

# Formulary Updates



## May 2025

Following is the update to the Highmark Drug Formularies and pharmaceutical management procedures for April 2025. The formularies and pharmaceutical management procedures are updated on a bi-monthly basis, and the following changes reflect the decisions made in April by our Pharmacy and Therapeutics Committee. These updates are effective on the dates noted throughout this document.

Please reference the guide below to navigate this communication:

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- A. Changes to the Highmark Comprehensive Formulary and the Highmark Healthcare Reform Comprehensive Formulary
- B. Changes to the Highmark Healthcare Reform Essential Formulary
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As an added convenience, you can also search our drug formularies and view utilization management policies on the Provider Resource Center (PRC) (accessible via Availity Essentials® or our website). Once on the PRC, go to **Policies & Programs > Highmark Formulary** and then scroll down to find the formulary you're looking for.



The following entities, which serve the noted regions, are independent licensees of the Blue Cross Blue Shield Association: Western and Northeastern PA: Highmark Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Choice Company, Highmark Health Insurance Company, Highmark Coverage Advantage Inc., Highmark Benefits Group Inc., First Priority Health, First Priority Life or Highmark Senior Health Company. Central and Southeastern PA: Highmark Inc. d/b/a Highmark Blue Shield, Highmark Benefits Group Inc., Highmark Health Insurance Company, Highmark Choice Company or Highmark Senior Health Company. Delaware: Highmark BCBSD Inc. d/b/a Highmark Blue Cross Blue Shield. West Virginia: Highmark West Virginia Inc. d/b/a Highmark Blue Cross Blue Shield, Highmark Health Insurance Company or Highmark Senior Solutions Company. Western NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Cross Blue Shield. Northeastern NY: Highmark Western and Northeastern New York Inc. d/b/a Highmark Blue Shield.

All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

Availity is an independent company that contracts with Highmark to offer provider portal services.

## Important Drug Safety Updates

### [Alvogen Issues Voluntary Nationwide Recall for One Lot of Fentanyl Transdermal System 25 mcg/h Due to a Defective Delivery System](#)

On Jan. 31, 2025, Alvogen, Inc. is voluntarily recalling one lot of Fentanyl Transdermal System 25 mcg/h transdermal patches to the consumer level. The reason for the recall is that there is a potential that patches could be multi-stacked, adhered one on top of the other, in a single product pouch. This transdermal system is manufactured by Kindeva Drug Delivery L.P., Northridge, CA, and is distributed by Alvogen, Inc. as a private label distributor.

There is a possibility that the application of a multi-stacked 25 mcg/h patch could result in serious, life threatening, or fatal respiratory depression. Groups at potential increased risk could include first-time recipients of such patches, children, and the elderly. To date, Alvogen has received one serious adverse event related to this recall.

## Highmark Formulary Update – April 2025

### SECTION I. Highmark Commercial and Healthcare Reform Formularies

#### **A. Changes to the Highmark Comprehensive Formulary and the Highmark Healthcare Reform Comprehensive Formulary**

The Highmark Pharmacy and Therapeutics Committee has reviewed the medications listed in the tables below. Please note that the Highmark Comprehensive Closed/Incentive Formulary is a complete subset of the Open Formulary; therefore, all medications added to the Comprehensive Closed/Incentive Formulary are also added to the Open Formulary. These updates are effective on the dates noted throughout this document. For your convenience, you can search the following formularies online:

- [Highmark Comprehensive Formulary](#)
- [Highmark Healthcare Reform Comprehensive Formulary](#)

Highmark is happy to inform you that Table 1 includes products that have been added to the formulary. Adding products to the formulary may mean lower co-pays or coinsurance rates for members. By adding products to the formulary, Highmark hopes to promote adherence to medication protocols and improve the overall health of our members.

#### **Table 1. Products Added**

All products added to the formulary effective April 2025, unless otherwise noted.

Brand Name	Generic Name	Comments
Penmenvy	Meningococcal Groups A, B, C, W, and Y Vaccine	Active immunization to prevent invasive disease caused by Neisseria meningitidis serogroups A, B, C, W, and Y in individuals 10 through 25 years of age.
Vimkunya*	chikungunya vaccine, recombinant	Prevention of disease caused by chikungunya virus in individuals 12 years of age and older.

Coverage may be contingent upon plan benefits.

\* Commercial Comprehensive Formulary Only

#### **Table 2. Products Not Added\*\***

Brand Name	Generic Name	Preferred Alternatives
Avtozma	tocilizumab-anoh	Actemra syringe (mL), Actemra Actpen
Brynovin	sitagliptin	Januvia tablets, Tradjenta tablets
Ctexli	chenodiol	Prescriber Discretion
Evrysdi	risdiplam	Prescriber Discretion
Fulvicin P/G 165 mg	griseofulvin ultramicrosize	griseofulvin microsize tablet 500 mg, griseofulvin ultramicrosize tablet 125 mg, griseofulvin ultramicrosize tablet 250 mg

Brand Name	Generic Name	Preferred Alternatives
Gabarone	gabapentin	gabapentin capsule, gabapentin tablet
Gomekli	mirdametinib	Prescriber Discretion
Inzirqo	hydrochlorothiazide	hydrochlorothiazide tablets, hydrochlorothiazide capsules
Journavx	suzetrigine	ibuprofen tablets , naproxen tablets
Merilog / Merilog Solostar	insulin aspart-szjj	Novolog, Humalog
Metaxalone 640 mg	metaxalone	cyclobenzaprine 5 mg tabs, cyclobenzaprine 10 mg tabs, methocarbamol 500 mg tabs
Metformin 750 mg	metformin	metformin oral tablet 500 mg, metformin oral tablet 850 mg, metformin oral tablet 1000 mg
Miudella	copper intrauterine system	Paragard T 380-A; Mirena
Neffy	epinephrine	epinephrine Auto-Injct
Omlyclo	omalizumab-igec	Xolair auto-injector, Xolair syringe
Onapgo	apomorphine hydrochloride	carbidopa-levodopa tablets, ropinirole tablets, pramipexole tablets
Osenvelt	denosumab-bmwo	Prescriber Discretion
Ospomyv	denosumab-dssb	alendronate sodium tablet, risedronate sodium tablet 5 mg, risedronate sodium tablet 150 mg
Raldesy 150mL, 300 mL	trazodone HCl	trazodone 50 mg tablets, trazodone 100 mg tablets, trazodone 150 mg tablets
Romvimza	vimseltinib	Prescriber Discretion
Stoboclo	denosumab-bmwo	alendronate sodium tablet, risedronate sodium tablet 5 mg, risedronate sodium tablet 150 mg
Symbravo	meloxicam and rizatriptan	rizatriptan, meloxicam tablet, sumatriptan succinate tablet
Vimkunya***	chikungunya vaccine, recombinant	Prescriber Discretion
Xbryk	denosumab-dssb	Prescriber Discretion

Coverage may be contingent upon plan benefits.

\*Effective date to be determined.

\*\*Physicians may request coverage of these products using the Prescription Drug Medication Request Form. To access this form for your region, go to the [Provider Resource Center](#) and choose your region from the top right. Select **Resources & Education > Forms > Pharmacy Prior Authorization Forms** and then scroll down to the **Prescription Drug Medication Request Form**.

\*\*\* HCR Comprehensive Formulary Only

### Table 3. Additions to the Specialty Tier Copay Option

Note: The specialty tier does not apply to Highmark Delaware Healthcare Reform members; see Highmark Delaware's online Provider Resource Center and access the Pharmacy

Program/Formularies link for details on the formularies and formulary options that apply to Highmark Delaware Healthcare Reform members. Once on the page, click on Healthcare Reform, which is under the “Line of Business” header.

Effective upon completion of internal review and implementation.

Brand Name	Generic Name
Avtozma	tocilizumab-anoh
Ctexli	chenodiol
Evrysdi	risdiplam
Fulvicin P/G 165 mg	griseofulvin ultramicrosize
Gabarone	gabapentin
Gomekli	mirdametinib
Metaxalone 640 mg	metaxalone
Metformin 750 mg	metformin
Omlyclo	omalizumab-igec
Onapgo	apomorphine hydrochloride
Osenvelt	denosumab-bmwo
Ospomyv	denosumab-dssb
Raldesy	trazodone HCl
Romvimza	vimseltinib
Stoboclo	denosumab-bmwo
Xbryk	denosumab-dssb

**Table 4. Products to Be Removed or Shifted to Higher Tier – Effective July 2025**

Brand name	Generic Name	Preferred Alternatives
<b>All Commercial &amp; Healthcare Reform Comprehensive products</b>		
Clemastine Fum 2.68 mg tablet	clemastine fumarate	hydroxyzine HCl tablet
Mesnex 400 mg tablet	mesna	mesna 400 mg tablet
Tretinoin 0.025% gel	tretinoin	tretinoin 0.025% cream

**B. Changes to the Highmark Healthcare Reform Essential Formulary**

The Essential Formulary is a closed formulary for select Healthcare Reform (HCR) Individual plans. A list of drugs included on the Essential Formulary, listed by therapeutic class, is available [here](#).

**Table 1. Formulary Updates**

All formulary changes effective April 2025, unless otherwise noted.

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
<b>Items listed below were added to the formulary</b>			
Penmenvy	Meningococcal Groups A, B, C, W, and Y Vaccine	3	Active immunization to prevent invasive disease caused by Neisseria meningitidis

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
			serogroups A, B, C, W, and Y in individuals 10 through 25 years of age.
Vimkunya	chikungunya vaccine, recombinant	3	Prevention of disease caused by chikungunya virus in individuals 12 years of age and older.
<b>Items listed below were not added to the formulary</b>			
Avtozma	tocilizumab-anoh	NF	Actemra syringe (mL), Actemra Actpen
Brynovin	sitagliptin	NF	Januvia tablets, Tradjenta tablets
Ctexli	chenodiol	NF	Prescriber Discretion
Evrysdi	risdiplam	NF	Prescriber Discretion
Fulvicin P/G 165 mg	griseofulvin ultramicrosize	NF	griseofulvin microsize tablet 500 mg, griseofulvin ultramicrosize tablet 125 mg, griseofulvin ultramicrosize tablet 250 mg
Gabarone	gabapentin	NF	gabapentin capsule, gabapentin tablet
Gomekli	mirdametinib	NF	Prescriber Discretion
Inzirqo	hydrochlorothiazide	NF	hydrochlorothiazide tablets, hydrochlorothiazide capsules
Journavx	suzetrigine	NF	ibuprofen tablets , naproxen tablets
Merilog / Merilog Solostar	insulin aspart-szjj	NF	Novolog; Humalog
Metaxalone 640 mg	metaxalone	NF	cyclobenzaprine 5 mg tabs, cyclobenzaprine 10 mg tabs, methocarbamol 500 mg tabs
Metformin 750 mg	metformin	NF	metformin oral tablet 500 mg, metformin oral tablet 850 mg, metformin oral tablet 1000 mg
Miudella	copper intrauterine system	NF	Paragard T 380-A; Liletta
Omlyclo	omalizumab-igec	NF	Xolair auto-injector, Xolair syringe
Onapgo	apomorphine hydrochloride	NF	carbidopa-levodopa tablets, ropinirole tablets, pramipexole tablets
Osenvelt	denosumab-bmwo	NF	Prescriber Discretion
Ospomyv	denosumab-dssb	NF	Prolia
Raldesy	trazodone HCl	NF	trazodone 50 mg tablets, trazodone 100 mg tablets, trazodone 150 mg tablets
Romvimza	vimseltinib	NF	Prescriber Discretion
Stoboclo	denosumab-bmwo	NF	Prolia
Symbravo	meloxicam and rizatriptan	NF	rizatriptan, meloxicam tablet, sumatriptan succinate tablet
Xbryk	denosumab-dssb	NF	Prescriber Discretion

Formulary options: **Tier 1:** Generic drugs; **Tier 2:** Generic and Brand drugs; **Tier 3:** Generic and Brand drugs; **Tier 4:** Generic and Brand drugs; **Non-formulary (NF).**

\*Effective date to be determined.

**Table 2. Products to Be Removed or Shifted to Higher Tier – Effective July 2025**

Brand Name	Generic Name	Preferred Alternatives
<b>All Healthcare Reform Essential Products</b>		
Cipro HC Otic suspension	ciprofloxacin/hydrocortisone	ciproflox-dexameth Otic susp
Clemastine fum 2.68 mg tablet	clemastine fumarate	hydroxyzine HCl tablet
Doxepin 5% cream	doxepin hcl	triamcinolone cream, tacrolimus ointment
Meperidine 50 mg tablet	meperidine hcl	oxycodone HCl (IR) 5 mg tablet
Mesnex 400 mg tablet	mesna	mesna 400 mg tablet
Tretinoin 0.025% gel	tretinoin	tretinoin 0.025% cream

### **C. Changes to the Highmark Core Formulary**

The Core Formulary is a closed formulary for select Commercial Individual plans. A list of drugs included on the Core Formulary, listed by therapeutic class, is available [here](#).

#### **Table 1. Formulary Updates**

All formulary changes effective April 2025 unless otherwise noted.

