San Francisco Health Plan (SFHP)
Quarterly Formulary and Prior Authorization Criteria Update
April 2020

The following changes to SFHP formulary and prior authorization criteria were reviewed and approved by the SFHP Pharmacy and Therapeutics (P&T) Committee on Wednesday, 4/15/2020. Effective date for all changes is **Wednesday**, **5/20/2020**.

SFHP formulary and prior authorization criteria can be accessed at http://www.sfhp.org/providers/formulary/. Generic criteria are linked in the searchable formulary preamble for each line of business, and drug- and drug-class specific criteria are linked to the formulary listing for each relevant drug.

Contents

Formulary Maintenance Items

Infectious Disease: Oral and Topical Antifungals

Formulary Update: Medi-Cal

- Removed tier 5 listing for flucytosine due to lack of utilization or specific criteria

Prior Authorization Criteria Update:

- Updated Azole Antifungals criteria to include approval duration for Cresemba® (isavuconazonium):
  - Initial: 6 months; Renewal: up to 1 year

Drug Utilization Review Update:

- No DUR changes made

Infectious Disease: Oral and Topical Antivirals

Formulary Update: Medi-Cal, Healthy Workers HMO, and Healthy San Francisco

- No formulary changes made

Prior Authorization Criteria Update:

- No PA criteria changes made

Drug Utilization Review Update:

- No DUR changes made

Obstetrics & Gynecology: Endometriosis

Formulary Update: Medi-Cal, Healthy Workers HMO, and Healthy San Francisco

- No formulary changes made

Prior Authorization Criteria Update:

- Updated Endometriosis Medications criteria for Orilissa® (elagolix) to include reauthorization for existing users and to indicate no reauthorization allowed for 200 mg per package label:
  - For Orilissa® 150mg QD dose only, maximum 24 months total duration.
  - For Orilissa® 200mg twice daily, no continuation of therapy, maximum duration of 6 months only.

Drug Utilization Review Update:

- No DUR changes made

Otorhinolaryngology: Miscellaneous Otic Medications

Formulary Update: Medi-Cal, Healthy Workers HMO, and Healthy San Francisco

- No formulary changes made

Prior Authorization Criteria Update:

- No PA criteria changes made (no active criteria)

Drug Utilization Review Update:

- No DUR changes made

Psychiatry: Opioid, Nicotine, & Alcohol Dependence

Formulary Update: Medi-Cal, Healthy Workers HMO, and Healthy San Francisco

- No formulary changes made

Prior Authorization Criteria Update:

- Updated Narcotic Withdrawal Agents criteria to reflect generic status of buprenorphine-naloxone (Suboxone®) sublingual film

Drug Utilization Review Update:

- Separate analysis evaluated SFHP smoking cessation medication new starts, single-fill rates, combination regimens, and duration of therapy

Pulmonology: Asthma Biologics

Formulary Update: Medi-Cal & Healthy Workers HMO

- Listed Fasenra® (benralizumab) and Nucala® (mepolizumab) as tier 5 to link relevant criteria; maintain non-formulary due to available alternative Dupixent® (dupilumab)

Prior Authorization Criteria Update:

- Updated Pulmonary Biologics criteria to include the following:
  - coverage requirements for self-administered Fasenra® and Nucala® reflecting the current requirements for Dupixent®, plus trial and failure of Dupixent®
  - coverage requirements for Dupixent® in adults with CRSwNP requiring trial and failure of nasal corticosteroid

Drug Utilization Review Update:

- No DUR changes made

Drug Class Reviews

Cardiology: Vyndaqel®/Vyndamax™ (tafamidis) Monograph

Formulary Update: Medi-Cal, Healthy Workers HMO, & Healthy San Francisco

- Maintained non-formulary at this time based on lack of utilization or requests and limited target population; review any requests utilizing blanket Non-Formulary Medications criteria

Prior Authorization Criteria Update:

- No PA criteria changes made (no active criteria)

Drug Utilization Review Update:

- No DUR changes made

Dermatology: Dermatology Miscellaneous Medications Abbreviated Class Review

Formulary Update: Medi-Cal, Healthy Workers HMO, and Healthy San Francisco

- Removed sulfacetamide sodium (Ovace®) 10% cleanser gel from formulary tier 3 based on lack of utilization and available alternatives for bacterial infections and seborrheic dermatitis/sicca

Prior Authorization Criteria Update:

- Retired Sulfacetamide Cleanser Gel criteria based on removal from formulary

Drug Utilization Review Update:

- No DUR changes made

Endocrinology: Diabetes Types 1 & 2 Therapeutic Class Review

Formulary Update: Medi-Cal and Healthy Workers HMO

- Listed the following medications tier 5 non-formulary in order to link relevant drug/class-specific criteria:
  - Bydureon Bcise® (exenatide microspheres) SC auto injector
  - Qtern® (dapagliflozin-saxagliptin) tablet
  - Jentadueto XR® (linagliptin-metformin) 24h ER tablet
  - Trijardy™ XR (empagliflozin-linagliptin-metformin) 24h ER tablet
- Removed tier 5 non-formulary listings for the following medications due to limited or no utilization and lack of specific criteria:
  - metformin (Riomet®) 500mg/5mL oral solution
  - pioglitazone-metformin (Actoplus Met®) tablet
  - tolbutamide tablet

Prior Authorization Criteria Update:

- Updated DPP-4 Inhibitors and SGLT-2 Inhibitors criteria to include tier 5 medication listings above

Drug Utilization Review Update:

- Recommended development of provider education on DPP-4 inhibitors, including guideline recommendations, limitations of clinical utility, and SFHP formulary alternatives

Endocrinology: Diabetes Supplies Abbreviated Class Review

Formulary Update: Medi-Cal and Healthy Workers HMO

- Added Freestyle Libre 14-day Sensor and Reader to formulary tier 3 and require PA to align with 10-day products

Prior Authorization Criteria Update:

- Updated Blood Glucose Test Strips criteria to clarify FreeStyle Libre supply quantity limit

Drug Utilization Review Update:

- Recommended further analysis evaluating antidiabetic medication regimens for members utilizing CGM

Hematology: Oxbryta™ (voxelotor) Monograph

Formulary Update: Medi-Cal and Healthy Workers HMO

- Added Oxbryta™ to formulary tier 3 with prior authorization required to ensure appropriate diagnosis and treatment history

Prior Authorization Criteria Update:

- Adopted new prior authorization criteria for appropriate use, requiring documentation of pertinent labs and sufficient trial or contraindication to/intolerance of hydroxyurea

Drug Utilization Review Update:

- No DUR changes made

Obstetrics & Gynecology: Contraceptives Abbreviated Review

Formulary Update: Medi-Cal, Healthy Workers HMO, and Healthy San Francisco

- Removed quantity limit for norethindrone tablet to align with other combined oral contraceptive dosage forms

Prior Authorization Criteria Update:

- No PA criteria changes made (no active criteria)

Drug Utilization Review Update:

- Separate drug utilization review analysis on contraceptives evaluated prevalence of contraceptive use in the SFHP Medi-Cal population stratified by age, ethnicity, and type of contraceptive

Obstetrics & Gynecology: Miscellaneous Abbreviated Class Review

Formulary Update: Medi-Cal, Healthy Workers HMO, and Healthy San Francisco

- Added tioconazole 6.5% PF vaginal ointment to formulary based on utilization and cost-effectiveness
- Removed the following medications from formulary based on limited utilization and cost-effective alternatives available:
  - Vaginal antibiotic: Cleocin® (clindamycin) 100mg suppository
  - Vaginal antifungals: terconazole suppository, butoconazole 2% PF cream, miconazole 1200mg-2% kit

Prior Authorization Criteria Update:

- Updated Makena® (hydroxyprogesterone caproate) criteria to prefer generic vial over brand autoinjector

Drug Utilization Review Update:

- No DUR changes made

Pulmonology: Trikafta® (elexacaftor-ivacaftor-tezacaftor) Monograph

Formulary Update: Medi-Cal and Healthy Workers HMO

- Added Trikafta® to formulary tier 4 due to limited alternatives, with prior authorization required to ensure appropriate diagnosis

Prior Authorization Criteria Update:

- Updated Cystic Fibrosis criteria to include Trikafta®

Drug Utilization Review Update:

- No DUR changes made

Pulmonology: Asthma/COPD Therapeutic Class Review

Formulary Update: Medi-Cal, Healthy Workers HMO, and Healthy San Francisco

- Added Incruse® Ellipta® (umeclidinium bromide) to formulary tier 2 with quantity limit one inhaler per 30 days based on cost-effectiveness within the anticholinergic subclass
- Added Bevespi® Aerosphere® (glycopyrrolate-formoterol) to formulary tier 3 with step therapy (prior use of LAMA, LABA, or ICS-LABA) based on cost effectiveness within the LAMA-LABA subclass, and quantity limit one inhaler per 30 days
- Added Trelegy® Ellipta® to formulary tier 3 with step therapy (prior use of LAMA, LABA and ICS, or combinations thereof) based on PA approvals and current status as the sole triple therapy for COPD, and quantity limit one inhaler per 30 days
- Increased budesonide-formoterol (Symbicort®) quantity limit from one to two inhalers per 30 days based on GINA guideline recommendations for rescue and maintenance use
- Added Dulera® (mometasone-formoterol) 50-5 mcg MDI to formulary tier 2 with quantity limit one inhaler per 30 days to align with other strengths
- Maintained Asmanex® HFA (mometasone furoate) 50 mcg inhaler as non-formulary based on available alternatives
- Removed albuterol ER tablet tier 5 listings due to lack of utilization and specific criteria
- Removed Tudorza® Pressair® (aclidinium bromide) from formulary (grandfathering current users) based on cost-effective alternatives and limited utilization
- Removed theophylline (Theo-Dur®) 12h ER tablet and (Theolair®) 80mg/15mL oral solution from formulary due to lack of utilization and limited place in therapy

Prior Authorization Criteria Update:

- Updated Inhaled Corticosteroid-Long-Acting Beta Agonist (ICS-LABA) criteria to include new generic and pediatric formulations

Drug Utilization Review Update:

- No DUR changes made

Interim Prior Authorization Criteria Changes (1/6/20 – 4/5/20)

The following is a summary of changes to SFHP prior authorization (PA) criteria including new criteria and revisions to existing criteria. Current prior authorization criteria can be found at SFHP website at https://www.sfhp.org/providers/pharmacy-services/sfhp-formulary/.

New Criteria

The following new criteria were implemented in the interim since January 2020 P&T.

HYDROXYCHLOROQUINE & CHLOROQUINE

Standard/Specific Therapeutic Class: *Antimalarials/Antimalarial Drugs*
Formulary Status:
• Formulary, PA required:
  ○ chloroquine tablet
  ○ hydroxychloroquine (Plaquenil®) tablet

Coverage Duration: Diagnosis-dependent: • malaria chemoprophylaxis: up to four weeks after leaving endemic area • uncomplicated malaria treatment: up to 48 hours • extraintestinal amebiasis (chloroquine only): up to 3 weeks • lupus erythematosus (hydroxychloroquine only): indefinite • rheumatoid arthritis (hydroxychloroquine only): indefinite • COVID-19 infection: up to 14 days • Other off-label indications:

Diagnosis Considered for Coverage:
• FDA-approved indications:
  ○ chloroquine:
  ▪ Malaria chemoprophylaxis or uncomplicated treatment
  ▪ Extraintestinal amebiasis
  ○ hydroxychloroquine:
  ▪ Malaria chemoprophylaxis or uncomplicated treatment
  ▪ Lupus erythematosus
  ▪ Rheumatoid arthritis
• Treatment of COVID-19
• Other off-label uses: medically accepted indications are defined using the following sources: American Hospital Formulary Service-Drug Information (AHFS-DI), Truven Health Analytics Micromedex DrugDEX (DrugDEX), National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Wolters Kluwer Lexi-Drugs, and Elsevier/Gold Standard Clinical Pharmacology and/or positive results from two peer-reviewed published studies.

