Inland Empire Health Plan

Pharmacy Times

BY IEHP PHARMACEUTICAL SERVICES DEPARTMENT

To: PCPs & Pharmacy Network

From: IEHP Pharmaceutical Services

Date: September 25, 2025

Subject: **August 2025 Pharmacy & Therapeutics Update**

IEHP Pharmacy and Therapeutics (P&T) Subcommittee met virtually on Friday, August 1, 2025. As a reminder, all Medi-Cal prescription formulary decisions are no longer made by IEHP and should be addressed with Medi-Cal Rx directly.

Medicare Formulary Updates:

Highlights from the Medicare D-SNP formulary additions include Gomekli, Raldesy, and Lutrate Depot. Gomekli and Raldesy are now available on the formulary with prior authorization and quantity limit effective 06/01/2025. Lutrate Depot has been added to the formulary with prior authorization and new start effective 07/01/2025.

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

Covered California Formulary Updates:

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

Pharmacy Utilization Management Updates:

This quarter, there were no IEHP Pharmacy Policies presented to the P&T subcommittee. This quarter, there were no Prior Authorization Criteria presented to the P&T Subcommittee Members.

Drug Utilization Review (DUR) Updates:

IEHP reviewed four DUR reports which included Asthma Medication Ration (AMR) for Medi-Cal, Medication Adherence for Cholesterol, Diabetes, Hypertension, Statin Use in Persons with Diabetes (SUPD), Statin Therapy for Patients with Cardiovascular Disease (SPC), and Naloxone Drug Use Evaluation for both

Medicare and Covered CA. We will continue to work on quality measures throughout the remainder of the year and collaborate with providers to optimize better outcomes.

To access the full August 2025 Pharmacy & Therapeutics Subcommittee update, please visit:

www.providerservices.iehp.org/en/news-and-updates/notices

or

www.providerservices.iehp.org/en/pharmacy/pharmacy-resources/pharmacy-provider-communications

The next IEHP P&T Subcommittee Meeting is Friday, December 5, 2025.

Inland Empire Health Plan

Pharmacy Times

BY IEHP PHARMACEUTICAL SERVICES DEPARTMENT

To: PCPs & Pharmacy Network

From: IEHP Pharmaceutical Services

Date: September 25, 2025

Subject: **August 2025 Pharmacy & Therapeutics Update**

August 2025 Pharmacy & Therapeutics Committee Update

IEHP Pharmacy and Therapeutics (P&T) Subcommittee met virtually on Friday, August 1, 2025. As a reminder, all Medi-Cal prescription formulary decisions are no longer made by IEHP and should be addressed with Medi-Cal Rx directly.

Medicare Formulary Updates

Drug Name	Strength(s) and Dosage Form(s)	Medicare Formulary Action	Effective Date
Abirtega (abiraterone)	250 mg tablet	Add to formulary, PA, Quantity Limit	6/1/2025
auranofin	3 mg capsule	Add to formulary	6/1/2025
clindamycin	150 mg/ml injection solution	Add to formulary	6/1/2025
clindamycin	150 mg/ml injection solution (4 ml)	Add to formulary	6/1/2025
Eliquis (apixaban)	5 mg tablet	Increase quantity limit, Quantity Limit	8/1/2025
eslicarbazepine	200 mg tablet, 400 mg tablet, 600 mg tablet, 800 mg tablet	Add to formulary, PA, Quantity Limit	8/1/2025
Eulexin (flutamide)	125 mg capsule	Add to formulary, PA	6/1/2025
Gomekli (mirdametinib)	1 mg capsule, 2 mg capsule	Add to formulary, PA, Quantity Limit	6/1/2025
Gomekli (mirdametinib)	1 mg tablet for oral suspension	Add to formulary, PA, Quantity Limit	6/1/2025
Kaletra (lopinavir/ritonavir)	400 mg-100 mg/5 ml oral solution	Add to formulary, Quantity Limit	8/1/2025
Leukeran (chlorambucil)	2 mg tablet	Add to formulary	6/1/2025
Lutrate Depot (leuprolide acetate)	(3 month) 22.5 mg IM suspension	Add to formulary, PA	7/1/2025
mercaptopurine	20 mg/mL oral suspension	Add to formulary, PA	6/1/2025
metformin	750 mg tablet	Add to formulary, Quantity Limit	6/1/2025