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
<b>Items listed below were added to the formulary</b>			
Penmenvy	Meningococcal Groups A, B, C, W, and Y Vaccine	3	Active immunization to prevent invasive disease caused by Neisseria meningitidis serogroups A, B, C, W, and Y in individuals 10 through 25 years of age.
Vimkunya	chikungunya vaccine, recombinant	3	Prevention of disease caused by chikungunya virus in individuals 12 years of age and older.
<b>Items listed below were not added to the formulary</b>			
Avtozma	tocilizumab-anoh	NF	ACTEMRA SYRINGE (ML), ACTEMRA ACTPEN
Brynovin	sitagliptin	NF	Januvia tablets, Tradjenta tablets
Ctexli	chenodiol	NF	Prescriber Discretion
Evrysdi	risdiplam	NF	Prescriber Discretion
Fulvicin P/G 165 mg	griseofulvin ultramicrosize	NF	griseofulvin microsize tablet 500 mg, griseofulvin ultramicrosize tablet 125 mg, griseofulvin ultramicrosize tablet 250 mg
Gabarone	gabapentin	NF	gabapentin capsule, gabapentin tablet
Gomekli	mirdametinib	NF	Prescriber Discretion
Inzirqo	hydrochlorothiazide	NF	hydrochlorothiazide tablets, hydrochlorothiazide capsules
Journavx	suzetrigine	NF	ibuprofen tablets , naproxen tablets
Merilog / Merilog Solostar	insulin aspart-szjj	NF	Novolog

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
Metaxalone 640 mg	Metaxalone	NF	cyclobenzaprine 5 mg tabs, cyclobenzaprine 10 mg tabs, methocarbamol 500 mg tabs
Metformin 750 mg	metformin	NF	metformin oral tablet 500 mg, metformin oral tablet 850 mg, metformin oral tablet 1000 mg
Miudella	copper intrauterine system	NF	Paragard T 380-A; Mirena
Omlyclo	omalizumab-igec	NF	Xolair auto-injector, Xolair syringe
Onapgo	apomorphine hydrochloride	NF	carbidopa-levodopa tablets, ropinirole tablets, pramipexole tablets
Osenvelt	denosumab-bmwo	NF	Prescriber Discretion
Ospomyv	denosumab-dssb	NF	Prolia
Raldesy	trazodone HCl	NF	trazodone 50 mg tablets, trazodone 100 mg tablets, trazodone 150 mg tablets
Romvimza	vimseltinib	NF	Prescriber Discretion
Stoboclo	denosumab-bmwo	NF	Prolia
Symbravo	meloxicam and rizatriptan	NF	rizatriptan, meloxicam tablet, sumatriptan succinate tablet
Xbryk	denosumab-dssb	NF	Prescriber Discretion

Formulary options: **Tier 1:** Generic drugs; **Tier 2:** Generic and Brand drugs; **Tier 3:** Generic and Brand drugs; **Tier 4:** Generic and Brand drugs; **Non-formulary (NF).**

\*Effective date to be determined.

**Table 2. Products to Be Removed or Shifted to Higher Tier – Effective July 2025**

Brand Name	Generic Name	Preferred Alternatives
<b>All Core Products</b>		
Clemastine Fum 2.68 mg tablet	clemastine fumarate	hydroxyzine HCl tablet
Doxepin 5% cream	doxepin HCl	triamcinolone cream, tacrolimus ointment
Meperidine 50 mg tablet	meperidine HCl	oxycodone HCl (IR) 5 mg tablet
Mesnex 400 mg tablet	mesna	mesna 400 mg tablet
Prudoxin 5% cream	doxepin HCl	triamcinolone cream, tacrolimus ointment
Tretinoin 0.025% gel	tretinoin	tretinoin 0.025% cream

#### **D. Changes to the Highmark National Select Formulary**

The National Select Formulary is an incentive formulary with a non-formulary drug list to manage products in therapeutic categories for which preferred alternatives are available. The National Select Formulary is available for select Commercial self-funded (ASO) plans. A list of drugs included on the National Select Formulary, listed by therapeutic class, is available [here](#).

**Table 1. Formulary Updates**

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
<b>Items listed below were added to the formulary (Preferred)</b>			
Neffy	epinephrine	2	Emergency treatment of type I allergic reactions, including anaphylaxis, in adult and pediatric patients aged 4 years and older who weigh 15 kg or greater.
Vimkunya	chikungunya vaccine, recombinant	2	
Ctexli	chenodiol	2	
<b>Items listed below were added to the formulary (Non-Preferred)</b>			
Gomekli	mirdametinib	3	Prescriber Discretion
Inzirqo	hydrochlorothiazide	3*	hydrochlorothiazide tablets, hydrochlorothiazide capsules
Journavx	suzetrigine	3*	ibuprofen tablets (+Rx), naproxen tablets
Onapgo	apomorphine hydrochloride	3*	carbidopa-levodopa tablets, ropinirole tablets, pramipexole tablets
Romvimza	vimseltinib	3*	Prescriber Discretion
Evrysdi	risdiplam	3	Prescriber Discretion
Avtozma	tocilizumab-anoh	3*	Actemra syringe (mL), Actemra Actpen
Brynovin	sitagliptin	3*	Januvia tablets
Merilog / Merilog Solostar	insulin aspart-szjj	3*	Novolog
Miudella	copper intrauterine system	3*	Paragard T 380-A; Mirena
Omlyclo	omalizumab-igec	3*	Xolair
Osenvelt	denosumab-bmwo	3*	Prescriber Discretion
Ospomyv	denosumab-dssb	3*	alendronate sodium tablet, risedronate sodium tablet 5 mg, risedronate sodium tablet 150 mg
Penmenvy	Meningococcal Groups A, B, C, W, and Y Vaccine	3*	
Stoboclo	denosumab-bmwo	3*	alendronate sodium tablet, risedronate sodium tablet 5 mg, risedronate sodium tablet 150 mg
Symbravo	meloxicam and rizatriptan	3*	rizatriptan, meloxicam tablet, sumatriptan succinate tablet

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
Xbryk	denosumab-dssb	3*	Prescriber Discretion
<b>Items listed below were not added to the formulary</b>			
Fulvicin P/G 165 mg	griseofulvin ultramicrosize	NF	griseofulvin microsize tablet 500 mg, griseofulvin ultramicrosize tablet 125 mg, griseofulvin ultramicrosize tablet 250 mg
Gabarone	gabapentin	NF	gabapentin capsule, gabapentin tablet
Metformin 750 mg	metformin	NF	metformin oral tablet 500 mg, metformin oral tablet 850 mg, metformin oral tablet 1000 mg
Metaxalone 640 mg	metaxalone	NF	cyclobenzaprine 5 mg tabs, cyclobenzaprine 10 mg tabs, methocarbamol 500 mg tabs
Raldesy	trazodone HCl	NF	trazodone 50 mg tablets, trazodone 100 mg tablets, trazodone 150 mg tablets

Formulary options: **Tier 1:** Generic drugs; **Tier 2:** Preferred Brand drugs; **Tier 3:** Non-Preferred Brand drugs; **Non-formulary (NF).**

\*Effective date and final formulary position to be determined.

### Table 2. Additions to the Specialty Tier Copay Option

Effective upon completion of internal review and implementation.

Brand Name	Generic Name
Avtozma	tocilizumab-anoh
Ctexli	chenodiol
Evrysdi	risdiplam
Fulvicin P/G	griseofulvin ultramicrosize
Gabarone	gabapentin
Gomekli	mirdametinib
Metaxalone 640 mg	metaxalone
Metformin 750 mg	metformin
Omlyclo	omalizumab-igec
Onapgo	apomorphine hydrochloride
Osenvelt	denosumab-bmwo
Ospomyv	denosumab-dssb
Raldesy	trazodone HCl
Romvimza	vimseltinib
Stoboclo	denosumab-bmwo
Xbryk	denosumab-dssb

### Table 3. Products to Be Removed or Shifted to Higher Tier – Effective July 2025

Brand Name	Generic Name	Preferred Alternatives
<b>All National Select Products</b>		
Apexicon e 0.05% cream	diflorasone diacet/emollient	triamcinolone, betamethasone dipropionate

Caplyta 10.5 mg capsule	lumateperone tosylate	aripiprazole, quetiapine
Caplyta 21 mg capsule	lumateperone tosylate	aripiprazole, quetiapine
Caplyta 42 mg capsule	lumateperone tosylate	aripiprazole, quetiapine
Clemastine 0.5 mg/5 ml syrup	clemastine fumarate	hydroxyzine hcl syrup, cetirizine solution
Clemastine Fum 2.68 mg tablet	clemastine fumarate	hydroxyzine hcl tablet
Clocortolone Pivalate 0.1% crm	clocortolone pivalate	triamcinolone, mometasone furoate
Dexlansoprazole dr 30 mg cap	dexlansoprazole	omeprazole, pantoprazole
Dexlansoprazole dr 60 mg cap	dexlansoprazole	omeprazole, pantoprazole
Diflorasone 0.05% cream	diflorasone diacetate	triamcinolone, betamethasone dipropionate
Diflorasone 0.05% ointment	diflorasone diacetate	clobetasol 0.05% ointment, betamethasone dp aug 0.05% oin
Doxepin 5% cream	doxepin hcl	triamcinolone cream, tacrolimus ointment
Eylea 2 mg/0.05 ml syringe	aflibercept	Pavblu
Eylea 2 mg/0.05 ml vial	aflibercept	Pavblu
Flurandrenolide 0.05% cream	flurandrenolide	triamcinolone, mometasone furoate
Flurandrenolide 0.05% lotion	flurandrenolide	triamcinolone, mometasone furoate
Flurandrenolide 0.05% ointment	flurandrenolide	triamcinolone, mometasone furoate
Halcinonide 0.1% cream	halcinonide	triamcinolone, betamethasone dipropionate
Halcinonide 0.1% solution	halcinonide	triamcinolone, betamethasone dipropionate
Ibuprofen-famotidine 800-26.6mg	ibuprofen/famotidine	ibuprofen, famotidine
Levorphanol 2 mg tablet	levorphanol tartrate	morphine sulfate er
Levorphanol 3 mg tablet	levorphanol tartrate	morphine sulfate er
Livalo 1 mg tablet	pitavastatin calcium	pitavastatin calcium
Livalo 2 mg tablet	pitavastatin calcium	pitavastatin calcium
Livalo 4 mg tablet	pitavastatin calcium	pitavastatin calcium
Naproxen-esomeprazole dr 375-20mg	naproxen/esomeprazole mag	naproxen, esomeprazole
Naproxen-esomeprazole dr 500-20mg	naproxen/esomeprazole mag	naproxen, esomeprazole
Nolix 0.05% cream	flurandrenolide	triamcinolone, mometasone furoate
Nolix 0.05% lotion	flurandrenolide	triamcinolone, mometasone furoate
Novarel 5,000-unit vial	chorionic gonadotropin, human	Ovidrel, Pregnyl

Ponvory 14-day starter pack	ponesimod	dimethyl fumarate, fingolimod
Ponvory 20 mg tablet	ponesimod	dimethyl fumarate, fingolimod
Prudoxin 5% cream	doxepin hcl	triamcinolone cream, tacrolimus ointment
Sprycel 100 mg tablet	dasatinib	dasatinib
Sprycel 140 mg tablet	dasatinib	dasatinib
Sprycel 20 mg tablet	dasatinib	dasatinib
Sprycel 50 mg tablet	dasatinib	dasatinib
Sprycel 70 mg tablet	dasatinib	dasatinib
Sprycel 80 mg tablet	dasatinib	dasatinib
Sumatriptan-naproxen 85-500 mg	sumatriptan succ/naproxen sod	sumatriptan succinate, naproxen
Taclonex 0.005%-0.064% suspens	calcipotriene/betamethasone	calcipotriene-betamethasone
Taclonex ointment	calcipotriene/betamethasone	calcipotriene-betamethasone
Terumo ins syringe u100-1 ml	syringe and needle,insulin,1ml	B-D insulin syringe
Thinpro ins syrin u100-0.3 ml	syringe-needle,disp,insul,0.3 ml	B-D insulin syringe
Thinpro ins syrin u100-0.5 ml	syringe-needle,insulin,0.5 ml	B-D insulin syringe
Thinpro ins syrin u100-1 ml	syringe and needle,insulin,1ml	B-D insulin syringe
Tykerb 250 mg tablet	lapatinib ditosylate	lapatinib
Ulticare ins 0.3 ml 30gx1/2	syringe-needle,disp,insul,0.3 ml	B-D insulin syringe
Ulticare ins 0.5 ml 30gx1/2	syringe-needle,insulin,0.5 ml	B-D insulin syringe
Ulticare ins syr 1 ml 30gx1/2	syringe and needle,insulin,1ml	B-D insulin syringe
Victoza 2-pak 18 mg/3 ml pen	liraglutide	liraglutide
Victoza 3-pak 18 mg/3 ml pen	liraglutide	liraglutide
Zileuton er 600 mg tablet	zileuton	montelukast, zafirlukast
Zyflo 600 mg tablet	zileuton	montelukast, zafirlukast

