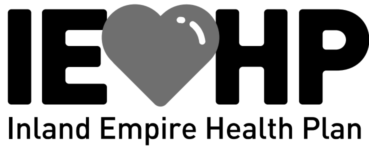

To: IEHP Provider Network

From: IEHP Pharmaceutical Services

Date: August 12, 2024

Subject: July 2024 IEHP Covered Pharmacy & Therapeutics Update

July 2024 Pharmacy and Therapeutics (P&T) Committee approved changes for IEHP Covered formulary are now available online.

To access the full document of changes, please visit:

IEHP - Plan Updates : Correspondence

www.iehp.org > Providers > News & Updates > Notices

To access the full IEHP Covered Formulary, please visit:

IEHP - Pharmacy: Formulary

www.iehp.org > Providers > Pharmacy > IEHP Covered California > IEHP Covered Formulary Book (PDF)

Sincerely,

IEHP Pharmaceutical Services

IEHP
Inland Empire Health Plan

Pharmacy Times
BY IEHP PHARMACEUTICAL SERVICES DEPARTMENT

To: IEHP Provider Network

From: IEHP Pharmaceutical Services

Date: August 12, 2024

Subject: July 2024 IEHP Covered Pharmacy & Therapeutics Update

July 2024 IEHP Covered Pharmacy & Therapeutics Committee Update

Please see below for Pharmacy and Therapeutics (P&T) Committee approved changes for IEHP Covered formulary.

DRUG NAME	EFFECTIVE DATE
Add to formulary	
Sodium sulfacetamide-sulfur 9 %-4.5 % cleanser	10/1/2024
Sulfacetamide sodium-sulfur 8 %-4 % cleanser	10/1/2024
Add to formulary with Prior Authorization	
TANDEM MOBI CARTRIDGE	10/1/2024
TANDEM MOBI SYSTEM	10/1/2024
TYENNE 162 MG/0.9 SYRINGE	10/1/2024
TYENNE 200MG/10ML VIAL	10/1/2024
TYENNE 400MG/20ML VIAL	10/1/2024
TYENNE 80 MG/4 ML VIAL	10/1/2024
TYENNE AUTOINJECTOR 162 MG/0.9 PEN INJCTR	10/1/2024
ADBRY 150 MG/ML SYRINGE	10/1/2024
AUSTEDO XR 12 MG TAB ER 24H	10/1/2024
AUSTEDO XR 24 MG TAB ER 24H	10/1/2024
AUSTEDO XR 6 MG TAB ER 24H	10/1/2024
CIBINQO 100 MG TABLET	10/1/2024
CIBINQO 200 MG TABLET	10/1/2024
CIBINQO 50 MG TABLET	10/1/2024
CINRYZE 500 (5 ML) VIAL	10/1/2024
DUPIXENT PEN 200MG/1.14 PEN INJCTR	10/1/2024