Drug Name	Strength(s) and Dosage Form(s)	Medicare Formulary Action	Effective Date
Natacyn (natamycin ophthalmic suspension)	5 % eye drops, suspension	Add to formulary	6/1/2025
Opipza (aripiprazole)	10 mg oral film, 2 mg oral film, 5 mg oral film	Add to formulary, PA, Quantity Limit	6/1/2025
Paxlovid (nirmatrelvir and ritonavir)	150 mg (6)-100 mg(5) tablets in a dose pack(severe renal dose)	Add to formulary	7/1/2025
Raldesy (trazodone hydrochloride)	10 mg/ml oral solution	Add to formulary, PA, Quantity Limit	6/1/2025
Revuforj (revumenib)	25 mg tablet	Add to formulary, PA, Quantity Limit	6/1/2025
Romvimza (vimseltinib)	14 mg capsule, 20 mg capsule, 30 mg capsule	Add to formulary, PA, Quantity Limit	6/1/2025
Sunlenca (lenacapavir)	300 mg tablet	Add to formulary	8/1/2025
Tabloid (thioguanine)	40 mg tablet	Add to formulary, PA	6/1/2025
Vimkunya (Chikungunya Vaccine, Recombinant)	40 mcg/0.8 ml Intramuscular Syringe	Add to formulary	6/1/2025
Xpovio (selinexor)	40 mg/week (10 mg x 4) tablet	Add to formulary, PA, Quantity Limit	6/1/2025

Highlights from the Medicare D-SNP formulary additions include Gomekli, Raldesy, and Lutrate Depot. Gomekli and Raldesy are now available on the formulary with prior authorization and quantity limit effective 06/01/2025. Lutrate Depot has been added to the formulary with prior authorization and new start effective 07/01/2025.

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

IEHP Inland Empire Health Plan

Pharmacy Times
BY IEHP PHARMACEUTICAL SERVICES DEPARTMENT

Covered California Formulary Updates

Drug Name	Strength(s) and Dosage Form(s)	Covered California Formulary Action	Effective Date
Actemra (tocilizumab)	162 MG/0.9 SYRINGE	Change in Prior Authorization Criteria	7/1/2025
Actemra (tocilizumab)	200MG/10ML VIAL 400MG/20ML VIAL 80 MG/4 ML VIAL	Change in Prior Authorization Criteria	7/1/2025
Actemra (tocilizumab)	ACTPEN 162 MG/0.9 PEN INJCTR	Change in Prior Authorization Criteria	7/1/2025
Avsola (infliximab-axxq)	100 MG VIAL	Change in Prior Authorization Criteria	7/1/2025
Berinert (C1 esterase inhibitor (human))	500(10 ML) VIAL	Change in Prior Authorization Criteria	7/1/2025
Bylvay (odevixibat)	1200 MCG CAPSULE 400 MCG CAPSULE	Change in Prior Authorization Criteria	7/1/2025
Bylvay (odevixibat)	200 MCG PEL DSP CP 600 MCG PEL DSP CP	Change in Prior Authorization Criteria	7/1/2025
Cibinqo (abrocitinib)	100 MG TABLET 200 MG TABLET 50 MG TABLET	Change in Prior Authorization Criteria	7/1/2025
Cimzia (certolizumab pegol)	(2 PACK) 400 MG KIT	Change in Prior Authorization Criteria	7/1/2025
Cimzia (certolizumab pegol)	200 MG/ML SYRINGEKIT 400 MG/2ML SYRINGEKIT	Change in Prior Authorization Criteria	7/1/2025
Ebglyss (lebrikizumab-lbkz)	PEN 250 MG/2ML PEN INJCTR	Change in Prior Authorization Criteria	7/1/2025
Ebglyss (lebrikizumab-lbkz)	SYRINGE 250 MG/2ML SYRINGE	Change in Prior Authorization Criteria	7/1/2025
Entyvio (vedolizumab)	300 MG VIAL	Change in Prior Authorization Criteria	7/1/2025
Entyvio (vedolizumab)	PEN 108MG/0.68 PEN INJCTR	Change in Prior Authorization Criteria	7/1/2025
Epysqli (eculizumab-aagh)	300MG/30ML VIAL	Add to formulary with Prior Authorization	7/1/2025
Genotropin (somatropin)	0.2MG/0.25 SYRINGE 0.4MG/0.25 SYRINGE 0.6MG/0.25 SYRINGE 0.8MG/0.25 SYRINGE 1.2MG/0.25 SYRINGE 1.4MG/0.25 SYRINGE 1.6MG/0.25 SYRINGE 1.8MG/0.25 SYRINGE	Change in Prior Authorization Criteria	7/1/2025