## **E. Updates to the Pharmacy Utilization Management Programs**

### **1. Prior Authorization Program**

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Anti-Obesity – Administrative Services Only (ASO) Commercial	04/25/2025	Policy revised for maintenance of all targets to require the same amount of weight loss specified in initiation or continuation criteria.
Anti-Obesity – Commercial and Healthcare Reform	04/25/2025	Policy revised for maintenance of all targets to require the same of same of weight loss specified in initiation or continuation criteria.
Anti-Obesity – Fully Insured Commercial and Healthcare Reform	04/25/2025	Policy revised for Zepbound (tirzepatide) for Delaware commercial fullyinsured or healthcare reform plans without the obesity benefit obstructive sleep apnea to require sleep specialist and to allow for custom, titratable, oral appliance (OA) use if the member has experienced therapeutic failure, intolerance, or contraindication to positive airway pressure (PAP), the OA is prescribed by a sleep specialist, and the prescriber documents the member has been adherent to the OA.
Apokyn (apomorphine hydrochloride) – Commercial and Healthcare Reform	04/25/2025	Policy revised for Apokyn (apomorphine) to require the member has a diagnosis of Parkinson's disease classified as advanced.
Apomorphine Products – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy updated to include Onapgo (apomorphine hydrochloride) injection to require FDA approved indication, the member is using Onapgo (apomorphine) for the treatment of motor fluctuations in adults, the member is experiencing motor fluctuations despite an optimally dosed oral carbidopa/levodopa regimen. The member has experienced therapeutic failure, intolerance, or contraindication to both generic products: pramipexole and ropinirole, and the member has experienced therapeutic failure, intolerance, or contraindication to one of the following generic products: entacapone, rasagiline, or selegiline. The member has experienced therapeutic failure or intolerance to generic apomorphine hydrochloride injection. For reauthorization, the prescriber attests that the member has experienced positive clinical response to therapy. Policy also

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		updated for Apokyn (apomorphine) to require the member has a diagnosis of Parkinson's disease classified as advanced.
BRAF Mutation-Targeting & MEK1/2 Kinase Inhibitors – Commercial and Healthcare Reform	04/25/2025	Policy revised for Mekinist (trametinib) and Tafinlar (dabrafenib) to include revised FDA-approved indication for treatment of patients with locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation, as detected by an FDA-approved test, the member has no satisfactory locoregional treatment options and that Mekinist and Tafinlar are used in combination for melanoma, non-small cell lung cancer (NSCLC), thyroid cancer, solid tumors and low-grade glioma. For low-grade glioma policy revised to include age of at least 1 year of age to 17 years of age. For Braftovi (encorafenib) and Mektovi (binimetinib) policy revised to include criteria for use in combination for both melanoma and NSCLC. For Cotellic (cobimetinib) and Zelboraf (vemurafenib), policy revised to include criteria for use in combination for melanoma. Policy updated to include Gomekli (mirdametinib) as a target requiring diagnosis of FDA-approved indication.
Branded Hydroxyurea Products – Commercial and Healthcare Reform	04/25/2025	Policy revised for Xromi (hydroxyurea) to update age criteria to 6 months to 17 years of age for initial criteria and 17 years of age or less for reauthorization
BTK Inhibitors – Commercial and Healthcare Reform	04/25/2025	Policy revised for Calquence (acalabrutinib) to include new indication of the member has not received prior therapy for mantle cell lymphoma (MCL), the member is ineligible for autologous hematopoietic stem cell transplantation (HSCT), and is using in combination with bendamustine and rituximab.
Chenodiol Products – Commercial and Healthcare Reform	04/25/2025	Policy revised to add newly FDA-approved product, Ctexli (chenodiol). Chenodal (chenodiol) will no longer be approved for orphan drug designation for the treatment of cerebrotendinous xanthomatosis (CTX). Approval for coverage of Ctexli requires

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		that the member is 18 years of age or older, the prescriber is a specialist who focuses on the treatment of CTX, or the prescriber is acting in consultation with a specialist who focuses on the treatment of CTX, and the member has a diagnosis of CTX confirmed with generic testing (ICD-10: E75.5). Reauthorization requires attestation of improvement in one of the following: normalization of elevated serum or urine 23S-pentol (bile alcohols), normalization of elevated serum cholestanol levels, or improvement in neurologic and psychiatric symptoms.
Chronic Inflammatory Diseases – Commercial and Healthcare Reform	03/24/2025	Policy revised to update Bimzelx (bimekizumab-bkzx) from a double step to a single step through a preferred product.
Chronic Inflammatory Diseases – Commercial and Healthcare Reform	04/25/2025	Policy revised for Omvoh (mirikizumab-mrkz) SC and Tremfya (guselkumab) SC to add new indication Crohn's disease (CD) to require diagnosis and age based on FDA approved indication, prescribed in consultation with a gastroenterologist. Omvoh for CD requires either received or currently undergoing IV induction therapy, and therapeutic failure or intolerance to at least two step 1 or 2 agents for CD. Tremfya for CD requires received or currently undergoing IV induction therapy or using Tremfya SC for induction dosing, and for UC and CD documentation that prescribed Tremfya SC maintenance dose is the lowest effective recommended dosage to maintain therapeutic response. Criteria revised for Velsipity (etrasimod) and Zeposia (ozanimod) to remove the requirement to step through one systemic therapy.
Chronic Inflammatory Diseases – Commercial National Select Formulary	03/24/2025	Policy revised to update Bimzelx (bimekizumab-bkzx) from a double step to a single step through a preferred product.
Chronic Inflammatory Diseases – Commercial National Select Formulary	04/25/2025	Policy revised for Omvoh (mirikizumab-mrkz) SC and Tremfya (guselkumab) SC to add new indication Crohn's disease (CD) to require diagnosis and age based

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		<p>on FDA approved indication, prescribed in consultation with a gastroenterologist. Omvoh for CD requires received or currently undergoing IV induction therapy. Tremfya for CD requires received or currently undergoing IV induction therapy or using Tremfya SC for induction dosing, and for UC and CD documentation that prescribed Tremfya SC maintenance dose is the lowest effective recommended dosage to maintain therapeutic response. Criteria revised for Velsipity (etrasimod) and Zeposia (ozanimod) to remove the requirement to step through one systemic therapy.</p>
<p>CSF1R Tyrosine Kinase Inhibitors – Commercial and Healthcare Reform</p>	<p>04/25/2025</p>	<p>Policy revised to add Romvimza (vimseltinib) requiring diagnosis based on age and FDA-approved indication.</p>
<p>Cystic Fibrosis Inhaled Medications – Commercial and Healthcare Reform</p>	<p>04/25/2025</p>	<p>Policy updated to include additional examples of standard cystic fibrosis therapies for Bronchitol (mannitol inhalation powder) and Pulmozyme (dornase alfa) of hypertonic saline, cystic fibrosis transmembrane conductance regulator modulators, and pancreatic enzymes.</p>
<p>Denosumab Products for Bone Disease and Evenity (romosozumab-aqqg) – Commercial and Healthcare Reform</p>	<p>Effective upon completion of internal review and implementation.</p>	<p>Policy revised to add Ospomyv (denosumab-dssb) and Stoboclo (denosumab-bmwo) to require diagnosis based on FDA-approved indication. If use is for osteoporosis or osteopenia (including glucocorticoid-induced osteoporosis) it is supported by lab values such as T-score or FRAX calculator, trial/failure to one bisphosphonate or all are contraindicated, and is not using product with other injectable osteoporosis medications. Jubbonti (denosumab-bbdz), Ospomyv, and Stoboclo require trial and failure of Prolia (denosumab).</p>
<p>Denosumab Products for Oncology – Commercial and Healthcare Reform</p>	<p>Effective upon completion of internal review and implementation.</p>	<p>New policy for Xgeva (denosumab), Wyost (denosumab-bbdz), Xbryk (denosumab-dssb), and Osenvelt (denosumab-bmwo), to require diagnosis and age based on FDA-approved indication. For Xgeva (denosumab), therapeutic failure or</p>

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		intolerance to Wyost (denosumab-bbdz), Xbryk (denosumab-dssb), and Osenvelt (denosumab-bmwo). Reauthorization to require attestation that the member has demonstrated disease stability or a beneficial response to therapy.
Dupixent (dupilumab) – Commercial and Healthcare Reform	04/25/2025	Policy revised for Dupixent (dupilumab) in prurigo nodularis to add the member has greater than or equal to 10 identifiable lesions.
Dupixent (dupilumab) – Commercial and Healthcare Reform	02/27/2025	Policy revised for Dupixent (dupilumab) the diagnosis of COPD for a patient to either have an eosinophilic count of $\geq 300$ cells/mcL or the member is currently taking daily or alternate-day oral corticosteroids.
Empaveli (pegcetacoplan) and Fabhalta (iptacopan) – Commercial and Healthcare Reform	04/25/2025	Policy revised to add a new FDA-approved indication for Fabhalta: Complement 3 Glomerulopathy (C3G). Members must be 18 years of age or older, have a diagnosis of C3G confirmed by biopsy, experiencing all of the following: urine protein-to-creatinine ration (UPCR) $\geq 30$ mL/min per $1.72 \text{ m}^2$ , also member must be maximally recommended dose of an angiotensin converting enzyme (ACE) inhibitor or an angiotensin receptor blocker (ARB). Reauthorization requires a reduction in the UPCR from baseline.
Entresto Sprinkle (sacubitril/valsartan) – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised to require step through generic sacubitril-valsartan tablets or inability to swallow for patients at least 40 kg but less than 50 kg.
Evrysdi (risdiplam) – Commercial and Healthcare Reform	04/25/2025	Policy revised to clarify quantity limit exception only applies to Evrysdi (risdiplam) oral solution.
Fertility – Commercial and Healthcare Reform – New York	04/25/2025	Policy revised to clarify authorization duration for fertility preservation is 6 months.
Furoscix (furosemide) – Commercial and Healthcare Reform	04/25/2025	Policy revised for Furoscix (furosemide) to require FDA-approved diagnosis. Criteria requiring congestion or fluid overload updated to require edema.
Gabarone (gabapentin) – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	New policy for Gabarone (gabapentin) requiring FDA approved diagnosis and therapeutic failure, intolerance, or contraindication to generic gabapentin.

<b>Policy Name*</b>	<b>Policy Effective Date**</b>	<b>Updates and/or Approval Criteria</b>
Hedgehog Pathway Inhibitors – Commercial and Healthcare Reform	04/25/2025	Policy revised for Daurismo (glasdegib) to require age based on FDA-approved indication. Authorization duration updated to 12 months.
Hereditary Angioedema – Commercial and Healthcare Reform	04/25/2025	Policy revised to add the additional mutations of angiotensin-converting enzyme 1, plasminogen, kininogen-1, myoferlin and heparin sulfate-glucosamine 3-O-sulfotransferase 6 to support the diagnosis of hereditary angioedema with normal C1 inhibitor.
Horizant (gabapentin enacarbil) – Commercial and Healthcare Reform	04/25/2025	Policy revised for Horizant (gabapentin enacarbil) to require attestation of addressed exacerbating factors for restless leg syndrome (RLS), documentation of iron levels, and failure or intolerance to both generic gabapentin immediate-release and generic pregabalin.
Human Growth Hormone – Commercial and Healthcare Reform	04/25/2025	Policy revised for growth hormone products for treatment of burns to require positive clinical response to therapy for reauthorization. For Serostim (somatropin), reauthorization revised to require that the member has experienced and maintained an increase in weight from the start of therapy.
Human Growth Hormone – Delaware Commercial and Healthcare Reform	04/25/2025	Policy revised for growth hormone products for treatment of burns to require positive clinical response to therapy for reauthorization. For Serostim (somatropin), reauthorization revised to require that the member has experienced and maintained an increase in weight from the start of therapy.
Imcivree (setmelanotide) – Commercial and Healthcare Reform	04/25/2025	Policy revised for Imcivree (setmelanotide) to require FDA-approved age. For members 2 to less than 6 years of age, requiring baseline weight $\geq$ 97th percentile and $\geq$ 20 kg.
Interferons – Commercial and Healthcare Reform	04/25/2025	Policy revised to remove discontinued medication, Intron A (interferon alfa-2b) and to remove Pegasys (peginterferon alpha-2A) criteria for non-FDA approved indication of polycythemia vera.
Jornavx (suzetrigine) – Commercial and Healthcare Reform	03/24/2025	Policy created for Jornavx (suzetrigine) to require that the member be 18 years of age or older, member has a diagnosis of

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		<p>moderate-to-severe acute pain, prescriber attests that the episode of acute pain is anticipated to last less than one (1) month, and the prescriber attests that the treatment of pain is not amenable to conservative measures such as acetaminophen, NSAIDs, and non-pharmacologic measures. For reauthorization, the prescriber attests that the member is experiencing a new episode of moderate-to-severe acute, separate and distinct from the previous episode, the prescriber attests that the new episode of acute pain is anticipated to last less than one (1) month, and the prescriber attests that the treatment of the new episode of acute pain is not amenable to conservative measures.</p>
<p>KRAS G12C Inhibitors – Commercial and Healthcare Reform</p>	<p>04/25/2025</p>	<p>Policy revised for Lumakras (sotorasib) to include revised FDA-approved indication for treatment of patients with non-small cell lung cancer (NSCLC) to require Lumakras to be used as a single agent and to include new FDA-approved indication for treatment of Kirsten rat sarcoma viral oncogene homolog (KRAS) G12C-mutated metastatic colorectal cancer (mCRC) to require diagnosis determined by an FDA approved test and age based on FDA approved indication, used in combination with panitumumab, and has received prior fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy.</p>
<p>Market Watch Programs – Delaware</p>	<p>Effective upon completion of internal review and implementation.</p>	<p>Policy revised to add Gabarone (gabapentin) and Gralise (gabapentin extended release) to high cost, low value table with the alternative of gabapentin immediate release. Metronidazole 125 mg also added with the alternative of metronidazole 250 mg. Minocycline immediate release (IR) tablets also added with the alternative of minocycline IR capsules. Fulvicin P/G 165 mg and Griseofulvin ultramicrosize 165 mg added with alternatives of griseofulvin microsize 500 mg tablets, griseofulvin ultramicrosize</p>

