



This list of services applies to **GHP Family (Medicaid)** line of business unless otherwise noted. All drugs newly approved by the FDA should be considered to require prior authorization until such time as they are reviewed by the GHP Pharmacy & Therapeutics Committee. Final Determination to require prior authorization for specific drugs will be added to this list as they are made. The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Drugs indicated as "Statewide Preferred Drug List (PDL) Managed" are part of the Pennsylvania Department of Human Services Statewide Preferred Drug List (PDL). Policies and Prior Authorization requirements for those medications are governed by the Pennsylvania Department of Human Services and Implemented by GHP. Current Procedural Terminology (CPT®) ©American Medical Association: Chicago IL.

Procedure / Service	Effective Date for Providers	Comments	Most Recent Communication to Providers	Associated Medical Policy #
Abecma® (idecabtagene vicleucel)	8/15/2021		Monthly Provider Update July 2021	MBP 235.0
Q2055				
Abilify Asimtufii®	9/15/2023		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J0402; Prior authorization is required for any member under 18 years of age				
Abilify Maintena®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J0401; Prior authorization is required for any member under 18 years of age				
Abraxane® (paclitaxel protein bound particles)	4/1/2006		Briefly March 2006	MBP 36.0
J9264				
Actemra®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
J3262				
Adakveo®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	SICKLE CELL ANEMIA AGENTS
J0791				
Adcetris® (brentuximab vedotin)	4/15/2018		Monthly Provider Update March 2018	MBP 166.0
J9042				
Adstiladrin® (nadofaragene firadenov-vncg)	3/15/2024		Monthly Provider Update February 2024	MBP 303.0
J9029				
Advate®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7192				

Adynovate®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7207				
Adzynma® (ADAMTS13, recombinant-krhn)	7/1/2024		Monthly Provider Update June 2024	MBP 325.0
J7171				
Afstyla®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7210				
Ahzantive®	4/1/2025		Statewide Preferred Drug List (PDL) Managed	MACULAR DEGENERATION AGENTS
Q5150				
Akynzeo® IV	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIEMETICS-ANTIVERTIGO AGENTS
J1454				
Aldurazyme® (laronidase)	1/1/2006		Briefly March 2006	MBP 7.0
J1931				
Alhemo®	10/1/2025		Statewide Preferred Drug List (PDL) Managed	Not Applicable
J7173				
Aliqopa® (copanlisib)	3/15/2018		Monthly Provider Update February 2018	MBP 161.0
J9057				
Alpha 1-Antitrypsin Inhibitor Therapy (Aralast®, Glassia®, Prolastin-C®, Zemaira®)	4/1/2007		Briefly March 2007	MBP 43.0
J0256, J0257				
Alphanate®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7186				
Alphanine® SD	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7193				
Alprolix®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7201				

Altuviii®	1/15/2025		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7214				
Alyglo® (immune globulin)	1/1/2025		Monthly Provider Update December 2024	MBP 4.0
J1552				
Ameluz® (aminolevulinic acid)	4/15/2017		Postcard March 2017	MBP 149.0
J7345				
Amondys 45™ (casimersen)	10/1/2021		Monthly Provider Update September 2021	MBP 241.0
J1426				
Amtagvi® (lifileucel)	10/15/2024		Monthly Provider Update September 2024	MBP 324.0
Currently this drug is reported with an unlisted procedure code				
Amvuttra® (vutrisiran)	1/1/2023		Monthly Provider Update December 2022	MBP 268.0
J0225				
Andexxa® (andexanet alfa)	12/15/2018		Monthly Provider Update November 2018	MBP 183.0
J7169				
Anjeso® (meloxicam injection)	8/15/2022		Monthly Provider Update July 2022	MBP 261.0
J1738				
Anktiva® (nogapendekin alpha inbakicept-pmIn)	10/1/2024		Monthly Provider Update September 2024	MBP 320.0
J9028				
Aphexda® (motixafortide)	7/15/2024		Monthly Provider Update June 2024	MBP 315.0
J2277				
Aponvie	11/15/2023		Statewide Preferred Drug List (PDL) Managed	Not Applicable
C9145				
Aralast® (alpha 1-proteinase inhibitor (human))	4/1/2007		Briefly March 2007	MBP 43.0
J0256				

Aranesp®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ERYTHROPOIESIS STIMULATING AGENTS
J0881, J0882				
Arexvy™ (Respiratory Syncytial Virus Vaccine (Adjuvanted) Injection)	2/15/2025	Arexvy™ (Respiratory Syncytial Virus Vaccine (Adjuvanted) Injection) will not require prior authorization for patients greater than or equal to 60 years of age. Arexvy™ (Respiratory Syncytial Virus Vaccine (Adjuvanted) Injection) will require prior authorization for patients greater than or equal to 50 years of age to less than 59 years of age. Arexvy™ (Respiratory Syncytial Virus Vaccine (Adjuvanted) Injection) is provided by Vaccines for Children (VFC) Program and is not eligible for reimbursement for patients less than 19 years of age.	Monthly Provider Update January 2025	MBP 329.0
90679				
Aristada®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J1944; Prior authorization is required for any member under 18 years of age				
Aristada Initio®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J1943; Prior authorization is required for any member under 18 years of age				
Arranon® (nelarabine)	4/1/2009		Postcard June 2017-Annual Policy Review	MBP 64.0
J9261				
Arzerra® (ofatumumab)	7/1/2010		Briefly June 2010	MBP 73.0
J9302				
Asceniv (immune globulin)	1/1/2021		Monthly Provider Update December 2020	MBP 4.0
J1554				
Ativan®	1/5/2021		Statewide Preferred Drug List (PDL) Managed	ANXIOLYTICS
J2060; The following NDC numbers require prior authorization; 00641600001, 00641600010, 00641600101, 00641600125, 54868240701, 60977011201, 60977011202, 60977011271, 60977011281, 60977011601, 60977011602, 00641600201, 00641600210, 00641600301, 00641600325, 60977011301, 60977011302, 60977011371, 60977011381				
Aucatzyl® (obecabtagene autoleucel)	4/1/2025		Monthly Provider Update March 2025	MBP 335.0
Q2058				

Aveed®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANDROGENIC AGENTS
J3145				
Avsola®	7/1/2020		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
Q5121				
Avtozma®	10/1/2025		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
Q5156				
Avycaz® (cefazidime/avibactam)	1/1/2016		Postcard August 2017-Annual Policy Review	MBP 132.0
J0714				
Azedra® (iobenguane I 131)	3/15/2019		Monthly Provider Update February 2019	MBP 184.0
A9590				
Azmiro™	4/1/2025		Statewide Preferred Drug List (PDL) Managed	ANDROGENIC AGENTS
J1072				
Bavencio® (avelumab)	8/15/2017		Postcard July 2017	MBP 152.0
J9023				
Baxdela® IV (delafloxacin)	6/15/2018		Monthly Provider Update May 2018	MBP 169.0
C9462				
Beleodaq® (belinostat)	1/1/2015		Postcard June 2017-Annual Policy Review	MBP 117.0
J9032				
Benefix®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7195				
Benlysta® (belimumab)	10/1/2011		Postcard June 2017-Annual Policy Review	MBP 90.0
J0490				
Beovu®	5/15/2022		Statewide Preferred Drug List (PDL) Managed	MACULAR DEGENERATION AGENTS
J0179				

