

To: IEHP Provider Network
From: IEHP Pharmaceutical Services
Date: March 6, 2025
Subject: February 2025 Pharmacy & Therapeutics Update

February 2025 Pharmacy & Therapeutics Subcommittee Update

IEHP Pharmacy and Therapeutics (P&T) Subcommittee met virtually on Friday, February 7, 2025. As a reminder, all Medi-Cal prescription formulary decisions are no longer made by IEHP and should be addressed with Medi-Cal Rx directly.

Medicare Formulary Updates

Drug Name	Strength(s) and Dosage Form(s)	Medicare Formulary Action	Effective Date
Augtyro (repotrectinib)	160 mg capsule	Add to Formulary, PA for New Start, Quantity Limit	02/01/2025
Cobenfy (xanomeline and trospium chloride)	100 mg-20 mg capsule, 125 mg-30 mg capsule, 50 mg-20 mg capsule,	Add to Formulary, PA for New Start, Quantity Limit	02/01/2025
Cobenfy (xanomeline and trospium chloride)	Starter pack 50 mg-20 mg/100 mg-20 mg capsules in a dose pack	Add to Formulary, PA for New Start	02/01/2025
dasatinib	100 mg tablet, 140 mg tablet, 20 mg tablet, 50 mg tablet, 70 mg tablet, 80 mg tablet	Add to Formulary, PA for New Start, Quantity Limit	02/01/2025
Gallifrey (norethindrone acetate)	5 mg tablet	Add to Formulary	02/01/2025
Itovebi (inavolisib)	3 mg tablet, 9 mg tablet	Add to Formulary, PA for New Start, Quantity Limit	02/01/2025
Lazcluze (lazertinib)	240 mg tablet, 80 mg tablet	Add to Formulary, PA for New Start, Quantity Limit	02/01/2025
Lumakras (sotorasib)	240 mg tablet	Add to Formulary, PA for New Start, Quantity Limit	02/01/2025
oxcarbazepine	ER 150 mg tablet, extended release 24 hr., ER 300 mg tablet, extended release 24 hr., ER 600 mg tablet, extended release 24 hr.	Add to Formulary, PA for New Start, Quantity Limit	02/01/2025

Drug Name	Strength(s) and Dosage Form(s)	Medicare Formulary Action	Effective Date
quinapril	10 mg-hydrochlorothiazide 12.5 mg tablet, 20 mg-hydrochlorothiazide 12.5 mg tablet, 20 mg-hydrochlorothiazide 25 mg tablet	Add to Formulary, Quantity Limit	02/01/2025
Rinvoq (upadacitinib)	LQ 1 mg/ml oral solution	Add to Formulary, PA, Quantity Limit	02/01/2025
tazarotene	0.05 % topical cream	Add to Formulary, PA	02/01/2025
Voranigo (vorasidenib)	10 mg tablet, 40 mg tablet	Add to Formulary, PA for New Start, Quantity Limit	02/01/2025
mometasone	50 mcg/actuation nasal spray	Add to Formulary	02/01/2025
Oxbryta (voxelotor)	300 mg tablet, 300 mg tablet for oral suspension, 500 mg tablet	Remove from Formulary	02/01/2025

Highlights from the Medicare D-SNP formulary additions include Lumakras and Rinvoq. Lumakras is now available on the formulary with prior authorization and quantity limits. Additionally, Rinvoq LQ, the oral liquid formulation, has been added to the formulary with prior authorization and quantity limits.