Prescribing Restriction • Quantity*: Approve based on FDA-approved or supported off-label dosing up to duration above, based on diagnosis. **Requests for quantities above indicated Quantity Limits will be reviewed on a case by case basis*
Clinical Information Required for Review • Diagnosis • Dose

HYDROXYCHLOROQUINE & CHLOROQUINE
Coverage Criteria: **I. Initiation of Therapy:** • For **FDA-approved diagnoses** for hydroxychloroquine and chloroquine**,** approve for FDA-approved dosing & duration • **For COVID-19,** approve as requested for treatment of active illness up to 14 days • For **off-label diagnoses**, approve if**:** ○ No other formulary medication has a medically accepted use for the patient's specific diagnosis as referenced in the medical compendia AND ○ Medication is being requested for an accepted off-label use and is listed in the standard clinical decision support resources (as noted in Diagnosis section above) OR ○ Requested use can be supported by at least two published peer reviewed clinical studies **II. Continuation of Therapy for NEW Members** (within the last 6 months), approve if: • Patient is stable and continuing the medication AND • Medication is used for appropriate indication and at appropriate dose AND • If using for active treatment of COVID-19, approve up to total duration 14 days **III. Continuation of Therapy for EXISTING Members** (medication filled within the last 6 months or provider attestation on PA request that member is continuing the medication), approve if: • Patient is stable and continuing the medication (chronic diagnosis such as lupus or rheumatoid arthritis) OR • Documentation is provided that retreatment of infectious disease (e.g., malaria, amebiasis, COVID-19) is required
References: • UpToDate; Wolters Kluwer. https://www.uptodate.com/contents/search. Accessed 3/20/2020 • Colson P, Rolain JM, Lagier JC, et al. Chloroquine and hydroxychloroquine as available weapons to fight COVID-19. International J Antimicrob Agents. Online 3/4/2020. • Yao X, Ye F, Zhang M, et al. In Vitro Antiviral Activity and Projection of Optimized Dosing Design of Hydroxychloroquine for the Treatment of Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2). Clin Infect Dis. online 3/9/2020.
Last review/revision date: 3/2020 Update: new criteria

Revisions to Existing Criteria

In accordance with the National Committee for Quality Assurance (NCQA) health plan accreditation requirements, all criteria not yet evaluated by P&T within the last year were reviewed. Criteria were evaluated to check formulary status, review for clinical appropriateness and applicability as well as review for formatting and reference check. Criteria with recommended updates are included in the table above with effective date May 20th, 2020.

Title	Date Effective	Revision Summary
ATOPIC DERMATITIS	1/10/2020	Reduced age requirement for Dupixent® (dupilumab) from ≥18yo to ≥12yo based on FDA approval and updated prescribing information.
BLOOD PRESSURE MONITORS	3/9/2020	Updated NDCs based on manufacturer changes.
ANTI-OBESITY MEDICATIONS	2/27/2020	Removed listing of Belviq® (lorcaserin) based on FDA-requested removal from market.
LOVAZA® AND VASCEPA®	3/20/2020	Updated to include new FDA-approved indication for Vascepa®: cardiovascular risk reduction with mild hypertriglyceridemia (as adjunct to maximally tolerated statin) Criteria require: • Elevated triglycerides ≥150mg/dL • Established cardiovascular disease or multiple risk factors