Beqvez™ (fidanacogene elaparvovec-dzkt)	1/1/2025		Monthly Provider Update December 2024	MBP 332.0
J1414				
Berinert®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	HEREDITARY ANGIOEDEMA (HAE) AGENTS
J0597				
Besponsa® (inotuzumab ozogamicin)	1/1/2018		Monthly Provider Update December 2017	MBP 160.0
J9229				
Bevacizumab (Avastin®) and Biosimilars	4/15/2024	Avastin® (bevacizumab) used for intravitreal injection does NOT require prior authorization	Monthly Provider Update March 2024	MBP 309.0
C9257, J9035				
Bivigam® (immune globulin)	1/1/2014		Postcard December 2013	MBP 4.0
J1556				
Bizengri® (zenocutuzumab-zbco)	5/15/2025		Monthly Provider Update April 2025	MBP 338.0
J9382				
Bkemy™ (eculizumab-aeab)	1/1/2025		Monthly Provider Update December 2024	Not Applicable
Q5152				
Blinicyto® (blinatumomab)	4/1/2015		Postcard June 2015	MBP 128.0
J9039				
Blood Clotting Factors Given in a Nonemergency Outpatient Facility Setting (Advate®, Adynovate®, Afstyla®, Alphanate®, Alphanine® SD, Alprolix®, Altuviiio®, Benefix®, Eloctate®, Esperoct®, Feiba NF®, Hemlibra®, Hemofil M®, Humate-P®, Idelvion®, Ixinity, Jivi®, Koate®, Kogenate FS®, Kovaltry®, Novoeight®, Novoseven RT®, Nuwiq®, Obizur®, Profilnine®, Rebinyn®, Recombinate®, Rixubis®, Sevenfact, Vonvendi®, Wilate®, Xyntha®, Xyntha® Solofuse)	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7192, J7207, J7210, J7186, J7193, J7201, J7214, J7195, J7205, J7204, J7198, J7170, J7190, J7187, J7202, J7213, J7208, J7211, J7182, J7189, J7209, J7188, J7194, J7203, J7200, J7212, J7179, J7183, J7185				

Bomyntra® / Conexence®	10/1/2025		Statewide Preferred Drug List (PDL) Managed	BONE DENSITY REGULATORS
Q5158				
Boniva®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	BONE DENSITY REGULATORS
J1740				
Boruzu™ (bortezomib)	4/1/2025		Monthly Provider Update March 2025	Not Applicable
J9054				
Botox®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	BOTULINUM TOXINS
J0585				
Botulinum Toxin and Derivatives (Botox®, Daxxify®, Dysport®, Myobloc®, Xeomin®)	1/1/2020		Statewide Preferred Drug List (PDL) Managed	BOTULINUM TOXINS
J0585, J0589, J0586, J0587, J0588				
Breyanzi® (lisocabtagene maraleucel)	6/15/2021		Monthly Provider Update May 2021	MBP 228.0
Q2054				
Brineura® (cerliponase alfa)	12/15/2017		Postcard November 2017	MBP 157.0
J0567				
Briumvi®	9/15/2023		Statewide Preferred Drug List (PDL) Managed	MULTIPLE SCLEROSIS AGENTS
J2329				
Byooviz™	4/1/2022		Statewide Preferred Drug List (PDL) Managed	MACULAR DEGENERATION AGENTS
Q5124				
cabazitaxel	10/1/2023		Monthly Provider Update September 2023	MBP 82.0
J9064				
Camcevi®	1/1/2022		Statewide Preferred Drug List (PDL) Managed	PITUITARY SUPPRESSIVE AGENTS, LHRH
J1952				
Carimune® NF (immune globulin)	1/1/2006		Postcard June 2017-Annual Policy Review	MBP 4.0
J1566				

Carvykti® (ciltacabtagene autoleucl)	7/1/2022		Monthly Provider Update June 2022	MBP 256.0
Q2056				
Casgevvy®	7/15/2024		Statewide Preferred Drug List (PDL) Managed	Not Applicable
J3392				
Cerezyme®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ENZYME REPLACEMENTS, GAUCHER DISEASE
J1786				
Cimerli®	3/15/2023		Statewide Preferred Drug List (PDL) Managed	MACULAR DEGENERATION AGENTS
Q5128				
Cimzia®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
J0717				
Cinqair®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	MONOCLONAL ANTIBODIES (MABs) – ANTI-IL, ANTI-IgE, ANTI-TLSP
J2786				
Cinryze®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	HEREDITARY ANGIOEDEMA (HAE) AGENTS
J0598				
Cinvanti®	1/8/2024		Statewide Preferred Drug List (PDL) Managed	ANTIEMETICS-ANTIVERTIGO AGENTS
J0185				
Columvi™ (glofitamab-gxbm)	12/15/2023		Monthly Provider Update November 2023	MBP 298.0
J9286				
Conexence® / Bomynta®	10/1/2025		Statewide Preferred Drug List (PDL) Managed	BONE DENSITY REGULATORS
Q5158				
Cosela® (trilaciclib)	7/1/2021		Monthly Provider Update June 2021	MBP 232.0
J1448				
Cosentyx®	4/1/2024		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS

J3247			
Cresemba® IV (isavuconazonium sulfate)	12/15/2015		Monthly Provider Update November 2015 MBP 134.0
J1833			
Crysvita® (burosumab-twza)	12/15/2018		Monthly Provider Update November 2018 MBP 182.0
J0584			
Cutaquig® (immune globulin)	3/15/2020		Monthly Provider Update February 2020 MBP 4.0
J1551			
Cuvitru® (immune globulin)	1/1/2006		Postcard June 2017-Annual Policy Review MBP 4.0
J1555			
Cyramza® (ramucirumab)	12/1/2014		Monthly Provider Update November 2014 MBP 115.0
J9308			
Dalvance® (dalbavancin)	3/1/2015		Postcard February 2015 MBP 121.0
J0875			
Danyelza® (naxitamab-gqqk)	6/15/2021		Monthly Provider Update May 2021 MBP 227.0
J9348			
Darzalex® (daratumumab)	4/15/2016		Monthly Provider Update March 2016 MBP 139.0
J9145			
Darzalex Faspro® (daratumumab/hyaluronidase)	6/15/2021		Monthly Provider Update May 2021 MBP 230.0
J9144			
Datroway® (datopotamab deruxtecan-dlnk)	6/15/2025		Monthly Provider Update May 2025 MBP 339.0
J9011			
Daxxify®	6/15/2024		Statewide Preferred Drug List (PDL) Managed BOTULINUM TOXINS
J0589			
Depo-Provera®	1/1/2020		Statewide Preferred Drug List (PDL) Managed CONTRACEPTIVES, OTHER

J1050; The following NDC numbers require prior authorization; 00009737611, 00009074630, 00009074635				
Depo-Testosterone®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANDROGENIC AGENTS
J1071				
Dextenza	6/15/2022		Statewide Preferred Drug List (PDL) Managed	OPHTHALMICS, ANTI- INFLAMMATORIES
J1096				
Dexycu®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	OPHTHALMICS, ANTI- INFLAMMATORIES
J1095				
Diazepam	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANXIOLYTICS
J3360; The following NDC numbers require prior authorization; 69339013632, 69339013602, 69374096502, 11704060001 The following NDC numbers require prior authorization for any member under 21 years of age; 00409321312, 00409321310, 00409321309				
Dihydroergotamine Mesylate	1/1/2020		Statewide Preferred Drug List (PDL) Managed	MIGRAINE ACUTE TREATMENT AGENTS
J1110				
Dimenhydrinate Vial	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIEMETICS-ANTIVERTIGO AGENTS
J1240				
Duopa®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPARKINSON'S AGENTS
J7340				
Durolane®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES
J7318				
Durysta®	11/15/2021		Statewide Preferred Drug List (PDL) Managed	OPHTHALMICS, GLAUCOMA
J7351				
Dysport®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	BOTULINUM TOXINS
J0586				
Elahere® (mirvetuximab soravtansine-gynx)	7/1/2023		Monthly Provider Update June 2023	MBP 277.0
J9063				
Elaprase® (idursulfase)	7/1/2007		Briefly June 2007	MBP 44.0