The full Medicare formulary may be found on the IEHP website at: <https://www.iehp.org/en/browse-plans/dualchoice/prescription-drugs>

Covered California Formulary Updates

Drug Name	Strength(s) and Dosage Form(s)	Covered California Formulary Action	Effective Date
Actemra (tocilizumab)	162 mg/0.9 syringe, 200mg/10ml vial, 400mg/20ml vial, 80 mg/4 ml vial, Actpen 162 mg/0.9 pen injectr	Change in Prior Authorization Criteria	01/01/2025
Actimmune (interferon gamma-1b)	100mcg/0.5 vial	Change in Prior Authorization Criteria	01/01/2025
Adbry (tralokinumab-ldrm)	150 mg/ml syringe, Autoinjector 300 mg/2ml auto inject	Change in Prior Authorization Criteria	01/01/2025
Adzenys XR-ODT (amphetamine extended release orally disintegrating tablets)	12.5 mg tab rap bp, 15.7 mg tab rap bp, 18.8 mg tab rap bp, 3.1 mg tab rap bp, 6.3 mg tab rap bp, 9.4 mg tab rap bp	Change in Step Therapy Criteria	01/01/2025

Drug Name	Strength(s) and Dosage Form(s)	Covered California Formulary Action	Effective Date
Arcalyst (rilonacept)	220 mg vial	Change in Prior Authorization Criteria	01/01/2025
Avsola (infliximab-axxq)	100 mg vial	Change in Prior Authorization Criteria	01/01/2025
Azstarys (serdexmethylphenidate and dexmethylphenidate)	26.1-5.2mg capsule, 39.2-7.8mg capsule, 52.3-10.4 capsule	Change to lower tier and change in Step Therapy Criteria	01/01/2025
Benlysta (belimumab)	120 mg vial, 200 mg/ml auto injct, 200 mg/ml syringe, 400 mg vial	Change in Prior Authorization Criteria	01/01/2025
Cibinqo (abrocitinib)	100 mg tablet, 200 mg tablet, 50 mg tablet	Change in Prior Authorization Criteria	01/01/2025
Cinqair (reslizumab)	10 mg/ml vial	Change in Prior Authorization Criteria	01/01/2025
Cosentyx (secukinumab)	(2 syringes) 150 mg/ml syringe 125 mg/5ml vial Sensoready (2 pens) 150 mg/ml pen injctr Syringe 75mg/0.5ml syringe Unoready pen 300 mg/2ml pen injctr	Change in Prior Authorization Criteria	01/01/2025
Cotempla XR-ODT (methylphenidate extended release orally disintegrating tablets)	17.3 mg tab RAP BP, 25.9 mg tab RAP BP, 8.6 mg tab RAP BP	Change in Step Therapy Criteria	01/01/2025
doxycycline	IR-DR 40 mg CAP IR DR	Add to Formulary with Step Therapy, Quantity Limit, and Age Restriction	1/1/2025
Dyanavel XR (amphetamine)	10 mg TAB BP 24h, 15 mg TAB BP 24h, 2.5 mg/ml SUS BP 24h, 20 mg TAB BP 24h, 5 mg TAB BP 24h	Change in Step Therapy Criteria	01/01/2025
Ebglyss (lebrikizumab-lbkz)	Pen 250 mg/2ml pen injctr	Change in Prior Authorization Criteria	01/01/2025

Drug Name	Strength(s) and Dosage Form(s)	Covered California Formulary Action	Effective Date
Enbrel (etanercept)	25mg/0.5ml syringe, 25mg/0.5ml vial, mini 50mg/ml (1) cartridge, sureclick 50mg/ml (1) pen injctr	Change in Prior Authorization Criteria	01/01/2025
Entyvio (vedolizumab)	300 mg vial Pen 108mg/0.68 pen injctr	Change in Prior Authorization Criteria	01/01/2025
Fabhalta (iptacopan)	200 mg capsule	Change in Prior Authorization Criteria	01/01/2025
Filspari (sparsentan)	200 mg tablet 400 mg tablet	Change in Prior Authorization Criteria	01/01/2025
Humira (adalimumab)	40mg/0.8ml syringe Pediatric crohn's 40mg/0.8ml syringe Pen 40mg/0.8ml pen inj kit Pen crohn's-uc-hs 40mg/0.8ml pen inj kit Pen psor-uveits-adol hs 40mg/0.8ml pen inj kit (cf) 10mg/0.1ml syringe (cf) 20mg/0.2ml syringe (cf) 40mg/0.4ml syringe (cf) pen 40mg/0.4ml pen inj kit (cf) pen 80mg/0.8ml pen inj kit (cf) pen crohn's-uc-hs 80mg/0.8ml pen inj kit (cf) pen pediatric uc 80mg/0.8ml pen inj kit (cf) pen psor-uv-adol hs 80 mg-40mg pen inj kit	Change in Prior Authorization Criteria	01/01/2025
Ilaris (canakinumab)	150 mg/ml vial	Change in Prior Authorization Criteria	01/01/2025
Ilet (automated insulin delivery system)	Infusion kit-Inset Combo. Pkg, Infusion-Contact Detach Combo. Pkg, Infusion-Contact Detach Kit, Insulin Pump Each, Starter kit-inset kit	Add to Formulary with Prior Authorization	1/1/2025
Ilumya (tildrakizumab-asmn)	100 mg/ml syringe	Change in Prior Authorization Criteria	01/01/2025

