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Formulary *Update*

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A PUBLICATION OF THE GEORGIA PHARMACY AND THERAPEUTICS (P&T) COMMITTEE. The Formulary Update contains information regarding formulary additions, deletions, exclusions, brief descriptions of products, and current drug related news. It also lists items to be discussed at upcoming P&T meetings. Please refer to the web pages: KP Georgia Formulary and Drug List OR Drug Formulary for Practitioners for all KPGA Drug Formularies.

Formulary Additions

- Bromfenac Sodium 0.09% Solution (generic Bromday)
- Emtricitabine/Tenofovir Disoproxil Fumarate 100-150mg, 133-200mg, 167-250mg Tablets (generic Truvada)
- Kirsty (insulin aspart-xjhz) Injection
- Lubiprostone Capsules (generic Amitiza)
- Prucalopride Tablets (generic Motegrity)
- Sodium Sulfate, Potassium Sulfate, and Magnesium Sulfate 17.5-3.13-1.6 GM/177mL Solution (generic Suprep)

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- Wegovy (semaglutide)
- Xiaflex (collagenase clostridium histolyticum)
- Zavzpret (zavegepant)

Upcoming Formulary Items:

An important aspect of the formulary process is the involvement of all clinicians. Please contact your P&T Committee representative or your clinical department chief by November 21 if you wish to comment on any of the medications, class reviews, or other agenda items under consideration. To make formulary addition requests, you must submit a Formulary Additions/Deletions Form and Conflict of Interest Form to Drug Information Services via email at KPGA-DrugInformation@kp.org.

Medication Class Review
December 2025

- Alternative Medicines
- Antacids
- Antidiarrheals/probiotic agents
- Antidotes
- Cardiotonics
- Chemicals
- Compounds
- Contraceptives, Oral
- Estrogens
- Laxatives
- Medical Devices
- Miscellaneous Therapeutic Classes
- Nutrients
- Oxytocics
- Progestins
- Ulcer drugs
- Vaginal Products

Prior Authorization (QRM) Removals

- **Jesduvroq (daprodustat)**
- **Natpara (parathyroid hormone)**
- **Oxbryta (voxelotor)**
- **Symlin (pramlinitide)**
- **Vyndaqel (tafamidis) – effective 1.1.2026**

Commercial HMO/Closed Formulary Additions

The following medications will be ADDED to the Commercial Formulary effective November 12, 2025:

Note: Commercial Formulary additions may result in tier changes on the QHP (ACA)/Open Formulary.

Bromfenac Sodium 0.09% Solution (generic Bromday)	Indicated for the treatment of postoperative inflammation and reduction of ocular pain following cataract surgery
Emtricitabine/Tenofovir Disoproxil Fumarate 100-150mg, 133-200mg, 167-250mg Tablets (generic Truvada)	Indicated for the treatment of HIV-1 infection in combination with other antiretroviral agents in adults and pediatric patients weighing ≥17 kg
Kirsty (insulin aspart-xjhz) 100 units/mL Injection	Treatment of type 1 diabetes mellitus and type 2 diabetes mellitus to improve glycemic control
Lubiprostone 8mcg, 24 mcg Capsules (generic Amitiza)	Indicated for the treatment of the following: • chronic idiopathic constipation (CIC) in adults • irritable bowel syndrome (IBS) with constipation in women ≥18 years of age • opioid-induced constipation (OIC) in adults with chronic noncancer pain
Prucalopride 1mg, 2mg Tablets (generic Motegrity)	• Indicated for the treatment of chronic idiopathic constipation in adults
Sodium Sulfate, Potassium Sulfate, and Magnesium Sulfate 17.5-3.13-1.6 GM/177mL Solution (generic Suprep)	• Indicated for cleansing of the colon as a preparation for colonoscopy in adults and pediatric patients ≥12 years of age

Approved Floor Stock List Changes

Medication	Department
Approved Floor Stock List Additions	
Celestone Soluspan 6mg/mL (betamethasone) injection	Dermatology
Depo-Medrol 80 mg/mL (methylprednisolone) injection	Podiatry
Sotradecol 1% (sodium tetradecyl sulfate) IV solution	General Surgery
Approved Floor Stock List Removals	
5% Dextrose in Water IV solution	Adult Primary Care
Humulin N 100 U/mL suspension	Adult Primary Care
Hydroxyprogesterone Caproate 250mg/mL injection	Women's Health

Approved Compound List Changes

Medication	Change
Approved Outpatient Compounds List	
Betamethasone dipropionate 0.05%, Salicylic acid 10%, Urea 10% topical ointment	Added to the approved outpatient compounds list
Hydrocortisone 2 mg/mL oral suspension	Removed due to availability of commercial product - Khindivi 1 mg/mL oral solution by Eton Pharmaceuticals, Inc.
Hydrocortisone 2.5%, Camphor 0.5%, Menthol 0.5% Topical Lotion	Added to the approved outpatient compounds list
Metronidazole 50 mg/mL oral suspension	Removed due to relaunch of commercial product - Likmez 500 mg/5 mL oral suspension by Saptalis Pharmaceuticals, LLC.
Triamcinolone 0.1%, Camphor 0.5%, Menthol 0.5% Topical lotion	Added to the approved outpatient compounds list

Standing Order Approved for Insulin Lispro (Humalog) TO Insulin Aspart-xjhz (Kirsty)

KP Pharmacists are authorized to:

- Replace existing prescriptions of insulin lispro (Humalog) with the equivalent dose and directions of insulin aspart-xjhz (Kirsty) and as approved by the Regional Pharmacy and Therapeutics Committee
- If no refills remain, add ONE refill to the existing prescription to allow the conversion to be completed

Interregional Practice Recommendations

The Emerging Therapeutics Strategy Program (ETSP) is a centralized effort that applies our evidence-based model to develop interregional practice recommendations with KP physician specialists, coordinates KP HealthConnect clinical content for decision support, and monitors outcomes to measure uptake of the clinical and strategy recommendations. Through the collaboration of Pharmacy, Permanente physicians, and Federation partners, the ETSP offers a unified approach in the provision and management of specialty drugs to help ensure that our members derive the greatest value from these products.