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		125 mg and 250 mg. Symbravo (rizatriptan/meloxicam) added with alternatives of rizatriptan with meloxicam, sumatriptan with meloxicam, and zolmitriptan with meloxicam. Add Metaxalone 640 mg to high cost, low value table with the alternative of baclofen, cyclobenzaprine HCl, or methocarbamol 500 mg or 750 mg. Fenopron (fenoprofen) added with alternatives of ibuprofen, meloxicam, naproxen.
Market Watch Programs – New York, Pennsylvania and West Virginia	Effective upon completion of internal review and implementation.	Policy revised to add Gabarone (gabapentin) and Gralise (gabapentin extended release) to high cost, low value table with the alternative of gabapentin immediate release. Metronidazole 125 mg also added with the alternative of metronidazole 250 mg. Minocycline immediate release (IR) tablets also added with the alternative of minocycline IR capsules. Fulvicin P/G 165 mg and Griseofulvin ultramicrosize 165 mg added with alternatives of griseofulvin microsize 500 mg tablets, griseofulvin ultramicrosize 125 mg and 250 mg. Symbravo (rizatriptan/meloxicam) added with alternatives of rizatriptan with meloxicam, sumatriptan with meloxicam, and zolmitriptan with meloxicam. Add Metaxalone 640 mg to high cost, low value table with the alternative of baclofen, cyclobenzaprine HCl, or methocarbamol 500 mg or 750 mg. Fenopron (fenoprofen) added with alternatives of ibuprofen, meloxicam, naproxen.
Non-Preferred Metronidazole Formulations – Commercial and Healthcare Reform	04/25/2025	Policy updated to include metronidazole 125 mg tablets to require an appropriate diagnosis and age based on FDA-approved indications and has experienced failure/intolerance to plan-preferred, generic metronidazole tablets (not including metronidazole 125 mg tablets). Reauthorization requiring documentation of repeat episode of infection, a minimum 4 week gap if repeat course is for trichomoniasis infection and

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		failure/intolerance to plan-preferred, generic metronidazole tablets (not including metronidazole 125 mg tablets).
Opzelura (ruxolitinib) – Commercial and Healthcare Reform	04/25/2025	Policy revised for Opzelura (ruxolitinib) to remove step through topical corticosteroid.
Pizensy (lactitol) – Commercial and Healthcare Reform	TERMED 04/18/2025	Policy terminated
Pretomanid – Commercial and Healthcare Reform	04/25/2025	Reauthorization criteria updated to the member has experienced positive clinical response to therapy and requires additional antimicrobial therapy. The authorization duration was also updated to 12 months.
Prevymis (letermovir) Oral Pellets – Commercial and Healthcare Reform	04/25/2025	Policy revised to remove therapeutic failure or intolerance to Prevymis (letermovir) tablets. In addition to previously established criteria, member must be unable to swallow tablets or unable to use Prevymis tablets due to body weight dosing limitations.
Product Shortages Exceptions – Commercial and Healthcare Reform	03/24/2025	Policy revised for language of drug to be updated to product.
Provigil (modafinil) and Nuvigil (armodafinil) – Commercial and Healthcare Reform	04/25/2025	Policy revised for Provigil (modafinil) and Nuvigil (armodafinil) to add criteria for use of a custom, titratable oral appliance if the member experienced therapeutic failure, intolerance, or contraindication to positive airway pressure.
Repository Corticotropin Injection – Commercial and Healthcare Reform	04/25/2025	Policy revised to add Purified Cortrophin Gel (repository corticotropin injection) prefilled syringes, matching existing criteria for vials.
Rezdiffra (resmetirom) – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised for Rezdiffra (resmetirom) to require documentation throughout policy, change liver biopsy requirement from within 6 months to 3 years, require one cardiometabolic risk factor (BMI $\geq 25$ kg/m <sup>2</sup> or $\geq 23$ kg/m <sup>2</sup> for asian ethnicity or for males, waist circumference $\geq 94$ cm (European), $\geq 90$ cm (South Asian and Chinese), or $\geq 85$ cm (Japanese) or for females, $\geq 80$ cm (European, South Asian,

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		<p>or Chinese) or <math>\geq 90</math> cm (Japanese), fasting serum glucose <math>\geq 100</math> mg/dL, 2-hour post-prandial serum glucose <math>\geq 140</math> mg/dL, HbA1c <math>\geq 5.7\%</math>, diagnosis of type 2 diabetes or is on treatment for type 2 diabetes, plasma triglycerides <math>\geq 150</math> mg/dL or is on lipid lowering treatment, plasma HDL <math>\leq 40</math> mg/dL (males) or <math>\leq 50</math> mg/dL (female) or is on lipid lowering treatment, or blood pressure <math>\geq 130/85</math> mmHg or is on treatment for hypertension), and require alcohol consumption <math>\leq 20</math> grams/day for females or <math>\leq 30</math> grams/day for males for initial and reauthorization, addition to reauthorization requirements of prescribed by or in consultation with gastroenterologist or hepatologist and member does not have cirrhosis, hepatic decompensation, or hepatocellular carcinoma.</p>
Sublingual Immunotherapies – Commercial and Healthcare Reform	04/25/2025	Policy revised for Odactra (House Dust Mite Allergen Extract) to update age to 5 through 65 years.
Sunosi (solriamfetol) – Commercial and Healthcare Reform	04/25/2025	Policy revised to add criteria for use of a custom, titratable oral appliance if the member experienced therapeutic failure, intolerance, or contraindication to positive airway pressure.
Testosterone (Androgens) – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised to separate out initial testosterone criteria for hypogonadism in males new to testosterone therapy or established on testosterone therapy, and criteria for reauthorization for testosterone therapy includes subsequent requests; established on testosterone therapy. The criteria for initial request; established on testosterone therapy includes the member is male, diagnosis of hypogonadism, meets one of the following criteria: primary or secondary hypogonadism with testicular failure due to one of the following: bilateral torsions, chemotherapy damage, cryptorchidism, Klinefelter's syndrome, orchitis, radiation damage, single orchidectomy, surgery damage, toxic

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		<p>damage, or vanishing testis syndrome, primary or secondary hypogonadism in males with symptoms of low testosterone, diagnosis of secondary hypogonadism due to hypopituitarism, weight loss due to HIV-infection, or chronic steroid treatment, and has documented low testosterone levels supported by one of the following: at least two documented low total testosterone levels or attestation the member is not producing testosterone or the provider attests the member's pre-treatment medical records are not available and the provider attests the member had at least one low pretreatment serum testosterone level, and the provider submits documentation of a testosterone level within the past 12 months and meets one of the following: member's testosterone level is within normal limit or member's testosterone level is out of normal limit and the provider attests the dosage is being adjusted, and if the request is for brand Methitest, the member has experienced trial and failure of plan-preferred, generic methyltestosterone capsules, and if the request is for brand Androgel 1%, Androgel 1.62%. Fortesta, Testim, Vogelxo, Natesto, Jatenzo, Kyzatrex, Tlando, Undecatrex, or Xyosted the member has tried and failed plan-preferred, generic testosterone topical product.</p>
<p>Tocilizumab Biosimilars – Commercial and Healthcare Reform</p>	<p>Effective upon completion of internal review and implementation.</p>	<p>Policy revised to add new biosimilar Avtozma (tocilizumab-anoh) requiring age and diagnosis based on FDA-approved indication and therapeutic failure or intolerance to Actemra (tocilizumab). For rheumatoid arthritis, the member has experienced therapeutic failure or intolerance to: 1) one (1) non-biologic disease modifying anti-rheumatic drug (DMARD) or all non-biologic DMARDs are contraindicated and 2) a plan-preferred adalimumab product. For giant cell arteritis, the member has experienced</p>

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		therapeutic failure or intolerance to one (1) systemic corticosteroid, or all corticosteroids are contraindicated. For polyarticular juvenile idiopathic arthritis, the member has experienced therapeutic failure or intolerance to a plan-preferred adalimumab product and meets one (1) of the following: 1) the member has experienced therapeutic failure or intolerance to one (1) non-biologic DMARD or all non-biologic DMARDs are contraindicated or 2) the member requires initial biologic therapy due to involvement of high-risk joints, high disease activity, and/or those judged to be at high-risk of disabling joint damage. For reauthorization, attestation of disease stability or beneficial response to therapy. Quantity limitation criteria added based on FDA-approved dosing.
Transthyretin Amyloid Cardiomyopathy (ATTR-CM) TTR Stabilizers – Commercial and Healthcare Reform	04/25/2025	Policy revised for all targets requiring documentation of cardiac involvement supported by cardiac magnetic resonance, echocardiography, or serum cardiac biomarkers. For all targets, initial and reauthorization criteria revised to require that the member is not simultaneously utilizing transthyretin-lowering agents other than the requested drug.
Valsartan oral solution – Commercial and Healthcare Reform	TERMED 04/18/2025	Policy terminated (added into J-0395).
Venclexta (venetoclax) – Commercial and Healthcare Reform	04/25/2025	Policy revised for Venclexta (venetoclax) to update authorization duration to 12 months.
Voquezna (vonoprazan) Products – Commercial and Healthcare Reform	02/27/2025	Policy revised for Voquezna (vonoprazan) in Non-Erosive Gastroesophageal Reflux Disease (NERD) to clarify in reauthorization that total treatment duration with Voquezna will not exceed 24 weeks in the past 365 days.
Zytiga and Yonsa (abiraterone acetate) – Commercial and Healthcare Reform	04/25/2025	Policy revised for Zytiga (abiraterone) and Yonsa (abiraterone) to require use in combination with a gonadotropin-releasing hormone analog or the member has had a bilateral orchiectomy. Authorization

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		duration updated to 12 months. Policy revised to add Abirtega (abiraterone acetate) as a target requiring FDA-approved diagnosis and use in combination with a gonadotropin-releasing hormone analog or the member has had a bilateral orchiectomy. For initial and reauthorization, if the request is for Yonsa (abiraterone acetate micronized), brand Zytiga (abiraterone acetate), or abiraterone acetate 500 mg, the member has experienced therapeutic failure or intolerance to generic abiraterone acetate 250 mg or Abirtega (abiraterone acetate).

\*For Commercial and Healthcare Reform policies, an exception to some or all the criteria above may be granted for select members and/or circumstances based on state and/or federal regulations.

\*\*All effective dates are tentative and subject to delay pending internal review or approval.

## 2. Managed Prescription Drug Coverage (MRxC) Program

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
Acute Migraine Therapies - Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised to add Symbravo (rizatriptan/meloxicam) requiring FDA approved diagnosis and therapeutic failure, intolerance, or contraindication to generic sumatriptan with meloxicam, generic rizatriptan with meloxicam, and generic zolmitriptan with meloxicam. Also added limitation of coverage that additional quantities of Symbravo more than 9 tablets per 30 days will not be approved.
Additional Antibiotic Quantities – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy updated for Zyvox (linezolid) to revise the criteria to the member has a diagnosis of an infection where linezolid use is supported by clinical literature or guidelines (for example, infective endocarditis, meningitis, osteomyelitis, tuberculosis, etc.). Reauthorization criteria was added for the member who has experienced positive clinical response to therapy and who requires additional antimicrobial therapy. The policy was also updated to adjust the authorization period to up to 12 months based on type of infection.
Additional Quantities of Stromectol (ivermectin) –	Effective upon completion	Policy revised to include newly available generic 6 mg ivermectin tablets. All strengths of ivermectin

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
Commercial and Healthcare Reform	of internal review and implementation.	subject to the same indications and criteria as previously established.
Ampyra (dalfampridine) – Commercial and Healthcare Reform	04/25/2025	Policy revised for Ampyra (dalfampridine) to include reauthorization criteria of the prescriber attests the member is ambulatory, the member has experienced a 20% improvement from baseline in 25-foot walk test or the member has not experienced a 20% improvement from baseline in timed 25-foot walk test and meets the following criteria: the prescriber attests the member has experienced an improvement in walking speed or other objective measures related to ambulation and the prescriber attests the member will benefit from ongoing therapy with Ampyra (dalfampridine).
Brand Reliever Inhalers – Commercial and Healthcare Reform	04/25/2025	Policy updated to include the member is using Airsupra (budesonide and albuterol) for the as-needed treatment or prevention of bronchospasm.
Bystolic (nebivolol) – Healthcare Reform Essential Formulary	Effective upon completion of internal review and implementation.	Policy terminated
Concomitant Dipeptidyl Peptidase-4 (DPP-4) Inhibitors and Glucagon-Like Peptide-1 Receptor Agonist (GLP-1 RAs) Therapy – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy created to adhere to recommended American Diabetes Association (ADA) and American Association of Clinical Endocrinologists (AACE) guidelines that DPP-4 inhibitors and GLP-1 RAs not be given concomitantly. Prescriber must attest that going forward the member will not be using these 2 agents concomitantly.
Cyclobenzaprine, Metaxalone, and Methocarbamol Products – Commercial and Healthcare Reform	04/25/2025	Policy revised to add Metaxalone 640 mg, a new single-source product, with a new strength, to the metaxalone products. As with the current metaxalone products, the member must have an FDA-approved diagnosis, experienced therapeutic failure or intolerance to three of the following plan-preferred, generic medications, or all are contraindicated: cyclobenzaprine 5 of 10 mg, methocarbamol (excluding 1000 mg), chlorzoxazone 500 mg, or orphenadrine, and the member has experienced therapeutic failure or intolerance to either plan-preferred, generic metaxalone 400 mg or metaxalone 800 mg.