Drug Name	Strength(s) and Dosage Form(s)	Covered California Formulary Action	Effective Date
Inflectra (infliximab-dyyb)	100 mg vial	Change in Prior Authorization Criteria	01/01/2025
infliximab	100 mg vial	Change in Prior Authorization Criteria	01/01/2025
Jornay PM (methylphenidate hydrochloride)	100 mg CPDR ER SP, 20 mg CPDR ER SP, 40 mg CPDR ER SP, 60 mg CPDR ER SP, 80 mg CPDR ER SP	Change to lower tier and change in Step Therapy Criteria	01/01/2025
Kerendia (finerenone)	10 mg tablet 20 mg tablet	Change in Prior Authorization Criteria	01/01/2025
Kevzara (sarilumab)	150mg/1.14 pen injctr, 150mg/1.14 syringe, 200mg/1.14 pen injctr, 200mg/1.14 syringe	Change in Prior Authorization Criteria	01/01/2025
Kineret (anakinra)	100mg/0.67 syringe	Change in Prior Authorization Criteria	01/01/2025
Litfulo (ritlecitinib)	50 mg capsule	Change in Prior Authorization Criteria	01/01/2025
Nemluvio (nemolizumab-ilto)	30 mg pen injctr	Change in Prior Authorization Criteria	01/01/2025
Nucala (mepolizumab)	100 mg vial, 100 mg/ml auto injct, 100 mg/ml syringe, 40mg/0.4ml syringe	Change in Prior Authorization Criteria	01/01/2025
Olumiant (baricitinib)	1 mg tablet, 2 mg tablet, 4 mg tablet	Change in Prior Authorization Criteria	01/01/2025
OmvoH (mirikizumab-mrkz)	100 mg/ml syringe, 300mg/15ml vial, pen 100 mg/ml pen injctr.	Change in Prior Authorization Criteria	01/01/2025
Orencia (abatacept)	125 mg/ml syringe, 250 mg vial, 50mg/0.4ml syringe, 87.5mg/0.7 syringe, Clickject 125 mg/ml auto injct.	Change in Prior Authorization Criteria	01/01/2025

