



Medication Benefit Management

Medical & Pharmacy Benefit

2024

Updated 11/1/2023



Medication Coverage Guidelines

This guide provides an overview of medication management for both the medical and pharmacy benefit, including Prior Authorization requirements, through Health Options Medical Management and Express Scripts, Health Options Pharmacy Benefit Manager (PBM).

Medical Benefit

Prior Approval Requirements

The current Medication Prior Approval Form must be used for all medication-related requests. This guide includes a representative, but not all-inclusive, list of outpatient medications that require Prior Approval. If the medication falls within one of the following drug classes and there is any doubt if Prior Approval is required, submit an authorization request. Our Medical Management team will then provide additional guidance as needed.

Submit authorization requests via:

Provider Portal (preferred): Provider.HeathOptions.org

Health Options (Medical Management):

Fax: (877) 314-5693

Phone: (855) 542-0880

Medications – Recent Approvals

All medications require FDA approval.

Providers can inquire about a specific medication's coverage status by calling Members Services at (855) 624-6463.

Providers can submit Prior Approval requests for exception to coverage considerations for medications denoted as non-covered.

Note: New to market drugs and new FDA approved indications for existing drugs will be considered non-covered for up to 180 days after release onto the market pending internal clinical review.

Temporary Codes

Temporary codes (S-codes) are a non-covered benefit once CMS assigns another code to the item/service. The provider is required to use a current year HCPCs reference guide for codes and modifiers for billing purposes.

Medication Classifications that generally require Prior Approval

- Alpha-1 proteinase inhibitor (human)
- Botulinum toxins
- Blood clotting factors
- Enzyme replacement drugs
- Erythropoiesis-stimulating agents
- Gene Therapy
- Granulocyte-colony stimulating factors
- Growth Hormones
- Hepatitis C drugs
- Hereditary angioedema agents
- HER2 Receptor drugs
- Immunoglobulins
- Immunologic agents
- Lyme Disease (IV/Injectable antibiotics)
- Metabolic Disorders
- Miscellaneous High-Cost Infusions/Injections
- Newly approved/Temporary Codes
- Multiple sclerosis drugs
- Oncology agents (infusions, injections)
- Oral agents covered under the pharmacy benefit
- Ophthalmic injections
- Osteoporosis agents
- Pegylated interferons
- Pulmonary arterial hypertension drugs
- Unclassified biologics/drugs

*Per Community Health Options National Drug Code (NDC) Billing Requirements, providers are required to submit the NDC number for all hospital outpatient and professional medical drug claims.

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



Prior Approval Required through Health Options

This list includes medications that require Prior Approval submission to Health Options. We have listed current Brand names, but due to new drugs coming to the market on a regular basis, it may not be all-inclusive and may be subject to change.

Coverage designations for all HCPCs codes are denoted in our provider portal online authorization platform located at Provider.HealthOptions.org. NOTE: some medications on this list may be eligible for distribution through our specialty Pharmacy or home infusion.

Health Options Medical Management team will contact Members and providers to discuss these options, when applicable.

Medications Requiring Prior Approval Through Medical Benefit

Medications that are subject to voluntary Site of Care transition are denoted with an asterisk ().*

BRAND NAME	Generic Name
ABECMA	<i>idecabtagene vicleucel</i>
ACTEMRA (IV-ONLY)*	<i>tocilizumab*</i>
ACTHAR GEL	<i>corticotropin</i>
ADAKVEO	<i>crizanlizumab-tmca</i>
ADCETRIS	<i>brentuximab</i>
ADSTILADRIN	<i>nadofaragene firadenovec-vnccg</i>
ADVATE*	<i>antihemophilic factor*</i>
ADYNOVATE*	<i>antihemophilic factor*</i>
AFSTYLA*	<i>antihemophilic factor*</i>
ALDURAZYME*	<i>laronidase*</i>
ALIQOPA	<i>Copanlisib</i>
ALPHANATE*	<i>antihemophilic factor*</i>
ALPHANINE SD*	<i>coagulation factor ix*</i>
ALPROLIX*	<i>coagulation factor ix*</i>
ALTUVIPIO	<i>antihemophilic factor (recombinant), Fc-VWF-XTEN fusion protein-ehtl</i>
ALYMSYS	<i>bevacizumab-maly</i>
AMJEVITA*	<i>adalimumab-atto*</i>
AMVUTTRA	<i>vutrisiran</i>
APOKYN*	<i>apomorphine*</i>
ARALAST NP*	<i>alpha 1-potteinase*</i>
ARANESP*	<i>darbepoetin alfa*</i>
ARCALYST	<i>rilonacept</i>
ARTISS	<i>fibrinogen human, human thrombin solution</i>
ASCENIV*	<i>immune globulin*</i>

BRAND NAME	Generic Name
ASPARLAS	<i>calaspargase pegol</i>
ATGAM	<i>lymphocyte immune globulin, antithymocyte globulin, equine</i>
AVASTIN	<i>bevacizumab</i>
AVEED	<i>testosterone</i>
AVSOLA*	<i>infliximab-axxq*</i>
AZEDRA	<i>iodine i-131 iobenguane</i>
BAVENCIO	<i>avelumumab</i>
BEBULIN*	<i>factor IX complex*</i>
BELEODAQ	<i>belinostat</i>
BENEFIX*	<i>coagulation factor ix*</i>
BENLYSTA*	<i>belimumab*</i>
BEOVU	<i>brolicizumab-bdli</i>
BERINERT*	<i>c1 esterase inhibitor*</i>
BESONSA	<i>inotuzumab ozogamicin</i>
BETHKIS	<i>tobramycin</i>
BIVIGAM*	<i>immune globulin*</i>
BLINCYTO	<i>blinatumomab</i>
BONIVA*	<i>ibandronate*</i>
BOTOX	<i>botulinum toxin</i>
BREYANZI	<i>lisocabtagene maraleucel</i>
BRINEURA	<i>cerliponase alfa</i>
BRIUMVI	<i>ublituximab-xiyy</i>
BYOOVIZ	<i>ranibizumab-nuna</i>
CABENUVA	<i>cabotegravir/rilpivirine</i>
CABLIVI	<i>caplacizumab</i>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



Brand Name	Generic Name
CAMCEVI*	<i>Leuprolide*</i>
CARDIOGEN-82	<i>rubidium rb-82, diagnostic</i>
CARIMUNE NF*	<i>immune globulin*</i>
CARVYKTI	<i>ciltacabtagene autoleucel</i>
CEPROTIN*	<i>protein c concentrate*</i>
CEREZYME*	<i>imiglucerase*</i>
CERIANNIA	<i>fluoroestradiol f18</i>
CIMERLI	<i>ranibizumab-eqrn</i>
CIMZIA*	<i>certolizumab*</i>
CINQAIR*	<i>reslizumab*</i>
CINRYZE*	<i>c1 esterase inhibitor*</i>
COAGADEX	<i>coagulation factor x</i>
COLUMVI	<i>glofitamab-gxbm</i>
COPAXONE	<i>glatiramer acetate</i>
CORIFACT*	<i>factor xiii*</i>
COSELA	<i>trilaciclib</i>
COSENTYX	<i>secukinumab</i>
CRYSVITA*	<i>burosumab-twza*</i>
CUTAQUIG*	<i>immune globulin subcutaneous (human)-hipp*</i>
CUVITRU*	<i>immune globulin*</i>
CYLTEZO*	<i>adalimumab-adbm*</i>
CYRAMZA	<i>ramucirumab</i>
CRYSVIEW	<i>hexaminolevulinate hydrochloride</i>
CYTOGAM*	<i>cytomegalovirus immune globulin*</i>
DACOGEN	<i>decitabine</i>
DANYELZA	<i>naxitamab-gqgk</i>
DARZALEX	<i>daratumumab</i>
DARZALEX FASPRO	<i>daratumumab and hyaluronidase</i>
DATSCAN	<i>iodine 1-123 ioflupane, diagnostic</i>
DDAVP*	<i>desmopressin*</i>
DENGVAXIA	<i>dengue vaccine</i>
DOTATOC GA 68	<i>gallium ga-68</i>
DURYSTA	<i>bimatoprost implant</i>
DYSPORT	<i>botulinum toxin</i>
ELAHERE	<i>mirvetuximab soravtansine-gynx</i>
ELAPRASE*	<i>idursulfase*</i>
ELELYSO*	<i>taliglucerase alfa*</i>

Brand Name	Generic Name
ELEVIDYS	<i>delandistrogene moxeparovvec-rokl</i>
ELFABRIO	<i>pegunigalsidase alfa-iwxj</i>
ELIGARD*	<i>Leuprolide*</i>
ELOCTATE*	<i>antihemophilic factor*</i>
ELUCIREM	<i>gadopiclenol</i>
ELZONRIS	<i>tagrazofusp</i>
EMPAVELI	<i>pegcetacoplan</i>
EMPLICITI	<i>elotuzumab</i>
ENBREL	<i>etanercept</i>
ENHERTU	<i>fam-trastuzumab</i>
ENJAYMO	<i>sutimlimab-jome</i>
ENTYVIO*	<i>vedolizumab*</i>
EPKINLY	<i>epcoritamab-bysp</i>
EPOGEN*	<i>epoetin alfa*</i>
ERBITUX	<i>cetuximab</i>
ESPEROCT*	<i>factor viii (recombinant)*</i>
EVENITY*	<i>romosozumab*</i>
EVKEEZA	<i>evinacumab-dgnb</i>
EYLEA	<i>afibercept</i>
FABRAZYME*	<i>agalsidase beta*</i>
FASENRA	<i>benralizumab</i>
FASLODEX	<i>fulvestrant</i>
FEIBA NF*	<i>anti-inhibitor coagulant*</i>
FENSOLVI*	<i>leuprolide acetate*</i>
FIBRYGA	<i>fibrinogen concentrate (human)</i>
FIRAZYR*	<i>icatibant*</i>
FLEBOGAMMA*	<i>immune globulin*</i>
FLOLAN*	<i>epoprostenol*</i>
FLUORODOPA F18	<i>n/a</i>
FOLOTYN	<i>pralatrexate</i>
FORTEO	<i>teriparatide</i>
FULPHILA*	<i>pegfilgrastim-jmbd*</i>
FYARRO	<i>sirolimus protein-bound particles</i>
FYLNETRA*	<i>pegfilgrastim-pbbk*</i>
GALLIUM Ga-68 PSMA-11	<i>n/a</i>
GAMIFANT	<i>emapalumab</i>
GAMMAGARD LIQUID*	<i>immune globulin*</i>
GAMMAGARD S-D*	<i>immune globulin*</i>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