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
		Reauthorization requires that the member is experiencing a new episode of mild to moderate pain of an acute musculoskeletal disorder (s).
Doxycycline Products – Commercial and Healthcare Reform	04/25/2025	Policy revised for Oracea (doxycycline monohydrate IR-DR 40 mg) to update age to 18 years and older. Brands Lympak and Vibramycin (doxycycline hyclate) removed as they are no longer available on the market.
Epinephrine Products – Commercial and Healthcare Reform	04/25/2025	Policy revised for brand EpiPen (epinephrine) and Neffy (epinephrine) to remove Symjepi (epinephrine) step requirement since not available on the market. For Neffy, added documentation the member is not a candidate for autoinjector products or unable to use a self-injection due to phobia or mental/physical impairment.
Epinephrine Products – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised for Neffy (epinephrine) nasal spray to add expanded FDA-approved indication requiring age of 4 years and older, and weight of 15 kg or greater.
Fulvicin P/G (griseofulvin ultramicrosize) 165 mg – Commercial and Healthcare Reform	04/25/2025	Policy created for Fulvicin P/G (griseofulvin ultramicrosize) 165 mg tablet to require an FDA-approved indication with fungal species, age greater than 2 years of age, and therapeutic failure or intolerance to generic griseofulvin (not including the 165 mg strength). If the request is for brand Fulvicin P/G 165 mg, the patient has experienced therapeutic failure or intolerance to generic griseofulvin ultramicrosize 165 mg.
Glucagon-Like Peptide-1 Receptor Agonists (GLP-1 RAs) for Diabetes – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised for all targets to require documentation of diabetes diagnosis.
Gralise (gabapentin) – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised to remove automatic approval criteria of a member having one of the following oral antiviral medications used for the treatment of herpes zoster infection: Zovirax (acyclovir), Famvir (famciclovir), or Valtrex (valacyclovir) in the member's prescription drug claims history within the previous 180 days and a claim for generic

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
		immediate-release gabapentin in the member's prescription drug claims history within the previous 180 days.
Ibsrela (tenapanor) – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised for Ibsrela (tenapanor) requiring an additional plan-preferred step of trial/failure of Trulance (plecanatide) for initial authorization and for reauthorization criteria requiring a step of trial/failure of Linzess (linaclotide), generic lubiprostone [Females only] and Trulance (plecanatide). Policy revised to include Trulance (plecanatide) in the automatic approval criteria.
Liquid Formulations of Anti-Hypertensive Medications – Commercial and Healthcare Reform	04/25/2025	Policy revised to add Inzirqo (hydrochlorothiazide) and valsartan oral solution as targets requiring FDA-approved age, diagnosis, and trial/failure of a plan-referred alternative tablet or capsule with the same active ingredient. Reauthorization requiring positive clinical response to therapy and inability to swallow tablets or capsules.
Lyrica/Lyrica CR (pregabalin/pregabalin ER) – Commercial and Healthcare Reform	04/25/2025	Policy revised for generic pregabalin capsules to add medically accepted indication for restless leg syndrome (RLS) requiring age, diagnosis, attestation of addressed exacerbating factors of RLS and of iron levels.
Mesalamine Ulcerative Colitis Treatments – Commercial and Healthcare Reform	04/25/2025	Policy revised for Pentasa (mesalamine) to include member is 18 years of age and older.
Minocycline and Tetracycline Tablets – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy updated to remove automatic approval criteria.
Minocycline Products – Commercial and Healthcare Reform	04/25/2025	Policy revised to remove brand Coremino, Minolira ER, Solodyn (minocycline extended-release [ER]) and brand Minocin (minocycline) as products are no longer available on the market.
Minocycline Products – Commercial National Select	04/25/2025	Policy revised to remove brand Minolira (minocycline extended-release [ER]) and brand Minocin (minocycline) as products are no longer available on the market.
Motegrity (prucalopride) – Commercial and Healthcare Reform	Effective upon completion	Policy revised to include prucalopride as a target and if the request is for brand Motegrity, the member has experienced therapeutic failure,

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
	of internal review and implementation.	contraindication, or intolerance to generic prucalopride for both initial and reauthorization criteria. Auto-authorization criteria updated to include generic prucalopride.
Motegrity (prucalopride) – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised to include prucalopride as a target and a step through generic prucalopride if the request is for brand Motegrity for initial authorization and reauthorization.
Non-Preferred Metformin Products – Commercial and Healthcare Reform	04/25/2025	Policy revised to add metformin 750 mg as a target requiring FDA approved diagnosis and trial/failure of generic.
Non-Preferred Dipeptidyl Peptidase IV (DPP-IV) Inhibitors – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised to add Brynovin (sitagliptin) as a target requiring FDA approved diagnosis, the member has experienced therapeutic failure, contraindication, or intolerance to a metformin-containing product, and the member has experienced therapeutic failure, contraindication, or intolerance to all of the following: a linagliptin product and a sitagliptin product OR the member has an inability to swallow tablets. For reauthorization of Brynovin, the member requires continued therapy with Brynovin and the member continues to have an inability to swallow tablets.
Non-Preferred NSAIDs – Commercial and Healthcare Reform	04/25/2025	Policy revised to include Fenopron (fenoprofen calcium); another brand name fenoprofen. Members must have an FDA-approved diagnosis and have experienced therapeutic failure or intolerance to three (3) of the following plan-preferred, generic products or contraindications to all of the products: diclofenac potassium tablets or diclofenac sodium tablets, ibuprofen tablets, indomethacin capsules or indomethacin extended-release capsules, meloxicam tablets, nabumetone tablets, naproxen tablets or naproxen sodium tablets. For reauthorization, the prescriber must attest that the member has experienced positive clinical response to therapy. For Dolobid (diflunisal), added diclofenac sodium tablets to the diclofenac potassium line, as a qualifier.
Non-Preferred Sodium-Glucose CoTransporter 2 (SGLT2) Inhibitors –	04/25/2025	Policy revised to clarify required step therapy for heart failure diagnosis without concurrent type 2 diabetes is Farxiga (dapagliflozin) and Jardiance (empagliflozin) and heart failure with concurrent

<b>Policy Name*</b>	<b>Policy Effective Date**</b>	<b>Updates and Automatic Approval Criteria</b>
Commercial and Healthcare Reform		type 2 diabetes is Farxiga (dapagliflozin) or Xigduo XR (dapagliflozin/metformin extended release) and Jardiance (empagliflozin), Synjardy (empagliflozin/metformin), or Synjardy XR (empagliflozin/metformin extended release).
Seysara (sarecycline) – Commercial and Healthcare Reform	04/25/2025	Policy revised for Seysara (sarecycline) to add reauthorization criteria allowing reauthorization if the member's acne requires additional courses of treatment.
Topical Acne Products – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised to add adapalene 0.1% solution to require diagnosis, and trial and failure to adapalene 0.1% gel and adapalene 0.1% cream and adapalene-benzoyl peroxide 0.1-2.5%. Policy revised to add Clindacin (clindamycin) 1% foam to require diagnosis, age and trial and failure to 1 plan preferred generic from 2 different therapeutic categories (topical retinoids and topical antibiotics).
Topical Corticosteroids – Commercial and Healthcare Reform	04/25/2025	Policy updated to add Clobetasol Propionate Cream 0.025%, a single-source brand product, as a target to the high potency topical corticosteroids.
Trazodone – Commercial and Healthcare Reform	04/25/2025	Policy updated to include Raldesy (trazodone hydrochloride) to require the member to be 18 years of age and older, have a diagnosis of major depressive disorder, and the member is unable to swallow capsules/tablets. For reauthorization, the prescriber attests the member has experienced positive clinical response to therapy and the member continues to have an inability to swallow capsules/tablets. Criteria also updated for trazodone 300 mg to require the member to be 18 years of age or older.
Trulance (plecanatide) – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised for Trulance (plecanatide) to add generic Motegrity (prucalopride) as an additional step requirement for chronic idiopathic constipation (CIC)

\*For Commercial and Healthcare Reform policies, an exception to some or all the criteria above may be

granted for select members and/or circumstances based on state and/or federal regulations.

\*\*All effective dates are tentative and subject to delay pending internal review or approval.

Standard prior authorization criteria will apply for members who do not meet the automatic approval criteria.

### 3. Formulary Program

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
Self-Administered Injectables – New York Commercial and Healthcare Reform	04/25/2025	Policy revised for Cutaquig (immune globulin subcutaneous (human) – hipp), Cuvitru (immune globulin subcutaneous (human)), Flolan (epoprostenol sodium), Veletri (epoprostenol) and Xembify (immune globulin subcutaneous, human – klhw) to add reauthorization criteria requiring self-administration and improvement/stability in symptoms. Criteria revised for Gammaked (immune globulin injection (human), 10% caprylate/chromatography purified) and Gammunex-C (immune globulin injection (human), 10% caprylate/chromatography purified) to remove failure with splenectomy.
Zero-Dollar Cost Share: HIV PrEP Therapy – Commercial and Healthcare Reform plans Compliant with the Affordable Care Act Preventative Service Mandates	02/27/2025	Based on recently published guidance in FAQ 68, Descovy was added to the drugs which could be automatically modified to a \$0 at the point of sale if diagnosis on prescription claim was for HIV PrEP or the member has no other HIV treatment medication in claims history and policy criteria was updated to remove risk assessment documentation.

\*For Commercial and Healthcare Reform policies, an exception to some or all the criteria above may be granted for select members and/or circumstances based on state and/or federal regulations.

\*\*All effective dates are tentative and subject to delay pending internal review or approval. Standard prior authorization criteria will apply for members who do not meet the automatic approval criteria.

### 4. Quantity Level Limit (QLL) Programs\*

Effective immediately upon completion of internal review and implementation, unless otherwise noted.

**Table 1. Quantity Level Limits – Quantity per Duration for Commercial and Healthcare Reform Plans**

Drug Name	Retail Edit Limit	Mail Edit Limit
Avtozma (tocilizumab-anoh) prefilled syringe/autoinjector	4 syringes/autoinjectors per 28 days	12 syringes/autoinjectors per 84 days
Brynovin (sitagliptin)	120 ml per 30 days	360 ml per 90 days
Gomekli (mirdametininib) 1 mg capsule	126 capsules per 28 days	378 capsules per 84 days
Gomekli (mirdametininib) 1 mg tablet for suspension	168 tablets per 28 days	504 tablets per 84 days

<b>Drug Name</b>	<b>Retail Edit Limit</b>	<b>Mail Edit Limit</b>
Gomekli (mirdametinib) 2 mg capsule	84 capsules per 28 days	252 capsules per 84 days
Inzirqo (hydrochlorothiazide)	3,000 mL per 30 days	9,000 mL per 90 days
Ivermectin 6 mg	10 tablets per 25 days	10 tablets per 25 days
Ivermectin 6 mg	20 tablets per 365 days	20 tablets per 365 days
Journavx (Suzetrigine)	29 tablets per 90 days	29 tablets per 90 days
Omlyclo (omalizumab-igec)	2 mL per 21 days	6 mL per 63 days
OmvoH (mirikizumab-mrkz) 300 mg (200 mg/2 mL + 100 mg/mL)	2 injections (3 mL) per 28 days	6 injections (9 mL) per 84 days
Palforzia 1 mg (level 0)	2 packs (30 capsules) per 365 days	2 packs (30 capsules) per 365 days
Palforzia 12 mg (level 3)	2 packs (90 capsules) per 365 days	2 packs (90 capsules) per 365 days
Palforzia 120 mg (level 7)	2 packs (60 capsules) per 365 days	2 packs (60 capsules) per 365 days
Palforzia 160 mg (level 8)	2 packs (120 capsules) per 365 days	2 packs (120 capsules) per 365 days
Palforzia 20 mg (level 4)	2 packs (30 capsules) per 365 days	2 packs (30 capsules) per 365 days
Palforzia 200 mg (level 9)	2 packs (60 capsules) per 365 days	2 packs (60 capsules) per 365 days
Palforzia 240 mg (level 10)	2 packs (120 capsules) per 365 days	2 packs (120 capsules) per 365 days
Palforzia 3 mg (level 1)	2 packs (90 capsules) per 365 days	2 packs (90 capsules) per 365 days
Palforzia 300 mg (level 11)	2 packs (30 sachets) per 365 days	2 packs (30 sachets) per 365 days
Palforzia 40 mg (level 5)	2 packs (60 capsules) per 365 days	2 packs (60 capsules) per 365 days
Palforzia 6 mg (level 2)	2 packs (180 capsules) per 365 days	2 packs (180 capsules) per 365 days
Palforzia 80 mg (level 6)	2 packs (120 capsules) per 365 days	2 packs (120 capsules) per 365 days
Palforzia initial (1-3 yrs)	2 packs (14 capsules) per 365 days	2 packs (14 capsules) per 365 days
Palforzia initial dose pack	2 packs (26 capsules) per 365 days	2 packs (26 capsules) per 365 days
Penmenvy (Meningococcal Groups A, B, C, W, and Y Vaccine)	2 (0.5 mL) per 365 days	2 (0.5 mL) per 365 days
Raldesy (trazodone HCl) (150 mL bottle)	2 of the 150 mL bottles/30 days	6 of the 150 mL bottles/30 days
Raldesy (trazodone HCl) (300 mL bottle)	4 of the 300 mL bottles/30 days	12 of the 300 mL bottles/30 days
Romvimza (vimseltinib)	8 capsules per 28 days	24 capsules per 84 days
Symbravo (meloxicam and rizatriptan)	9 tablets per 25 days	27 tablets per 75 days

Drug Name	Retail Edit Limit	Mail Edit Limit
Tremfya (guselkumab) Induction pack for Crohn's Disease	3 induction packs per 365 days	3 induction packs per 365 days
Xpovio (selinexor) 40 mg once weekly	16 tablets per 28 days	48 tablets per 84 days

\*Effective date to be determined.