Title	Date Effective	Revision Summary
		• Trial and failure of maximally tolerated statins with ≥80% compliance for ≥90 days
HEPATITIS C	4/3/2020	Update to remove genotype testing from required information for review based on updated DHCS Hepatitis C Treatment Policy
NON-FORMULARY MEDICATIONS	5/20/2020	Update to include the following diagnosis considered for coverage (Healthy Workers HMO only), per DMHC APL 20-001: • fertility preservation when a covered treatment may directly or indirectly cause iatrogenic infertility, specifically ovarian stimulation for cryopreservation, or ovarian protection when cryopreservation is not feasible
ORAL AND INTRAVENOUS ONCOLYTICS	5/20/2020	Update to include the following diagnosis considered for coverage (Healthy Workers HMO only), per DMHC APL 20-001: • fertility preservation when a covered treatment may directly or indirectly cause iatrogenic infertility, specifically ovarian stimulation for cryopreservation, or ovarian protection when cryopreservation is not feasible
ENDOMETRIOSIS MEDICATIONS	5/20/2020	Update to include the following diagnosis considered for coverage (Healthy Workers HMO only), per DMHC APL 20-001: • fertility preservation when a covered treatment may directly or indirectly cause iatrogenic infertility, specifically ovarian stimulation for cryopreservation, or ovarian protection when cryopreservation is not feasible
EMFLAZA® (DEFLAZACORT)	5/20/2020	Update age of approval from at least five to at least two years old, based on expanded FDA approval in June 2019.
HIV MEDICATIONS	5/20/2020	Retire criteria based on transition of Healthy Kids HMO into Medi-Cal

Interim Formulary Changes (1/6/20 – 4/5/20)

Pharmacy Benefit Medications

Date	Therapeutic class	Medication	Formulary Status	Comment
01/06/2020	Acne Agents, Systemic	Absorica (isotretinoin) LD 8, 16, 24, 32 mg capsule	Medi-Cal, HW: T5-NF HSF, C-Wrap: X	New strength
01/27/2020	Antipsychotic, Atypical, Dopamine, Serotonin Antagnst	Caplyta (lumateperone) 42 mg capsule	Medi-Cal: T5-NF HW, HSF, C-Wrap: X	Carve out
02/03/2020	Antineoplastic - Protein Methyltransferase Inhibit	Tazverik (tazemetostat) 200 mg tablet	Medi-Cal: T4-F/PA, HW: T3-F/PA HSF, C-Wrap: X	New entity
02/17/2020	Opioid Analgesics	tramadol 100 mg tablet	Medi-Cal, HW: T5-NF HSF, C-Wrap: X	New strength
02/20/2020	Anti-Obesity Serotonin 2C Receptor Agonists	Belviq (lorcaserin) 10mg tablet	Medi-Cal, HW: T3-F/PA → NF-NL HSF, C-Wrap: X	Market removal
02/20/2020	Influenza Virus Vaccines	Flublok Quad 2019-2020 (PF) 180 mcg (45 mcg x 4)/0.5 mL IM syringe - 18 yr up	Medi-Cal: T2-F AL ≥19y, fill limit #1/270d HW, HSF, C-Wrap: X	FFS CDL comparability
03/02/2020	Prenatal Vitamin Preparations	Vitafol Fe Plus (PNV #102-iron-folate-DHA) 90 mg iron-1 mg-200 mg capsule	Medi-Cal, HW, HSF: T2-F C-Wrap: X	Covered as a class
03/09/2020	Antineoplastic Systemic Enzyme Inhibitors	Ibrance (palbociclib) 75, 100, 125 mg tablet	Medi-Cal: T4-F/PA, HW: T3-F/PA HSF, C-Wrap: X	New dosage form
03/30/2020	Antihemophilic Factors	Esperoct (factor VIII recombinant) 500, 1,000, 1,500, 2,000, 3,000 (+/-) unit IV solution	Medi-Cal: T5-NF HW, HSF, C-Wrap: X	Carve out
03/30/2020	Antineoplastic Systemic Enzyme Inhibitors	Ayvakit (avapritinib) 100, 200, 300 mg tablet	Medi-Cal: T4-F/PA, HW: T3-F/PA HSF, C-Wrap: X	New entity
03/30/2020	Janus Kinase (JAK) Inhibitors	Xeljanz (tofacitinib) XR 22 mg ER tablet	Medi-Cal: T4-F/PA, HW: T3-F/PA HSF, C-Wrap: X	New strength
03/30/2020	Bone Formation Stim. Agents - Parathyroid Hormone	teriparatide 20 mcg/dose (620 mcg/2.48 mL) subcutaneous pen injector	Medi-Cal, HW: T3-F/PA HSF, C-Wrap: X	Follow-on biosimilar
03/30/2020	Vaccine/Toxoid Preparations, Combinations	Pentacel DTaP-IPV Component (PF) 15 Lf-48 mcg-62 DU/0.5 mL IM susp (component 1 of 2)	Medi-Cal: T2 AL ≥19y QL #4 Rx/lifetime HW, HSF, C-Wrap: X	Updated listing
03/30/2020	Vaccine/Toxoid Preparations, Combinations	Pentacel PF (DTap-polio-HIB) 15 Lf-48 mcg-62 DU-10 mcg/0.5 mL IM kit	Medi-Cal: T2 AL ≥19y QL #4 Rx/lifetime HW, HSF, C-Wrap: X	Updated listing