Brand Name	Generic Name	Brand Name	Generic Name
GAMMAKED*	<i>immune globulin*</i>	ISTODAX	<i>romidepsin</i>
GAMMAPLEX*	<i>immune globulin*</i>	IXIFI*	<i>infliximab-qbtx*</i>
GAMMUNEX-C*	<i>immune globulin*</i>	IXINITY*	<i>coagulation factor IX *</i>
GAZYVA	<i>oinutuzumab</i>	JELMYTO	<i>mitomycin</i>
GENTROPIN	<i>somatropin</i>	JEMPERLI	<i>dostarlimab-gxly</i>
GIVLAARI*	<i>givosiran*</i>	JEVTANA	<i>cabazitaxel</i>
GLASSIA*	<i>alpha 1-proteinase inhibitor*</i>	JIVI*	<i>factor viii (antihemophilic factor, recombinant, pegylated-aucl)*</i>
GLATOPA	<i>glatiramer acetate</i>	KADCYLA	<i>ado-trastuzumab</i>
GLEOLAN	<i>aminolevulinic acid hydrochloride</i>	KALBITOR	<i>ecallantide</i>
GRANIX*	<i>tbo-filgrastim*</i>	KANJINTI	<i>trastuzumab-anns</i>
HADLIMA*	<i>adalimumab-bwwd*</i>	KANUMA*	<i>sebelipsae alfa*</i>
HAEGARDA*	<i>c1 esterase inhibitor*</i>	KEPIVANCE	<i>palifermin</i>
HELIXATE FS*	<i>antihemophilic factor*</i>	KESIMPTA	<i>ofatumumab</i>
HEMGENIX	<i>etranacogene dezaparvovec-drlb</i>	KEYTRUDA	<i>pembrolizumab</i>
HEMLIBRA*	<i>emicizumab-kxwh*</i>	KHAPZORY	<i>levoleucovorin</i>
HEMOFIL M*	<i>antihemophilic factor*</i>	KIMMTRAK	<i>tebentafusp-tebn</i>
HERCEPTIN	<i>trastuzumab</i>	KITABIS	<i>tobramycin</i>
HERCEPTIN HYLECTA	<i>trastuzumab and hyaluronidase</i>	KOATE*	<i>antihemophilic factor*</i>
HERZUMA	<i>trastuzumab-pkrb</i>	KOATE-DVI*	<i>antihemophilic factor*</i>
HIZENTRA*	<i>immune globulin*</i>	KOGENATE FS*	<i>antihemophilic factor*</i>
HULIO*	<i>adalimumab-fkjp*</i>	KORSUVA	<i>difelikefalin</i>
HUMATE-P*	<i>antihemophilic factor*</i>	KOVALTRY*	<i>antihemophilic factor*</i>
HUMATROPE	<i>somatropin</i>	KRYSTEXXA*	<i>pegloticase*</i>
HUMIRA*	<i>adalimumab*</i>	KYMRIAH	<i>tisagenlecleucel</i>
HYCAMTIN	<i>topotecan</i>	KYPROLIS	<i>carilzomib</i>
HYQVIA*	<i>immune globulin hyaluronidase*</i>	LAMZEDE	<i>velmanase alfa-tycv</i>
HYRIMOZ*	<i>adalimumab-adaz*</i>	LEMTRADA*	<i>alemtuzumab*</i>
IDACIO*	<i>adalimumab-aacf*</i>	LEQEMBI	<i>lecanemab-irmb</i>
IDELVION*	<i>coagulation factor IX*</i>	LEQVIO	<i>inclisiran</i>
ILARIS*	<i>canakinumab*</i>	LEUKINE*	<i>sargramostim*</i>
ILLUCIX	<i>gallium ga-68 gozetotide</i>	LIBTAYO	<i>cemiplimab</i>
ILUMYA*	<i>tildrakizumab*</i>	LOCAMETZ	<i>gallium ga 68 gozetotide (psma-11)</i>
ILUVIEN	<i>fluocinolone acetonide implant</i>	LUCENTIS	<i>ranibizumab</i>
IMFINZI	<i>durvalumab</i>	LUMIZYME*	<i>alglucosidase alfa*</i>
IMJUDO	<i>tremelimumab-act1</i>	LUMOXITI	<i>moxetumomab pasidotex</i>
IMLYGIC	<i>imlygic</i>	LUNSUMIO	<i>mosunetuzumab-axgb</i>
INCRELEX	<i>mecasermin</i>	LUPRON DEPOT*	<i>leuprolide*</i>
INFLECTRA*	<i>infliximab*</i>	LUXURNA	<i>voretigene nepravovec</i>
INFUGEM	<i>gemcitabine</i>		

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



Brand Name	Generic Name
MARGENZA	<i>margetuximab-cmkb</i>
MEPSEVII*	<i>vestronidase alfa*</i>
MIRCERA	<i>epoetin beta</i>
MONJUVI	<i>tafasitamab-cxix</i>
MONONINE*	<i>coagulation factor ix*</i>
MOZOBIL*	<i>plerixafor*</i>
MVASI	<i>bevacizumab-awwb</i>
MYLOTARG	<i>gemtuzumab ozogamicin</i>
MYOBLOC	<i>botulinum toxin</i>
NAGLAZYME*	<i>galsufase*</i>
NEULASTA*	<i>pegfilgrastim*</i>
NEUPOGEN*	<i>filgrastim*</i>
NEUROLITE	<i>technetium tc-99m bicisate, diagnostic</i>
NEXVIAZYME*	<i>avalglucosidase alfa-ngpt*</i>
NITRIC OXIDE	<i>inhaled nitric oxide</i>
NIVESTYM*	<i>filgrastim g-csf*</i>
NORDITROPIN	<i>somatropin</i>
NOVOEIGHT*	<i>antihemophilic factor*</i>
NOVOSEVEN RT*	<i>coagulation factor viia*</i>
NPLATE*	<i>romiplostim*</i>
NUCALA*	<i>mepolizumab*</i>
NULIBRY	<i>fosdenopterin</i>
NULOJIX*	<i>belatacept*</i>
NUTROPIN	<i>somatropin</i>
NUWIQ*	<i>antihemophilic factor*</i>
NYVEPRIA*	<i>pegfilgrastim-apgf*</i>
OBIZUR	<i>antihemophilic factor</i>
OCREVUS*	<i>ocrelizumab*</i>
OCTAGAM*	<i>immune globulin*</i>
OGIVRI	<i>trastuzumab-dkst</i>
OMISRIGE	<i>omidubicel-only</i>
OMNITROPE	<i>somatropin</i>
ONCASPAR	<i>pegaspargase</i>
ONIVYDE	<i>irinotecan</i>
ONPATTRO	<i>patisiran</i>
ONTRUZANT	<i>trastuzumab-dttb</i>
OPDIVO	<i>nivolumab</i>
OPDUALAG	<i>nivolumab and relatlimab-rmbw</i>
ORENCIA*	<i>abatacept*</i>

Brand Name	Generic Name
OTIPRIO	<i>ciprofloxacin</i>
OXLUMO	<i>lumasiran</i>
PADCEV	<i>enfortumab vedotin-ejfv</i>
PANZYGA*	<i>immune globulin*</i>
PARAPLATIN	<i>carboplatin</i>
PEDMARK	<i>sodium thiosulfate</i>
PEMFEXY	<i>pemetrexed</i>
PERJETA	<i>pertuzumab</i>
PHESGO	<i>pertuzumab, trastuzumab, hyaluronidase</i>
PHOTREXA	<i>riboflavin 5'-phosphate ophth</i>
PLUVICTO	<i>lutetium Lu 177 vipivotide tetraxetan</i>
POLIVY	<i>polatuzumab vedotin-piq</i>
POSLUMA	<i>flotufolastat f 18, diagnostic, 1 millicurie</i>
POTELIGEO	<i>mogamulizumab-kpkc</i>
PRECEDEX	<i>dexmedetomidine</i>
PRIVIGEN*	<i>immune globulin*</i>
PROCRIT*	<i>epoetin alfa*</i>
PROFILNINE*	<i>factor ix complex*</i>
PROLASTIN-C*	<i>alpha 1-proteinase inhib*</i>
PROLEUKIN	<i>aldesleukin</i>
PROLIA*	<i>denosumab*</i>
PROPEL	<i>mometasone furoate sinus implant</i>
PROVENGE	<i>sipuleucel-t</i>
PYLARIFY	<i>piplifeolastat f18</i>
QALSODY	<i>tofersen</i>
QUZYTIR	<i>cetirizine</i>
RADICAVA	<i>edaravone</i>
REBINYN*	<i>coagulation factor ix*</i>
REBLOZYL	<i>luspatercept-aamt</i>
REBYOTA	<i>fecal microbiota</i>
RECARBRIOD	<i>imipenem, cilastatin, rebactam</i>
RECLAST*	<i>zoledronic acid*</i>
RECOMBINATE*	<i>antihemophilic factor*</i>
RELEUKO*	<i>filgrastim-ayow*</i>
REMICADE*	<i>infliximab*</i>
REMODULIN*	<i>treprostinil*</i>
RENFLEXIS*	<i>infliximab*</i>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