J1743				
ElELYso®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ENZYME REPLACEMENTS, GAUCHER DISEASE
J3060				
Elevidys® (delandistrogene moxeparvovec-rokl)	1/1/2024		Monthly Provider Update December 2023	MBP 307.0
J1413				
Elfabrio® (pegunigalsidase alfa-iwxj)	10/15/2023		Monthly Provider Update September 2023	MBP 289.0
J2508				
Eligard®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	PITUITARY SUPPRESSIVE AGENTS, LHRH
J9217				
Elitek® (rasburicase)	3/1/2005		Briefly March 2006	MBP 29.0
J2783				
Eloctate®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7205				
Elrexfio™ (elranatamab-bcmm)	1/1/2024		Monthly Provider Update December 2023	MBP 301.0
J1323				
Elzonris® (Tagraxofusp-erzs)	8/15/2019		Monthly Provider Update July 2019	MBP 197.0
J9269				
Empaveli (pegcetacoplan)	1/15/2022		Monthly Provider Update December 2021	MBP 245.0
Currently this drug is reported with an unlisted procedure code				
Empliciti® (elotuzumab)	4/15/2016		Postcard March 2016	MBP 140.0
J9176				
Emrelis™ (telisotuzumab vedotin-tllv)	10/1/2025		Monthly Provider Update September 2025	MBP 346.0
C9306				
Encelto™ (taroretccl-lwey)	10/1/2025		Monthly Provider Update September 2025	MBP 351.0

J3403				
Enhertu® (fam-trastuzumab deruxtecan-nxki)	6/15/2020		Monthly Provider Update May 2020	MBP 208.0
J9358				
Enjaymo® (sutimlimab-jome)	10/15/2022		Monthly Provider Update September 2022	MBP 264.0
J1302				
Entyvio®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
J3380				
Enzeevu™	4/1/2025		Statewide Preferred Drug List (PDL) Managed	MACULAR DEGENERATION AGENTS
Q5149				
Epkinly® (epcoritamab-bysp)	10/1/2023		Monthly Provider Update September 2023	MBP 290.0
J9321				
Epogen®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ERYTHROPOIESIS STIMULATING AGENTS
J0885, Q4081				
Eraxis® (anidulafungin)	1/1/2008		Briefly December 2007	MBP 53.0
J0348				
Erythropoietin and Darbepoetin Therapy (Aranesp®, Epogen®, Mircera®, Procrit®, Retacrit®)	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ERYTHROPOIESIS STIMULATING AGENTS
J0881, J0882, J0885, Q4081, J0887, J0888, Q5105, Q5106				
Erzofri®	4/1/2025		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J2428; Prior authorization is required for any member under 18 years of age				
Esperoct®	7/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7204				
Euflexxa®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES
J7323				
Evenity®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	BONE DENSITY REGULATORS

J3111				
Evkeeza®	10/1/2021		Statewide Preferred Drug List (PDL) Managed	LIPOTROPICS, OTHER
J1305				
Exondys 51® (eteplirsen)	4/1/2017		Postcard June 2017	MBP 148.0
J1428				
Eylea® / Eylea® HD	1/1/2020		Statewide Preferred Drug List (PDL) Managed	MACULAR DEGENERATION AGENTS
J0178, J0177				
Fabrazyme® (agalsidase beta)	1/1/2006		Briefly March 2006	MBP 18.0
J0180				
Fasenra®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	MONOCLONAL ANTIBODIES (MABs) – ANTI-IL, ANTI-IGE, ANTI-TLSP
J0517				
Feiba NF®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7198				
Fensolvi®	7/1/2021		Statewide Preferred Drug List (PDL) Managed	PITUITARY SUPPRESSIVE AGENTS, LHRH
J1951				
Feraheme®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	IRON, PARENTERAL
Q0138, Q0139				
Fetroja® (cefiderocol)	1/1/2021		Monthly Provider Update December 2020	MBP 219.0
J0699				
Flebogamma® / Flebogamma DIF® (immune globulin)	1/1/2006		Postcard June 2017-Annual Policy Review	MBP 4.0
J1572				
Flolan® or Veletri® (epoprostenol)	1/1/2009		Postcard July 2017-Annual Policy Review	MBP 61.0
J1325				
Fluphenazine Decanoate	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS

J2680; Prior authorization is required for any member under 18 years of age				
Fluphenazine HCl	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J2679; Prior authorization is required for any member under 18 years of age				
Fulphila®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	COLONY STIMULATING FACTORS
Q5108				
Fyarro® (sirolimus protein-bound particles for injectable suspension) (albumin-bound)	8/15/2022		Monthly Provider Update July 2022	MBP 262.0
J9331				
Flynetra®	4/1/2023		Statewide Preferred Drug List (PDL) Managed	COLONY STIMULATING FACTORS
Q5130				
Gamifant® (emapalumab-lzsg)	8/15/2019		Monthly Provider Update July 2019	MBP 198.0
J9210				
Gammagard Liquid® (immune globulin)	1/1/2008		Postcard December 2007	MBP 4.0
J1569				
Gammagard S/D (immune globulin)	1/1/2020		Monthly Provider Update December 2019	MBP 4.0
J1566				
Gammaked® / Gamunex® / Gamunex-C®	1/1/2006		Postcard June 2017	MBP 4.0
J1561				
Gammaplex® (immune globulin)	1/1/2012		Postcard December 2011	MBP 4.0
J1557				
Gazyva® (obinutuzumab)	8/1/2014		Postcard July 2017	MBP 113.0
J9301				
Gel-One®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES
J7326				
Gelsyn-3	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES

J7328				
Genvisc 850®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES
J7320				
Geodon®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J3486; Prior authorization is required for any member under 18 years of age				
Givlaari® (givosiran)	7/1/2020		Monthly Provider Update June 2020	MBP 211.0
J0223				
Glassia® (alpha 1 proteinase inhibitor (human))	1/1/2012		Briefly March 2007	MBP 43.0
J0257				
Grafapex™ (treosulfan)	7/1/2025		Monthly Provider Update June 2025	MBP 343.0
J0614				
Granix®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	COLONY STIMULATING FACTORS
J1447				
Halaven® (eribulin mesylate)	7/1/2011		Postcard May 2016	MBP 88.0
J9179				
Haldol Decanoate®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J1631; The following NDC numbers require prior authorization for any member under 18 years of age; 50458025414, 50458025303				
Haloperidol Decanoate	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J1631; The following NDC numbers require prior authorization for any member under 18 years of age; 70069003105, 10147092205, 70069003101, 70069003001, 10147092103, 70069003003, 25021083301, 00703702301, 00703702103, 67457040913, 67457038158, 67457040900, 00703702101, 67457038100, 63323047141, 63323047105, 63323047101, 00703701103, 00703701101, 63323046901, 63323046905, 67457041013, 25021083101,00703701301, 67457041000				
Haloperidol Lactate	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J1630; Prior authorization is required for any member under 18 years of age				
Hemgenix® (etranacogene dezaparvovec-drlb)	10/15/2023		Monthly Provider Update September 2023	MBP 286.0
J1411				

Hemlibra®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7170				
Hemofil M®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7190				
Hepzato Kit™ (melphalan/hepatic delivery system [HDS])	10/15/2024		Monthly Provider Update September 2024	MBP 321.0
J9248				
Hizentra® (immune globulin)	1/1/2011		Monthly Provider Update December 2010	MBP 4.0
J1559				
Humate-P®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7187				
Hyalgan®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES
J7321				
Hympavzi™	4/1/2025		Statewide Preferred Drug List (PDL) Managed	Not Applicable
J7172				
Hymovis®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES
J7322				
Hyqvia® (immune globulin/hyaluronidase)	1/1/2016		Postcard June 2017	MBP 4.0
J1575				
Ibandronate	1/1/2020		Statewide Preferred Drug List (PDL) Managed	BONE DENSITY REGULATORS
J1740				
Idelvion®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7202				
Igalmi®	9/15/2022		Statewide Preferred Drug List (PDL) Managed	SEDATIVE HYPNOTICS
J1105				

Ilaris®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONIST
J0638				
Ilumya®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
J3245				
Iluvien®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	OPHTHALMICS, ANTI-INFLAMMATORIES
J7313				
Imaavy™ (nipocalimab-aahu)	10/1/2025		Monthly Provider Update September 2025	Not Applicable
C9305				
Imdelltra™ (tarlatamab-dlle)	10/1/2024		Monthly Provider Update September 2024	MBP 322.0
J9026				
Imfinzi® (durvalumab)	10/1/2017		Monthly Provider Update September 2017	MBP 156.0
J9173				
Imjudo® (tremelimumab-actl)	3/15/2023		Monthly Provider Update February 2023	MBP 270.0
J9347				
Imlygic® (talimogene laherparepvec)	4/15/2016		Postcard March 2016	MBP 136.0
J9325				
Imuldosa™ IV	7/15/2025		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
Q5098				
Inflectra	1/1/2020		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
Q5103				
Injectafer®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	IRON, PARENTERAL
J1439				