The following IR Practice Recommendation ADDITION was recently approved:

Semaglutide (Wegovy) and resmetirom (Rezdiffra) for Metabolic Dysfunction-Associated Steatohepatitis (MASH)	Indicated as an adjunct to diet and exercise for the treatment of noncirrhotic metabolic dysfunction–associated steatohepatitis in adults with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis)

ETSP recommendations as well as pipeline candidates can be found here: ETSP Home Page
Please note: Newly marketed medications requiring ETSP review will also receive prior authorization (PA) review. These medications will not be eligible for consideration of drug benefit coverage until completion of drug specific ETSP and PA criteria review processes.

Information Concerning Coverage Determinations

Medicare Part D: Medicare Part D Plan Non-Formulary and Prior Authorization criteria and coverage determination are made externally by the Pharmacy Benefit Manager Optum Rx.

Prescriber completes the .NFRequestForm when entering drug order. Your documentation is used by OptumRx to determine whether the prescribed drug is eligible for drug benefit coverage. No documentation = No coverage.

The KP Pharmacy Consult Service will send your documentation to OptumRx for their coverage determination decision within the labeled time frame (standard: 72 hours; urgent: 24 hours). If not received by the deadline, the PBM will deny the request. If OptumRx has further questions, you will be contacted for responses. You may phone OptumRx at 1-888-791-7255 to address any patient / drug coverage specific questions. To see the MPD Formulary, please visit: Medicare Part D Formulary.

Dual Choice: Dual Choice Plan Non-Formulary and Prior Authorization criteria and coverage determination are made externally by the Pharmacy Benefit Manager MedImpact.

Prescriber completes the .NFRequestForm when entering drug order. Your documentation is used by MedImpact to determine whether the prescribed drug is eligible for drug benefit coverage. No documentation = No coverage.

The KP Pharmacy Consult Service will send your documentation to MedImpact for their coverage determination decision within the labeled time frame (standard: 72 hours; urgent: 24 hours). If not received by the deadline, the PBM will deny the request. If MedImpact has further questions, you will be contacted to provide responses. You may phone MedImpact at 1-888-336-2676 to address any patient / drug coverage specific questions. The Dual Choice formulary differs from the KPHC formulary (i.e. DOACs, ADHD, asthma). Please visit: Choice Formulary.

Additions to the QRM Prior Authorization Review List of Medications for the Commercial/HMO Closed Formularies & QHP-ACA/Open Formularies

Note: The updates below DO NOT APPLY to Medicare Part D or Dual Choice Prescription Benefit Plans. Optum and MedImpact are the external PBMs for each of these plans, respectively, externally administering all non-formulary or prior authorization criteria and coverage review.

The following medications will be ADDED to the QRM PA Review List effective November 12, 2025:

Aucatzyl (obecabtagene autoleucel)	Indicated for the treatment of relapsed or refractory B-cell precursor acute lymphoblastic leukemia in adults.
Dupixent (dupilumab) for the treatment of chronic spontaneous urticaria	Indicated for the treatment of adult and pediatric patients aged 12 years and older with CSU who remain symptomatic despite H1 antihistamine treatment.
Itovebi (inavolisib)	Indicated for the treatment (in combination with palbociclib and fulvestrant) of endocrine-resistant, hormone receptor (HR)–positive, human epidermal growth factor 2 (HER2)–negative, PIK3CA-mutated (as detected by an approved test), locally advanced or metastatic breast cancer in adults following recurrence on or after completing adjuvant endocrine therapy.
Kebilidi (eladocagene exuparvovec)	Indicated for the treatment of aromatic L-amino acid decarboxylase (AADC) deficiency in adults and pediatric patients.
Romvimza (vimseltinib)	Indicated for the treatment (as a single agent) of symptomatic tenosynovial giant cell tumor (TGCT) in adults for which surgical resection will potentially cause worsening functional limitation or severe morbidity.
Wegovy (semaglutide) for the treatment of metabolic dysfunction-associated steatohepatitis	Indicated as an adjunct to diet and exercise for the treatment of noncirrhotic metabolic dysfunction–associated steatohepatitis in adults with moderate to advanced liver fibrosis (stages F2 to F3).
Yeztugo (lenacapavir)	Indicated for preexposure prophylaxis (PrEP) in adults and adolescents weighing ≥35 kg to reduce the risk of sexually acquired HIV-1. Individuals must have a negative HIV-1 test prior to initiating lenacapavir for HIV-1 PrEP.

QRM Prior Authorization Review Criteria Updates

Note: The updates below DO NOT APPLY to Medicare Part D or Dual Choice Prescription Benefit Plans. Optum and MedImpact are the external PBMs for each of these plans, respectively, externally administering all non-formulary or prior authorization criteria and coverage review.