Brand Name	Generic Name
RETACRIT*	<i>epoetin alfa*</i>
RETHYMIC	<i>allogeneic processed thymus tissue-agdc</i>
RETISERT	<i>fluocinolone acetonide implant</i>
RIABNI*	<i>rituximab-arrx*</i>
RIASTAP*	<i>fibrinogen concentrate*</i>
RITUXAN*	<i>rituximab*</i>
RITUXAN HYCELA	<i>rituximab and hyaluronidase</i>
RIXUBIS*	<i>coagulation factor ix*</i>
ROCTAVIAN	<i>valoctocogene roxaparvovec-rvox</i>
ROLVEDON	<i>eflapegrastim-xnst</i>
RUCONEST*	<i>c1 esterase inhibitor*</i>
RUXIENCE*	<i>rituximab-pvvr*</i>
RYBREVANT	<i>amivantamab-vmjw</i>
RYLAZE	<i>recombinant erwinia asparaginase</i>
RYPLAZIM	<i>plasminogen, human-tvmh</i>
RYSTIGGO	<i>rozanolixizumab-noli</i>
SAIZEN	<i>somatropin</i>
SANDOSTATIN	<i>octreotide, non-depot</i>
SANDOSTATIN LAR DEPOT	<i>octreotide, depot</i>
SAPHNELO	<i>anifrolumab</i>
SARCLISA	<i>isatuximab-irfc</i>
SCENESSE	<i>afamelanotide implant</i>
SEROSTIM	<i>somatropin</i>
SEVENFACT*	<i>factor via*</i>
SIGNIFOR LAR*	<i>pasireotide*</i>
SIMPONI ARIA*	<i>golimumab*</i>
SINUVA	<i>mometasone furoate</i>
SKYRIZI	<i>risankizumab</i>
SKYSONA	<i>elivaldogene autotemcel</i>
SOLIRIS*	<i>eculizumab*</i>
SOMATULINE*	<i>lanreotide*</i>
SOMAVERT	<i>pegvisomant</i>
SPEVIGO	<i>spesolimab-sbzo</i>
SPINRAZA	<i>nusinersen</i>
SPRAVATO	<i>esketamine intranasal</i>
STELARA*	<i>ustekinumab*</i>
STIMUFEND*	<i>pegfilgrastim-fpgk*</i>
SUNLENCA	<i>lenacapavir</i>

Brand Name	Generic Name
SUPPRELLIN LA	<i>histrelin acetate</i>
SYFOVRE	<i>pegcetacoplan</i>
SYLVANT	<i>siltuximab</i>
SYNAGIS	<i>palivizumab</i>
SYNRIBO	<i>omacetaxine</i>
TAKHYRO	<i>lanadelumab-flyo</i>
TALTZ*	<i>ixekizumab*</i>
TAUVID	<i>flortaucipir f 18</i>
TAXOTERE	<i>docetaxel</i>
TECARTUS	<i>brexucabtagene autoleucel</i>
TECENTRIQ	<i>atezolizumab</i>
TECHNESCAN MAG3	<i>Technetium tc-99m mertiatide, diagnostic</i>
TECVAYLI	<i>teclistamab-cqyy</i>
TEMODAR	<i>temozolamide</i>
TEPEZZA*	<i>teprotumumab-trbw*</i>
TESTOPEL	<i>testosterone</i>
TEZSPIRE*	<i>Tezepelumab-ekko*</i>
TIVDAK	<i>tisotumab vedotin-tftv</i>
TOBI	<i>tobramycin</i>
TRAZIMERA	<i>trastuzumab-qyyp</i>
TRELSTAR	<i>triptorelin pamoate</i>
TREMFYA*	<i>gusekumab*</i>
TRETEN*	<i>coagulation factor xiii*</i>
TRIPTODUR	<i>triptorelin</i>
TRODELVY	<i>sacituzumab govitecan</i>
TROGARZO*	<i>ibalizumab-uiyk*</i>
TRUXIMA*	<i>rituximab-abbs*</i>
TYSBRI*	<i>natalizumab*</i>
TYVASO*	<i>treprostинil*</i>
TZIELD	<i>teplizumab-mzwv</i>
UDENYCA*	<i>pegfilgrastim-cbqv*</i>
ULTOMIRIS*	<i>ravulizumab-cwvz*</i>
UNITUXIN	<i>dinutuximab</i>
UPLIZNA*	<i>inebilizumab-cdon*</i>
UPTRAVI	<i>selexipag</i>
VABYSMO	<i>faricimab-svoa</i>
VECTIBIX	<i>panitumumab</i>
VEGZELMA	<i>bevacizumab-adcd</i>
VEKLURY	<i>remdesivir</i>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



Brand Name	Generic Name
VELCADE	<i>bortezomib</i>
VELETRI*	<i>epoprostenol sodium*</i>
VENTAVIS*	<i>iloprost*</i>
VIMIZIM*	<i>elosulfase alfa*</i>
VONVENDI*	<i>von willebrand factor*</i>
VPRIV*	<i>velaglucerase alfa*</i>
VUEWAY	<i>gadopiclenol</i>
VYEPTI	<i>eptinezumab-jjmr</i>
VYJUVEK	<i>beremagene geperpavec-svdt (topical)</i>
VYVGART	<i>efgartigimod alfa-fcab</i>
VYVGART HYTRULO	<i>efgartigimod alfa and hyaluronidase-qvfc</i>
VYXEOS	<i>daunorubicin-cytarabine</i>
WILATE*	<i>von willebrand factor*</i>
XEMBIFY*	<i>immune globulin*</i>
XENOVIEW	<i>xenon xe-129 hyperpolarized gas</i>
XENOZYME	<i>olipudase alfa-rpcp</i>
XEOMIN	<i>botulinum toxin</i>
XGEVA*	<i>denosumab*</i>
XIPERE	<i>triamcinolone acetonide, suprachoroidal</i>
XOLAIR*	<i>omalizumab*</i>
XYNTHA*	<i>antihemophilic factor*</i>

Brand Name	Generic Name
YERVOY	<i>ipilimumab</i>
YESCARTA	<i>axicabtagene ciloleucel</i>
YUFLYMA*	<i>adalimumab-aaty*</i>
YUSIMRY*	<i>adalimumab-aqvh*</i>
YUTIQ	<i>fluocinolone acetonide implant</i>
ZALTRAP	<i>ziv-aflibercept</i>
ZARXIO*	<i>filgrastim*</i>
ZEMAIRA*	<i>alpha 1-proteinase inhib*</i>
ZEPZELCA	<i>lurbinectedin</i>
ZIEXTENZO*	<i>pegfilgrastim-bmez*</i>
ZILRETTA	<i>triamcinolone acetonide</i>
ZIRABEV	<i>bevacizumab-bvzr</i>
ZOLADEX	<i>goserelin</i>
ZOLGENSMA	<i>onasemnogene abeparvovec</i>
ZOMACTON	<i>somatotropin</i>
ZOMETA*	<i>zoledronic acid*</i>
ZORBTIVE	<i>somatotropin</i>
ZULRESSO	<i>brexanolone</i>
ZYNLONTA	<i>loncastuximab tesirine-lpyl</i>
ZYNTEGLO	<i>betibeglogene autoemcel</i>
ZYNZY	<i>retifanlimab-dlw</i>

Excluded Medications/Supplies Under Medical Benefit

Oral and self-injectable medications are not covered under the medical benefit for outpatient services, but they may be covered under the pharmacy benefit when dispensed by a pharmacy. Please refer to the Pharmacy section below for Prior Approval requirements and the Health Options' formulary for oral and self-injectable medication coverage at HealthOptions.org/Formulary.

This list is not all-inclusive and is subject to change

Brand Name	Generic Name
ADUHELM	<i>aducanumab-avwa</i>
AMONDYS	<i>casimersen</i>
DUROLANE	<i>sodium hyaluronate</i>
EXONDYS 51	<i>eteplirsen</i>
LEQEMBI	<i>Lecanemab-irmb</i>

Brand Name	Generic Name
SUSVIMO	<i>ranibizumab</i>
TICOVAC	<i>tick-borne encephalitis vaccine</i>
VILTEPSO	<i>viltolarsen</i>
VYONDYS 53	<i>golodirsen</i>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



Health Options utilizes a drug formulary provided by our Pharmacy Benefit Manager, Express Scripts, to ensure rational selection and use of medications, and to ensure quality, cost-effective prescribing. The formulary is developed with the input of practicing providers and pharmacists that participate in the Express Scripts® National Pharmacy and Therapeutics (P&T) Committee. The P&T Committee reviews medications for clinical appropriateness, formulary management activities (therapeutic or generic substitution, formulary exceptions) and is responsible for approving changes to existing or new utilization management criteria, such as Prior Authorization, Step Therapy, and Quantity Limits. The Pharmacy Benefit Manager in coordination with Health Options continually reviews new medications as well as information related to medications currently included in the Formulary.

Formulary changes are made each year in January and July. These changes will be included in the Provider Bulletin.

A minimum of sixty (60) days' advance notice is provided to Members utilizing medications being removed from the formulary. No advanced notice is provided when the approval or withdrawal of a medication is made by the Food and Drug Administration.

The formulary provides the following pharmaceutical management information:

- Covered pharmaceuticals
- Explanation of limits
- Tiering information
- Restrictions and limits, such as prior authorization, step therapy, and quantity limit

Because Health Option's formulary is updated frequently, we recommend that you consult it before writing a prescription for a Health Options Member. This will better enable you to prescribe a covered medication and minimize the Member's out-of-pocket costs. The current Health Options formulary can be found at: HealthOptions.org/Formulary

Requesting Prior Approval

Health Option's Pharmacy Benefit Manager, Express Scripts, maintains a process by which prescribing practitioners can:

- Request Prior Approval for medication(s) designated in the formulary by:
 - PA (Prior Approval)
 - ST (Step Therapy)
 - QL (Quantity Limit)
- Request an exception to coverage consideration for non-formulary medications
 - Information to support the request can be submitted via the following:
 - Telephone (PA line): (800) 417-8164
 - Fax: (877) 251-5896
 - Electronic PA (ePA): www.esrx.com/pa
 - ExpressPAth: <https://www.express-path.com/login.aspx>
 - Cover My Meds: <https://www.covermymeds.com>
 - SureScripts: <https://providerportal.surescripts.net/ProviderPortal/login>

Prior Authorization forms are available in the provider portal and on the www.HealthOptions.org website under HealthCare Providers > Resources > Forms

Prescribing Practitioners can initiate such requests by contacting Express Scripts via the following:

- Telephone (PA line): (800) 417-8164
- Fax: (877) 251-5896
- Electronic PA (ePA): www.esrx.com/pa
- ExpressPAth: <https://www.express-path.com/login.aspx>
- Cover My Meds: <https://www.covermymeds.com>
- SureScripts: <https://providerportal.surescripts.net/ProviderPortal/login>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