	Status	Definition
T1	Formulary Drug, Generic (can have quantity limits, age, gender and other code 1 restrictions as defined by Medi-Cal)	Drug is a generic and is covered at point of sale if quantity limits, age, gender, and other code 1 restrictions are met (NOTE: If quantity limits, age, gender, and other code 1 restrictions are not met, drug may still be covered through Prior Authorization process).
T2	Formulary Drug, Brand (can have quantity limits, age, gender and other code 1 restrictions)	Drug is a brand and is covered at point of sale if quantity limits, age, gender, and other code 1 restrictions are met (NOTE: If quantity limits, age, gender, and other code 1 restrictions are not met, drug may still be covered through Prior

		Authorization process).
T3	Formulary Drug, Step Therapy or Prior Authorization required	Drug is a brand or generic and is covered through Prior Authorization process or at point of sale if step therapy criteria are met.
T4	Formulary Specialty Drug, Prior Authorization required	Drug requires distribution through a specialty pharmacy or is a limited distribution drug (LDD). Prior authorization process is required.
T5	Non-Formulary Drug	Drug is non-formulary, provided through a Medi-Cal benefit or excluded. Non-formulary drugs may be covered through Prior Authorization process. Excluded drugs (e.g. FFS Medi-Cal) are not covered.

All changes apply to Medi-Cal, Healthy Workers HMO, and Healthy San Francisco formularies unless otherwise indicated.
*Applies to Medi-Cal formulary only. FFS Carve Out=CO Excluded= X
All Rx-only products are excluded for Medicare/Medi-Cal. T3 & 4 products are NF for HSF
The following new products are not listed in above table:

- Newly generic formulary products moved to tier 1 from tier 2
- Bulk chemicals (excluded from benefit)
- Products that are not FDA approved including emollients (excluded from benefit)
- Topical combination kits (NF if separate ingredient products are available on formulary and/or available as OTC)
- Local anesthetics (NF if formulary agents are available)