Drug Name	Strength(s) and Dosage Form(s)	Covered California Formulary Action	Effective Date
Otezla (apremilast)	10 mg-20mg tab ds pk, 10-20-30mg tab ds pk, 20 mg tablet, 30 mg tablet	Change in Prior Authorization Criteria	01/01/2025
Quillichew ER (methylphenidate hydrochloride)	20 mg TAB CBP24H, 30 mg TAB CBP24H, 40 mg TAB CBP24H, XR 5 mg/ml SU ER RC24,	Change in Step Therapy Criteria	01/01/2025
Renflexis (infliximab-abda)	100 mg vial	Change in Prior Authorization Criteria	01/01/2025
Retevmo (selpercatinib)	120 mg tablet, 160 mg tablet, 40 mg capsule, 40 mg tablet, 80 mg capsule, 80 mg tablet,	Change in Prior Authorization Criteria	01/01/2025
Riabni (rituximab-arrx)	10 mg/ml vial	Change in Prior Authorization Criteria	01/01/2025
Rinvoq (upadacitinib)	15 mg tab er 24h, 30 mg tab er 24h, 45 mg tab er 24h, LQ 1 mg/ml solution	Change in Prior Authorization Criteria	01/01/2025
Rituxan (rituximab)	10 mg/ml vial, hycela 1400/11.7 vial, hycela 1600/13.4 vial,	Change in Prior Authorization Criteria	01/01/2025
Ruxience (rituximab-pvvr)	10 mg/ml vial	Change in Prior Authorization Criteria	01/01/2025
Saphnelo (anifrolumab-fnia)	300 mg/2ml vial	Change in Prior Authorization Criteria	01/01/2025
Siliq (brodalumab)	210 mg/1.5 syringe	Change in Prior Authorization Criteria	01/01/2025
SimlandI (adalimumab-ryvk)	(Cf) autoinjector 40mg/0.4ml autoinjkit	Change in Prior Authorization Criteria	01/01/2025
Simponi (golimumab)	100 mg/ml pen injctr, 100 mg/ml syringe, 50mg/0.5ml pen injctr, 50mg/0.5ml syringe, Aria 50 mg/4 ml vial	Change in Prior Authorization Criteria	01/01/2025

Drug Name	Strength(s) and Dosage Form(s)	Covered California Formulary Action	Effective Date
Skyrizi (risankizumab-rzaa)	150 mg/ml syringe, 600mg/10ml vial, On-body 180 mg/1.2 wear injct, On-body 360 mg/2.4 wear injct, Pen 150 mg/ml pen injctr,	Change in Prior Authorization Criteria	01/01/2025
Sotyktu (deucravacitinib)	6 mg tablet	Change in Prior Authorization Criteria	01/01/2025
Spevigo (spesolimab-sbzo)	150 mg/ml syringe, 450 mg/7.5 vial	Change in Prior Authorization Criteria	01/01/2025
Stelara (ustekinumab)	130mg/26ml vial, 45mg/0.5ml syringe, 45mg/0.5ml vial, 90 mg/ml syringe	Change in Prior Authorization Criteria	01/01/2025
Taltz (ixekizumab)	Autoinjector 80 mg/ml auto injct, Syringe 20 mg/0.25 syringe, Syringe 40mg/0.5ml syringe, Syringe 80 mg/ml syringe	Change in Prior Authorization Criteria	01/01/2025
Tarpeyo (budesonide)	4 mg capsule dr	Change in Prior Authorization Criteria	01/01/2025
Tezspire (tezepelumab-ekko)	210mg/1.91 pen injctr, 210mg/1.91 syringe	Change in Prior Authorization Criteria	01/01/2025
Tremfya (guselkumab)	100 mg/ml auto injct, 100 mg/ml syringe, 200 mg/2ml pen injctr, 200 mg/2ml syringe, 200mg/20ml vial	Change in Prior Authorization Criteria	01/01/2025
Truxima (rituximab-abbs)	10 mg/ml vial	Change in Prior Authorization Criteria	01/01/2025
Tyenne (tocilizumab-aazg)	162 mg/0.9 syringe, 200mg/10ml vial, 400mg/20ml vial, 80 mg/4 ml vial, Autoinjector 162 mg/0.9 pen injctr	Change in Prior Authorization Criteria	01/01/2025
Tysabri (natalizumab)	300mg/15ml vial	Change in Prior Authorization Criteria	01/01/2025
Velsipity (etrasimod)	2 mg tablet	Change in Prior Authorization Criteria	01/01/2025