Excluded Medications Under Pharmacy Benefit

Drug Class	Excluded Medications	Preferred Alternatives
ANTIINFECTIVES		
Antibiotic Agents – Vancomycins (Oral)	FIRVANQ, VANCOMYCIN 25 MG/ML SOLUTION	<i>vancomycin capsules, vancomycin 50 mg/ml oral solution</i>
Antibiotic Agents Other	SIVEXTRO	<i>linezolid</i>
Antifungal Agents (Oral)	TOLSURA	<i>itraconazole</i>
Antivirals (Oral)	SITAVIG, XERESE	<i>acyclovir oral or cream, famciclovir, valacyclovir</i>
Chagas Disease Agents	LAMPIT	BENZNIDAZOLE
AUTONOMIC & CENTRAL NERVOUS SYSTEM		
Alpha-2 Adrenergic Agonists (for Opioid Withdrawal)	LUCEMYRA	<i>clonidine</i>
Alzheimer's Agents	ADUHELM, LEQEMBI	No alternatives recommended
Amyotrophic Lateral Sclerosis (ALS) Agents	QALSODY, RELYVRIO	No alternatives recommended
Anticonvulsants	EPRONTIA	<i>topiramate sprinkle capsules</i>
	FINTEPLA	DIACOMIT, EPIDIOLEX
	PRIMIDONE 125 MG TABLETS	<i>primidone 50 mg or 250 mg tablets</i>
	ZONISADE	<i>zonisamide</i>
Antimigraine Agents	ONZETRA XSAIL, ZOLMITRIOTAN NASAL SPRAY 2.5 MG	<i>sumatriptan nasal spray, ZOMIG NASAL 2.5 MG</i>
	VYEPTI	AIMOVIG, AJOVY, EMGALITY
	ZAVZPRET	NURTEC ODT, UBRELVY
Antiparkinsonism Agents	APOKYN	Coverage may be approved for the treatment of Parkinson's Disease under certain conditions
	DHIVY	<i>carbidopa / levodopa</i>
	GOCOVRI ER, OSMOLEX ER	<i>amantadine capsules, amantadine oral solution, amantadine tablets</i>
	ONGENTYS	<i>entacapone</i>
	XADAGO, ZELAPAR	<i>rasagiline, selegiline</i>
Antipsychotics (Injectable)	INVEGA HAFYERA, UZEDY ER	ABILIFY ASIMTUFI, ABILIFY MAINTENA, ARISTADA, RSIPERDAL CONSTA
Antipsychotics (Oral)	LYBALVI	<i>ariPIPrazole, asenapine, lurasidone, olanzapine, paliperidone er, quetiapine, quetiapine er, ziprasidone</i>
	QUETIAPINE 150 MG TABLETS	<i>quetiapine, quetiapine er</i>
Antispasmodic Agents	BALCOFEN SOLUTION, BACLOFEN SUSPENSION, FLEQSUVY, LYVISPAH, OZOBAX	<i>baclofen tablets</i>
Anxiolytic Agents	LOREEV XR	<i>lorazepam tablets</i>
Cataplexy Treatment	XYREM	LUMRYZ, SODIUM OXYBATE, XYWAV
Central Nervous System Stimulants	DYANAVEL XR, XELSTRYM	<i>dextroamphetamine er, dextroamphetamine/amphetamine er, MYDAYUS, VYVANSE</i>
	METHYPHENIDATE ER 45 MG, 63 MG & 72 MG,	<i>dexamethylphenidate er, dextroamphetamine</i>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



	QUILLCHEW ER, QUILLIVANT XR, RELEXXII ER	<i>sulfate er, dextroamphetamine/amphetamine er, methylphenidate cd, methylphenidate er, methylphenidate la, MYDAYIS, VYVANSE</i>
Duchenne Muscular Dystrophy (DMD) Agents	AMONDYS 45, EXONDYS 51, VILTEPSO, VYONDYS 53	No alternatives recommended
	EMFLAZA	<i>prednisone solution, prednisone tablets</i>
Friedreich's Ataxia Agents	SKYCLARYS	No alternatives recommended
Multiple Sclerosis Agents	BRIUMVI	KESPIMTA, OCREVUS
	EXTAVIA	AVONEX, BETASERON, PLEGRIKY, REBIF
	GILENYA, TASCENO ODT	<i> fingolimod, teriflunomide, BAFIERTAM, BAFIERTAM, MAYZENT, PONVORY, VUMERTY</i>
Narcotic Analgesics & Combinations	APADAZ, BENZHYDROCODONE/ACETAMINOPEHN	<i>hydrocodone/acetaminophen</i>
	CONZIP, QDOLO, TRAMADOL 100 MG TABLETS, TRAMADOL ER CAPSULES, TRAMADOL SOLUTION	<i>tramadol tablets, tramadol er tablets</i>
	NUCYNTA	<i>hydrocodone/acetaminophen, morphine sulfate, oxycodone, tramadol, tramadol/acetaminophen</i>
	NUCYTNA ER, OXYCODONE ER, XTAMPZA ER	<i>hydrocodone bitartrate er, hydromorphone er, morphine sulfate er, oxymorphone hcl er, HYSINGLA ER, OXYCONTIN</i>
	OXAYDO, ROXYBOND	<i>oxycodone</i>
	PRIMLEV, PROLATE SOLUTION	<i>oxycodone/acetaminophen</i>
	SEGLENTIS	<i>tramadol tablets plus celecoxib</i>
Narcotic Antagonists	ZIMHI	<i>naloxone syringes</i>
Rett Syndrome Agents	DAYBUE	No alternatives recommended
Sedative-Hypnotic Agents	DORAL, QUAZEPAM	<i>estazolam, lorazepam</i>
	ZOLPIDEM 7.5 MG CAPSULES, ZOLPIMIST	<i>Eszopiclone, zaleplon, zolpidem</i>
Selective Serotonin Reuptake Inhibitors (SSRIs) Antidepressants	CITALOPRAM CAPSULES, PEKEVA, SERTRALINE CAPSULES	<i>citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, sertraline</i>
Serotonin/Norepinephrine Reuptake Inhibitor Antidepressants	DRIZALMA SPRINKLE, VENLAFAXINE BESYLATE ER	<i>desvenlafaxine er, duloxetine, venlafaxine hcl er, FETZIMA</i>
Transmucosal Fentanyl Analgesics	FENTANYL CITRATE Buccal TABLETS, FENTORA, SUBSYS	<i>fentanyl citrate lozenges</i>
Miscellaneous Antidepressants	APLENZIN, BUPROPION XL 450 MG, FORFIVO XL	<i>bupropion xl 150 mg or 300 mg</i>
	AUVELITY ER	<i>bupropion, citalopram, duloxetine, paroxetine, sertraline, venlafaxine, FETZIMA</i>
	SPRAVATO	<i>olanzapine/fluoxetine, bupropion, desvenlafaxine er, duloxetine, escitalopram, mirtazapine, sertraline</i>
CARDIOVASCULAR		
ACE Inhibitors	QBRELIS	<i>lisinopril</i>
Alpha-Adrenergic Agonists	CLONIDINE ER 0.17 MG, NEXICLON XR	<i>clonidine patches, clonidine tablets</i>
Angiotensin Receptor Blockers (ARBs) and Combinations	EDARBI	<i>candesartan, irbesartan, losartan, olmesartan, telmisartan, valsartan</i>
	EDARBYCLOL	<i>candesartan/hydrochlorothiazide, irbesartan/hydrochlorothiazide, losartan/hydrochlorothiazide, olmesartan/hydrochlorothiazide,</i>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



		<i>telmisartan/hydrochlorothiazide, valsartan/hydrochlorothiazide, chlorthalidone plus valsartan</i>
	VALSARTAN SOLUTION	<i>valsartan tablets</i>
Anticoagulants	PRADAXA, SAVAYSA	ELIQUIS, XARELTO
Beta Blockers & Combinations	HEMANGEOL	<i>propranolol solution</i>
	INDERAL XL, INNOPRAN XL	<i>propranolol er</i>
	KAPSPARGO SPRINKLE	<i>metoprolol succinate</i>
Calcium Channel Blockers	CONJUPRI, LEVAMLODIPINE	<i>amlodipine, felodipine er, nifedipine er, nisoldipine</i>
	KATERZIA, NORLIQVA	<i>amlodipine tablets</i>
Diuretics	CAROSPIR	<i>spironolactone</i>
	FUROSCIX, SOAANZ	<i>bumetanide, furosemide, torsemide</i>
	THALITONE	<i>chlorthalidone</i>
Fenofibrates	ANTARA, FENOFIBRATE CAPSULES (30 MG, 50 MG, 90 MG, 150 MG), LIPOFEN	<i>fenofibrate capsules (43 mg, 67 mg, 130 mg, 134 mg, 200 mg), fenofibrate tablets, fenofibric acid</i>
HMG & Cholesterol Inhibitor Combinations	ALTOPREV, ATORVALIQ, EZALLOR SPRINKLE	<i>atorvastatin, fluvastatin er, lovastatin, pravastatin, rosuvastatin, simvastatin tablets, LIVALO</i>
	ROSVASTATIN/EZETIMIBE	<i>ezetimibe plus atorvastatin or rosuvastatin</i>
PCSK9 & siRNA Inhibitors	LEQVIO, PRALUENT	REPATHA
Pulmonary Arterial Hypertension (PAH) Agents	LIQREV, TADLIQ	<i>sildenafil oral suspension, sildenafil 20 mg tablets, tadalafil 20 mg tablets</i>
Miscellaneous Cardiovascular Agents	ASPRUZO SPRINKLE ER	<i>ranolazine er</i>
	CORLANOR	<i>atenolol, bisoprolol, carvedilol, metoprolol succinate, metoprolol tartrate, propranolol</i>
	NORPACE CR	<i>amiodarone, quinidine sulfate, sotalol</i>
DERMATOLOGICAL		
Agents for Hyperhidrosis	DRYSOL, QBREXZA	<i>Over-the-Counter aluminum chloride containing products</i>
Oral Agents for Acne	ABSORICA LD	<i>isotretinoin capsules</i>
	DORYX DR 80 MG, DORYX MPC, DOXYCYCLINE HYCLATE DR 80 MG	<i>doxycycline hyclate, doxycycline monohydrate</i>
	MINOCYCLINE BIPHASIC TABLETS, MINOCYCLINE ER CAPSULES, XIMINO	<i>minocycline 24 hour er tablets</i>
Rosacea Agents (Oral)	DOXYCYCLINE 40 MG CAPSULES, ORACEA	<i>Oral: doxycycline hyclate, doxycycline monohydrate Topical: azelaic acid, ivermectin, metronidazole</i>
Rosacea Agents (Topical)	NORITATE	<i>metronidazole</i>
	ZILXI	<i>azelaic acid, ivermectin, metronidazole, sodium sulfacetamide/sulfur, FINACEA FOAM</i>
Topical Agents for Acne	CLENIA PLUS, SULFACETAMIDE/SULFUR 8%-4% CLEANSER, SULFACETAMIDE/SULFUR 9%-4.25% SUSPENSION, ZMA CLEAR	<i>sulfacetamide/sulfur 9%-4% cleanser, sulfacetamide/sulfur 8%-4% suspension</i>
	FABIOR, TAZAROTENE FOAM	<i>tazarotene cream, tretinoin</i>
	VELTIN	<i>clindamycin/benzoyl peroxide,</i>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



