtliche Auxiliary Aids un Helfe um Information zu gewwe in helfreiche Formats sin aa meeglich mit aus Koscht. Ruf 1-844-536-2168 (TTY: 711).

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