Injectable Antipsychotic Medications (Abilify Asimtufii®, Abilify Maintena®, Aristada®, Aristada Initio®, Erzo®/Erzofri®, Fluphenazine Decanoate, Fluphenazine HCl, Geodon®, Haldol Decanoate®, Haloperidol Decanoate, Haloperidol Lactate, Invega Hafyera®, Invega Sustenna®, Invega Trinza®, Olanzapine, Perseris®, Risperdal Consta®, Rykindo®, Uzedy®, Zyprexa Relprevv, Zyprexa®)	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J0402, J0401, J1944, J1943, J2428, J2680, J2679, J3486, J1631, J1630, J2427, J2426, J2359, J2798, J2794, J2801, J2799, J2358				
Intravenous Immune Globulin (IVIG) (Alyglo®, Asceniv, Bivigam®, Carimune® NF, Cutaquig®, Cuvitru®, Flebogamma® / Flebogamma DIF®, Gammagard Liquid®, Gammagard S/D, Gammaked® / Gamunex® / Gamunex-C®, Gammaplex®, Hizentra®, Hyqvia®, Octagam®, Panzyga®, Privigen®, Xembify®)	1/1/2006		Postcard June 2017-Annual Policy Review	MBP 4.0
J1552, J1554, J1556, J1566, J1551, J1555, J1572, J1569, J1561, J1557, J1559, J1575, J1568, J1576, J1459, J1558				
Intravenous (IV) Iron	7/15/2025		Statewide Preferred Drug List (PDL) Managed	IRON, PARENTERAL
J1437, J1439				
Invega Hafyera®	3/15/2022		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J2427; Prior authorization is required for any member under 18 years of age				
Invega Sustenna®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J2426; Prior authorization is required for any member under 18 years of age				
Invega Trinza®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J2427; Prior authorization is required for any member under 18 years of age				
Istodax® (romidepsin)	10/1/2010		Briefly September 2010	MBP 78.0
J9318, J9319				
Ixempra® (ixabepilone)	10/1/2008		Postcard June 2017-Annual Policy Review	MBP 63.0
J9207				
Ixinity	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS

J7213				
Izervay™	4/1/2024		Statewide Preferred Drug List (PDL) Managed	MACULAR DEGENERATION AGENTS
J2782				
Jelmyto® (mitomycin ureteral gel)	2/15/2023		Monthly Provider Update January 2023	MBP 266.0
J9281				
Jemperli (dostarlimab-gxly)	10/15/2021		Monthly Provider Update September 2021	MBP 236.0
J9272				
Jevtana® (cabazitaxel)	1/1/2011		Briefly December 2010	MBP 82.0
J9043				
Jivi®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7208				
Jubbonti® / Wyost®	9/9/2025		Statewide Preferred Drug List (PDL) Managed	BONE DENSITY REGULATORS
Q5136				
Kadcyla® (ado-trastuzumab emtansine)	9/1/2013		Postcard June 2017-Annual Policy Review	MBP 108.0
J9354				
Kalbitor®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	HEREDITARY ANGIOEDEMA (HAE) AGENTS
J1290				
Kanuma® (sebelipase alfa)	1/1/2017		Monthly Provider Update December 2016	MBP 180.0
J2840				
Kebilidi™ (eladocagene exuparvovec-tneq)	8/15/2025		Monthly Provider Update July 2025	MBP 344.0
Currently this drug is reported with an unlisted procedure code				
Keytruda® (pembrolizumab)	3/1/2015		Postcard July 2017-Annual Policy Review	MBP 119.0
J9271				
Khapzory® (Levoleucovorin)	4/15/2020		Monthly Provider Update March 2020	MBP 206.0

J0642				
Kimtrak® (tebentafusp-tebn)	5/15/2022		Monthly Provider Update April 2022	MBP 250.0
J9274				
Kimyrsa® (oritavancin)	3/15/2022		Monthly Provider Update February 2022	MBP 247.0
J2406				
Kisunla™ (donanemab-azbt)	10/1/2024		Monthly Provider Update September 2024	MBP 333.0
J0175				
Koate®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7190				
Kogenate FS®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7192				
Korsuva® (difelikefalin)	7/15/2023		Monthly Provider Update June 2023	MBP 279.0
J0879				
Kovaltry®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7211				
Krystexxa®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHYPERURICEMICS
J2507				
Kymriah® (tisagenlecleucel)	3/15/2018		Monthly Provider Update January 2018	MBP 159.0
Q2042				
Kyprolis® (carfilzomib)	1/1/2013		Postcard August 2016-Annual Policy Review	MBP 97.0
J9047				
Lamzede® (velmanase alfa-tycv)	10/15/2023		Monthly Provider Update September 2023	MBP 291.0
J0217				
Lantidra (donislecel-jujn)	10/15/2024		Monthly Provider Update September 2024	MBP 323.0

Currently this drug is reported with an unlisted procedure code				
Lemtrada®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	MULTIPLE SCLEROSIS AGENTS
J0202				
Lenmeldy™ (atidarsagene autotemcel)	2/15/2025		Monthly Provider Update January 2025	MBP 328.0
J3391				
Leqembi® (lecanemab-irmb)	7/15/2023		Monthly Provider Update June 2023	MBP 288.0
J0174				
Leqvio®	6/15/2022		Statewide Preferred Drug List (PDL) Managed	LIPOTROPICS, OTHER
J1306				
Leukine®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	COLONY STIMULATING FACTORS
J2820				
Leuprolide Acetate	1/1/2020		Statewide Preferred Drug List (PDL) Managed	PITUITARY SUPPRESSIVE AGENTS, LHRH
J9218				
leuprolide acetate for depot suspension (Cipla)	1/1/2023		Statewide Preferred Drug List (PDL) Managed	PITUITARY SUPPRESSIVE AGENTS, LHRH
J1954				
leuprolide acetate for depot suspension (lutrate)	1/1/2023		Statewide Preferred Drug List (PDL) Managed	PITUITARY SUPPRESSIVE AGENTS, LHRH
J1954				
Levothyroxine	1/1/2020		Statewide Preferred Drug List (PDL) Managed	THYROID HORMONES
J0650, J0651, J0652				
Libtayo® (cemiplimab-rwlc)	3/15/2019		Monthly Provider Update March 2019	MBP 186.0
J9119				
Liothyronine	1/1/2020		Statewide Preferred Drug List (PDL) Managed	THYROID HORMONES

Currently this drug is reported with an unlisted procedure code				
Loqtorzi® (toripalimab-tpzi)	6/15/2024		Monthly Provider Update May 2024	MBP 314.0
J3263				
Lorazepam	1/5/2021		Statewide Preferred Drug List (PDL) Managed	ANXIOLYTICS
J2060; The following NDC numbers require prior authorization for any member under 21 years of age; 00409198505, 00409198510, 00409198530, 00409677802, 00409677805, 00409677811, 00409677815, 00409677862, 00409678002, 00409678011, 00641604401, 00641604425, 00641604601, 00641604610, 00641604801, 00641604825, 00641605001, 00641605010, 00641620701, 00641620725, 10019010201, 10019010210, 10019010237, 10019010239, 10019010501, 10019010502, 10019010544, 10019010571, 17478004001, 54868356600, 54868356601, 54868356602, 55390016810, 55390017010, 72572038001, 72572038025, 76329826100, 76329826101, 00074153901, 00074153921, 00409153931, 00409677902, 00409677911, 00409678102, 00641604501, 00641604525, 00641604701, 00641604710, 00641604901, 00641604925, 00641605101, 00641605110, 10019010301, 10019010310, 10019010337, 10019010339, 10019010601, 10019010602, 10019010644, 10019010671, 55390016910, 55390017110				
Lucentis®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	MACULAR DEGENERATION AGENTS
J2778				
Lumizyme® (alglucosidase alfa)	1/1/2011		Postcard June 2017-Annual Policy Review	MBP 83.0
J0221				
Lumoxiti® (moxetumomab pasudotox-tdfk)	4/1/2019		Monthly Provider Update March 2019	MBP 189.0
J9313				
Lunsumio™ (mosunetuzumab-axgb)	7/1/2023		Monthly Provider Update June 2023	MBP 280.0
J9350				
Lupron Depot®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	PITUITARY SUPPRESSIVE AGENTS, LHRH
J1950				
Lupron Depot®-Ped	1/1/2020		Statewide Preferred Drug List (PDL) Managed	PITUITARY SUPPRESSIVE AGENTS, LHRH
J1950				
Lutathera® (lutetium Lu 177 dotatate)	6/15/2018		Monthly Provider Update May 2018	MBP 170.0
A9513				
Luxturna® (voretigene-neparvovec-rzyl)	8/15/2018		Monthly Provider Update July 2018	MBP 174.0
J3398				
Lyfgenia™	7/1/2024		Statewide Preferred Drug List (PDL) Managed	Not Applicable