Drug Name	Strength(s) and Dosage Form(s)	Covered California Formulary Action	Effective Date
Genotropin (somatropin)	1MG/0.25ML SYRINGE 2MG/0.25ML SYRINGE	Change in Prior Authorization Criteria	7/1/2025
Genotropin (somatropin)	12 MG/ML CARTRIDGE 5 MG/ML CARTRIDGE	Change in Prior Authorization Criteria	7/1/2025
Humatrope (somatropin)	12 MG CARTRIDGE 24 MG CARTRIDGE 6 MG CARTRIDGE	Change in Prior Authorization Criteria	7/1/2025
Humatrope (somatropin)	5 MG VIAL	Change in Prior Authorization Criteria	7/1/2025
Firazyr (icatibant)	30 mg/3 ml syringe	Change in Prior Authorization Criteria	7/1/2025
Increlex (mecasermin)	10 MG/ML VIAL	Change in Prior Authorization Criteria	7/1/2025
Inflectra (infliximab-dyyb)	100 MG VIAL	Change in Prior Authorization Criteria	7/1/2025
infliximab	100 MG VIAL	Change in Prior Authorization Criteria	7/1/2025
Journavx (suzetrigine)	50 MG TABLET	Change in Prior Authorization Criteria	7/1/2025
Kalbitor (ecallantide)	10MG/ML(1) VIAL	Change in Prior Authorization Criteria	7/1/2025
Livdelzi (seladelpar)	10 MG CAPSULE	Change in Prior Authorization Criteria	7/1/2025
Livmarli (maralixibat)	19 MG/ML SOLUTION 9.5 MG/ML SOLUTION	Change in Prior Authorization Criteria	7/1/2025
metyrosine	250 mg capsule	Add Prior Authorization	4/14/2025
Nemluvio (nemolizumab-ilto)	30 MG PEN INJCTR	Change in Prior Authorization Criteria	7/1/2025
Ngenla (somatrogon-ghla)	24MG/1.2ML PEN INJCTR 60MG/1.2ML PEN INJCTR	Change in Prior Authorization Criteria	7/1/2025
Norditropin (somatropin)	FLEXPRO 10MG/1.5ML PEN INJCTR FLEXPRO 15MG/1.5ML PEN INJCTR FLEXPRO 30 MG/3 ML PEN INJCTR FLEXPRO 5 MG/1.5ML PEN INJCTR	Change in Prior Authorization Criteria	7/1/2025