- **Alhemo (concizumab-mtci):** Criteria updated to (1) include the expanded indication for hemophilia A/B prophylaxis with or without inhibitors and (2) remove dosing and administration information from the criteria.
- **Amtagvi (lifileucel):** Criteria updated to include the Winship Cancer Institute of Emory University as an authorized treatment center in Georgia.
- **Botulinum Toxins:** Criteria for cerebral palsy updated to only require trial and failure of a muscle relaxant.
- **Calcitonin Gene-Related Peptide (CGRP) Inhibitors:** Criteria updated to (1) replace wording 'onabotulinumtoxinA' with 'botulinum toxin' and (2) remove reasons for non-coverage regarding pregnancy, liver disease, central nervous arteriovenous malformation, aneurysm, arterial dissection or reversible cerebral vasoconstriction syndrome.
- **Denosumab Products:** Criteria updated to (1) add osteoporotic fracture as a covered diagnosis, (2) clarify that Fracture Risk Assessment (FRAX) requirements only applies to patients with osteopenia, and (3) add statement under continued approval to approve subsequent treatments for patients started on denosumab.
- **Doptelet (avatrombopag):** Criteria updated to allow a trial of either rituximab or a rituximab biosimilar.
- **Dupixent (dupilumab):** Criteria updated to include criteria for the treatment of chronic spontaneous urticaria.
- **Eloctate (antihemophilic factor (recombinant), Fc fusion protein):** Criteria updated to (1) include continued approval criteria and (2) remove dosing and administration information.
- **Elrexfio (elranatamab-bcmm):** Criteria updated to change the initial approval duration to 12 months.
- **Empaveli (pegcetacoplan):** Criteria updated to include criteria for the treatment of C3 glomerulopathy (C3G).
- **Endari (l-glutamine):** Criteria updated to (1) remove option for patients to decline trial of hydroxyurea and (2) change the continued approval duration to 12 months.
- **Entyvio (vedolizumab):** Criteria updated to (1) clarify that the IV formulation is preferred, (2) update the initial approval duration for adults for both IV and SC formulations, (3) clarify the continued approval criteria for both new members initiated on Entyvio outside of KPGA and for existing members, (4) clarify pediatric criteria requirements, and (5) remove subcutaneous dosage and administration information.
- **Fotivda (tivozanib):** Criteria updated to (1) remove concomitant use of strong CYP3A4 inducers as a reason for non-coverage and (2) change the initial approval period to 12 months.
- **GLP-1 Receptor Agonists (GLP-1 RAs), Cardiovascular Indication:** Criteria updated to align the reasons for non-coverage with clinical practice.
- **GLP-1 RAs, Diabetes Indication:** Criteria updated to (1) clarify for reviewers that generic liraglutide is preferred and does not require PA review, (2) add required age ranges for GLP-1 RAs listed in criteria, (3) specify the A1C goal percentage for new members with DM and ASCVD, (4) highlight a trial of liraglutide is not required for new members with DM and ASCVD on a GLP-1 RA or GLP-1 RA/GIP with an A1C within 2% of goal within the past 3 months, (5) clarify when to approve preferred Ozempic or Rybelsus for new members with DM and ASCVD, and (6) specify the A1C goal and clarify when to approve preferred Ozempic or Rybelsus for new members without ASCVD.
- **GLP-1 RAs, Weight Management Indication:** Criteria updated to (1) clarify the oral medication required for ages 12-17 years to trial prior to coverage and (2) remove note concerning long term use of phentermine.
- **Growth Hormones**: Criteria updated to (1) change the order of preference of growth hormones and (2) remove age restrictions for use of Skytrofa, to allow use in adults.
- **Hereditary Transthyretin-Mediated Amyloidosis – Polyneuropathy (hATTR-PN) Therapies:** Criteria updated to highlight Amvutrra (vutrisiran) as the preferred hATTR-PN therapy.
- **Human C1 Esterase Inhibitors:**
    - **Berinert:** Criteria updated to allow off label use for short-term/pre-procedural prophylaxis.
    - **Cinryze/Haegarda:** Criteria updated to (1) highlight that Haegarda is the preferred agent, (2) allow approval of Cinryze in children age 6-11 years, (3) allow use of Cinryze off label for hereditary angioedema (HAE) attacks, and (4) require trial of Takhzyro prior to coverage approval of Cinryze and Haegarda for patients age ≥12 years.
- **Infliximab Products:** Criteria updated to (1) indicate Inflectra as the KPGA preferred product that does not require QRM PA review and (2) remove reasons for non-coverage criteria.
- **Iqirvo (elafibranor):** Criteria updated to (1) remove criteria for medical management of cholestatic pruritic, (2) remove required trial of Ocaliva (obeticholic acid), and (3) remove reasons for non-coverage criteria.
- **Livdelzi (maralixibat):** Criteria updated to (1) remove required trial of Ocaliva and Iqirvo and (2) remove reasons for non-coverage criteria.

QRM Prior Authorization Review Criteria Updates (continued)

- **Noxafil (posaconazole):** Criteria updated to (1) add hematopoietic stem cell transplant (HSCT) as one of the covered conditions and (2) change initial approval duration to 3 months.
- **Nucala (mepolizumab):** Criteria updated to add criteria for the treatment of hypereosinophilic syndrome.
- **Nurtec ODT (rimegepant):** Criteria updated to (1) remove requirement for history of moderate to severe migraines and reduce the number of required triptans for acute migraine attack abortive therapy, (2) add requirement that patient is not receiving an injectable CGRP or its receptor for migraine preventative therapy, and (3) remove the reasons for non-coverage for both indications.
- **Orladeyo (berotralstat):** Criteria updated to (1) provide criteria for Type I and Type II hereditary angioedema and (2) require a trial of Takhyzro and Haegarda prior to approval.
- **Palforzia (peanut allergen powder):** Criteria updated to change the required age for coverage to 1-17 years.
- **Qulipta (atogepant):** Criteria updated to remove the reasons for non-coverage.
- **Reyvow (lasmiditan):** Criteria updated to (1) require a neurologist or provider in the Department of Neurology as prescriber, (2) add requirements to trial Ubrelvy (ubrogepant) and Nurtec (rimegepant) prior to coverage, (3) reduce the number of triptans required to trial to three, and (4) remove the reasons for non-coverage criteria.
- **Rezdiffra (resmetirom):** Criteria updated to remove criteria regarding liver biopsy.
- **SGLT-2 Inhibitors:** Criteria updated to (1) change age requirements to ≥ 10 years of age, (2) remove eGFR requirements in the continuation criteria, and (3) change eGFR requirements and add dialysis and renal transplant under reasons for non-coverage.
- **Tecvayli (teclistamab-cqyv):** Criteria updated to remove criteria outlining continuation therapy following inpatient administration.
- **Tukysa (tucatinib):** Criteria updated to (1) remove requirements for baseline labs and pregnancy tests and (2) change the initial approval duration to 12 months.
- **Ubrelvy (ubrogepant):** Criteria updated to (1) remove requirement for history of moderate to severe migraines, (2) reduce the number of required triptans to trial to three, and (3) remove reasons for non-coverage.
- **Ultomiris (ravulizumab):** Criteria updated to (1) remove required trial of Vyvgart and (2) add concomitant monoclonal antibody therapy for myasthenia gravis as a reason for non-coverage.
- **Xiaflex (collagenase clostridium histolyticum):** Criteria updated to remove plastic surgeons as covered prescribers.
- **Zavzpret (zavegepant):** Criteria updated to (1) remove requirement for history of moderate to severe migraines, (2) reduce the number of required triptans to trial to three, and (3) remove reasons for non-coverage.

Medications Reviewed But Not Accepted to the Commercial HMO Formulary

Note: Medications that can be dispensed via the outpatient pharmacy benefit but are not accepted to the closed Commercial HMO formulary, will be placed on a tier for the QHP-ACA/ Open formularies.