J3394				
Lymphir™ (denileukin diftitox-cxdl)	4/1/2025		Monthly Provider Update March 2025	Not Applicable
J9161				
Lynozytic™ (linvoseltamab-gcpt)	12/15/2025		Monthly Provider Update November 2025	MBP 352.0
Currently this drug is reported with an unlisted procedure code				
Margenza® (margetuximab-cmkb)	7/1/2021		Monthly Provider Update June 2021	MBP 231.0
J9353				
Mepsevii® (vestronidase alfa-vjvk)	8/15/2018		Monthly Provider Update July 2018	MBP 175.0
J3397				
Mircera®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ERYTHROPOIESIS STIMULATING AGENTS
J0887, J0888				
Monjuvi® (tafasitamab-cxix)	11/15/2020		Monthly Provider Update October 2020	MBP 221.0
J9349				
Monoferic®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	IRON, PARENTERAL
J1437				
Monovisc®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES
J7327				
Mresvia® (Respiratory syncytial virus vaccine, mRNA lipid nanoparticles)	11/19/2024	Mresvia® (Respiratory syncytial virus vaccine, mRNA lipid nanoparticles) will not require prior authorization for patients greater than or equal to 60 years of age. Mresvia® (Respiratory syncytial virus vaccine, mRNA lipid nanoparticles) will require prior authorization for patients greater than or equal to 19 years of age to less than 60 years of age. Mresvia® (Respiratory syncytial virus vaccine, mRNA lipid nanoparticles) is provided by Vaccines for Children (VFC) Program and is not eligible for reimbursement for patients less than 19 years of age.	Monthly Provider Update October 2024	Not Applicable

90683				
Mylotarg™ (gemtuzumab ozogamicin)	4/15/2018		Monthly Provider Update March 2018	MBP 163.0
J9203				
Myobloc®	1/1/2020		statewide Preferred Drug List (PDL) Managed	BOTULINUM TOXINS
J0587				
Naglazyme® (galsulfase)	10/1/2006		Briefly September 2006	MBP 39.0
J1458				
Neulasta® / Neulasta Onpro®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	COLONY STIMULATING FACTORS
J2506				
Neupogen®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	COLONY STIMULATING FACTORS
J1442				
Nexvazyme® (avalglucosidase alfa-ngpt)	4/15/2022		Monthly Provider Update March 2022	MBP 248.0
J0219				
Niktimvo™ (axatilimab-csfr)	11/15/2025		Monthly Provider Update October 2025	MBP 347.0
J9038				
Nivestym®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	COLONY STIMULATING FACTORS
Q5110				
Novoeight®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7182				
Novoseven RT®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7189				
Nplate®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	THROMBOPOIETICS
J2802				

			Statewide Preferred Drug List (PDL) Managed	MONOCLONAL ANTIBODIES (MABs) – ANTI-IL, ANTI-IGE, ANTI-TLSP
J2182				
			Monthly Provider Update August 2021	MBP 238.0
J1809				
			Postcard June 2017-Annual Policy Review	MBP 93.0
J0485				
			Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7209				
			Monthly Provider Update February 2020	MBP 203.0
J0121				
			Statewide Preferred Drug List (PDL) Managed	COLONY STIMULATING FACTORS
C9173				
			Statewide Preferred Drug List (PDL) Managed	COLONY STIMULATING FACTORS
Q5122				
			Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7188				
			Statewide Preferred Drug List (PDL) Managed	MULTIPLE SCLEROSIS AGENTS
J2350				
			Statewide Preferred Drug List (PDL) Managed	MULTIPLE SCLEROSIS AGENTS
J2351				
			Postcard June 2017-Annual Policy Review	MBP 4.0
J1568				
			Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J2358, J2359; Prior authorization is required for any member under 18 years of age				

Olinvyk (oliceridine)	6/15/2021		Monthly Provider Update May 2021	MBP 229.0
C9101				
Omisirge® (omidubicel-only)	10/15/2023		Monthly Provider Update September 2023	MBP 292.0
Currently this drug is reported with an unlisted procedure code				
Omlyclo®	10/1/2025		Statewide Preferred Drug List (PDL) Managed	MONOCLONAL ANTIBODIES (MABs) – ANTI-IL, ANTI-IGE, ANTI-TSLP
Q5154				
OmvoH®	4/1/2024		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
J2267				
Onivyde® (irinotecan liposome injection)	4/15/2016		Postcard March 2016	MBP 138.0
J9205				
Onpattro® (patisiran)	4/15/2019		Monthly Provider Update March 2019	MBP 188.0
J0222				
Opdivo® (nivolumab)	7/1/2015		Postcard July 2017-Annual Policy Review	MBP 126.0
J9299				
Opdivo Qvantig™ (nivolumab-hyaluronidase-nvhy)	6/15/2025		Monthly Provider Update May 2025	MBP 342.0
J9289				
Opdualag™ (nivolumab and relatlimab-rmbw)	7/15/2022		Monthly Provider Update June 2022	MBP 257.0
J9298				
Orencia® IV	1/1/2020		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
J0129				
Orthovisc®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES
J7324				
Osenvelt® / Stoboclo®	10/1/2025		Statewide Preferred Drug List (PDL) Managed	BONE DENSITY REGULATORS
Q5157				

Otulfi®	4/1/2025		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
Q9999				
Oxlumo® (lumasiran)	7/1/2021		Monthly Provider Update June 2021	MBP 234.0
J0224				
Ozurdex®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	OPHTHALMICS, ANTI-INFLAMMATORIES
J7312				
Padcev® (enfortumab vedotin-ejfv)	6/15/2020		Monthly Provider Update May 2020	MBP 209.0
J9177				
Panzyga® (immune globulin)	1/1/2020		Monthly Provider Update December 2019	MBP 4.0
J1576				
Parsabiv® (etelcalcetide)	6/15/2018		Monthly Provider Update May 2018	MBP 168.0
J0606				
Pavlu™	4/1/2025		Statewide Preferred Drug List (PDL) Managed	MACULAR DEGENERATION AGENTS
Q5147				
Pedmark® (sodium thiosulfate)	4/1/2023		Monthly Provider Update March 2023	MBP 275.0
J0208				
Perseris®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J2798; Prior authorization is required for any member under 18 years of age				
Phenergan®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIEMETICS-ANTIVERTIGO AGENTS
J2550; The following NDC numbers require prior authorization; 00641608425, 00641608401, 00641608525, 00641608501, 00641608225, 00641608201, 00641608301, 00641608325				
PiaSky™ (crovalimab-akkz)	5/15/2025		Monthly Provider Update April 2025	MBP 340.0
J1307				
Pluvicto® (lutetium Lu 177 vipivotide tetraxetan)	9/15/2022		Monthly Provider Update August 2022	MBP 263.0
A9607				