## Table 2. Quantity Level Limits – Quantity per Dispensing Event – Commercial and Healthcare Reform Plans

No changes at this time.

\*Effective date to be determined.

Quantity per dispensing event limits the quantity of medication that can be dispensed per each fill. If the submitted day supply on a claim is 34 days or less, the retail limit will apply. If the submitted day supply on a claim is greater than 34 days, the mail limit will apply.

## Table 3. Maximum Daily Quantity Limits – Commercial and Healthcare Reform Plans

Drug Name	Daily Limit
Ctexli (Chenodiol)	3 tablets per day
Evrysdi (Risdiplam)	1 tablet per day
Fulvicin P/G (griseofulvin ultramicrosize) 165 mg	4 tablets per day
Gabarone (gabapentin) 100 mg	18 tablets per day
Gabarone (gabapentin) 400 mg	9 tablets per day
Juxtapid (lomitapide) 20 mg	3 capsules per day
Juxtapid (lomitapide) 5 mg, 10 mg	1 capsule per day
Metaxalone 640 mg	4 tablets per day
Metformin 750 mg	3 tablets per day
Onapgo (apomorphine hydrochloride)	One (98 mg/20 mL) single-dose cartridge per day
Revuforj (revumenib) 25 mg	8 tablets per day
Veltassa (patiomer ) 1 gram packet	4 packets per day

\*Quantity per Duration (QD) rule also applies to this medication (refer to Table 1).

Members can receive up to the maximum day supply according to their benefits, but the daily limit must not be exceeded for each individual day.

Requests for coverage of select medications exceeding the defined quantity level limits may be submitted for clinical review. Maximum-day supply on certain medications may vary depending on member's benefit design.

## SECTION II. Highmark Medicare Part D Formularies

### A. Changes to the Highmark Medicare Part D 5-Tier Open Formularies

The Highmark Pharmacy and Therapeutics Committee has reviewed the medications listed in the tables below. For your convenience, you can search the Highmark Medicare Part D Formularies online at:

- [Incentive Formulary](#)
- [Compass Formulary](#)

**Table 1. Preferred Products**

Effective immediately pending Centers for Medicare and Medicaid Services (CMS) approval and upon completion of internal review and implementation.

Brand Name	Generic Name	Comments
Penmenvy	Meningococcal Groups A, B, C, W, and Y Vaccine	Active immunization to prevent invasive disease caused by Neisseria meningitidis serogroups A, B, C, W, and Y in individuals 10 through 25 years of age.
Vimkungunya	chikungunya vaccine, recombinant	Prevention of disease caused by chikungunya virus in individuals 12 years of age and older.

**Table 2. Non-Preferred Products**

Effective immediately pending CMS approval and upon completion of internal review and implementation.

Brand Name	Generic Name	Preferred Alternatives
Brynovin	sitagliptin	Januvia tablets, Tradjenta tablets
Inzirqo	hydrochlorothiazide	hydrochlorothiazide tablets, hydrochlorothiazide capsules
Journavx	suzetrigine	ibuprofen tablets (+Rx), naproxen tablets
Merilog / Merilog Solostar	insulin aspart-szjj	Humalog; insulin lispro
Miudella	copper intrauterine system	Liletta
Neffy	epinephrine	epinephrine auto-inject, Epipen, Epipen Jr
Ospomyv	denosumab-dssb	Prolia
Stoboclo	denosumab-bmwo	Prolia
Symbravo	meloxicam and rizatriptan	rizatriptan, meloxicam tablet, sumatriptan succinate tablet

**B. Changes to the Highmark Medicare Part D 5-Tier Closed Formulary**

The Highmark Pharmacy and Therapeutics Committee has reviewed the medications listed in the tables below. For your convenience, you can search the Highmark Medicare Part D Formularies online at:

- [Performance Formulary](#)

- [Venture Formulary](#)
- [Fundamental Formulary](#)

**Table 1. Preferred Products**

Effective immediately pending CMS approval and upon completion of internal review and implementation.

Brand Name	Generic Name	Comments
Penmenvy	Meningococcal Groups A, B, C, W, and Y Vaccine	Active immunization to prevent invasive disease caused by Neisseria meningitidis serogroups A, B, C, W, and Y in individuals 10 through 25 years of age.
Vimkungya	chikungunya vaccine, recombinant	Prevention of disease caused by chikungunya virus in individuals 12 years of age and older.

**Table 2. Non-Preferred Products**

Effective immediately pending CMS approval and upon completion of internal review and implementation.

Brand Name	Generic Name	Preferred Alternatives
Neffy	epinephrine	epinephrine auto-inject, Epipen, Epipen Jr

**Table 3. Products Not Added\***

Effective immediately pending CMS approval and upon completion of internal review and implementation.

Brand Name	Generic Name	Preferred Alternatives
Avtozma prefilled syringe/autoinjector	tocilizumab-anoh	Actemra ACTPen, Actemra
Avtozma vial	tocilizumab-anoh	Actemra ACTPen, Actemra
Brynovin	sitagliptin	Januvia tablets, Tradjenta tablets
Ctexli	chenodiol	Prescriber Discretion
Fulvicin P/G 165 mg	griseofulvin ultramicrosize	griseofulvin microsize tablet 500 mg, griseofulvin ultramicrosize tablet 125 mg, griseofulvin ultramicrosize tablet 250 mg
Gabarone 100 mg, 400 mg	gabapentin	gabapentin tablet, gabapentin capsule
Gabarone		gabapentin tablet, gabapentin capsule
Inzirqo	hydrochlorothiazide	hydrochlorothiazide tablets, hydrochlorothiazide capsules

Journavx	suzetrigine	Ibuprofen tablets (+Rx), naproxen tablets
Merilog / Merilog Solostar	insulin aspart-szjj	Humalog; insulin lispro
Metaxalone 640 mg	metaxalone	metaxalone 400 mg tablets, metaxalone 800 mg tablets
Metformin 750 mg	metformin	metformin oral tablet 500 mg, metformin oral tablet 850 mg, metformin oral tablet 1000 mg
Miudella	copper intrauterine system	Liletta
Onapgo	apomorphine hydrochloride	carbidopa-levodopa tablets, ropinirole tablets, pramipexole tablets
Ospomyv	denosumab-dssb	Prolia
Raldesy (150 mL bottle)	trazodone HCl	trazodone 50 mg tablets, trazodone 100 mg tablets, trazodone 150 mg tablets
Stoboclo	denosumab-bmwo	Prolia
Symbravo	meloxicam and rizatriptan	rizatriptan, meloxicam tablet, sumatriptan succinate tablet

\*Physicians may request coverage of these products using the [Prescription Drug Medication Request Form](#).

### **C. Additions to the Specialty Tier**

Effective immediately pending CMS approval and upon completion of internal review and implementation.

<b>Brand Name</b>	<b>Generic Name</b>
Avtozma*	tocilizumab-anoh
Ctexli*	Chenodiol
Datroway	datopotamab deruxtecan-dlnk
Emblaveo	aztreonam and avibactam
Encelto	revakinagene taroretcel-lwe
Evrysdi	risdiplam
Fulvicin P/G*	griseofulvin ultramicrosize
Gabarone* 100mg, 400mg	gabapentin
Gomekli 1 mg capsule, 2 mg capsule, 1 mg tablet for suspension	mirdametinib
Grafapex	treosulfan
Metaxalone* 640 mg	metaxalone
Metformin* 750 mg	metformin
Omlyclo	omalizumab-igec
Onapgo*	apomorphine hydrochloride
Osenvelt	denosumab-bmwo
Raldesy* 150 mL bottle, 300 mL bottle	trazodone HCl
Romvimza	vimseltinib
Susvimo	ranibizumab
Xbryk	denosumab-dssb

\* Pertains only to Incentive and Compass Formularies

## **D. Updates to the Pharmacy Utilization Management Programs**

### **1. Prior Authorization Program**

<b>Policy Name</b>	<b>Policy Effective Date*</b>	<b>Updates and/or Approval Criteria</b>
Administrative Prior Authorizations for Medicare Part D Plans – Medicare	04/25/2025	Policy revised to add new product Onapgo (apomorphine hcl) to II. BvD section L. Drugs Administered via Infusion Pump and added newly Medicare eligible product Mircera (methoxy polyethylene glycol-epoetin beta) to II. BvD section J. Renal Dialysis Drugs. Administrative updates to increase clarity of 'Drugs Administered via Infusion Pump' criteria.
Amvuttra (vutrisiran) – Medicare	Termed 04/18/2025	Policy terminated (combined with J-0945).
Apomorphine Products – Medicare	Effective upon completion of internal review and implementation.	Policy revised to include Onapgo (apomorphine) to require FDA approved indication, the member is experiencing motor fluctuations despite use of carbidopa/levodopa, and the member has experienced therapeutic failure, contraindication, or intolerance to one of the following generic products: pramipexole, ropinirole, entacapone, selegiline, or rasagiline.
BCR-ABL Kinase Inhibitors – Medicare	03/03/2025	Policy revised for Imkeldi (imatinib) to remove requirement of therapeutic failure or intolerance to generic imatinib tablets.
BRAF Mutation-Targeting & MEK1/2 Kinase Inhibitors – Medicare	04/25/2025	Policy revised for Mekinist (trametinib) and Tafinlar (dabrafenib) to include revised FDA-approved indication for treatment of patients with locally advanced or metastatic anaplastic thyroid cancer (ATC) with BRAF V600E mutation, as detected by an FDA-approved test, the member has no satisfactory locoregional treatment options and that Mekinist and Tafinlar are used in combination for melanoma, non-small cell lung cancer (NSCLC), thyroid cancer, solid tumors and low-grade glioma. For low-grade glioma policy revised to include age of at least 1 year of age to 17 years of age. For Braftovi (encorafenib) and Mektovi (binimetinib) policy revised to include

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		criteria for use in combination for both melanoma and NSCLC. For Cotellic (cobimetinib) and Zelboraf (vemurafenib), policy revised to include criteria for use in combination for melanoma. Policy updated to include Gomekli (mirdametinib) as a target requiring diagnosis of FDA-approved indication.
BTK Inhibitors – Medicare	04/25/2025	Policy revised for Calquence (acalabrutinib) to include new indication of the member has not received prior therapy for mantle cell lymphoma (MCL), the member is ineligible for autologous hematopoietic stem cell transplantation (HSCT) and is using in combination with bendamustine and rituximab.
Chenodiol Products – Medicare	04/25/2025	Policy revised to add newly FDA-approved product, Ctexli (chenodiol). Chenodal (chenodiol) will no longer be approved for orphan drug designation for the treatment of cerebrotendinous xanthomatosis (CTX). Approval for coverage of Ctexli requires that the member has a diagnosis of CTX confirmed with generic testing. Reauthorization requires attestation of improvement in one of the following: normalization of elevated serum or urine 23S-pentol (bile alcohols), normalization of elevated serum cholestanol levels, or improvement in neurologic and psychiatric symptoms.
Chronic Inflammatory Diseases – Medicare	Effective upon completion of internal review and implementation.	Policy revised for Omvoh (mirikizumab-mrkz) and Tremfya (guselkumab) to add new indication Crohn's disease (CD) to require diagnosis and age based on FDA approved indication, and therapeutic failure or intolerance to at least two preferred agents for CD. Omvoh for CD requires received or currently undergoing IV induction therapy. Tremfya for CD requires received or currently undergoing IV induction therapy or using Tremfya SC for induction dosing, and documentation that prescribed Tremfya SC maintenance dose is the lowest effective recommended

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		dosage to maintain therapeutic response. Criteria revised for Velsipity (etrasimod) and Zeposia (ozanimod) to remove requirement to step through one systemic therapy. Tyenne (tocilizumab-aazg) IV expanded indications added into existing tocilizumab IV criteria; for cytokine release syndrome, step through Actemra (tocilizumab) IV and COVID-19 is not eligible under Medicare Part D.
Concomitant Dipeptidyl Peptidase-4 (DPP-4) Inhibitors and Glucagon-Like Peptide-1 Receptor Agonist (GLP-1 RAs) Therapy – Medicare	Effective upon completion of internal review and implementation.	Policy created to adhere to recommended American Diabetes Association (ADA) and American Association of Clinical Endocrinologists (AACE) guidelines that DPP-4 inhibitors and GLP-1 RAs not be given concomitantly. Prescriber must attest that the risks vs. benefits of concomitant use of these 2 agents have been considered.
CSF1R Tyrosine Kinase Inhibitors – Medicare	04/25/2025	Policy revised to add Romvimza (vimseltinib) requiring diagnosis based on FDA-approved indication.
Cystic Fibrosis Inhaled Medications – Medicare	04/25/2025	Policy updated to include additional examples of standard cystic fibrosis therapies for Bronchitol (mannitol inhalation powder) and Pulmozyme (dornase alfa) of hypertonic saline, cystic fibrosis transmembrane conductance regulator modulators, and pancreatic enzymes.
Datroway (datopotamab deruxtecan-dlnk) – Medicare	04/25/2025	New policy for Datroway (datopotamab deruxtecan-dlnk) requiring diagnosis based on FDA-approved indication.
Denosumab Products for Bone Disease – Medicare	Effective upon completion of internal review and implementation.	Policy revised to add Ospomyv (denosumab-dssb) and Stoboclo (denosumab-bmwo) to require diagnosis based on FDA-approved indication. If use is for osteoporosis or osteopenia (including glucocorticoid-induced osteoporosis) it is supported by lab values such as T-score or FRAX calculator, and trial/failure/contraindication to one bisphosphonate. Jubbonti (denosumab-bbdz) Ospomyv, and Stoboclo require trial and failure of Prolia (denosumab).