Drug Name	Strength(s) and Dosage Form(s)	Covered California Formulary Action	Effective Date
Nutropin (somatropin)	AQ NUSPIN 10 MG/2 ML PEN INJCTR AQ NUSPIN 20 MG/2 ML PEN INJCTR AQ NUSPIN 5 MG/2 ML PEN INJCTR	Change in Prior Authorization Criteria	7/1/2025
Omnitrope (somatropin)	10MG/1.5ML CARTRIDGE 5 MG/1.5ML CARTRIDGE	Change in Prior Authorization Criteria	7/1/2025
Omnitrope (somatropin)	5.8 MG VIAL	Change in Prior Authorization Criteria	7/1/2025
Omvoh (mirikizumab-mrkz)	100 MG/ML SYRINGE 200 MG/2ML SYRINGE 300 MG/3ML SYRINGE	Change in Prior Authorization Criteria	7/1/2025
Omvoh (mirikizumab-mrkz)	300MG/15ML VIAL	Change in Prior Authorization Criteria	7/1/2025
Omvoh (mirikizumab-mrkz)	PEN 100 MG/ML PEN INJCTR PEN 200 MG/2ML PEN INJCTR PEN 300 MG/3ML PEN INJCTR	Change in Prior Authorization Criteria	7/1/2025
Orenitram (treprostinil)	ER 0.125 MG TABLET ER ER 0.25 MG TABLET ER ER 1 MG TABLET ER ER 2.5 MG TABLET ER ER 5 MG TABLET ER	Change in Prior Authorization Criteria	7/1/2025
Orenitram (treprostinil)	MONTH 1 TITRATION KT 0.125-0.25 TB ER DSPK MONTH 2 TITRATION KT 0.125-.25 TB ER DSPK MONTH 3 TITRATION KT 0.125-1 MG TB ER DSPK	Change in Prior Authorization Criteria	7/1/2025
phenoxybenzamine	hcl 10 mg capsule	Change in Prior Authorization Criteria	7/1/2025
pregabalin	165 mg tab er 24h 330 mg tab er 24h 82.5 mg tab er 24h	Add to formulary with Step Therapy and Quantity Limit	7/1/2025
quetiapine fumarate	150 mg tablet	Add to formulary with Quantity Limit	7/1/2025
ramelteon	8 mg tablet	Add to formulary with Step Therapy	7/1/2025
Renflexis (infliximab-abda)	100 MG VIAL	Change in Prior Authorization Criteria	7/1/2025
Rezdiffra (resmetirom)	100 MG TABLET 60 MG TABLET 80 MG TABLET	Change in Prior Authorization Criteria	7/1/2025

Drug Name	Strength(s) and Dosage Form(s)	Covered California Formulary Action	Effective Date
Ruconest (C1 esterase inhibitor (recombinant)	2100 UNIT VIAL	Change in Prior Authorization Criteria	7/1/2025
Rystiggo (rozanolixizumab-noli)	280 MG/2ML VIAL 420 MG/3ML VIAL 560 MG/4ML VIAL 840 MG/6ML VIAL	Change in Prior Authorization Criteria	7/1/2025
Saizen (somatropin)	5 MG VIAL 8.8 MG VIAL	Change in Prior Authorization Criteria	7/1/2025
Saizen-Saizenprep (somatropin)	8.8MG/1.51 CARTRIDGE	Change in Prior Authorization Criteria	7/1/2025
Serostim (somatropin)	4 MG VIAL 5 MG VIAL 6 MG VIAL	Change in Prior Authorization Criteria	7/1/2025
Simponi (golimumab)	100 MG/ML PEN INJCTR	Change in Prior Authorization Criteria	7/1/2025
Simponi (golimumab)	100 MG/ML SYRINGE	Change in Prior Authorization Criteria	7/1/2025
Skytrofa (lonapegsomatropin-tcgd)	11 MG CARTRIDGE 13.3 MG CARTRIDGE	Change in Prior Authorization Criteria	7/1/2025
Skytrofa (lonapegsomatropin-tcgd)	3 MG CARTRIDGE 3.6 MG CARTRIDGE 4.3 MG CARTRIDGE 5.2 MG CARTRIDGE 6.3 MG CARTRIDGE 7.6 MG CARTRIDGE 9.1 MG CARTRIDGE	Change in Prior Authorization Criteria	7/1/2025
Sogroya (somapacitan-beco)	10MG/1.5ML PEN INJCTR 15MG/1.5ML PEN INJCTR 5 MG/1.5ML PEN INJCTR	Change in Prior Authorization Criteria	7/1/2025
Soliris (eculizumab)	300MG/30ML VIAL	Change in Prior Authorization Criteria	7/1/2025
Tyenne (tocilizumab-aazg)	162 MG/0.9 SYRINGE	Change in Prior Authorization Criteria	7/1/2025
Tyenne (tocilizumab-aazg)	200MG/10ML VIAL 400MG/20ML VIAL 80 MG/4 ML VIAL	Change in Prior Authorization Criteria	7/1/2025
Tyenne (tocilizumab-aazg)	AUTOINJECTOR 162 MG/0.9 PEN INJCTR	Change in Prior Authorization Criteria	7/1/2025
Tysabri (natalizumab)	300MG/15ML VIAL	Change in Prior Authorization Criteria	7/1/2025
Tyvaso (treprostinil)	1.74MG/2.9 AMPUL-NEB	Change in Prior Authorization Criteria	7/1/2025