Polivy® (polatuzumab vedotin-piiq)	11/15/2019		Monthly Provider Update October 2019	MBP 200.0
J9309				
Pombiliti® (cipagucosidase alfa-atga)	2/15/2025		Monthly Provider Update January 2025	MBP 326.0
J1203				
Portrazza® (necitumumab)	6/15/2016		Postcard May 2016-Annual Policy Review	MBP 142.0
J9295				
Posfrea® (palonosetron)	12/15/2025		statewide Preferred Drug List (PDL) Managed	ANTIEMETICS-ANTIVERTIGO AGENTS
J2468				
Poteligeo® (mogamulizumab-kpkc)	3/15/2019		Monthly Provider Update February 2019	MBP 185.0
J9204				
Praxbind® (idarucizumab)	6/15/2016		Postcard May 2016-Annual Policy Review	MBP 143.0
Currently this drug is reported with an unlisted procedure code				
Premarin®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ESTROGENS
J1410				
Prevymis® IV (letermovir)	8/15/2018		Monthly Provider Update July 2018	MBP 177.0
Currently this drug is reported with an unlisted procedure code				
Prialt® (ziconotide intrathecal infusion)	1/1/2008		Briefly December 2007	MBP 58.0
J2278				
Privigen® (immune globulin)	1/1/2006		Postcard June 2017-Annual Policy Review	MBP 4.0
J1459				
Procrit®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ERYTHROPOIESIS STIMULATING AGENTS
J0885, Q4081				
Profilnine®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7194				

Prograf® Granules	4/1/2025		Statewide Preferred Drug List (PDL) Managed	IMMUNOSUPPRESSIVES, ORAL
J7521				
Prolastin-C® (alpha 1-proteinase inhibitor (human))	4/1/2007		Briefly March 2007	MBP 43.0
J0256				
Prolia®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	BONE DENSITY REGULATORS
J0897				
Prolixin (fluphenazine hcl)	1/1/2024		Monthly Provider Update December 2023	Not Applicable
J2679				
Promethazine	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIEMETICS-ANTIVERTIGO AGENTS
J2550; The following NDC numbers require prior authorization for any member under 6 years of age; 00641092821, 00641095521, 00703219104, 00641620825, 00641095525, 00641092825, 00641620801, 00641095621, 00703220104, 00641092921, 00641092925, 00641095625, 39822552502, 00641149535, 00641094831, 39822552503, 00641149531, 00641094835, 39822555006, 00641094935, 00641149635, 00641094931, 39822555005, 00641149631				
Provenge® (sipuleucel-T)	1/1/2011		Postcard June 2017-Annual Policy Review	MBP 79.0
Q2043				
Pyzchiva IV®	1/1/2025		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
Q9997				
Qalsody® (tofersen)	10/1/2023		Monthly Provider Update September 2023	MBP 293.0
J1304				
Qfitlia™	10/1/2025		Statewide Preferred Drug List (PDL) Managed	Not Applicable
J7174				
Qutenza®	2/15/2023		Statewide Preferred Drug List (PDL) Managed	NEUROPATHIC PAIN AGENTS
J7336				
Quzyttir® (cetirizine hydrochloride injection)	6/15/2025		Monthly Provider Update May 2025	MBP 341.0
J1201				
Radicava® (edaravone)	10/1/2017		Postcard September 2017	MBP 154.0

J1301				
Rapivab®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIVIRALS, INFLUENZA
J2547				
Rebinyn®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7203				
Reblozyl® (luspatercept-aamt)	7/1/2020		Monthly Provider Update June 2020	MBP 210.0
J0896				
Rebyota® (fecal microbiota, live-jslm)	7/1/2023		Monthly Provider Update June 2023	MBP 281.0
J1440				
Recarbrio™ (imipenem/cilastatin/relebactam)	7/1/2020		Monthly Provider Update June 2020	MBP 215.0
J0742				
Reclast®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	BONE DENSITY REGULATORS
J3489; The following NDC number requires prior authorization; 00078043561				
Recombinate®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7192				
Releuko®	7/1/2022		Statewide Preferred Drug List (PDL) Managed	COLONY STIMULATING FACTORS
Q5125				
Remicade®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
J1745				
Remodulin IV (treprostinil sodium)	1/1/2009		Briefly December 2008	MBP 62.0
J3285				
Renflexis®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
Q5104				
Retacrit®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ERYTHROPOIESIS STIMULATING AGENTS

Q5105, Q5106				
Retisert®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	OPHTHALMICS, ANTI-INFLAMMATORIES
J7311				
Revcovi® (elapegedemase-ivlr)	6/15/2019		Monthly Provider Update May 2019	MBP 193.0
Currently this drug is reported with an unlisted procedure code				
Rezzayo® (rezafungin)	4/15/2024		Monthly Provider Update March 2024	MBP 313.0
J0349				
Riabni® (rituximab-arrx)	7/1/2021	Prior authorization is not required for Riabni® (rituximab-arrx) for diagnosis codes C91.00-C91.02, C91.10-C91.12, C91.40-C91.42, C82.00-C85.99, C86.0- C88.9, C81.00-C81.09, G35.B0, G35.B1, G35.B2, G35.C, G35.C0, G35.C1, G35.C2 and G35.D	Monthly Provider Update June 2021	MBP 48.0
Q5123				
Risperdal Consta®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J2794; Prior authorization is required for any member under 18 years of age				
Rituxan® (rituximab)	4/1/2018		Monthly provider Update September 2018	MBP 48.0
J9312				
Rituxan Hycela® (rituximab/hyaluronidase)	4/15/2018		Monthly Provider Update March 2018	MBP 165.0
J9311				
Rixubis®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7200				
Roctavian® (valoctocogene roxaparvovec-rvox)	1/1/2024		Monthly Provider Update December 2023	MBP 308.0
J1412				
Rovedon®	4/1/2023		Statewide Preferred Drug List (PDL) Managed	COLONY STIMULATING FACTORS
J1449				

Ruconest®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	HEREDITARY ANGIOEDEMA (HAE) AGENTS
J0596				
Ruxience® (rituximab-pvvr)	7/1/2020	Prior authorization is not required for Ruxience® (rituximab-pvvr) for diagnosis codes C91.00-C91.02, C91.10-C91.12, C91.40-C91.42, C82.00-C85.99, C86.0- C88.9, C81.00-C81.09, G35.B0, G35.B1, G35.B2, G35.C, G35.C0, G35.C1, G35.C2 and G35.D	Monthly Provider Update June 2020	MBP 48.0
Q5119				
Rybrevant® (amivantamab-vmjw)	9/15/2021		Monthly Provider Update August 2021	MBP 239.0
J9061				
Rykindo®	6/15/2024		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J2801; Prior authorization is required for any member under 18 years of age				
Rylaze® (asparaginase erwinia chrysanthemi (recombinant)- rywn)	11/15/2021		Monthly Provider Update October 2021	MBP 244.0
J9021				
Ryoncil® (remestemcel-l-rknd)	10/1/2025		Monthly Provider Update September 2025	Not Applicable
J3402				
Ryplazim® (plasminogen, human-tvmh)	7/1/2022		Monthly Provider Update June 2022	MBP 258.0
J2998				
Rystiggo® (rozanolixizumab-noli)	1/1/2024		Monthly Provider Update December 2023	MBP 305.0
J9333				
Rytelo® (imetelstat)	1/1/2025		Monthly Provider Update December 2024	MBP 336.0
J0870				
Sandostatin LAR® (Octreotide acetate)	4/1/2013		Briefly March 2013	MBP 99.0
J2353				
Saphnelo® (anifrolumab-fnia)	4/15/2022		Monthly Provider Update March 2022	MBP 249.0

