Medicaid Preferred Drug List (PDL) Changes – Molina Healthcare of Illinois
October 6, 2023

Key			
AL = Age Limit	ST = Step Therapy	OTC = Over the Counter	PA = Prior Authorization
PA, QL = Quantity Limit is applied after Prior Authorization approval	QL = Quantity Limit	SP = Specialty Drugs; these drugs must be obtained through a specialty pharmacy	

Date Effective	Product Name	Change	Notes
10/06/2023	AUVI-Q INJ 0.15 MG	Update to preferred	
10/06/2023	AUVI-Q INJ 0.1 MG	Update to preferred	
10/06/2023	AUVI-Q INJ 0.3 MG	Update to preferred	
10/06/2023	ORSERDU TAB 86 MG	Update to preferred	
10/06/2023	ORSERDU TAB 345 MG	Update to preferred	
10/06/2023	ENDARI POW 5GM 60-PK	Add to formulary, preferred	
10/06/2023	ENDARI POW 5GM 1-PK	Add to formulary, preferred	
10/06/2023	DROXIA CAP 200 MG	Add to formulary, preferred	
10/06/2023	DROXIA CAP 300 MG	Add to formulary, preferred	
10/06/2023	DROXIA CAP 400 MG	Add to formulary, preferred	
10/06/2023	SIKLOS TAB 100 MG	Add to formulary, non-preferred, PA	
10/06/2023	SIKLOS TAB 1000 MG	Add to formulary, non-preferred, PA	
10/06/2023	OXBRYTA TAB 500 MG	Add to formulary, non-preferred, PA	
10/06/2023	OXBRYTA TAB 300 MG	Add to formulary, non-preferred, PA	
10/06/2023	ADAKVEO INJ 100/10 ML	Add to formulary, non-preferred, PA	