Preferred Non-Preferred Excluded Medical Drug List

Effective November 1, 2022

Within certain drug classes, there are medically-administered drugs that are considered therapeutically equivalent. According to the Therapeutic Equivalence Policy PP/T002, a preferred medication(s) or product may be required to be trialed before a non-preferred medication(s) when the medication(s) or product is therapeutically equivalent and when there is a lower net cost in comparison to its biosimilar, brand, generic, or reference product. Below is a summary of the preferred, non-preferred, and non-covered drugs, as it is reflected in their respective policies. Please see each drug's policy for more detailed information. Additionally, certain medically-administered drugs have been determined to have no benefit over another formulation or drug and are considered excluded based on the Cost Benefit Program. Those drugs are also listed below and can be referenced in the Cost Benefit Policy PP/C002. This list is not inclusive of every preferred, non- preferred, and excluded medical drug and is to be used only as a reference guide for the drugs listed below. This list is subject to change based on the Therapeutic Equivalence Policy PP/T002, Cost Benefit Policy PP/C002, and the specific policy of each drug(s).

DRUG CLASSES	COVERED OR PREFERRED DRUGS	NON-PREFERRED DRUGS	EXCLUDED DRUGS FROM COVERAGE
Hyaluronic Acids *covered drugs do not require prior authorization*	Euflexxa Synvisc Synvisc-One		Durolane Gel-One Gelsyn-3 Genvisc 850 Hyalgan Hymovis Monovisc Orthovisc Supartz Synojoynt Triluron TriVisc Visco-3
Pegfilgrastim- Granulocyte Colony Stimulating Factors (G-CSF) *preferred drugs do not require prior authorization*	Neulasta Fulphila	Udenyca Ziextenzo Nyvepria	
Rituximab *all drugs require prior authorization*	Ruxience Truxima	Rituxan Rituxan Hycela Riabni	
Trastuzumab *preferred drugs do not require prior authorization*	Kanjinti Ogivri Trazimera	Herceptin Herceptin Hylecta Herzuma Ontruzant	
Bevacizumab – for oncology only *preferred drugs do not require prior authorization, + prior authorization required for oncology diagnosis only*	Mvasi Zirabev	Avastin + Alymsys + Vegzelma +	
Infliximab *all drugs require prior authorization*	Remicade Inflectra	Renflexis Avsola	
Vascular Endothelial Growth Factor Antagonists for Intravitreal Use *preferred drugs do not require prior authorization*	Avastin (bevacizumab) Mvasi (bevacizumab-awwb) Zirabev (bevacizumab-bvzr) Alymsys (bevacizumab-maly) Vegzelma (bevacizumab-adcd)	Beovu (brolucizumab-dbll) Byooviz (ranibizumab-nuna) Cimerli (ranibizumab-eqrn) Eylea (aflibercept) Lucentis (ranibizumab) Vabysmo (faricimab-svoa)	

MEDICAL DRUGS ON COST-BENEFIT LIST AND ARE NOT COVERED
Acthar Gel (injection, repository corticotropin, up to 40 mg) J0800 Cortrophin Gel (injection, corticotropin) J3490 (NOC) Makena (injection, hydroxyprogesterone caproate, 10 mg) J1726 Susvimo (injection, ranibizumab, via sustained release intravitreal implant, 0.1 mg) J2779 Quzyttir (injection, cetirizine hydrochloride, 1 mg) J1201