J0491				
Sarclisa® (isatuximab-irfc)	9/15/2020		Monthly Provider Update August 2020	MBP 213.0
J9227				
Scenesse® (afamelanotide)	10/15/2020		Monthly Provider Update December 2020	MBP 220.0
J7352				
Selarsdi™ IV	7/15/2025		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
Q9998				
Sevenfact	1/1/2021		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7212				
Signifor LAR® (pasireotide LAR)	1/1/2016		Postcard July 2017-Annual Policy Review	MBP 133.0
J2502				
Simponi Aria®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
J1602				
Sinuva™	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRANASAL RHINITIS AGENTS
J7402				
Site of Care Review Guidelines for Infusion Drugs and Specialty Medications	10/15/2018		Statewide Preferred Drug List (PDL) Managed	Not Applicable
Specific intravenous and injectable drugs must meet applicable medical necessity criteria for coverage. If these criteria are met, this coverage policy will be used to determine the medical necessity of administration in the hospital based outpatient setting. If medical necessity criteria for administration in the hospital based outpatient setting are not met, an alternative less intensive site of care facility should be utilized.				
Sivextro® (tedizolid phosphate) IV	3/1/2015		Postcard February 2015	MBP 122.0
J3090				
Skyrizi®	1/15/2023		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
J2327				
Skysona™ (elivaldogene autotemcel)	7/15/2023		Monthly Provider Update June 2023	MBP 282.0

Currently this drug is reported with an unlisted procedure code				
Soliris® (eculizumab)	10/1/2008		Postcard May 2016-Annual Policy Review	MBP 54.0
J1299				
Spevigo®	4/15/2023		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
J1747				
Spinraza® (nusinersen)	7/1/2017		Postcard June 2017	MBP 151.0
J2326				
Spravato®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIDEPRESSANTS, OTHER
G2082, G2083, S0013				
Stelara®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
J3357, J3358				
Steqeyma® IV	7/15/2025		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
Q5099				
Stimufend®	4/1/2023		Statewide Preferred Drug List (PDL) Managed	COLONY STIMULATING FACTORS
Q5127				
Stoboclo® / Osenvelt®	10/1/2025		Statewide Preferred Drug List (PDL) Managed	BONE DENSITY REGULATORS
Q5157				
Sunlenca®	7/1/2023		Statewide Preferred Drug List (PDL) Managed	HIV/AIDS ANTIRETROVIRALS
J1961				
Supartz® FX	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES
J7321				
Supprelin LA®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	PITUITARY SUPPRESSIVE AGENTS, LHRH
J1675, J9226				

Sustol®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIEMETICS-ANTIVERTIGO AGENTS
J1627; The following NDC number requires prior authorization; 47426010106				
Susvimo™	4/1/2022		Statewide Preferred Drug List (PDL) Managed	MACULAR DEGENERATION AGENTS
J2779				
Syfovre®	6/15/2023		Statewide Preferred Drug List (PDL) Managed	MACULAR DEGENERATION AGENTS
J2781				
Sylvant® (siltuximab)	3/1/2015		Postcard February 2015	MBP 120.0
J2860				
Synagis® (palivizumab)	10/1/2005		Briefly March 2006	MBP 2.0
90378				
Synjoynt®	10/15/2023		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES
J7331				
Synvisc®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES
J7325				
Synvisc-One®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES
J7325				
Talvey® (talquetamab-tgvs)	1/1/2024		Monthly Provider Update December 2023	MBP 302.0
J3055				
Tecartus® (brexucabtagene autoleucel)	1/1/2021		Monthly Provider Update February 2021	MBP 224.0
Q2053				
Tecelra® (afamitresgene autoleucel)	12/15/2024		Monthly Provider Update November 2024	MBP 327.0
Currently this drug is reported with an unlisted procedure code				
Tecentriq™ (atezolizumab)	10/15/2016		Postcard July 2017-Annual Policy Review	MBP 144.0
J9022				

Tecentriq Hybreza™ (atezolizumab, and hyaluronidase-tqjs)	4/1/2025		Monthly Provider Update March 2025	Not Applicable
J9024				
Tecvayli® (teclistamab-cqyv)	4/1/2023		Monthly Provider Update March 2023	MBP 273.0
J9380				
Tepadina® (thiotepa)	12/15/2017		Postcard November 2017	MBP 158.0
J9342				
Tepezza® (teprotumumab-trbw)	10/1/2020		Monthly Provider Update September 2020	MBP 217.0
J3241				
Terlivaz® (terlipressin)	3/15/2023		Monthly Provider Update February 2023	MBP 271.0
Currently this drug is reported with an unlisted procedure code				
Testopel®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANDROGENIC AGENTS
S0189				
Testosterone Cypionate	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANDROGENIC AGENTS
J1071				
Testosterone Enanthate	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANDROGENIC AGENTS
J3121				
Tevimbra® (tislezumab-jsgr)	3/15/2025		Monthly Provider Update February 2025	MBP 331.0
J9329				
Tezspire®	7/1/2022		Statewide Preferred Drug List (PDL) Managed	MONOCLONAL ANTIBODIES (MABs) – ANTI-IL, ANTI-IGE, ANTI-TLSP
J2356				
Tigan®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIEMETICS-ANTIVERTIGO AGENTS
J3250				
Tivdak® (tisotumab vedotin-tftv)	3/15/2022		Monthly Provider Update February 2022	MBP 246.0
J9273				

Tofidence™	4/1/2024		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
Q5133				
Torisel® (temsirolimus)	4/1/2009		Postcard May 2016-Annual Policy Review	MBP 65.0
J9330				
Trastuzumab (Herceptin®) and Biosimilars	9/15/2023		Monthly Provider Update August 2023	MBP 294.0
J9355				
Trelstar®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	PITUITARY SUPPRESSIVE AGENTS, LHRH
J3315				
Tremfya®	12/15/2024		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
J1628				
Triesence®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	OPHTHALMICS, ANTI-INFLAMMATORIES
J3300				
Triluron®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES
J7332				
Triptodur®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	PITUITARY SUPPRESSIVE AGENTS, LHRH
J3316				
Trisenox® (arsenic trioxide)	6/15/2018		Monthly Provider Update May 2018	MBP 172.0
J9017				
Trivisc®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES
J7329				
Trodelyv® (sacituzumab govitecan-hziy)	10/1/2020		Monthly Provider Update September 2020	MBP 216.0
J9317				
Trogarzo®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	HIV/AIDS ANTIRETROVIRALS
J1746				

		Prior authorization is not required for Truxima® (rituximab-abbs) for diagnosis codes C91.00-C91.02, C91.10-C91.12, C91.40-C91.42, C82.00-C85.99, C86.0- C88.9, C81.00-C81.09, G35.B0, G35.B1, G35.B2, G35.C, G35.C0, G35.C1, G35.C2 and G35.D	Monthly Provider Update March 2020	
Truxima® (rituximab-abbs)	7/1/2019			MBP 48.0
Q5115				
Tyenne® IV	10/1/2024		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
Q5135				
Tyruko®	4/1/2024		Statewide Preferred Drug List (PDL) Managed	MULTIPLE SCLEROSIS AGENTS
Q5134				
Tysabri®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	MULTIPLE SCLEROSIS AGENTS
J2323				
Tzield® (teplizumab-mzwv)	7/1/2023		Monthly Provider Update June 2023	MBP 283.0
J9381				
Udenyca®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	COLONY STIMULATING FACTORS
Q5111				
Ultomiris® (Ravulizumab-cwvz)	8/15/2019		Monthly Provider Update July 2019	MBP 196.0
J1303				
Unituxin® (dinutuximab)	1/1/2016		Postcard October 2015	MBP 135.0
Currently this drug is reported with an unlisted procedure code				
Uplizna® (inebilizumab-cdon)	1/1/2021		Monthly Provider Update February 2021	MBP 225.0
J1823				
Uzedy®	9/15/2023		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J2799; Prior authorization is required for any member under 18 years of age				
Vabomere® (meropenem/vaborbactam)	6/15/2018		Monthly Provider Update May 2018	MBP 167.0
J2186				