DRUG NAME	EFFECTIVE DATE
DUPIXENT PEN 300 MG/2ML PEN INJCTR	10/1/2024
DUPIXENT SYRINGE 100MG/0.67 SYRINGE	10/1/2024
DUPIXENT SYRINGE 200MG/1.14 SYRINGE	10/1/2024
DUPIXENT SYRINGE 300 MG/2ML SYRINGE	10/1/2024
EMPAVELI 1080 MG/20 VIAL	10/1/2024
FABHALTA 200 MG CAPSULE	10/1/2024
GATTEX 5 MG KIT	10/1/2024
HAEGARDA 2000 UNIT VIAL	10/1/2024
HAEGARDA 3000 UNIT VIAL	10/1/2024
IMBRUVICA 140 MG CAPSULE	10/1/2024
IMBRUVICA 140 MG TABLET	10/1/2024
IMBRUVICA 280 MG TABLET	10/1/2024
IMBRUVICA 420 MG TABLET	10/1/2024
IMBRUVICA 70 MG CAPSULE	10/1/2024
IMBRUVICA 70 MG/ML ORAL SUSP	10/1/2024
JAKAFI 10 MG TABLET	10/1/2024
JAKAFI 15 MG TABLET	10/1/2024
JAKAFI 20 MG TABLET	10/1/2024
JAKAFI 25 MG TABLET	10/1/2024
JAKAFI 5 MG TABLET	10/1/2024
KEVZARA 150MG/1.14 PEN INJCTR	10/1/2024
KEVZARA 150MG/1.14 SYRINGE	10/1/2024
KEVZARA 200MG/1.14 PEN INJCTR	10/1/2024
KEVZARA 200MG/1.14 SYRINGE	10/1/2024
OPZELURA 1.50% CREAM (G)	10/1/2024
ORLADEYO 110 MG CAPSULE	10/1/2024
ORLADEYO 150 MG CAPSULE	10/1/2024
Orlistat 120 mg capsule	10/1/2024
QSYMIA 11.25-69MG CPMP 24HR	10/1/2024
QSYMIA 15 MG-92MG CPMP 24HR	10/1/2024
QSYMIA 3.75-23 MG CPMP 24HR	10/1/2024
QSYMIA 7.5MG-46MG CPMP 24HR	10/1/2024
REZUROCK 200 MG TABLET	10/1/2024
SAXENDA 3 MG/0.5ML PEN INJCTR	10/1/2024
SCEMBLIX 20 MG TABLET	10/1/2024

DRUG NAME	EFFECTIVE DATE
SCEMBLIX 40 MG TABLET	10/1/2024
SOLIRIS 300MG/30ML VIAL	10/1/2024
SPEVIGO 150 MG/ML SYRINGE	10/1/2024
TAKHZYRO 150 MG/ML SYRINGE	10/1/2024
TAKHZYRO 300 MG/2ML SYRINGE	10/1/2024
TAKHZYRO 300 MG/2ML VIAL	10/1/2024
ULTOMIRIS 1100 MG/11 VIAL	10/1/2024
ULTOMIRIS 300 MG/3ML VIAL	10/1/2024
VOYDEYA 100 MG TABLET	10/1/2024
VOYDEYA 150 MG TABLET	10/1/2024
EUCRISA 2% OINT. (G)	10/1/2024
NON-PREFERRED TEST STRIP	10/1/2024
RYTARY 23.75-95MG CAPSULE ER	10/1/2024
RYTARY 36.25-145 CAPSULE ER	10/1/2024
RYTARY 48.75-195 CAPSULE ER	10/1/2024
RYTARY 61.25-245 CAPSULE ER	10/1/2024
Change to lower tier	
INPEN (FOR HUMALOG) INSULN PEN	10/1/2024
INPEN (FOR NOVOLOG OR FIASP) INSULN PEN	10/1/2024
Change to lower tier and change in Prior Authorization Criteria	
TYRVAYA 0.03/SPRAY METER	10/1/2024
Change to lower tier and remove Prior Authorization Criteria	
MIEBO 100% DROPS	10/1/2024
Change to lower tier and remove Step Therapy	
BIJUVA 0.5-100 MG CAPSULE	10/1/2024
BIJUVA 1 MG-100MG CAPSULE	10/1/2024
FYCOMPA 0.5 MG/ML ORAL SUSP	10/1/2024
FYCOMPA 10 MG TABLET	10/1/2024
FYCOMPA 12 MG TABLET	10/1/2024
FYCOMPA 2 MG TABLET	10/1/2024
FYCOMPA 4 MG TABLET	10/1/2024
FYCOMPA 6 MG TABLET	10/1/2024
FYCOMPA 8 MG TABLET	10/1/2024
ONETOUCH ULTRA TEST STRIP	10/1/2024
ONETOUCH VERIO TEST STRIP	10/1/2024