Drug Name	Strength(s) and Dosage Form(s)	Covered California Formulary Action	Effective Date
Tyvaso (treprostinil)	DPI 16 MCG CART INHAL DPI 16-32 MCG CART INHAL DPI 16-32-48 CART INHAL DPI 32 MCG CART INHAL DPI 32-48 MCG CART INHAL	Change in Prior Authorization Criteria	7/1/2025
Tyvaso (treprostinil)	DPI 48 MCG CART INHAL DPI 64 MCG CART INHAL	Change in Prior Authorization Criteria	7/1/2025
Tyvaso (treprostinil)	REFILL KIT 1.74MG/2.9 AMPUL-NEB STARTER KIT 1.74MG/2.9 AMPUL-NEB	Change in Prior Authorization Criteria	7/1/2025
Ultomiris (ravulizumab-cwvz)	1100 MG/11 VIAL 300 MG/3ML VIAL 300MG/3ML VIAL 300MG/30ML VIAL	Change in Prior Authorization Criteria	7/1/2025
Uptravi (selexipag)	1000 MCG TABLET 1200 MCG TABLET 1400 MCG TABLET 1600 MCG TABLET 200 MCG TABLET 400 MCG TABLET 600 MCG TABLET 800 MCG TABLET	Change in Prior Authorization Criteria	7/1/2025
Uptravi (selexipag)	1800 MCG VIAL	Change in Prior Authorization Criteria	7/1/2025
Uptravi (selexipag)	200-800MCG TAB DS PK	Change in Prior Authorization Criteria	7/1/2025
Velsipity (etrasimod)	2 MG TABLET	Change in Prior Authorization Criteria	7/1/2025
Vevye (cyclosporine ophthalmic solution)	0.1 % DROPS	Change in Prior Authorization Criteria	7/1/2025
Vtama (tapinarof)	1 % CREAM (G)	Change in Prior Authorization Criteria	7/1/2025
Vyvgart (efgartigimod alfa-fcab)	400MG/20ML VIAL	Change in Prior Authorization Criteria	7/1/2025
Vyvgart (efgartigimod alfa-fcab)	HYTRULO 1000MG/5ML SYRINGE	Change in Prior Authorization Criteria	7/1/2025
Vyvgart (efgartigimod alfa-fcab)	HYTRULO 1008MG/5.6 VIAL	Change in Prior Authorization Criteria	7/1/2025
Wegovy (semaglutide)	0.25MG/0.5 PEN INJCTR 0.5MG/.5ML PEN INJCTR 1 MG/0.5ML PEN INJCTR 1.7MG/0.75 PEN INJCTR 2.4MG/0.75 PEN INJCTR	Change in Prior Authorization Criteria	7/1/2025