Drug Name	Commercial HMO/ Closed Formulary Status	QHP-ACA/ Open Formulary Status
Aucatzyl (obecabtagene autoleucel)	• Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage • Add to the QRM PA Review List of Medications	
Azstarys (serdexmethylphenidate and dexmethylphenidate	• Do not accept to formulary	• Add to Non-Preferred Tier 4 • Add step therapy restrictions
Dupixent (dupilumab) for chronic spontaneous urticaria (CSU)	• Do not accept to formulary • Add criteria for CSU to the existing criteria on the QRM PA Review List of Medications	• Retain on Specialty Tier 5 • Add criteria for CSU to the existing criteria on the QRM PA Review List of Medications
Itovebi (inavolisib)	• Do not accept to formulary • Add to the QRM PA Review List of Medications	• Add to Specialty Tier 5 • Add to the QRM PA Review List of Medications
Kebilidi (eladocagene exuparvovec)	• Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage • Add to the QRM PA Review List of Medications	
Lybalvi (olanzapine-samidorphan)	• Do not accept to formulary	• Retain on Specialty Tier 5 • Retain step therapy restrictions
Merilog (insulin aspart-szjj)	• Do not accept to formulary	• Add to Non-Preferred Tier 4 • Add step therapy restrictions
Penmenvy (meningococcal groups A, B, C, W and Y vaccine)	• Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage	
Qelbree (viloxazine extended-release)	• Do not accept to formulary	• Retain on Non-Preferred Tier 4 • Retain step therapy restrictions
Romvimza (vimseltinib)	• Do not accept to formulary • Add to the QRM PA Review List of Medications	• Add to Specialty Tier 5 • Add to the QRM PA Review List of Medications
Vimkunya (chikungunya vaccine, recombinant)	• Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage	
Wegovy (semaglutide) for the treatment of metabolic dysfunction-associated steatohepatitis	• Do not accept to formulary • Retain on the QRM PA Review List of Medications	• Retain on Specialty Tier 5 • Retain on the QRM PA Review List of Medications
Winlevi (clascoterone)	• Do not accept to formulary	• Retain on Non-Preferred Tier 4 • Retain step therapy restrictions

Yeztugo (lenacapavir)	• Tablets:
	  ○ Do not accept to formulary
	  ○ Add to the QRM PA Review List of Medications
	• Injection:
	  ○ Not accepted – clinic administered medication
	  ○ Approve for clinic administration under medical benefit coverage
	  ○ Add to the QRM PA Review List of Medications
		• Tablets:
		  ○ Add to Specialty Tier 5
		  ○ Add to the QRM PA Review List of Medications
		• Injection:
		  ○ Not accepted – clinic administered medication
		  ○ Approve for clinic administration under medical benefit coverage
		  ○ Add to the QRM PA Review List of Medications

Medicare Part D Formulary Changes

Kaiser Permanente has a National Medicare Part D (MPD) Formulary. Each regional P&T Committee reviews drugs and decides on tier status. The National Medicare Part D Pharmacy and Therapeutics Committee is charged with reconciling regional differences in MPD Formulary recommendations through consensus building in order to maintain one National MPD Formulary for Kaiser Permanente.

Medicare Part D Formulary Removal of Brand Drugs

During the year, Kaiser Permanente may make changes to our Medicare Part D Formulary (Drug List). The list below is intended to inform you of these changes. The following table lists all branded products recently removed from the Medicare Part D Formulary and replaced with a generic alternative.

Brand Medication	Brand Drug Current Tier	Generic Alternative	Generic Drug Tier	Effective Date
ENTRESTO TABS 24-26 MG	3	SACUBITRIL-VALSARTAN TABS 24-26 MG	2	10/1/2025
ENTRESTO TABS 49-51 MG	3	SACUBITRIL-VALSARTAN TABS 49-51 MG	2	10/1/2025
ENTRESTO TABS 97-103 MG	3	SACUBITRIL-VALSARTAN TABS 97-103 MG	2	10/1/2025
EPRONTIA SOLN 25 MG/ML	4	TOPIRAMATE SOLN 25 MG/ML	4	11/1/2025
FYCOMPA TABS 2 MG	4	PERAMPANEL TABS 2 MG	4	10/1/2025
FYCOMPA TABS 4 MG	5	PERAMPANEL TABS 4 MG	5	10/1/2025
FYCOMPA TABS 6 MG	5	PERAMPANEL TABS 6 MG	5	10/1/2025
FYCOMPA TABS 8 MG	5	PERAMPANEL TABS 8 MG	5	10/1/2025
FYCOMPA TABS 10 MG	5	PERAMPANEL TABS 10 MG	5	10/1/2025
FYCOMPA TABS 12 MG	5	PERAMPANEL TABS 12 MG	5	10/1/2025
XARELTO SUSR 1 MG/ML	5	RIVAROXABAN SUSR 1 MG/ML	5	11/1/2025

Questions and Concerns?

If you have any questions or concerns, please contact any of the following P&T Committee members and designated alternates:

P&T Committee Voting Members:

Debbi Baker, PharmD, BCPS
Clinical Pharmacy

Hector Clarke, PharmD, BCOP
Ambulatory Pharmacy

Halima Daboiko, MD
Obstetrics and Gynecology

Pierson Gladney, MD
Hematology/Oncology

Ramin Haddad, MD
Adult Hospitalist

Larry Kang, MD
Adult Primary Care

Craig Kaplan, MD
Adult Primary Care

Christine Kofman, MD
Pediatrics

Amy Levine, MD
Pediatrics

Sophie Lukashok, MD
Infectious Disease

Chad Madill, PharmD, MBA
Executive Director of Pharmacy Operations

Stanley Allen, III MD
Emergency Medicine/ ACC

Felecia Martin, PharmD
Pharmacy/Geriatrics

Shayne Mixon, PharmD
Pharmacy Operations

Jennifer Rodriguez, MD
Behavioral Health (Committee Chair)

P&T Committee Non-Voting Physician Members

Elizabeth Greco, MD
Physician Lead, Pharmacy Safety and Systems

Designated Alternates:

Jacqueline Anglade, MD
Obstetrics and Gynecology

Lesia Jackson, RN
Clinical Services

Satya Jayanthi, MD
Hospitalist

Ad Hoc Member:

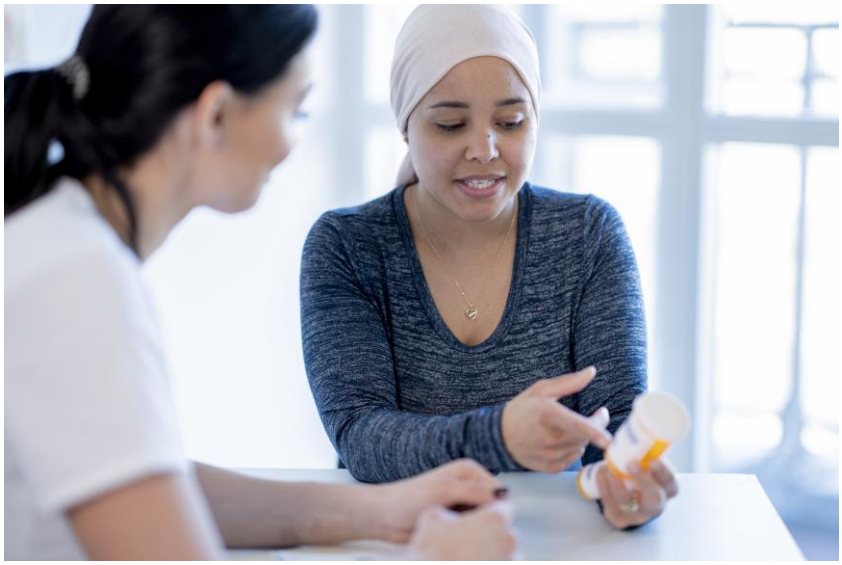
Mary Kangoma, RN, MSN
Employee Health Services

Medicare Part D Initial Tier Placement

Initial tier placements for recently launched and approved medications

#	Drug Name	Tier Status	Implementation Date
1	gepotidacin mesylate 750 mg tablets (Blujepa)	Specialty Tier 5	9/9/2025
2	rilzabrutinib 400 mg tablets (Wayrilz)	Specialty Tier 5	9/3/2025
3	lecanemab-irmb 360 mg/1.8 mL injection (Leqembi Iqlik)	Specialty Tier 5	9/3/2025
4	donidalorsen sodium 80 mg/0.8 mL injection (Dawnzera)	Specialty Tier 5	8/25/2025
5	cosibelimab-ipdl 300 mg/5 mL injection (Unloxcyt)**	Specialty Tier 5	8/25/2025
6	zanubrutinib 160 mg tablets (Brukinsa)**	Specialty Tier 5	8/21/2025
7	carboplatin 80 mg/8 mL, 500 mg/50 mL injection (Kyxata)**	Specialty Tier 5	8/21/2025
8	bevacizumab-nwgd 100 mg/4 mL, 400 mg/16 mL injection (Jobevne)**	Specialty Tier 5	8/18/2025
9	bosentan 32 mg tablets for oral suspension (generic)	Specialty Tier 5	8/15/2025
10	deflazacort 6 mg, 18 mg, 30 mg, 36 mg tablets (Jaythari)	Specialty Tier 5	8/14/2025
11	dordaviprone hcl 125 mg capsules (Modeyso)**	Specialty Tier 5	8/14/2025
12	brensocatib 10 mg, 25 mg tablets (Brinsupri)	Specialty Tier 5	8/14/2025
13	darunavir-cobicistat 675-150 mg tablets (Prezcobix)**	Specialty Tier 5	8/13/2025
14	butalbital-acetaminophen-caffeine 50 mg-325 mg-40 mg/15 mL oral solution (generic)	Specialty Tier 5	8/11/2025
15	zongertinib 60 mg tablets (Hernexeos)**	Specialty Tier 5	8/11/2025
16	sepiapterin 250 mg, 1,000 mg oral powder (Sephience)	Specialty Tier 5	7/30/2025
17	thiotepa and sodium chloride 200 mg/200 mL-0.9% injection (Tepadina and Sodium Chloride)	Specialty Tier 5	7/28/2025
18	delgocitinib 2% cream (Anzupgo)	Specialty Tier 5	7/25/2025

**Protected Class



2026 KPGA Commercial HMO/Closed Formulary & QHP-ACA Open Formulary Changes

Note: The updates below DO NOT APPLY to Medicare Part D or Dual Choice Prescription Benefit Plans.

QRM Prior Authorization Additions (Effective 1/1/2026)