		<i>clindamycin/tretinoin, erythromycin/benzoyl peroxide, ONEXTON</i>
	WINLEVI	<i>azelaic acid, clindamycin phosphate gel, clindamycin/tretinoin, dapsone, erythromycin gel, tretinoin, ONEXTON</i>
Topical Agents for Actinic Keratosis	CARAC, FLUOROURACIL 0.5% CREAM, KLISYRI, ZYCLARA	<i>diclofenac 3% gel, fluorouracil 5% cream, fluorouracil 2% solution, imiquimod 5% cream</i>
Topical Antifungals	ECOZA, ERTACZO, LULICONAZOLE, LUZU, OXISTAT LOTION, SULCONAZOLE, XOLEGEL	<i>ciclopirox, clotrimazole, econazole, ketoconazole, naftifine, oxiconazole</i>
	MICONAZOLE/ZINC OXIDE/PETROLATUM, VUSION	<i>clotrimazole, ketoconazole, miconazole, nystatin</i>
Topical Corticosteroids	CLOCORTOLONE PUMP, IMPEKLO, HALOBETASOL 0.05% FOAM, IMPOYZ, LEXETTE, SERNIVO, ULTRAVATE, VERDESO FOAM	<i>generic topical corticosteroids</i>
Vitamin D Analogs (Topical)	CALCIPOTRIENE FOAM, SORILUX	<i>calcipotriene, calcitriol</i>
Miscellaneous Topical Dermatological Agents	ACLORTIN A	<i>generic topical corticosteroids plus mupirocin</i>
	CONDYLOX, VEREGEN	<i>imiquimod 5% cream, podofilox solution</i>
	LIDOCAINE/TETRACAINE, PLIAGLIS	<i>lidocaine cream, lidocaine/prilocaine cream</i>
	TAZORAC 0.05% CREAM	<i>tazarotene 0.1% cream</i>
	TRI-LUMA	<i>fluocinolone acetonide, hydroquinone, tretinoin</i>
DIABETES		
Biguanide Agents	METFORMIN 625 MG TABLETS	<i>metformin 500 mg or 850 mg tablets</i>
Blood Glucose Meters & Test Strips	ASCENSIA (CONTOUR) ONETOUCH SOLUTIONS STARTER KIT ROCHE (ACCU-CHEK) TEMPO (WELCOME KIT, REFILL KIT, SMART BUTTON) TRIVIDIA (TRUETEST, TRUETRACK) ALL OTHER METERS & TEST STRIPS THAT ARE NOT LISTED AS PREFERRED	<i>FREESTYLE KITS/METERS (FREESTYLE FREEDOM, FREESTYLE FREEDOM LITE, FREESTYLE INSULINIX, FREESTYLE LITE) FREESTYLE TEST STRIPS (FREESTYLE, FREESTYLE INSULINIX, FREESTYLE LITE) ONETOUCH KITS/METERS (ULTRA2, ULTRAMINI, VERIO, VERIO FLEX) ONETOUCH TEST STRIPS (ULTRA, VERIO) PRECISION XTRA METERS, TEST STRIPS</i>
Diabetic Pen Needles & Syringes	PEN NEEDLES 7 SYRINGES BY: ARKRAY HOME AID DIAGNOSTICS HTL-STREFA NOVO NORDISK OWEN MUMFORD PRODIGY DIABETES CARE SIMPLE DIAGNOSTICS TRIVIDIA (NIPRO DIAGNOSTICS) ULTIMED ALL OTHER DIABETIC PEN NEEDLES & SYRINGES THAT ARE NOT LISTED AS PREFERRED	<i>BD DIABETES PEN NEEDLES BD DIABETS SYRINGES</i>
Diabetic Supply Kits	BIGFOOT UNITY PROGRAM KIT	<i>DEXOM G6: RECEIVER, SENSOR, TRANSMITTER DEXCOM G7: RECEIVER, SENSOR FREESTYLE LIBRE: READER, SENSOR</i>
Dipeptidyl Peptidase-4 (DDP-4) Inhibitors & Combinations	ALOGLIPTIN, NESINA, ONGLYZA, TRADJENTA	<i>JANUVIA</i>
	ALOGLIPTIN/METFORMIN, JENTADUETO, JENTADUETO XR, KAZANO, KOMBIGLYZE XR	<i>JANUMET, JANUMET XR</i>
	ALOGLIPTIN/PIOGLITAZONE	<i>pioglitazone plus JANUVIA</i>
Dipeptidyl Peptidase-4 (DDP-4)	QTERN, STEGLUJAN	<i>GLYXAMBI</i>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



Inhibitors/Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitor Combinations		
Glucagon-Like Peptide-1 Agonists	VICTOZA	BYDUREON BCISE, BYETTA, OZEMPI, TRULICITY
Glucose-Elevating Drugs	GLUCAGON HYPOKIT, GLUCAGON EMERGENCY KIT (by Fresenius), ZEGALOGUE	<i>glucagon emergency kit</i> (by Amphastar), BAQSIMI, GVOKE
Insulins	ADMEOLOG, AFREZZA, APIDRA, FIASP, HUMALOG TEMPO, INSULIN ASPART, LYUMJEV TEMPO, NOVOLOG, RELION NOVOLOG	HUMALOG, INSULIN LISPRO, LYUMJEV
	BASAGLAR TEMPO, INSULIN DEGLUDEC, INSULIN GLARGINE (BY WINTHROP), INSULIN GLARGINE-YFGN, LANTUS, LEVEMIR, REZVOGLAR	SEMGLEE (YFGN), TOUJEO, TRESIBA
	INSULIN ASPART PROTAMINE, NOVOLOG 70/30 MIX, RELION NOVOLOG 70/30 MIX	HUMALOG 75/25 MIX, INSULIN LISPRO PROTAMINE MIX
	NOVOLIN, RELION NOVOLIN	HUMULIN
Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors & Combinations	INVOKAMET, INVOKAMET XR	SEGLUROMET, SYNJARDY, SYNJARDY XR, XIGDUO XR
	INVOKANA	FARXIGA, JARDIANCE, STEGLATRO
EAR/NOSE		
Nasal Steroids	BECOMASE AQ, OMNARIS, QNASAL, ZETONNA	<i>flunisolide, fluticasone, mometasone</i>
OTIC Antibiotics & Combination Products	CETRAXAL	<i>ciprofloxacin otic, ofloxacin otic</i>
	CIPRO HC, CIPROFLOXACIN/FLUOCINOLONE OTIC	<i>ciprofloxacin/dexamethasone otic</i>
ENDOCRINE		
Cushing's Agents	ISTURISA	SIGNIFOR
	KORLYM	<i>ketoconazole</i> , LYSODREN, SIGNIFOR
	RECORLEV	<i>ketoconazole</i> , LYSODREN
Gonadotropin-Releasing Hormone (GnRH) Analogs (for Central Precocious Puberty)	LUPRON DEPOT-PED, SUPPRELIN LA	FENSOLVI, TRIPTODUR
Growth Hormones	HUMATROPE, NORDITROPIN FLEXPRO, NUTROPIN AQ NUSPIN, SAIZEN, SAIZENPREP, SKYTROFA, SOGROYA, ZOMACTON	GENOTROPIN, OMNITROPE
Somatostatin Analogs	LANREOTIDE, SANDOSTATIN LAR DEPOT	SOMATULINE DEPOT
	SIGNIFOR LAR	For Acromegaly: SOMATULINE DEPOT For Cushing's Disease: SIGNIFOR
Testosterone Products	AVEED	<i>testosterone cypionate, testosterone enanthate</i>
	KYZATREX, NATESTO, TLANDO	<i>testosterone gel, testosterone solution, ANDRODERM PATCHES</i>
Thyroid Replacement Therapy	ADTHYZA	<i>levothyroxine tablets</i> , ARMOUR THYROID
	LEVOTHYROXINE CAPSULES, THYQUIDITY, TIROSANT, TIROSANT-SOL	<i>levothyroxine tablets</i>
Miscellaneous Endocrine Agents	CORTROPHIN GEL	No alternatives recommended
GASTROINTESTINAL		
Antidiarrheal Agents	MYTESI	<i>diphenoxylate/atropine, loperamide</i>
Antiemetics (Oral)	AKYNZE CAPSULES	<i>granisetron, ondansetron, aprepitant, VARUBI TABLETS</i>
	ANTIVERT, MECLIZINE 50 MG TABLETS	<i>meclizine 25 mg tablets</i>
	ANZEMET	<i>granisetron, ondansetron</i>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