DRUG NAME	EFFECTIVE DATE
Remove Prior Authorization	
VEOZAH 45 MG TABLET	10/1/2024
Remove Prior Authorization and add Step Therapy	
AUVELITY 45MG-105MG TAB IR ER	10/1/2024
Remove Step Therapy	
APTIOM 200 MG TABLET	10/1/2024
APTIOM 400 MG TABLET	10/1/2024
APTIOM 600 MG TABLET	10/1/2024
APTIOM 800 MG TABLET	10/1/2024
FETZIMA 120 MG CAP SA 24H	10/1/2024
FETZIMA 20 MG CAP SA 24H	10/1/2024
FETZIMA 20 MG-40MG CAP24HDSPK	10/1/2024
FETZIMA 40 MG CAP SA 24H	10/1/2024
FETZIMA 80 MG CAP SA 24H	10/1/2024
TRINTELLIX 10 MG TABLET	10/1/2024
TRINTELLIX 20 MG TABLET	10/1/2024
TRINTELLIX 5 MG TABLET	10/1/2024
XCOPRI 100 MG TABLET	10/1/2024
XCOPRI 12.5-25MG TAB DS PK	10/1/2024
XCOPRI 150 MG TABLET	10/1/2024
XCOPRI 150-200 MG TAB DS PK	10/1/2024
XCOPRI 200 MG TABLET	10/1/2024
XCOPRI 250 MG/DAY TABLET	10/1/2024
XCOPRI 350 MG/DAY TABLET	10/1/2024
XCOPRI 50 MG TABLET	10/1/2024
XCOPRI 50MG-100MG TAB DS PK	10/1/2024
Add Prior Authorization, remove Quantity Limit, and remove Step Therapy	
SIVEXTRO 200 MG TABLET	1/1/2025
Add Step Therapy	
CLIMARA PRO 45-15/24H PATCH TDWK	1/1/2025
Estradiol 0.25/0.25g gel packet	1/1/2025
Estradiol 0.5mg/0.5g gel packet	1/1/2025
Estradiol 0.75/0.75g gel packet	1/1/2025
Estradiol 1 mg/gram gel packet	1/1/2025
Estradiol 1.25/1.25g gel packet	1/1/2025

DRUG NAME	EFFECTIVE DATE
Change in Prior Authorization Criteria	
ACTEMRA 162 MG/0.9 SYRINGE	1/1/2025
ACTEMRA 200MG/10ML VIAL	1/1/2025
ACTEMRA 400MG/20ML VIAL	1/1/2025
ACTEMRA 80 MG/4 ML VIAL	1/1/2025
ACTEMRA ACTPEN 162 MG/0.9 PEN INJCTR	1/1/2025
Change in Step Therapy Criteria	
ESTROGEL 1.25 G GEL MD PMP	1/1/2025
Change to higher tier	
PHOSPHOLINE IODIDE 0.13% DROPS	1/1/2025
PRALUENT PEN 150 MG/ML PEN INJCTR	1/1/2025
PRALUENT PEN 75 MG/ML PEN INJCTR	1/1/2025
Sertraline HCL 150 mg capsule	1/1/2025
Sertraline HCL 200 mg capsule	1/1/2025
ZURZUVAE 20 MG CAPSULE	1/1/2025
ZURZUVAE 25 MG CAPSULE	1/1/2025
ZURZUVAE 30 MG CAPSULE	1/1/2025
Remove from formulary	
BP 10-1 10 %-1 % cleanser	1/1/2025
Rosula 10 %-5 % med. pad	1/1/2025
Sodium sulfacetamide-sulfur 10 %-2 % cream (g)	1/1/2025
Sodium sulfacetamide-sulfur 10 %-4 % med. pad	1/1/2025
Sodium sulfacetamide-sulfur 10-5%(w/v) lotion	1/1/2025
Sodium sulfacetamide-sulfur 10-5%(w/w) lotion	1/1/2025
Sodium sulfacetamide-sulfur 10-5%(w/w) suspension	1/1/2025
Sodium sulfacetamide-sulfur 9.8%-4.8% cream (g)	1/1/2025
Sodium sulfacetamide-sulfur 9.8%-4.8% loti+p5+q32	1/1/2025
SSS 10-5 10 %-5 % foam	1/1/2025
SSS 10-5 10-5%(w/w) cream (g)	1/1/2025

For the updated IEHP Covered Formulary, please visit https://www.iehp.org/content/dam/iehp-org/en/documents/coveredcalifornia/Formulary.pdf