Drug Name	Strength(s) and Dosage Form(s)	Covered California Formulary Action	Effective Date
Vyndamax (tafamidis)	61 mg capsule	Change in Prior Authorization Criteria	01/01/2025
Vyndaqel (tafamidis meglumine)	20 mg capsule	Change in Prior Authorization Criteria	01/01/2025
Xeljanz (tofacitinib)	1 mg/ml solution, 10 mg tablet, 5 mg tablet, XR 11 mg tab er 24h, XR 22 mg tab er 24h	Change in Prior Authorization Criteria	01/01/2025
Xelstrym (dextroamphetamine)	13.5mg/9hr patch TD24, 18 mg/9 hr patch TD24, 4.5 mg/9hr patch TD24, 9 mg/9 hr patch TD24	Change in Step Therapy Criteria	01/01/2025
Xolair (omalizumab)	150 mg vial, 150 mg/ml auto injct, 150 mg/ml syringe, 300 mg/2ml auto injct, 300 mg/2ml syringe, 75mg/0.5ml auto injct, 75mg/0.5ml syringe	Change in Prior Authorization Criteria	01/01/2025
Zeposia (ozanimod)	0.23-0.46 cap ds pk, 0.46-0.92 cap ds pk, 0.92 mg capsule,	Change in Prior Authorization Criteria	01/01/2025
Zymfentra (infliximab-dyyb)	120 mg/ml pen ij kit, 120 mg/ml syringe kit	Change in Prior Authorization Criteria	01/01/2025

The full Covered California formulary may be found on the IEHP website at: <https://www.iehp.org/en/browse-plans/covered-california/prescription-drugs>

Pharmacy Annual Policy and Charter Updates

IEHP Annual Policy and Subcommittee Charter were presented to the P&T subcommittee for their approval.

Pharmacy Policy	Recommendation	P&T Date	Description
Formulary Management – Medicare	Update	February 2025	Updated to ensure patient’s diagnosis aligns with the FDA-approved indications and/or CMS approved compendia., incorporate step therapy requirements, exclusion criteria, required Medical Information, age restrictions based upon FDA label and/or medical literature, and prescriber restrictions based on FDA label and/or CMS compendia.
Pharmacy and Therapeutics Subcommittee Charter	Update	February 2025	Updated to include added responsibilities for overseeing Covered California selected matters when deviating from PBM standard formulary and utilization criteria. Additionally, the charter includes oversight of IEHP Covered California Physician Administered Drugs.

Pharmacy Utilization Management Updates

This quarter, three IEHP Pharmacy Policies were presented to the P&T subcommittee for their approval. The policies were submitted with the recommendation to update these policies.

Pharmacy Policy	Recommendation	P&T Date	Description
Discharge Medication	Update	February 2025	Updated to clarify the scope of the policy (prior authorization and appeals under medical/pharmacy benefits)
Intradialytic Parenteral Nutrition (IDPN) Therapy	Update	February 2025	Updated the approval duration to reflect the current review process
Off-Label Indication Policy	Update	February 2025	Updated to delete reference to IEHP formulary (Policy section 1e)

Four Medi-Cal Medical Drug Benefit Drug Classes have been reviewed along with corresponding Prior Authorization Criteria. The Prior Authorization Criteria were presented to the P&T Subcommittee Members with no recommended changes.

Drug Class Reviewed	Prior Authorization Group Name	Recommendation
Cardiovascular	(No PA Group)	(N/A)
Endocrine & Hormones	HP Acthar	No Change
Hematological	Romiplostim, luspatercept, epoetin, intravenous iron, luspatercept	No Change
Respiratory	Mepolizumab, omalizumab	No Change

Update to service code

Code	Drug Description	Change	Effective Date
J2002	Injection, lidocaine hcl in 5% dextrose, 1 mg	Add	03/01/2025
J2004	Injection, lidocaine hcl with epinephrine, 1 mg	Add	03/01/2025
J2802	Injection, romiplostim, 1 microgram	Add	03/01/2025

Drug Utilization Review (DUR) Updates

IEHP reviewed two DUR reports which include Statin Therapy for Patients with Diabetes (SPD) and Statin Therapy for Patients with Cardiovascular Disease (SPC). We will continue to work on quality measures throughout the remainder of the year and collaborate with providers to optimize better outcomes.

The next IEHP P&T Subcommittee Meeting is Friday, May 2, 2025.