PRODUCT DESCRIPTION		
ADALIMUMAB-RYVK(CF) 40 MG/0.4 ML	LIVDELZI CAPS 10 MG	TALTZ SOSY 20 MG/0.25ML
ADBRY SOAJ 300 MG/2 ML	LIVMARLI 19 mg/ml	TALTZ SOSY 40 MG/0.5ML
AGAMREE 40 MG/ML	LUMAKRAS TABS 240 MG	TREMFYA SOAJ 200 MG/2ML
ALYFTREK TABS 10-50-125 MG	LUMRYZ STARTER PACK THPK 4.5 & 6 & 7.5 GM	TREMFYA SOSY 200 MG/2ML
ALYFTREK TABS 4-20-50 MG	MIPLYFFA CAPS 124 MG	TRYNGOLZA SOAJ 80 MG/0.8ML
AQNEURSA PACK 1 GM	NEMLUVIO AUIJ 30 MG	TURALIO CAPS 125 MG
AUGTYRO CAPS 160 MG	OGSIVEO TABS 150 MG	TYVASO DPI MAINTENANCE KIT 64 MCG POWD
AUSTEDO XR PATIENT TITRATION TEPK 12 & 18 & 24 & 30 MG	OJEMDA SUSR 25 MG/ML	TYVASO DPI TITRATION KIT 16 & 32 & 48 MCG POWD
AUSTEDO XR TB24 18 MG	OJEMDA TABS 100 MG	TYVASO REFILL KIT SOLN 0.6 MG/ML
AUSTEDO XR TB24 30 MG	OJEMDA TABS 100 MG	UPTRAVI TABS 1000 MCG
AUSTEDO XR TB24 36 MG	OJEMDA TABS 100 MG	UPTRAVI TABS 1200 MCG
AUSTEDO XR TB24 42 MG	OMVOH SOSY 100 MG/ML	UPTRAVI TABS 1400 MCG
AUSTEDO XR TB24 48 MG	OPSYNVI TABS 10-20 MG	UPTRAVI TABS 1600 MCG
BIMZELX SOAJ 320 MG/2ML	OPSYNVI TABS 10-40 MG	UPTRAVI TABS 200 MCG
BIMZELX SOSY 320 MG/2ML	OTEZLA TBPK 4 x 10 & 51 x20 MG	UPTRAVI TABS 400 MCG
BOSULIF 100 MG	OTEZLA TABS 20 MG	UPTRAVI TABS 600 MCG
BOSULIF 50 MG	POTASSIUM CHLORIDE ER TBCR 15 MEQ	UPTRAVI TABS 800 MCG
COBENFY CAPS 100-20 MG	PROMACTA PACK 12.5 MG	UPTRAVI TITRATION TBPK 200 & 800 MCG
COBENFY CAPS 125-30 MG	PROMACTA PACK 25 MG	VIGAFYDE SOLN 100 MG/ML
COBENFY CAPS 50-20 MG	PROMACTA TABS 12.5 MG	VIJOICE PACK 50 MG
COBENFY STARTER PACK CPPK 50-20 & 100-20 MG	PROMACTA TABS 25 MG	VORANIGO TABS 10 MG
COMETRIQ (100 MG DAILY DOSE) KIT 80 & 20 MG	PROMACTA TABS 50 MG	VORANIGO TABS 40 MG
COMETRIQ (140 MG DAILY DOSE) KIT 3 x 20 MG & 80 MG	PROMACTA TABS 75 MG	VOYDEYA TABS 100 MG
COMETRIQ (60 MG DAILY DOSE) KIT 20 MG	RETEVMO TABS 120 MG	VOYDEYA TBPK 50 & 100 MG
CRENESSITY CAPS 100 MG	RETEVMO TABS 160 MG	WEZLANA SOLN 45 MG/0.5ML
CRENESSITY CAPS 50 MG	RETEVMO TABS 40 MG	WEZLANA SOSY 45 MG/0.5ML
CRENESSITY SOLN 50 MG/ML	RETEVMO TABS 80 MG	WEZLANA SOSY 90 MG/ML
DUVYZAT SUSP 8.86 MG/ML	REVLIMID CAPS 10 MG	WINREVAIR KIT 45 MG
EBGLYSS SOAJ 250 MG/2ML	REVLIMID CAPS 15 MG	WINREVAIR KIT 60 MG
EBGLYSS SYRINGE 250 MG/2 ML	REVLIMID CAPS 2.5 MG	XOLAIR SOAJ 150 MG/ML
FABHALTA 200 MG	REVLIMID CAPS 20 MG	XOLAIR SOAJ 300 MG/2ML
FASENRA 10 MG/0.5 ML	REVLIMID CAPS 25 MG	XOLAIR SOSY 300 MG/2ML
GLIMEPIRIDE TABS 3 MG	REVLIMID CAPS 5 MG	XOLAIR SOAJ 75 MG/0.5ML
INGREZZA CPSP 40 MG	REVUFORJ 110 mg Tab	XOLREMDI CAPS 100 MG
INGREZZA CPSP 60 MG	REVUFORJ 160 mg Tab	YORVIPATH SOPN 168 MCG/0.56ML
INGREZZA CPSP 80 MG	RINVOQ LQ SOLN 1 MG/ML	YORVIPATH SOPN 294 MCG/0.98ML
INLYTA TABS 1 MG	RIVFLOZA SOLN 80 MG/0.5ML	YORVIPATH SOPN 420 MCG/1.4ML
INLYTA TABS 5 MG	RIVFLOZA SOSY 128 MG/0.8ML	ZILBRYSQ SOSY 16.6 MG/0.416ML
IQIRVO TABS 80 MG	RIVFLOZA SOSY 160 MG/ML	ZILBRYSQ SOSY 23 MG/0.574ML
ITOVEBI TABS 3 MG	SKYCLARYS CAPS 50 MG	ZILBRYSQ SOSY 32.4 MG/0.81ML
ITOVEBI TABS 9 MG	SOFDRA GEL 12.45 %	ZITUVIMET XR TB24 100-1000 MG
LAZCLUZE 240MG	SPEVIGO SOSY 150 MG/ML	ZITUVIMET XR TB24 50-1000 MG
LAZCLUZE 80MG	STIVARGA TABS 40 MG	ZITUVIMET XR TB24 50-500 MG
ZOLINZA CAPS 100 MG		

Step Therapy Additions (Effective 1/1/2026)