Drug Name	Strength(s) and Dosage Form(s)	Covered California Formulary Action	Effective Date
Zeposia (ozanimod)	0.23-0.46 CAP DS PK 0.23-0.92 CAP DS PK 0.46-0.92 CAP DS PK	Change in Prior Authorization Criteria	7/1/2025
Zeposia (ozanimod)	0.92 MG CAPSULE	Change in Prior Authorization Criteria	7/1/2025
Zilbrysq (zilucoplan)	16.6/0.416 SYRINGE 23/0.574ML SYRINGE 32.4/0.81 SYRINGE	Change in Prior Authorization Criteria	7/1/2025
Zomacton (somatropin)	10 MG VIAL 5 MG VIAL	Change in Prior Authorization Criteria	7/1/2025
Zoryve (roflumilast)	0.15 % CREAM (G)	Change in Prior Authorization Criteria	7/1/2025
Zymfentra (infliximab-dyyb)	(2 PACK) 120 MG/ML SYRINGEKIT	Change in Prior Authorization Criteria	7/1/2025
Zymfentra (infliximab-dyyb)	120 MG/ML PEN IJ KIT PEN (2 PACK) 120 MG/ML PEN IJ KIT	Change in Prior Authorization Criteria	7/1/2025
Cequa (cyclosporine)	CEQUA 0.09 % DROPERETTE	Change in Step Therapy Criteria	7/1/2025
Bydureon (exenatide)	BYDUREON PEN 2MG/0.65ML PEN INJCTR	Change to higher tier	7/1/2025
Baqsimi (glucagon)	BAQSIMI 3 MG SPRAY	Change to lower tier and remove Step Therapy	7/1/2025
esomeprazole magnesium	10 mg suspdr pkt 2.5 mg suspdr pkt 20 mg suspdr pkt 40 mg suspdr pkt 5 mg suspdr pkt	Remove Step Therapy	7/1/2025

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

Pharmacy Policy	Recommendation
Pharmacy Benefit Manager (PBM) Oversight Responsibilities CCA	Policy created specific to Covered California Members to clearly define the responsibilities of IEHP and PBM, including but not limited to, pharmacy network development, membership, P&T Committee oversight, and monitoring and oversight.

Pharmacy Utilization Management Updates

This quarter, there were no IEHP Pharmacy Policies presented to the P&T subcommittee.

This quarter, there were no Prior Authorization Criteria presented to the P&T Subcommittee Members.

Four Medi-Cal Medical Drug Benefit Drug Classes have been reviewed along with corresponding Prior Authorization Criteria.

Drug Class Reviewed	Prior Authorization Group Name	Recommendation
Biologics & Immunological Agents	IVIG	NO CHANGE
Central Nervous System (CNS)	ABOBOTULINUMTOXINA INCOBOTULINUMTOXINA ONABOTULINUMTOXINA RIMABOTULINUMTOXINB	NO CHANGE
Musculoskeletal & Pain	HYALURONAN INFLIXIMAB	NO CHANGE
Oncology	ANTINEOPLASTIC CAR-T RITUXIMAB	NO CHANGE

Update to service code

Code	Drug Description	Change	Effective Date
J1201	Injection, cetirizine hydrochloride, 0.5 mg	ADD to drug list, without PA	09/01/2025
J1750	Injection, iron dextran, 50 mg	Remove PA requirement	09/01/2025
J1756	Injection, iron sucrose, 1 mg	Remove PA requirement	09/01/2025
J2916	Injection, sodium ferric gluconate complex in sucrose injection, 12.5 mg	Remove PA requirement	09/01/2025

Inland Empire Health Plan

Pharmacy Times

BY IEHP PHARMACEUTICAL SERVICES DEPARTMENT

Drug Utilization Review (DUR) Updates

IEHP reviewed four DUR reports which included Asthma Medication Ration (AMR) for Medi-Cal, Medication Adherence for Cholesterol, Diabetes, Hypertension, Statin Use in Persons with Diabetes (SUPD), Statin Therapy for Patients with Cardiovascular Disease (SPC) for Medicare, and Naloxone Drug Use Evaluation for both Medicare and Covered CA. We will continue to work on quality measures throughout the remainder of the year and collaborate with providers to optimize better outcomes.

To access the full August 2025 Pharmacy & Therapeutics Subcommittee update, please visit:

www.providerservices.iehp.org/en/news-and-updates/notices

or

www.providerservices.iehp.org/en/pharmacy/pharmacy-resources/pharmacy-provider-communications

The next IEHP P&T Subcommittee Meeting is Friday, December 5, 2025.

For the updated IEHP Covered Formulary, please go to www. ProviderServices.iehp.org > Pharmacy > Formulary > IEHP Covered or visit.