	BONJESTA	<i>doxylamine/pyridoxine hcl</i>
	EMEND POWDER PACKETS	<i>aprepitant, VARUBI TABLETS</i>
Bowel Evacuants	CLENPIQ, OSMOPREP, PLENNU, SUTAB	<i>magnesium sulfate/potassium sulfate/sodium sulfate solution, peg 3350/ascorbic acid powder packets</i>
Corticosteroids (Rectal Formulations)	CORTIFOAM	<i>hydrocortisone enema, UCERIS FOAM</i>
Fecal Microbiota Agents	REBYOTA	No alternatives recommended
Gallstone Dissolution Agents	RELTONE	<i>ursodiol</i>
Gastroparesis Agents	GIMOTI	No alternatives recommended
Helicobacter Pylori Agents	VOQUENZA	<i>bismuth/metronidazole/tetracycline, lansoprazole/amoxicillin/clarithromycin, TALCIA</i>
Hemorrhoidal Preparations	HYDROCORTISONE/PRAMOXINE 25-18 MG SUPPOSITORIES	<i>hydrocortisone ac suppositories, pramoxine/hydrocortisone cream</i>
	PROCTOFOAM-HC	<i>pramoxine/hydrocortisone cream</i>
Inflammatory Bowel Agents	DIPENTUM	<i>balsalazide disodium, mesalamine dr, mesalamine er, sulfasalazine, PENTASA 250 MG CAPSULES</i>
Irritable Bowel Syndrome & Chronic Constipation Agents	IBSRELA, MOTEGRITY, ZELNORM	<i>lubiprostone, LINZESS, TRULANCE</i>
Pancreatic Enzymes	PERTZYE	CREON, PANCREAZE, ZENPEP
Proton Pump Inhibitors	KONVOMEP, NEXIUM PACKETS, PRILOSEC SUSPENSION, RABEPRAZOLE DR SPRINKLE	<i>dexlansoprazole, esomeprazole magnesium, lansoprazole, omeprazole, pantoprazole, rabeprazole</i>
Miscellaneous Gastrointestinal Agents	DARTISLA ODT	<i>glycopyrrolate tablets</i>
HEMATOLOGICAL		
Antiplatelet Agents	ASPIRIN/OMEPRAZOLE DR, YOSPRALA DR	<i>aspirin plus omeprazole, esomeprazole, lansoprazole, pantoprazole or rabeprazole</i>
Erythropoiesis-Stimulating Agents	ARANESP, EPOGEN, MIRCERA	PROCRIT, RETACRIT
Factor Deficiency Agents & Related Products	IXINITY, RIXUBIS	BENEFIX
	NOVOSEVEN RT	SEVENFACT
	NUWIQ, RECOMBINATE	ADVATE, ADYNOVATE, AFSTYLA, ELOCTATE, ESPEROCT, JIVI, KOGENATE FS, KOVALTRY, NOVOEIGHT, XYNTHA, XYNTHA SOLOFUSE
	REBINYN	ALPROLIX, IDELVION
Granulocyte Colony Stimulating Factors	FULPHILA, FYLNETRA, NEULASTA, NYVEPRIA, ROLVEDON, STIMUFEND, UDENYCA	ZIEXTENZO
Iron Replacement Agents	MONOFERRIC	<i>sodium ferric gluconate complex, VENOFER</i>
Sickle Cell Disease Agents	OXBRYTA	<i>hydroxyurea, DROXIA</i>
	SIKLOS	DROXIA
Thrombocytopenia Agents	MULPLETA	DOPTELET
HEPATITIS		
Hepatitis C	LEDIPASVIR/SOFOSBUVIR, MAVYRET, SOFOSBUVIR/VELPATASVIR, SOVALDI	EPCLUSA, HARVONI, VOSEVI, ZEPATIER
HIV		
Antiretrovirals	CABENUVA	<i>atazanavir plus lamivudine, darunavir plus lamivudine, lopinavir/ritonavir plus lamivudine,</i>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



Note: Current patients established on therapy are allowed to continue therapy.		DOVATO, JULUCA, TIVICAY plus lamivudine, TIVICAY plus EDURANT
	COMPLERA	ODEFSY
	DELSTRIGO	<i>efavirenz/emtricitabine/tenofovir disoproxil fumarate, efavirenz/lamivudine/tenofovir disoproxil fumarate, BIKTARVY, GENVOYA, ODEFSY, SYMFI, SYMFI LO, SYMTUZA, TRIUMEQ</i>
	PIFELTRO	<i>efavirenz, EDURANT</i>
	PREZCOBIX	<i>atazanavir, lopinavir/ritonavir, ritonavir, PREZISTA</i>
	RUKOBIA ER	Coverage may be approved for the treatment of human immunodeficiency virus-1 infection in heavily treatment-experienced patients with multidrug-resistant infection.
	STRIBILD	BIKTARVY, GENVOYA
MUSCULOSKELETAL & RHEUMATOLOGY		
Gout Therapy	ALLOPURINOL 200 MG TABLETS	<i>allopurinol 100 mg tablets</i>
	COLCHICINE CAPSULES	<i>colchicine tablets, MITIGARE</i>
Muscle Relaxants & Antispasmodic Agents	METHOCARBAMOL 1,000 MG TABLETS	<i>methocarbamol 500 mg tablets</i>
Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)	DICLOFENAC 35 MG CAPSULES, INDOMETHACIN 20 MG CAPSULES, KETOROLAC NASAL SPRAY, RELAFEN DS, TIVORBEX, ZIPSOR, ZORVOLEX	<i>diclofenac, etodolac, flurbiprofen, ibuprofen, indomethacin, ketoprofen, me洛xicam, nabumetone, naproxen, oxaprozin, piroxicam</i>
	ELYXYB	<i>celecoxib</i>
	FENOPROFEN 200 MG CAPSULES	<i>fenoprofen calcium tablets, etodolac, flurbiprofen, ibuprofen, ketoprofen, me洛xicam, nabumetone</i>
	INDOCIN SUPPOSITORIES	<i>etodolac, flurbiprofen, ibuprofen, indomethacin, ketoprofen, me洛xicam, nabumetone, naproxen</i>
	INDOCIN SUSPENSION, MELOXICAM SUSPENSION	<i>ibuprofen suspension, naproxen suspension</i>
Topical Nonsteroidal Anti-Inflammatory Drugs (NSAIDs)	DICLOFENAC EPOLAMINE PATCHES	FLECTOR PATCHES, LICART PATCHES
OBSTETRICAL & GYNECOLOGICAL		
Combination Patches	CLIMARA PRO	COMBIPATCH
Contraceptives	BALCOLTRA, LO LOESTRIN FE, NATAZIA, NEXTSTELLIS, TWIRLA, TYBLUME	generic oral, patch and ring contraceptives
	PHEXXI	Barrier methos of contraception, such as condoms, diaphragms, spermicides, or sponges
	SLYND	generic progestin-only oral contraceptives
Estrogen & Estrogen Modifiers for Vaginal Symptoms	ESTRING, IMVEXXY, INTRAROSA, OSPHENA	<i>estradiol cream, estradiol vaginal inserts, PREMARIN CREAM</i>
	FEMRING	<i>estradiol cream, estradiol patches, estradiol tablets, estradiol vaginal inserts, PREMARIN CREAM</i>
Estrogen/Progestin Combinations (Oral)	BIJUVA, PREMPHASE, PREMPRO	<i>estradiol/norethindrone acetate, ethinyl estradiol/norethindrone acetate</i>
Estrogens (Oral)	MENEST, PREMARIN TABLETS	<i>estradiol tablets</i>
Human Chorionic Gonadotropin	CHORIONIC GONADOTROPIN	NOVAREL, OVIDREL
Ovulatory Stimulants (Follitropins)	FOLLISTIM AQ	GONAL-F, GONAL-F RFF, GONAL-F RFF REDI-

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



		JECT
Prenatal Vitamins	CITRANATAL, NATAL PNV, PREGENNA, TRINAZ	<i>generic prenatal vitamins</i>
Topical Estrogen Agents	ELESTRIN, ESTROGEL, EVAMIST	<i>estradiol gel, estradiol patches</i>
Vaginal Progesterones	CRINONE 4%	<i>medroxyprogesterone, megestrol, norethindrone, progesterone</i>
ONCOLOGY		
Acute Myeloid Leukemia (AML) Agents	ONUREG	No alternatives recommended
	REZLIDHIA	TIBSOVO
B-Cell Lymphoma Agents	EPKINLY	<i>Cyclophosphamide, cytarabine, dexamethasone, doxorubicin, prednisone, vincristine, CARVYKTI, KYMRIAH, RUXIENCE, YESCARTA</i>
Bendamustine Agents	VIVIMUSTA	<i>bendamustine, BENDEKA, TREANDA</i>
Bevacizumab-Containing Agents	ALYMSYS, AVASTIN, VEGZELMA	ZIRABEV
BRAF Inhibitors	BRAFTOVI	TAFINLAR, ZELBORA
Bruton Tyrosine Kinase Inhibitors	JAYPIRCA	CALQUENCE
Cyclin-Dependent Kinase 4/6 Inhibitors	IBRANCE	KISQALI, VERZENIO
Interferons	BESREMI	<i>hydroxyurea, PEGASYS</i>
MEK Inhibitors	MEKTOVI	COTELLIC, MEKINIST
Multiple Myeloma Agents	BLENREP, XPOVIO	<i>bortezomib, DARZALEX, KYPROLIS, NINLARO, POMALYST, REVIMID, THALOMID</i>
Myelodysplastic Syndrome Agents	INQOVI	<i>decitabine</i>
Myelofibrosis Agents	INREBIC	JAKAFI
Non-Small Cell Lung Cancer Agents	KRAZATI	Coverage may be approved for the treatment of KRAS G12C-mutated non-small cell lung cancer
	TEPMETKO	TABRECTA
Prostate Cancer Agents	CAMCEVI, LEUPROLIDE DEPOT, TRELSTAR	ELIGARD, FIRMAGON
	YONSA	<i>abiraterone, XTANDI</i>
Renal Cell Cancer Agents	FOTIVDA	CABOMETYX, INLYTA, LENVIMA
Rituximab-Containing Agents	RIABNI, RITUXAN, RITUXAN HYCELA, TRUXIMA	RUXIENCE
Trastuzumab-Containing Agents	HERCEPTIN, HERCEPTIN HYLECTA, HERZUMA, OGIVRI, ONTRUZANT	KANJINTI, TRAZIMERA
Tyrosine Kinase Inhibitors	QINLOCK	<i>imatinib, sorafenib, sunitinib malate, SPRYCEL, STIVARGA, TASIGNA, VOTRIENT</i>
	SCEMBLIX	<i>imatinib, BOSULIF, ICLUSIG, SPRYCEL, TASIGNA</i>
	TRUSELTIQ	PEMAZYRE
OPHTHALMIC		
Antiglaucoma Agents (Beta-Adrenergic Blockers)	BETIMOL	<i>timolol drops, betaxolol drops, carteolol drops, levobunolol drops</i>
Antiglaucoma Agents (Ophthalmic Prostaglandins)	DURYSTA, XELPROS	<i>bimatoprost drops, latanoprost drops, tafluprost drops, travoprost drops</i>
Antiglaucoma Agents (Other)	RHOPRESSA, ROCKLATAN	<i>betaxolol drops, bimatoprost drops, dorzolamide/timolol drops, latanoprost drops, levobunolol drops, tafluprost drops, timolol drops, travoprost drops</i>
Blepharoptosis Agents	UPNEEQ	No alternatives recommended