PRODUCT DESCRIPTION			
ACETAMINOPHEN-CODEINE SOLN 120-12 MG/5ML	DRIZALMA SPRINKLE CSDR 20 MG	MOTPOLY XR CP24 100 MG	PROMETHEGAN SUPP 12.5 MG
AIRSUPRA 90MCG/80MCG	DRIZALMA SPRINKLE CSDR 30 MG	MOTPOLY XR CP24 150 MG	PROMETHEGAN SUPP 25 MG
ALTOPREV TB24 20 MG	DRIZALMA SPRINKLE CSDR 40 MG	MOTPOLY XR CP24 200 MG	PROMETHEGAN SUPP 50 MG
ALTOPREV TB24 40 MG	DRIZALMA SPRINKLE CSDR 60 MG	MYCOPHENOLATE MOFETIL SUSR 200 MG/ML	RETACRIT SOLN 40000 UNIT/ML
ALTOPREV TB24 60 MG	DYANAVEL XR SUER 2.5 MG/ML	NEUAC GEL 1.2-5 %	RETIN-A MICRO PUMP GEL 0.06 %
AMNESTEEM CAPS 10 MG	EC-NAPROSYN TBEC 375 MG	NICARDIPINE HCL CAPS 20 MG	RISEDRONATE SODIUM TBEC 35 MG
AMNESTEEM CAPS 20 MG	EMROSI CP24 40 MG	NICARDIPINE HCL CAPS 30 MG	ROXYBOND TABA 30 MG
AMNESTEEM CAPS 40 MG	ENVARSUS XR TB24 4 MG	NYPOZI SOSY 300 MCG/0.5ML	ROXYBOND TABA 5 MG
AMOXAPINE TABS 100 MG	EPINEPHRINE SOAJ 0.15 MG/0.15ML	NYPOZI SOSY 480 MCG/0.8ML	SUMATRIPTAN-NAPROXEN SODIUM TABS 85-500 MG
AMOXAPINE TABS 150 MG	EPINEPHRINE SOAJ 0.15 MG/0.3ML	ONDANSETRON TBDP 16 MG	SUTAB 1.479/0.225/0.188GM TAB 24 (2X12)
AMOXAPINE TABS 25 MG	EPINEPHRINE SOAJ 0.3 MG/0.3ML	ONYDA XR 0.1 MG/ML	TAVABOROLE SOLN 5 %
AMOXAPINE TABS 50 MG	EPOGEN SOLN 10000 UNIT/ML	OPIPZA FILM 10 MG	TENCON TABS 50-325 MG
AMZEEQ FOAM 4 %	FLUPHENAZINE HCL CONC 5 MG/ML	OPIPZA FILM 2 MG	THIOLA EC TBEC 100 MG
ANCOBON CAPS 250 MG	FLUPHENAZINE HCL ELIX 2.5 MG/5ML	OPIPZA FILM 5 MG	THIOLA EC TBEC 300 MG
ANCOBON CAPS 500 MG	FLUPHENAZINE HCL SOLN 2.5 MG/ML	OPVEE 2.7 MG/0.1 ML	THIOLA TABS 100 MG
Baclofen Tabs 15 mg	FUROSCIX CTKT 80 MG/10ML	OXAPROZIN CAPS 300 MG	TOLAK CREA 4 %
BETAMETHASONE DIPROPIONATE AUG GEL 0.05 %	HYDROCODONE-ACETAMINOPHEN TABS 5-300 MG	OXAZEPAM CAPS 10 MG	TRAMADOL HCL TABS 100 MG
BUTALBITAL-ACETAMINOPHEN TABS 50-325 MG	HYDROCODONE-ACETAMINOPHEN TABS 7.5-300 MG	OXAZEPAM CAPS 15 MG	TRAMADOL HCL TABS 25 MG
CALCIPOTRIENE SOLN 0.005 %	IMITREX STATDOSE REFILL SOCT 4 MG/0.5ML	OXAZEPAM CAPS 30 MG	TRAMADOL HCL TABS 75 MG
CARBAMAZEPINE CHEW 200 MG	INDOMETHACIN ER CPCR 75 MG	OXYCODONE-ACETAMINOPHEN SOLN 5-325 MG/5ML	TRETINOIN GEL 0.05 %
CLINDAMYCIN PHOS-BENZOYL PEROX GEL 1.2-3.75 %	ITRACONAZOLE SOLN 10 MG/ML	OXYCODONE-ACETAMINOPHEN TABS 2.5-300 MG	TRIAMTERENE CAPS 100 MG
CLOMIPRAMINE HCL CAPS 75 MG	KETOPROFEN CAPS 50 MG	OXYCODONE-ACETAMINOPHEN TABS 2.5-325 MG	TRIAMTERENE CAPS 50 MG
CREXONT CPCR 35-140 MG	KLOXXADO 8 MG/0.1 ML	PAROXETINE HCL ER TB24 12.5 MG	TRI-LEGEST FE TABS 1-20/1-30/1-35 MG-MCG
CREXONT CPCR 52.5-210 MG	K-PHOS NO 2 TABS 305-700 MG	PAROXETINE HCL ER TB24 25 MG	VALTOCO 10 MG DOSE LIQD 10 MG/0.1ML
CREXONT CPCR 70-280 MG	LIBERVANT FILM 10 MG	PAROXETINE HCL ER TB24 37.5 MG	VALTOCO 15 MG DOSE LQPK 7.5 MG/0.1ML
CREXONT CPCR 87.5-350 MG	LIBERVANT FILM 12.5 MG	PERCOCET TABS 7.5-325 MG	VALTOCO 20 MG DOSE LQPK 10 MG/0.1ML
DEFERIPRONE TABS 500 MG	LIBERVANT FILM 15 MG	PRADAXA CAPS 110 MG	VALTOCO 5 MG DOSE LIQD 5 MG/0.1ML
DICLOFENAC-MISOPROSTOL TBEC 50-0.2 MG	LIBERVANT FILM 5 MG	PRADAXA CAPS 150 MG	VENLAFAXINE BESYLATE ER TB24 112.5 MG
DICLOFENAC-MISOPROSTOL TBEC 75-0.2 MG	LIBERVANT FILM 7.5 MG	PRADAXA CAPS 75 MG	XCOPRI 25 MG
DISULFIRAM TABS 250 MG	LITHIUM SOLN 8 MEQ/5ML	PROMETHAZINE HCL SUPP 12.5 MG	ZONISADE SUSP 100 MG/5ML
DISULFIRAM TABS 500 MG	METRONIDAZOLE CAPS 375 MG	PROMETHAZINE HCL SUPP 25 MG	

Prior Authorization/ Step Therapy Removals (Effective 1/1/2026)

PRODUCT DESCRIPTION	REMOVED (PRIOR AUTHORIZATION OR STEP THERAPY)
ACAMPROSATE CALCIUM TBEC 333 MG	STEP THERAPY
CABOMETYX TABS 20 MG	STEP THERAPY
CABOMETYX TABS 40 MG	STEP THERAPY
CABOMETYX TABS 60 MG	STEP THERAPY
CLINDAMYCIN PHOS-BENZOYL PEROX GEL 1.2-3.75 %	PRIOR AUTHORIZATION
TAVABOROLE SOLN 5 %	PRIOR AUTHORIZATION

Quantity Limit/ Day Supply Additions (Effective 1/1/2026)