<b>Policy Name</b>	<b>Policy Effective Date*</b>	<b>Updates and/or Approval Criteria</b>
Denosumab Products for Oncology – Medicare	Effective upon completion of internal review and implementation.	Policy revised to add Xbryk (denosumab-dssb) and Osenvelt (denosumab-bmwo) requiring FDA-approved indication.
Denosumab Products for Oncology – Medicare	Effective upon completion of internal review and implementation.	Policy revised for Xgeva (denosumab) to require therapeutic failure or intolerance to two of the following: Osenvelt (denosumab-bmwo), Wyost (denosumab-bbdz), or Xbryk (denosumab-dssb).
Dupixent (dupilumab) – Medicare	02/27/2025	Policy revised for Dupixent (dupilumab) for the diagnosis of COPD for a patient to either have an eosinophilic count of $\geq 300$ cells/mcL or the member is currently taking daily or alternate-day oral corticosteroids.
Eculizumab Products – Medicare	04/25/2025	Administrative changes to add expanded indication for Soliris (eculizumab) for treatment of generalized myasthenia gravis (gMG) in adult patients and pediatric patients six years of age and older who are anti-acetylcholine receptor (AChR) antibody positive.
Encelto (revakinagene taroretcel-lwey) – Medicare	Effective upon completion of internal review and implementation.	Policy created for Encelto (revakinagene taroretcel-lwey) requiring the member has a diagnosis of idiopathic macular telangiectasia (MacTel) type 2, determined by one of the following: optical coherence tomography (OCT), OCT angiography (OCTA), or fluorescein angiography (FA), the prescriber attests Amsler grid testing showed distorted areas in central vision, and the prescriber attests the eye in which the implant will be administered and the prespecified eye has not previously received an Encelto implant.
Entresto Sprinkle (sacubitril/valsartan) – Medicare	Effective upon completion of internal review and implementation.	Policy revised to require step through generic sacubitril-valsartan tablets or inability to swallow for patients at least 40 kg but less than 50 kg.
Ergotamines – Medicare	04/25/2025	Brand Cafergot (ergotamine tartrate-caffeine) removed from policy since it is off market.
Fabhalta (iptacopan) – Medicare	Effective upon completion of	Policy revised to add a new FDA-approved indication for Fabhalta: Complement 3 Glomerulopathy (C3G).

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
	internal review and implementation.	Members must have a diagnosis of C3G confirmed by biopsy, experiencing all of the following: urine protein-to-creatinine ration (UPCR) $\geq$ 30 mL/min per 1.72 m <sup>2</sup> , also member must be maximally recommended dose of an angiotensin converting enzyme (ACE) inhibitor or an angiotensin receptor blocker (ARB). Reauthorization requires a reduction in the UPCR from baseline.
FGFR Kinase Inhibitors – Medicare	04/25/2025	Policy revised for Balversa (erdafitinib), Lytgobi (futibatinib), and Pemazyre (pemigatinib) to remove age limitations.
Fulvicin P/G (griseofulvin ultramicrosize) 165 mg – Medicare	04/25/2025	Policy created for Fulvicin P/G (griseofulvin ultramicrosize) 165 mg tablet to require an FDA-approved indication with fungal species and therapeutic failure or intolerance to generic griseofulvin (not including the 165 mg strength). If the request is for brand Fulvicin P/G 165 mg, the patient has experienced therapeutic failure or intolerance to generic griseofulvin ultramicrosize 165 mg.
Furoscix (furosemide) – Medicare	Effective upon completion of internal review and implementation.	Policy revised for Furoscix (furosemide) to require FDA-approved diagnosis.
Gabapentin - Medicare	Effective upon completion of internal review and implementation.	Policy revised to add Gabarone (gabapentin) requiring FDA approved diagnosis and intolerance to generic immediate release gabapentin tablets or capsules.
Glucagon-Like Peptide-1 Receptor Agonists (GLP-1 RAs) – Medicare	04/25/2025	Policy revised to require step through preferred agents when utilized for the same age and indication.
Hereditary Angioedema – Medicare	04/25/2025	Policy revised to add the additional mutations of angiotensin-1, plasminogen, kininogen-1, myoferlin and heparin sulfate-glucosamine 3-O-sulfotransferase 6 to support the diagnosis of hereditary angioedema with normal C1 inhibitor.
Horizant (gabapentin enacarbil) – Medicare	Effective upon completion of internal review and implementation.	Policy revised for Horizant (gabapentin enacarbil) to require attestation of addressed exacerbating factors for restless leg syndrome (RLS), documentation of iron levels, trial, failure

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		or contraindication to pramipexole, ropinirole or the member is not a candidate for dopaminergic therapy due to concerns of augmentation and has therapeutic failure or intolerance or contraindication to all of generic pregabalin or generic gabapentin immediate-release.
Ibsrela (tenapanor) – Medicare	Effective upon completion of internal review and implementation.	Policy revised for Ibsrela (tenapanor) requiring females to trial/failure/contraindication to both Linzess (linaclotide) and lubiprostone or males to trial/failure/contraindication to both Linzess (linaclotide) and Trulance (plecanatide).
Iluvien (fluocinolone acetonide intravitreal implant) – Medicare	04/25/2025	Policy revised for Iluvien (fluocinolone acetonide intravitreal implant) to require diagnosis based on expanded FDA approved indication for chronic non-infectious uveitis affecting the posterior segment of the eye. Reauthorization to require reduction in the frequency of uveitis recurrences or stabilization or improvement in visual acuity or vitreous haze.
Journavx (suzetrigine) – Medicare	Effective upon completion of internal review and implementation.	Policy created for Journavx (suzetrigine) to require that the member has a diagnosis of moderate-to-severe acute pain, prescriber attests that the episode of acute pain is anticipated to last less than one (1) month, and the prescriber attests that the treatment of pain is not amenable to conservative measures such as acetaminophen, NSAIDs, and non-pharmacologic measures. For reauthorization, the prescriber attests that the member is experiencing a new episode of moderate-to-severe acute, separate and distinct from the previous episode, the prescriber attests that the new episode of acute pain is anticipated to last less than one (1) month, and the prescriber attests that the treatment of the new episode of acute pain is not amenable to conservative measures.

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
KRAS G12C Inhibitors – Medicare	04/25/2025	Policy revised for Lumakras (sotorasib) to include revised FDA-approved indication for treatment of patients with non-small cell lung cancer (NSCLC) to require Lumakras to be used as a single agent and to include new FDA-approved indication for treatment of Kirsten rat sarcoma viral oncogene homolog (KRAS) G12C-mutated metastatic colorectal cancer (mCRC) to require diagnosis determined by an FDA approved test based on FDA approved indication, to be used in combination with panitumumab, and has received prior fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy.
Latuda (lurasidone) – Medicare	Termed 04/21/2025	Terminated 04.21.2024
Lemtrada (alemtuzumab) – Medicare	Effective upon completion of internal review and implementation.	Policy revised to include criteria that the member meets one of the following criteria: the member has not completed a previous course of Lemtrada (alemtuzumab) or the member has completed a previous course of Lemtrada (alemtuzumab) and subsequent courses are at least 12 months after the last dose of the prior treatment course.
Lumryz (sodium oxybate), Xyrem (sodium oxybate) and Xywav (calcium, magnesium, potassium, and sodium oxybates) – Medicare	02/14/2025	Policy revised to only require step through modafinil and stimulants for patients 18 years of age or older.
Miscellaneous Immunomodulators – Medicare	04/25/2025	Policy revised for Revlimid (lenalidomide) to include criteria that the member has received previous treatment for follicular lymphoma (FL) and to remove age criteria.
Motegrity (prucalopride) – Medicare	Effective upon completion of internal review and implementation.	Policy revised to combine generic prucalopride and brand Motegrity into the same criteria requiring the member to experience therapeutic failure, contraindication, or intolerance to all of the following agents: Linzess (linaclotide) and generic lubiprostone, and if the request is

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		for brand Motegrity, then the member has tried and failed generic prucalopride.
Motegrity (prucalopride) – Medicare	04/25/2025	Policy revised to include prucalopride as a target and separate out criteria for generic prucalopride and brand Motegrity and removal of age criteria of 18 years or older. Prucalopride criteria includes a diagnosis of chronic idiopathic constipation and the member has experienced therapeutic failure, contraindication, or intolerance to all of the following agents: Linzess (linaclotide) and generic lubiprostone. Brand Motegrity criteria includes diagnosis of chronic idiopathic constipation and the member has experienced therapeutic failure, contraindication, or intolerance to generic prucalopride.
Namenda (memantine) and Namzaric (memantine/donepezil) – Medicare	04/25/2025	Policy revised to add generic memantine-donepezil as a target requiring FDA approved diagnosis and therapeutic failure, intolerance, or contraindication to generic memantine and donepezil.
Non-Preferred Metronidazole Formulations – Medicare	04/25/2025	Policy updated to include metronidazole 125 mg tablets to require an appropriate diagnosis based on FDA-approved indications and has experienced failure/intolerance to plan-preferred, generic metronidazole tablets (not including metronidazole 125 mg tablets). Reauthorization requiring documentation of repeat episode of infection and a minimum 4 week gap if repeat course is for trichomoniasis infection.
PCSK9 Therapies – Medicare	Effective upon completion of internal review and implementation.	Policy revised for Praluent (alirocumab) to add step through Repatha (evolocumab) for diagnosis of Primary Hyperlipidemia, Not Associated with ASCVD (atherosclerotic cardiovascular disease), HeFH (heterozygous familial hypercholesterolemia), or HoFH (homozygous familial hypercholesterolemia).
Pizensy (lactitol) – Medicare	Termed 04/18/2025	Policy terminated

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Pretomanid – Medicare	04/25/2025	Policy revised for pretomanid for pre-extensively drug resistant (pre-XDR) tuberculosis (TB) to require trial and failure of isoniazid and a rifamycin antibiotic. For XDR-TB to require trial and failure of isoniazid, a rifamycin antibiotic, a fluoroquinolone antibiotic and a second line injectable antibacterial. For treatment intolerant or nonresponsive multidrug resistant (MDR) TB, to require trial and failure to isoniazid and rifampin and the member is treatment-intolerant or nonresponsive to standard therapy. Reauthorization criteria updated to the member has experienced positive clinical response to therapy and requires additional antimicrobial therapy. The authorization duration was also updated to 12 months.
Prevymis (letermovir) Oral Pellets – Medicare	04/25/2025	Policy revised to remove therapeutic failure or intolerance to Prevymis (letermovir) tablets. In addition to previously established criteria, member must be unable to swallow tablets or unable to use Prevymis tablets due to body weight dosing limitations.
Procysbi (cysteamine bitartrate) – Medicare	04/25/2025	Policy revised for Procysbi (cysteamine bitartrate) to remove age restriction.
Programmed Death Receptor Therapies – Medicare	04/25/2025	Policy revised for Tevimbra (tislelizumab-jsgr) to require diagnosis based on FDA-approved expanded indication for first-line treatment of esophageal squamous cell carcinoma.
Pyrukynd (mitapivat) – Medicare	04/25/2025	Policy revised for Pyrukynd (mitapivat) to remove age restriction.
Repository Corticotropin Injections – Medicare	04/25/2025	Policy revised to add Purified Cortrophin Gel (repository corticotropin injection) prefilled syringes, matching existing criteria for vials.
Rezdiffra (resmetirom) – Medicare	Effective upon completion of internal review and implementation.	Policy revised for Rezdiffra (resmetirom) to change liver biopsy requirement from within 6 months to 3 years, require one cardiometabolic risk factor (BMI $\geq$ 25 kg/m <sup>2</sup> or $\geq$ 23 kg/m <sup>2</sup> for asian ethnicity or for males, waist circumference $\geq$ 94 cm (European), $\geq$ 90 cm (South Asian and