Vabysmo®	5/15/2022		Statewide Preferred Drug List (PDL) Managed	MACULAR DEGENERATION AGENTS
J2777				
Vectibix® (panitumumab)	7/1/2007		Briefly June 2007	MBP 50.0
J9303				
Velcade® (bortezomib)	8/1/2004		Briefly March 2006	MBP 23.0
J9041, J9046, J9051, J9049, J9048				
Veletri® or Flolan® (epoprostenol)	1/1/2009		Postcard July 2017-Annual Policy Review	MBP 61.0
J1325				
Veopoz™ (pozelimab-bbfg)	4/1/2024		Monthly Provider Update March 2024	MBP 312.0
J9376				
Viltepso® (viltolarsen)	4/1/2021		Monthly Provider Update March 2021	MBP 226.0
J1427				
Vimizim® (elosulfase alfa)	12/1/2014		Postcard November 2014	MBP 114.0
J1322				
Visco-3®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES
J7321				
Viscosupplementation using hyaluronan injections (Durolane®, Euflexxa®, Gel-One®, Gelsyn-3®, Genvisc 850®, Hyalgan®, Hymovis®, Monovisc®, Orthovisc®, Supartz FX®, Synjoynt®, Synvisc®, Synvisc-One®, Triluron®, Trivisc®, Visco-3®)	1/1/2020		Statewide Preferred Drug List (PDL) Managed	INTRA-ARTICULAR HYALURONATES
J7318, J7323, J7326, J7328, J7320, J7321, J7322, J7327, J7324, J7331, J7325, J7332, J7329				
Visudyne®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	MACULAR DEGENERATION AGENTS
J3396				
Vonvendi®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7179				

Voraxaze® (glucarpidase)	1/1/2014		Postcard June 2017-Annual Policy Review	MBP 96.0
C9293				
VPRIV®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ENZYME REPLACEMENTS, GAUCHER DISEASE
J3385				
Vyepti®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	MIGRAINE PREVENTION AGENTS (PREVIOUSLY ANTIMIGRAINE AGENTS, OTHER)
J3032				
Vyjuvek® (beremagene geperpavec-svdt)	1/1/2024		Monthly Provider Update December 2023	MBP 306.0
J3401				
Vyloy® (zolbetuximab-clzb)	3/15/2025		Monthly Provider Update February 2025	MBP 334.0
J1326				
Vyondys 53 (golodirsen)	7/1/2020		Monthly Provider Update June 2020	MBP 214.0
J1429				
Vyvgart® (efgartigimod alfa-fcab) and Vyvgart® Hytrulo (Efgartigimod Alfa and Hyaluronidase Injection)	7/1/2022		Monthly Provider Update June 2022	MBP 260.0
J9332, J9334				
Vyxeos® (daunorubicin/cytarabine liposomal)	4/15/2018		Monthly Provider Update March 2018	MBP 164.0
J9153				
Wezlana™ IV	7/15/2025		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
Q5138				
White Blood Cell Stimulating Factors (Fulphila®, Fylnetra®, Granix®, Leukine®, Neulasta® / Neulasta Onpro®, Neupogen®, Nivestym®, Nypozi®, Nyvepria™, Releuko®, Rolvedon®, Stimufend®, Udenyca®, Zarxio, Ziextenzo®)	1/1/2020		Statewide Preferred Drug List (PDL) Managed	COLONY STIMULATING FACTORS
Q5108, Q5130, J1447, J2820, J2506, J1442, Q5110, C9173, Q5122, Q5125, J1449, Q5127, Q5111, Q5101, Q5120				
Wilate®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS

J7183				
Wyost® / Jubbonti®	9/9/2025		Statewide Preferred Drug List (PDL) Managed	BONE DENSITY REGULATORS
Q5136				
Xacduro® (sulbactam and durlobactam)	4/15/2024		Monthly Provider Update March 2024	MBP 311.0
Currently this drug is reported with an unlisted procedure code				
Xembify® (immune globulin)	3/15/2022		Monthly Provider Update February 2022	MBP 4.0
J1558				
Xenleta® IV (lefamulin)	4/15/2020		Monthly Provider Update March 2020	MBP 207.0
J0691				
Xenpozyme® (olipudase alfa-rpcp)	4/1/2023		Monthly Provider Update March 2023	MBP 284.0
J0218				
Xeomin®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	BOTULINUM TOXINS
J0588				
Xerava® (eravacycline)	6/15/2019		Monthly Provider Update May 2019	MBP 194.0
J0122				
Xgeva®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	BONE DENSITY REGULATORS
J0897				
Xipere®	5/17/2022		Statewide Preferred Drug List (PDL) Managed	OPHTHALMICS, ANTI- INFLAMMATORIES
J3299				
Xofigo® (radium Ra 223 dichloride)	9/1/2013		Postcard August 2013	MBP 110.0
A9606				
Xolair®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	MONOCLONAL ANTIBODIES (MABs) – ANTI-IL, ANTI-IGE, ANTI-TLSP
J2357				
Xyntha®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS

J7185				
Xyntha® Solofuse	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIHEMOPHILIA AGENTS
J7185				
Ycanth® (cantharidin)	4/1/2024		Monthly Provider Update March 2024	MBP 310.0
J7354				
Yervoy® (Ipilimumab)	10/1/2011		Postcard May 2016-Annual Policy Review	MBP 91.0
J9228				
Yesafili	10/1/2025		Statewide Preferred Drug List (PDL) Managed	MACULAR DEGENERATION AGENTS
Q5155				
Yescarta® (axicabtagene ciloleucel)	4/1/2018		Monthly Provider Update March 2018	MBP 162.0
Q2041				
Yesintek™ IV	7/15/2025		Statewide Preferred Drug List (PDL) Managed	CYTOKINE AND CAM ANTAGONISTS
Q5100				
Yeztugo®	10/1/2025		Statewide Preferred Drug List (PDL) Managed	HIV/AIDS ANTIRETROVIRALS
J0738				
Yondelis® (trabectedin)	4/15/2016		Postcard March 2016	MBP 137.0
J9352				
Yutiq®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	OPHTHALMICS, ANTI-INFLAMMATORIES
J7314				
Zarxio	1/1/2020		Statewide Preferred Drug List (PDL) Managed	COLONY STIMULATING FACTORS
Q5101				
Zemaira® (alpha 1-proteinase inhibitor (human))	4/1/2007		Briefly March 2007	MBP 43.0
J0256				
Zemdri® (plazomicin)	4/15/2019		Monthly Provider Update March 2019	MBP 187.0

J0291				
Zemplar®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	VITAMIN D ANALOGS
J2501; The following NDC numbers require prior authorization; 00074165805, 00074463701, 00074165801				
Zepzelca® (lurbinectedin)	11/15/2020		Monthly Provider Update October 2020	MBP 222.0
J9223				
Zerbaxa® (ceftolozane/tazobactam)	3/15/2020		Monthly Provider Update February 2020	MBP 205.0
J0695				
Zevalin® (Ibritumomab tiuxetan (IDEC Y2B8))	1/1/2006		Briefly March 2006	MBP 15.0
A9542, A9543				
Ziextenzo®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	COLONY STIMULATING FACTORS
Q5120				
Ziihera® (zanidatamab-hrii)	4/1/2025		Monthly Provider Update March 2025	MBP 337.0
J9276				
Zilretta® (triamcinolone acetonide ER injection)	8/15/2018		Monthly Provider Update July 2018	MBP 178.0
J3304				
Zimhi®	1/1/2023		Statewide Preferred Drug List (PDL) Managed	OPIOID OVERDOSE AGENTS
J2311				
Ziprasidone	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J3486; Prior authorization is required for any member under 18 years of age				
Zolgensma® (onasemnogene abeparvovec-xioi)	11/15/2019		Monthly Provider Update October 2019	MBP 199.0
J3399				
Zulresso®	1/15/2020		Statewide Preferred Drug List (PDL) Managed	ANTIDEPRESSANTS, OTHER
J1632				
Zynlonta® (loncastuximab tesirine-lpyl)	9/15/2021		Monthly Provider Update August 2021	MBP 237.0

J9359				
Zynteglo® (betibeglogene autotemcel)	7/15/2023		Monthly Provider Update June 2023	MBP 276.0
J3393				
Zynyz® (retifanlimab-dlwr)	7/15/2023		Monthly Provider Update June 2023	MBP 285.0
J9345				
Zyprexa Relprevv	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J2358; Prior authorization is required for any member under 18 years of age				
Zyprexa®	1/1/2020		Statewide Preferred Drug List (PDL) Managed	ANTIPSYCHOTICS
J2358; Prior authorization is required for any member under 18 years of age				