New Drugs to Market, Unlisted

Date	Therapeutic class	Medication	Comment
01/13/2020	Estrogenic Agents	Divigel (estradiol) 1.25 mg/1.25 gram (0.1 %) transdermal gel packet	New strength
01/20/2020	Antimigraine Preparations	Ubrelvy (ubrogepant) 50, 100 mg tablet	New entity*
01/20/2020	Agents To Treat Hypoglycemia (Hyperglycemics)	Glucagon (HCl) Emergency Kit 1 mg solution for injection	New kit
01/20/2020	Anticonvulsant - Benzodiazepine Type	Valtoco (diazepam) 5 mg/spray, 10 mg/spray, 15 mg/2 sprays, 20 mg/2 sprays (0.1 mL) nasal spray	New entity
02/07/2020	Antimigraine Preparations	Reyvow (lasmiditan) 50, 100 mg tablet	New entity*
02/17/2020	Allergenic Extracts, Therapeutic	Palforzia (peanut allergen powder-dnfp) 3, 6, 12, 20, 40, 80, 120, 160, 200, 240, 300 mg (Levels 1-11) sprinkle capsule	New entity
02/24/2020	Cystine-Depleting Agents, Nephropathic Cystinosis	Procysbi (cysteamine) 75, 300 mg oral DR granules in packet	New dosage form
03/09/2020	Antimigraine Preparations	Nurtec ODT (rimegepant) 75 mg disintegrating tablet	New entity*
03/09/2020	Antihyperlipidemic - ATP Citrate Lyase Inhibitor	Nexletol (bempedoic acid) 180 mg tablet	New entity*
03/09/2020	Eye Antihistamines	Zerviate (cetirizine) 0.24 % eye drops in a droperette	New dosage form
03/23/2020	Vitamin A Derivatives, Topical Acne Agents	Arazlo (tazarotene) 0.045 % lotion	New dosage form & strength
03/30/2020	Anticonvulsants	Xcopri (cenobamate) 50, 100, 150, 200 mg tablet	New entity
03/30/2020	Anticonvulsants	Xcopri (cenobamate) 12.5 mg (14)-25 mg (14), 50 mg (14)-100 mg (14), 150 mg (14)-200 mg (14), 250 mg/day (200 mg x 1 and 50 mg x 1), 350 mg/day (200 mg x 1 and 150 mg x 1) tablets in a dose pack	New entity

*Scheduled for review at upcoming P&T

The following new products are not listed in above table:

- Bulk chemicals (excluded from benefit)
- Products that are not FDA approved including emollients (excluded from benefit)
- Topical combination kits (NF if separate ingredient products are available on formulary and/or available as OTC)
- Local anesthetics (NF if formulary agents are available)

New Drugs to Market, Medical Benefit

Therapeutic Class	Drug Name, Strengths, and Dosage Form
Antineoplast Hum VEGF Inhibitor Recomb MC Antibody	Zirabev (bevacizumab-bvzr) 25 mg/mL IV solution
Carbapenem Antibiotics (Thienamycins)	Recarbrio (imipenem-cilastatin-relebactam) 1.25 gram IV solution
Zinc Replacement	zinc sulfate 3 mg/mL IV solution
Antihistamines – 2nd Generation	Quzyttir (cetirizine) 10 mg/mL IV solution
Belladonna Alkaloids	hyoscyamine 0.5 mg/mL injection solution
Insulin-Like Growth Factor Receptor (IGF-R) Inhib	Tepezza (teprotumumab-trbw) 500 mg IV solution
Anti-CD20 (B Lymphocyte) Monoclonal Antibody	Ruxience (rituximab-pvvr) 10 mg/mL IV concentrate
Cephalosporin Antibiotics - Siderophore	Fetroja (cefiderocol) 1 gram IV solution
Thrombin Inhibitors, Sel, Direct, Revers-Hirudin Type	bivalirudin 250 mg/50 mL (5 mg/mL) IV solution
Antineoplastic EGF Receptor Blocker Mclon Antibody	Trazimera (trastuzumab-qyyp) 420 mg IV solution
Antimigraine Preparations	Vyepti (eptinezumab-jjmr) 100 mg/mL IV solution
Antineoplastic - Anti-CD38 Monoclonal Antibody	Sarclisa (isatuximab-irfc) 100 mg/5 mL, 500 mg/25 mL IV solution
Phosphate Replacement	potassium phos-mono-dibasic 3 mmol/mL (4.7 mEq potassium/mL) IV solution
Hyperpigmentation Agents, Systemic	Scenesse (afamelanotide acetate) 16 mg SC implant
Antineoplastic EGF Receptor Blocker Mclon Antibody	Herzuma 150, 420 mg (trastuzumab-pkrb) IV solution
NSAIDS, Cyclooxygenase Inhibitor - Type Analgesics	Anjeso (meloxicam) 30 mg/mL IV suspension

The following products are not listed in the above table:

- Allergenic extracts
- Diagnostic preparations
- Parenteral amino acid solutions and combinations
- IV fat emulsions