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



Ophthalmic Agents – Vascular Endothelial Growth Inhibitors	LUCENTIS	BYOOVIZ, CIMERLI
	SUSVIMO	No alternatives recommended
	VABYSMO	EYLEA
Ophthalmic Agents – Other	ATROPISE (PRESERVATIVE FREE) 1% EYE SINGLE USE DROPPERETTE	<i>atropine 1% drops</i>
	CYSTADROPS	CYSTARAN
	VERKAZIA	<i>azelastine drops, bepotastine drops, cromolyn drops, epinastine drops, olopatadine drops</i>
	VUITY	No alternatives recommended
Ophthalmic Anti-Allergic	ALOCRIL, ALOMIDE, ALREX, LASACRAFT, ZERVIADE	<i>azelastine drops, bepotastine drops, cromolyn drops, epinastine drops, olopatadine drops</i>
Ophthalmic Anti-Inflammatory	FLAREX, FML FORTE, FML S.O.P., MAXIDEX, PRED MILD	<i>dexamethasone drops, fluorometholone drops, loteprednol drops, prednisolone drops</i>
Ophthalmic Combinations	TOBRADEX ST, ZYLET	<i>tobramycin/dexamethasone drops</i>
Ophthalmic Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	ACUVAIL, BROMSITE, NEVANAC	<i>bromfenac drops, diclofenac drops, ketorolac drops</i>
Ophthalmic Quinolone Antibiotics	BESIVANCE, CILOXAN OINTMENT	<i>ciprofloxacin drops, gatifloxacin drops, levofloxacin drops, moxifloxacin drops, ofloxacin drops</i>
OSTEOARTHRITIS		
Hyaluronic Acid Derivatives	DUROLANE, GEL-ONE, GELSYN-3, GENVISC 850, HYALGAN, HYMOVIS, SUPARTZ FX, SYNOJOINT, SYNVISC, SYNVISC-ONE, TRILURON, TRIVISC, VISCO-3	EUFLEXXA, MONOVISC, ORTHOVISC
RENAL		
Nephropathic Cystinosis Agents	PROSYSBI	CYSTAGON
Nephropathy Agents	FILSPARI	<i>Benazepril, candesartan, irbesartan, lisinopril, losartan, ramipril, valsartan</i>
Nocturnal Polyuria Agents	NOCTIVIA	<i>desmopressin tablets</i>
Overactive Bladder Agents	OXYBUTYNIN 2.5 MG, VESICARE LS	<i>oxybutynin er, oxybutynin solution, oxybutynin 5 mg tablets, MYRBETRIQ ER</i>
Phosphate Binders	FOSRENOL POWDER PACKETS	<i>lanthanum, sevelamer carbonate, sevelamer hcl, PHOSLYRA, VELPHORO</i>
RESPIRATORY		
Epinephrine Auto-Injector Systems	EPINEPHRINE AUTO-INJECTOR (BY A-S MEDICATION, AMNEAL PHARMACY, AVKARE)	<i>epinephrine auto-injector (by Mylan, Teva), AUVI-Q, EPIPEN, EPIPEN JR</i>
Idiopathic Pulmonary Fibrosis Agents	PIRFENIDONE 534 mg Tablets	<i>pirfenidone, OFEV</i>
Immunological Agents for Asthma	CINQAIR	DUPIXENT, FASENRA, NUCALA, TEZSPIRE, XOLAIR
Long-Acting Beta Agonist Inhalers	SEREVENT DISKUS	STRIVERDI RESPIMAT
Long-Acting Muscarinic Antagonist Inhalers	INCRUSE ELLIPTA, TURDORZA PRESSAIR	SPRIVIA HANDIHALER, SPIRIVIA RESPIMAT
Long-Acting Muscarinic/Long-Acting Beta-Agonist Combination Inhalers	BEVESPI AEROSPHERE, DUAKLIR PRESSAIR	ANORO ELLIPTA, STILOTO RESPIMAT
Pulmonary Anti-Inflammatory Inhalers	ALVESCO, ARMONAIR DIGIHALER, FLOVENT DISKUS, FLOVENT HFA, FLUTICASONE PROPIONATE HFA, PULMICORT FLEXHALER	ARNURITY ELLIPTA, ASMANEX HFA, ASMANEX TWISTHALER, QVAR REDIHALER
Pulmonary Anti-Inflammatory/Beta-	AIRDUO RESPICLICK,	<i>Budesonide/formoterol</i>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



Agonist Combination Inhalers	FLUTICASONE/SALMETEROL DPI (BY A-S MEDICATION, TEVA), FLUTICASONE/SALMETEROL HFA, FLUTICASONE/VILANTEROL	<i>fluticasone/salmeterol dpi</i> (by Hikma, Prasco, Proficient Rx), ADVAIR HFA, BREO ELLIPTA, DULERA, SYMBICORT
Short-Acting Beta₂-Agonist Inhalers	ALBUTEROL HFA (BY A-S MEDICATION, PRASCO), LEVALBUTEROL HFA, PROAIR DIGITALER, PROAIR RESPICLICK, VENTOLIN HFA, XOPENEX HFA	<i>albuterol sulfate hfa</i> (By Cipla, Civica, Exelan, Lupin, Perrigo, Sandoz, Teva & West-Ward)
MISCELLANEOUS AGENTS		
Allergen Immunotherapy	PALFORZIA	No alternatives recommended
Benign Prostatic Hyperplasia Agents	ENTADFI	<i>finasteride 5 mg plus tadalafil 5 mg</i>
Botulinum Toxin Products	BOTOX	DYSPORT MYOBLOC Migraine – AIMOVIG, AJOVY, EMGALITY, QULIPTA Hyperhidrosis – over-the-counter aluminum chloride containing products
	XEOMIN	DYSPORT, MYOBLOC
Gaucher Disease Agents	ELEYSO, VPRIV	CEREZYME
Glucocorticoids	ALKINDI SPRINKLE	<i>hydrocortisone tablets</i>
	HEMADY	<i>dexamethasone tablets</i>
Hereditary Angioedema	BERINERT	CINRYZE, RUCONEST
Immune Globulins	CUTAQUIG	SC: GAMMAGARD LIQUID, GAMUNEX-C, XEMBIFY
	GAMMAKED	IV: GAMMAGARD LIQUID, GAMMAGARD S-D, GAMUNEX-C SC: GAMMAGARD LIQUID, GAMUNEX-C, XEMBIFY
Immunosuppressant Agents	ENVARSUS XR	<i>tacrolimus</i>
	OTREXUP, REDITREX	RASUVO
	XATMEP	<i>methotrexate</i>
Infused TNF Antagonists	AVSOLA, INFliximab, REMICADE, RENFLEXIS	INFLECTRA
Metabolic Agents	RAVICTI	<i>sodium phenylbutyrate</i> , PHEBURANE
Myasthenia Gravis Agents	RYSTIGGO	Coverage may be approved for the treatment of generalized myasthenia gravis
Neuromyelitis Optica Spectrum Disorder Agents	UPLIZNA	ENSPRYNG
Osteoporosis (Bone Modifiers)	EVENITY, PROLIA	<i>alendronate, ibandronate, risedronate, zoledronic acid</i> , FORTEO, TYMLOS
Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis	AMVUTTRA, ONPATRO	No alternatives recommended
Vasculitis Agents	TAVNEOS	<i>azathioprine, methotrexate, mycophenolate, RUXIENCE</i>
Wilson's Disease Agents	CUVRIOR	<i>trientene</i>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



INDICATION BASED MANAGEMENT		
Drug Class	Excluded Medications	Preferred Alternatives
Adalimumab Products for Inflammatory Conditions*	ADALIMUMAB-FKJP, AMJEVITA, HADLIMA, HULIO, IDACOP, YUFLYMA, YUSIMRY	ADALIMUMAB-ADAZ, CYLTEZO, HUMIRA or HYRIMOZ
Inflammatory Conditions* where SOTYKTU is indicated	SOTYKTU	See below for preferred alternatives
Drug Class	Other Medications	Preferred Alternatives
Inflammatory Conditions*	All other Brand Name medications for Inflammatory Conditions may require a trial of one or more Preferred medications as part of the Formulary exceptions process.	Preferred: ADALIMUMAB-ADAZ, CYLTEZO, ENBREL, HUMIRA, HYRIMOZ, OTEZLA, SKYRIZI, STELARA SC, TALTZ, TREMFYA Preferred after Step through ADALIMUMAB-ADAZ, CYLTEZO, HUMIRA or HYRIMOZ: ACTEMRA SC Preferred after Step through ADALIMUMAB-ADAZ, CYLTEZO, ENBREL, HUMIRA or HYRIMOZ: RINVOQ ER, XELJANZ, XELJANZ XR ULCERATIVE COLITIS ONLY Preferred after Step through ADALIMUMAB-ADAZ, CYLTEZO, HUMIRA or HYRIMOZ: SIMPONI 100 MG, XELJANZ, XELJANZ XR

*Please note that formulary and product placement for treatment of Inflammatory and Atopic Conditions in the Inflammatory and Atopic Conditions Care Value (IACCV) Program are subject to change throughout the year based upon changes in market dynamics, new indications for existing products, biosimilar and new product launches.

Multi-Source Brand Exclusions

BRAND NAME	Generic Name
ABILITY	aripiprazole
ACANYA	clindamycin and benzoyl peroxide
ACIPHEX	rabeprazole
ADCIRCA	tadalafil
ADDERALL, ADDERALL XR	dextroamphetamine/amphetamine
AFINITOR, AFINITOR DISPERZ	everolimus
ALINIA TABLETS	nitazoxanide
AMBIEN, AMBIEN CR	zolpidem
AMITIZA	lubiprostone
AMPYRA	dalfampridine
AMRIX	cyclobenzaprine
ANDROGEL	testosterone
ANUSOL-HC	hydrocortisone
APTENSIO XR	methylphenidate
ARIMIDEX	anastrozole
ASACOL HD	mesalamine
ATACAND, ATACAND HCT	candesartan
ATRALIN	topical tretinoin

BRAND NAME	Generic Name
ATRIPLA	efavirenz, emtricitabine, tenofovir disoproxil fumarate
AUBAGIO	teriflunomide
AVALIDE, AVAPRO	Irbesartan/hydrochlorothiazide, irbesartan
AVODART	dutasteride
AZOPT	brinzolamide
AZOR	amlodipine and olmesartan
BANZEL	rufinamide
BARACLUDE TABLETS	entecavir
BENICAR, BENICAR HCT	olmesartan
BEPREVE	bepotastine
BIDIL	isosorbide dinitrate and hydralazine
BUPAP	butalbital and acetaminophen
BUTRANS	buprenorphine
BYSTOLIC	nebivolol
CANASA	mesalamine
CARAFATE	sucralfate
CELEBREX	celecoxib
CELEXA	citalopram