PRODUCT DESCRIPTION
AIRSUPRA 90MCG/80MCG
ALMOTRIPTAN MALATE TABS 12.5 MG
ALMOTRIPTAN MALATE TABS 6.25 MG
AUSTEDO XR TB24 18 MG
AUSTEDO XR TB24 30 MG
AUSTEDO XR TB24 36 MG
AUSTEDO XR TB24 42 MG
AUSTEDO XR TB24 48 MG
ELETRIPTAN HYDROBROMIDE TABS 20 MG
ELETRIPTAN HYDROBROMIDE TABS 40 MG
FROVA TABS 2.5 MG
FROVATRIPTAN SUCCINATE TABS 2.5 MG
IMITREX STATDOSE REFILL SOCT 4 MG/0.5ML
RELPAX TABS 20 MG
RELPAX TABS 40 MG
REZDIFFRA TABS 100 MG
REZDIFFRA TABS 60 MG
REZDIFFRA TABS 80 MG
ROXYBOND TABA 30 MG
ROXYBOND TABA 5 MG
SUMATRIPTAN SOLN 20 MG/ACT
SUMATRIPTAN SOLN 5 MG/ACT
VELTASSA PACK 1 GM
XCOPRI 25 MG
ZEPBOUND SOAJ 10 MG/0.5ML
ZEPBOUND SOAJ 12.5 MG/0.5ML
ZEPBOUND SOAJ 15 MG/0.5ML
ZEPBOUND SOAJ 2.5 MG/0.5ML
ZEPBOUND SOAJ 5 MG/0.5ML
ZEPBOUND SOAJ 7.5 MG/0.5ML
ZOLMITRIPTAN SOLN 2.5 MG
ZOLMITRIPTAN SOLN 5 MG
ZOLMITRIPTAN TABS 2.5 MG
ZOLMITRIPTAN TABS 5 MG
ZOLMITRIPTAN TBDP 2.5 MG
ZOLMITRIPTAN TBDP 5 MG
ZOMIG SOLN 2.5 MG
ZOMIG SOLN 5 MG
ZOMIG TABS 2.5 MG
ZOMIG TABS 5 MG

QHP- ACA/ Open Formulary Tier Changes (Effective 1/1/2026)

Note: These tier changes may result in tier changes on the Commercial HMO/2-Tier Formulary.

Product Description	2025 Tier Level	Tier Description	2026 Tier Level	Tier Description
ACETAMINOPHEN-CODEINE SOLN 120-12 MG/5ML	2	PREFERRED GENERIC	4	NON-PREFERRED
AMNESTEEM CAPS 10 MG	2	PREFERRED GENERIC	4	NON-PREFERRED
AMNESTEEM CAPS 20 MG	2	PREFERRED GENERIC	4	NON-PREFERRED
AMNESTEEM CAPS 40 MG	2	PREFERRED GENERIC	4	NON-PREFERRED
AROMASIN TABS 25 MG	4	NON-PREFERRED	5	SPECIALTY
BETAMETHASONE DIPROPIONATE AUG GEL 0.05 %	2	PREFERRED GENERIC	4	NON-PREFERRED
BUMETANIDE TABS 0.5 MG	4	NON-PREFERRED	2	PREFERRED GENERIC
BUMETANIDE TABS 1 MG	4	NON-PREFERRED	2	PREFERRED GENERIC
BUMETANIDE TABS 2 MG	4	NON-PREFERRED	2	PREFERRED GENERIC
CALCIPOTRIENE SOLN 0.005 %	2	PREFERRED GENERIC	4	NON-PREFERRED
DISULFIRAM TABS 250 MG	2	PREFERRED GENERIC	4	NON-PREFERRED
DROXIA CAPS 200 MG	3	PREFERRED BRAND	4	NON-PREFERRED
DROXIA CAPS 300 MG	3	PREFERRED BRAND	4	NON-PREFERRED
DROXIA CAPS 400 MG	3	PREFERRED BRAND	4	NON-PREFERRED
ELETRIPTAN HYDROBROMIDE TABS 20 MG	4	NON-PREFERRED	2	PREFERRED GENERIC
ELETRIPTAN HYDROBROMIDE TABS 40 MG	4	NON-PREFERRED	2	PREFERRED GENERIC
EPINEPHRINE SOAJ 0.15 MG/0.15ML	2	PREFERRED GENERIC	5	SPECIALTY
EPINEPHRINE SOAJ 0.15 MG/0.3ML	2	PREFERRED GENERIC	5	SPECIALTY
EPINEPHRINE SOAJ 0.3 MG/0.3ML	2	PREFERRED GENERIC	5	SPECIALTY
EPLERENONE TABS 25 MG	4	NON-PREFERRED	2	PREFERRED GENERIC
EPLERENONE TABS 50 MG	4	NON-PREFERRED	2	PREFERRED GENERIC
ETRAVIRINE TABS 100 MG	5	SPECIALTY	2	PREFERRED GENERIC
ETRAVIRINE TABS 200 MG	5	SPECIALTY	2	PREFERRED GENERIC
FEMARA TABS 2.5 MG	4	NON-PREFERRED	5	SPECIALTY
FUROSCIX CTKT 80 MG/10ML	5	SPECIALTY	4	NON-PREFERRED
FYCOMPA TABS 10 MG	4	NON-PREFERRED	5	SPECIALTY
FYCOMPA TABS 12 MG	4	NON-PREFERRED	5	SPECIALTY
FYCOMPA TABS 2 MG	4	NON-PREFERRED	5	SPECIALTY
FYCOMPA TABS 4 MG	4	NON-PREFERRED	5	SPECIALTY
FYCOMPA TABS 6 MG	4	NON-PREFERRED	5	SPECIALTY
FYCOMPA TABS 8 MG	4	NON-PREFERRED	5	SPECIALTY
LOPINAVIR-RITONAVIR TABS 200-50 MG	5	SPECIALTY	2	PREFERRED GENERIC
OXYCODONE-ACETAMINOPHEN SOLN 5-325 MG/5ML	2	PREFERRED GENERIC	4	NON-PREFERRED
PRADAXA CAPS 110 MG	3	PREFERRED BRAND	4	NON-PREFERRED
PRADAXA CAPS 150 MG	3	PREFERRED BRAND	4	NON-PREFERRED
PRADAXA CAPS 75 MG	3	PREFERRED BRAND	4	NON-PREFERRED
RANOLAZINE ER TB12 1000 MG	4	NON-PREFERRED	2	PREFERRED GENERIC
RANOLAZINE ER TB12 500 MG	4	NON-PREFERRED	2	PREFERRED GENERIC
TRUDHESA AERS 0.725 MG/ACT	4	NON-PREFERRED	5	SPECIALTY
URSODIOL CAPS 300 MG	5	SPECIALTY	2	PREFERRED GENERIC