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		Chinese), or $\geq 85$ cm (Japanese) or for females, $\geq 80$ cm (European, South Asian, or Chinese) or $\geq 90$ cm (Japanese), fasting serum glucose $\geq 100$ mg/dL, 2-hour post-prandial serum glucose $\geq 140$ mg/dL, HbA1c $\geq 5.7\%$ , diagnosis of type 2 diabetes or is on treatment for type 2 diabetes, plasma triglycerides $\geq 150$ mg/dL or is on lipid lowering treatment, plasma HDL $\leq 40$ mg/dL (males) or $\leq 50$ mg/dL (female) or is on lipid lowering treatment, or blood pressure $\geq 130/85$ mmHg or is on treatment for hypertension), and require alcohol consumption $\leq 20$ grams/day for females or $\leq 30$ grams/day for males for initial and reauthorization, addition to reauthorization requirements of member has not progressed to stage F4 fibrosis and does not have cirrhosis, hepatic decompensation, or hepatocellular carcinoma.
Rituximab Products – Medicare	04/25/2025	Policy revised to remove age limitations for rituximab products for Non-Hodgkin's Lymphoma (NHL), Granulomatosis with Polyangiitis (GPA) and Microscopic Polyangiitis (MPA), Chronic Lymphocytic Leukemia (CLL), Rheumatoid Arthritis (RA), and Pemphigus Vulgaris (PV).
Sirturo (bedaquiline) – Medicare	04/25/2025	Reauthorization criteria updated to the member has experienced positive clinical response to therapy and requires additional antimicrobial therapy. The authorization duration was also updated to 12 months.
Spleen Tyrosine Kinase Inhibitors – Medicare	04/25/2025	Policy revised for Tavalisse (fostamatinib) to require insufficient response to corticosteroid therapy, immunoglobulin therapy, or splenectomy, based on FDA-approved indication.
Spravato (esketamine) – Medicare	04/25/2025	Policy revised to include revised FDA-approved indication for the treatment of treatment-resistant depression (TRD): Spravato (esketamine) may be used as monotherapy or in conjunction with an oral antidepressant. Removed the requirement

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		that the member will be taking an oral antidepressant concomitantly with the Spravato.
Stromectol (ivermectin) – Medicare	04/25/2025	Policy revised to include newly available generic 6 mg ivermectin tablets. All strengths of ivermectin subject to the same indications and criteria as previously established.
Sublingual Immunotherapies – Medicare	04/25/2025	Policy revised for Odactra (House Dust Mite Allergen Extract) to update age to 5 through 65 years.
Tazarotene Products – Medicare	Effective upon completion of internal review and implementation.	Policy revised for Brand Tazorac (tazarotene) cream to require therapeutic failure or intolerance to generic tazarotene cream and brand Tazorac (tazarotene) gel to require therapeutic failure or intolerance to generic tazarotene gel.
Tocilizumab Biosimilars – Medicare	Effective upon completion of internal review and implementation.	Policy revised to add Avtozma (tocilizumab-anoh) to require age and diagnosis based on FDA-approved indication and therapeutic failure or intolerance to Actemra (tocilizumab). For rheumatoid arthritis (RA), the member has experienced therapeutic failure or intolerance to: 1) one (1) non-biologic disease modifying anti-rheumatic drug (DMARD) or all non-biologic DMARDs are contraindicated for tocilizumab subcutaneous; or 2) one (1) preferred intravenous (IV) biologic for RA for tocilizumab IV. For giant cell arteritis, the member has experienced therapeutic failure or intolerance to one (1) systemic corticosteroid, or all corticosteroids are contraindicated. For polyarticular juvenile idiopathic arthritis (PJIA) and tocilizumab SC, the member has experienced therapeutic failure or intolerance to one (1) non-biologic DMARD or all non-biologic DMARDs are contraindicated or the member requires initial biologic therapy due to involvement of high-risk joints, high disease activity, and/or those judged to be at high-risk of disabling joint damage. Quantity limitation criteria added

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		based on FDA-approved dosing for tocilizumab SC.
Transthyretin Amyloid Cardiomyopathy (ATTR-CM) TTR Stabilizers – Medicare	03/06/2025	Policy revised to require diagnosis transthyretin-mediated amyloidosis as wild-type or variant for Attruby (acoramidis) and wild-type or hereditary for Vyndaqel (tafamidis meglumine) and Vyndamax (tafamidis).
Transthyretin-Mediated Amyloidosis (ATTR) – Medicare	04/25/2025	Policy revised to add Amvuttra (vutrisiran) as a target. Initial and reauthorization criteria for Amvuttra to treat cardiomyopathy added mirroring criteria for Attruby (acoramidis), Vyndaqel (tafamidis meglumine), and Vyndamax (tafamidis). Limitation of coverage excluding use in primary amyloidosis removed.
Trodelvy (sacituzumab govitecan-hziy) – Medicare	04/25/2025	Policy revised for Trodelvy (sacituzumab govitecan-hziy) to require unresectable locally advanced or metastatic breast cancer per FDA-approved indication.
Tryvio (aprocitentan) – Medicare	04/25/2025	Policy revised for Tryvio (aprocitentan) to remove adherence requirement.
Vectibix (panitumumab) – Medicare	04/25/2025	Policy revised for Vectibix (panitumumab) to include diagnosis based on new FDA-approved indication for treatment of patients with Kirsten rat sarcoma viral oncogene homolog (KRAS) G12C-mutated metastatic colorectal cancer (mCRC) as determined by an FDA approved test, used in combination with sotorasib and has received prior fluoropyrimidine-, oxaliplatin- and irinotecan-based chemotherapy.
Venclexta (venetoclax) – Medicare	04/25/2025	Policy revised for Venclexta (venetoclax) to remove age limitation.
Wegovy (semaglutide) and Zepbound (tirzepatide) – Medicare	02/28/2025	Policy revised for Zepbound (tirzepatide) to remove requirement of concurrent positive airway pressure use for MAPD plans.
Wegovy (semaglutide) and Zepbound (tirzepatide) – Medicare	Effective upon completion of internal review and implementation.	Policy revised to require use without oral appliance or positive airway pressure (PAP) for baseline polysomnography or recording time prior to the initiation of the requested therapy.

<b>Policy Name</b>	<b>Policy Effective Date*</b>	<b>Updates and/or Approval Criteria</b>
Wegovy (semaglutide) and Zepbound (tirzepatide) – Medicare	04/25/2025	Policy revised for Zepbound (tirzepatide) to add oral appliance as an example of guideline directed care.
Yorvipath (palopegteriparatide) – Medicare	02/04/2025	Policy revised for Yorvipath (palopegteriparatide) include established hypoparathyroidism despite treatment of calcium and an active form of vitamin D.
Zytiga and Yonsa (abiraterone acetate) – Medicare	04/25/2025	Policy revised to add Abirtega (abiraterone acetate) as a target requiring FDA-approved diagnosis. If the request is for brand Zytiga (abiraterone acetate), the member has experienced therapeutic failure or intolerance to generic abiraterone or Abirtega (abiraterone acetate).

\*All effective dates are tentative and subject to delay pending internal review or approval.

## 2. Updates to Step Therapy

<b>Policy Name</b>	<b>Policy Effective Date*</b>	<b>Updates and/or Approval Criteria</b>
Epinephrine Products – Medicare	04/25/2025	Policy revised for Neffy (epinephrine) and Auvi-Q (epinephrine) to remove Symjepi (epinephrine) step requirement since not available on the market. Single step only through generic epinephrine injection or brand EpiPen.
Erythropoiesis-Stimulating Agents – Medicare	04/25/2025	Policy revised to add Mircera (methoxy polyethylene glycol-epoetin beta) requiring FDA-approved diagnosis, and trial/failure to Procrit (epoetin alfa) and Retacrit (epoetin alfa).
Intravitreal Injections – Medicare	Effective upon completion of internal review and implementation.	Policy revised for Susvimo (ranibizumab injection) to include FDA-approved expanded indication for the treatment of patients with diabetic macular edema (DME) who have previously responded to at least two intravitreal injections of a vascular endothelial growth factor (VEGF) inhibitor.
Non-Preferred Metformin Products – Medicare	Effective upon completion of internal review and implementation.	Policy revised to add metformin 625 mg as a target requiring medically accepted indication and trial/failure of generic.

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Non-Preferred Metformin Products – Medicare	04/25/2025	Policy revised to add metformin 750 mg as a target requiring medically accepted indication and trial/failure of generic.
Non-Preferred Dipeptidyl Peptidase IV (DPP-IV) Inhibitors – Medicare	Effective upon completion of internal review and implementation.	Policy revised to add Brynovin as a target requiring an FDA-approved diagnosis, and the member must have experienced therapeutic failure, contraindication, or intolerance to a linagliptin product and a sitagliptin product OR the member has an inability to swallow tablets.
Non-Preferred Rapid-Acting Insulins – Medicare Compass	Effective upon completion of internal review and implementation.	Policy revised to add Merilog (insulin aspart-szjj) and Merilog Solostar (insulin aspart-szjj) as targets.
Roszet (rosuvastatin/ezetimibe) – Medicare	Termed 04/18/2025	Policy terminated.

### 3. Quantity Level Limit (QLL) Program

Effective date pending CMS approval, completion of internal review and implementation, unless otherwise noted.

Drug Name	Retail Quantity Limit (31 days)
Avtozma (tocilizumab-anoh) prefilled syringe/autoinjector	4 syringes/autoinjectors per 28 days
Avtozma (tocilizumab-anoh) vial	40 mL per 28 days
Brynovin (sitagliptin)	120 mL per 30 days
Ctexli (chenodiol)	93 tablets per 31 days
Datroway (datopotamab deruxtecan-dlnk)	6 vials per 21 days
Encelto (revakinagene taroretcel-lwe)	1 intravitreal implant per lifetime per eye
Evrysdi (risdiplam)	1 tablet per day
Fulvicin P/G (griseofulvin ultramicrosize) 165 mg	4 tablets per day
Gabarone (gabapentin) 100 mg	18 tablets per day
Gabarone (gabapentin) 400 mg	9 tablets per day
Gomekli (mirdametininib) 1 mg capsule	126 capsules per 28 days
Gomekli (mirdametininib) 1 mg tablet for suspension	168 tablets per 28 days
Gomekli (mirdametininib) 2 mg capsule	84 capsules per 28 days
Idhifa (enasidenib) 50 mg	1 tablet per day
Inzirqo (hydrochlorothiazide)	10 mL per day
Journavx (suzetrigine)	29 tablets per 90 days
Juxtapid (lomitapide) 20 mg	3 capsules per day
Juxtapid (lomitapide) 5 mg, 10 mg	1 capsule per day
Metaxalone 640 mg	4 tablets per day

<b>Drug Name</b>	<b>Retail Quantity Limit (31 days)</b>
Metformin 750 mg	3 tablets per day
OmvoH (mirikizumab-mrkz) 300 mg (200 mg/2 mL + 100 mg/mL)	2 injections (3 mL) per 28 days
OmvoH (mirikizumab-mrkz) 300 mg/15 mL	18 vials (270 mL) per 365 days
Onapgo (apomorphine hydrochloride)	One (98 mg/20 mL) single-dose cartridge per day
Ospomyv (denosumab-dssb)	1 syringe (60 mg/1 mL) per 180 days
Palforzia 1 mg (level 0)	1 capsule per day
Palforzia 1 mg (level 0)	2 packs (30 capsules) per 365 days
Palforzia 12 mg (level 3)	2 packs (90 capsules) per 365 days
Palforzia 120 mg (level 7)	2 packs (60 capsules) per 365 days
Palforzia 160 mg (level 8)	2 packs (120 capsules) per 365 days
Palforzia 20 mg (level 4)	2 packs (30 capsules) per 365 days
Palforzia 200 mg (level 9)	2 packs (60 capsules) per 365 days
Palforzia 240 mg (level 10)	2 packs (120 capsules) per 365 days
Palforzia 3 mg (level 1)	2 packs (90 capsules) per 365 days
Palforzia 300 mg (level 11)	2 packs (30 sachets) per 365 days
Palforzia 40 mg (level 5)	2 packs (60 capsules) per 365 days
Palforzia 6 mg (level 2)	2 packs (180 capsules) per 365 days
Palforzia 80 mg (level 6)	2 packs (120 capsules) per 365 days
Palforzia initial (1-3 yrs)	2 packs (14 capsules) per 365 days
Penmenvy (Meningococcal Groups A, B, C, W, and Y Vaccine)	2 (0.5 mL) per 365 days
Revuforj (revumenib) 25 mg	8 tablets per day
Romvimza (vimseltinib)	8 capsules per 28 days
Stoboclo (denosumab-bmwo)	1 syringe (60 mg/1 mL) per 180 days
Symbravo (meloxicam and rizatriptan)	9 tablets per 30 days
Tremfya (guselkumab) Induction pack for Crohn's Disease	6 induction packs (24 mL) per 365 days
Veltassa (patiomer ) 1 gram packet	4 packets per day
Xpovio (selinexor) 40 mg once weekly	16 tablets per 28 days