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



BRAND NAME	Generic Name
CIALIS	<i>tadalafil</i>
CLINDAGEL	<i>clindamycin (topical)</i>
COLCRYS	<i>colchicine</i>
CONCERTA	<i>methylphenidate</i>
COREG	<i>carvedilol</i>
COSOPT, COSOPT PF	<i>dorzolamide and timolol</i>
COZAAR, HYZAAR	<i>losartan, losartan and hydrochlorothiazide</i>
CRESTOR	<i>rosuvastatin</i>
CUPRIMINE	<i>penicillamine</i>
CUVPOSA	<i>systemic glycopyrrolate (glycopyrronium)</i>
CYMBALTA	<i>duloxetine</i>
CYSTADANE	<i>betaine (anhydrous)</i>
CYTOMEL	<i>liothyronine</i>
DALIRESP	<i>roflumilast</i>
DELZICOL	<i>mesalamine</i>
DETROL, DETROL LA	<i>tolterodine</i>
DEXILANT	<i>dexlansoprazole</i>
DIOVAN, DIOVAN HCT	<i>valsartan</i>
DIVIGEL	<i>estradiol transdermal gel</i>
DORYX DR 50 MG & 200 MG	<i>doxycycline</i>
DUREZOL	<i>difluprednate</i>
EFFEXOR XR	<i>venlafaxine er</i>
ELIDEL	<i>pimecrolimus</i>
EMEND CAPSULES, TRIFOLD PACK	<i>aprepitant</i>
EPANED	<i>enalapril</i>
ESBRIET	<i>pirfenidone</i>
ESTRACE CREAM	<i>estradiol</i>
EVEKEO	<i>amphetamine (single ingredient)</i>
EXFORGE, EXFORGE HCT	<i>valsartan and amlodipine; amlodipine, valsartan, hydrochlorothiazide</i>
EXJADE	<i>deferasirox</i>
FERAHEME	<i>ferumoxytol</i>
FIRAZYR	<i>icatibant</i>
FOCALIN, FOCALIN XR	<i>dexamethylphenidate</i>
FOSRENOL CHEWABLE TABLETS	<i>lanthanum</i>
GENERESS FE	<i>ethinyl estradiol and norethindrone</i>
GLEEVEC	<i>imatinib</i>
GLUMETZA	<i>metformin</i>

BRAND NAME	Generic Name
IMITREX	<i>sumatriptan</i>
INDERAL LA	<i>propranolol</i>
INTUNIV	<i>guanfacine</i>
ISTALOL	<i>timolol</i>
JADENU, JADENU SPRINKLE	<i>deferasirox</i>
KEPPRA, KEPPRA XR	<i>levetiracetam</i>
KERYDIN	<i>tavaborole</i>
KEVEYIS	<i>dichlorphenamide</i>
KLONOPIN	<i>clonazepam</i>
KUVAN	<i>sapropterin</i>
LAMICTAL, LAMICTAL ODT, LAMICAL XR	<i>lamotrigine</i>
LATUDA	<i>lurasidone</i>
LETAIRIS	<i>ambrisentan</i>
LEXAPRO	<i>escitalopram</i>
LIALDA	<i>mesalamine</i>
LIBRAX	<i>clidinium and chlordiazepoxide</i>
LIDODERM	<i>lidocaine</i>
LIPITOR	<i>atorvastatin</i>
LOCOID, LOCOID LIPOCREAM	<i>hydrochlorothiazide</i>
LOESTRIN, LOESTRIN FE	<i>ethinyl estradiol and norethindrone</i>
LOTREL	<i>amlodipine and benazepril</i>
LOTRONEX	<i>alosetron</i>
LOVAZA	<i>omega-3-acid ethyl esters (fish oil)</i>
LOVENOX	<i>enoxaparin</i>
LUNESTA	<i>eszopiclone</i>
LYRICA, LYRICA CR	<i>pregabalin</i>
MAXALT, MAXALT MLT	<i>rizatriptan</i>
MESTINON	<i>pyridostigmine</i>
MICARDIS, MICARDIS HCT	<i>telmisartan</i>
MINASTRIN 24 FE	<i>ethinyl estradiol and norethindrone</i>
MINIVELLE	<i>estradiol</i>
MIRCETTE	<i>ethinyl estradiol and desogestrel</i>
MOVIPREP	<i>polyethylene glycol electrolyte sol</i>
NALFON CAPSULES	<i>fenoprofen</i>
NAMENDA XR	<i>memantine</i>
NATROBA	<i>spinatosad</i>
NEURONTIN	<i>gabapentin</i>
NEXIUM CAPSULES	<i>esomeprazole</i>
NORPACE	<i>disopyramide</i>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



Brand Name	Generic Name	Brand Name	Generic Name
NORVASC	<i>amlodipine</i>	STRATTERA	<i>atomoxetine</i>
NOXAFIL TABLETS	<i>posaconazole</i>	SUBOXONE	<i>buprenorphine and naloxone</i>
NUVARING	<i>ethinyl estradiol and etonogestrel</i>	SUPREP	<i>sodium, potassium, and magnesium sulfates bowel preparation kit</i>
NUVIGIL	<i>armodafinil</i>	SYNTHROID	<i>levothyroxine</i>
ONFI	<i>clobazam</i>	TARGRETIN CAPSULES	<i>bexarotene</i>
OXISTAT CREAM	<i>oxiconazole</i>	TAYTULLA	<i>ethinyl estradiol and norethindrone</i>
PENNSAID	<i>diclofenac</i>	TAZORAC 0.1% CREAM, TAZORAC GEL	<i>tazarotene</i>
PERCO CET	<i>oxycodone and acetaminophen</i>	TECFIDERA	<i>dimethyl fumarate</i>
PERFOROMIST	<i>formoterol</i>	TEKTURN A	<i>aliskiren</i>
PLAQUENIL	<i>hydroxychloroquine</i>	TESTIM	<i>testosterone</i>
PLAVIX	<i>clopidogrel</i>	THIOLA	<i>tiopronin</i>
PREVACID, PREVACID SOLUTAB	<i>lansoprazole</i>	TIKOSYN	<i>dofetilide</i>
PRISTIQ	<i>desvenlafaxine</i>	TIMOPTIC OCUDOSE	<i>timolol</i>
PROAIR HFA	<i>albuterol hfa</i>	TOBI SOLUTION	<i>tobramycin</i>
PROTONIX	<i>pantoprazole</i>	TOPAMAX	<i>topiramate</i>
PROVENTIL HFA	<i>albuterol hfa</i>	TOPICORT SPRAY	<i>desoximetasone</i>
PROVIGIL	<i>modafinil</i>	TOPROL XL	<i>metoprolol succinate</i>
PROZAC	<i>fluoxetine</i>	TOVIAZ	<i>fesoterodine</i>
PULMICORT RESPULES	<i>budesonide</i>	TRANSDERM-SCOP	<i>scopolamine</i>
PYLERA	<i>bismuth subcitrate, metronidazole, and tetracycline</i>	TRAVATAN Z	<i>travoprost</i>
PYRIDIUM	<i>phenazopyridine</i>	TREXIMET	<i>sumatriptan and naproxen</i>
QUARTETTE	<i>ethinyl estradiol and levonorgestrel</i>	TRIBENZOR	<i>amlodipine, olmesartan, and hydrochlorothiazide</i>
RANEXA	<i>ranolazine</i>	TRICOR	<i>fenofibrate</i>
RAPAFLO	<i>silodosin</i>	TRILEPTAL	<i>oxcarbazepine</i>
RELPAX	<i>eletiptan</i>	TRUVADA	<i>tenofovir disoproxil fumarate and emtricitabine</i>
RENAGEL	<i>sevelamer</i>	ULORIC	<i>febuxostat</i>
RETIN-A MICRO	<i>tretinoin (topical)</i>	UROXATRAL	<i>alfuzosin</i>
RITALIN, RITALIN LA	<i>methylphenidate, methylphenidate er (24 hour)</i>	VAGIFEM	<i>estradiol</i>
ROZEREM	<i>ramelteon</i>	VALIUM	<i>diazepam</i>
SABRIL	<i>vigabatrin</i>	VALTREX	<i>valacyclovir</i>
SAFYRAL	<i>ethinyl estradiol and drospirenone with levomefolate</i>	VANOS	<i>fluocinonide</i>
SAMSCA	<i>tolvaptan</i>	VESICARE	<i>solifenacin</i>
SAPHRIS	<i>asenapine</i>	VIAGRA	<i>sildenafil</i>
SEASONIQUE, LOSEASONIQUE	<i>ethinyl estradiol and levonorgestrel</i>	VIIBRYD	<i>vilazodone</i>
SENSIPAR	<i>cinacalcet</i>	VIMOVO	<i>esomeprazole and naproxen</i>
SEROQUEL, SEROQUL XR	<i>quetiapine</i>	VIMPAT	<i>lacosamide</i>
SINGULAIR	<i>montelukast</i>	VIVELLE-DOT	<i>estradiol</i>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.

All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.

Effective 1/1/2024



BRAND NAME	Generic Name
VIVLODEX	<i>meloxicam</i>
VYTORIN	<i>ezetimibe and simvastatin</i>
WELCHOL	<i>colesevelam</i>
WELLBUTRIN SR, WELLBUTRIN XL	<i>bupropion</i>
XALATAN	<i>latanoprost</i>
XANAX, XANAX XR	<i>alprazolam</i>
XENAZINE	<i>tetrabenazine</i>
YASMIN	<i>ethinyl estradiol and drospirenone</i>
ZAVESCA	<i>miglustat</i>

BRAND NAME	Generic Name
ZEGERID	<i>omeprazole and sodium bicarbonate</i>
ZETIA	<i>ezetimibe</i>
ZIOPTAN	<i>taflupost</i>
ZOCOR	<i>simvastatin</i>
ZOLOFT	<i>sertraline</i>
ZOMIG TABLETS	<i>zolmitriptan</i>
ZONEGRAN	<i>zonisamide</i>
ZOVIRAX OINTMENT	<i>acyclovir</i>
ZYTIGA	<i>abiraterone</i>

This document provides general guidance regarding Notification and Prior Approval Requirements. It is not all-inclusive and is subject to change without notice. Providers will receive a 60-day notice of any substantive changes.
 All benefits listed are subject to Member Benefit Agreement or plan document, contract terms and medical review.
 Effective 1/1/2024