

Summary of Updates

PHC P & T Committee, July 11, 2024

Effective Date: October 1, 2024

The following TAR criteria, coverage requirements, &/or restrictions, apply to PHC's Medical Drug Benefit (also referred to as Physician Administered Drugs). These are drugs that are (1) purchased by a medical office, clinic or hospital, (2) administered to the member in a medical setting (not for use at home), and (3) billed directly to PHC as a medical claim using HCPCS codes (and NDCs where appropriate). For pharmacy drug coverage, please refer to Medi-Cal Rx documents on the [State's Medi-Cal Rx web pages](#).

NOTE: Brand names are for reference only. Criteria and billing requirements apply to the drug itself (active ingredient) regardless of the manufacturer/brand, unless otherwise specified.

Class Review: Dermatological, Anorectal, Mouth – Throat, Dental, Eye - Ear		
HCPCS	HCPCS Description	Summary of Updates
J3245	Injection, tildrakizumab, 1 mg (Ilumya™)	<ul style="list-style-type: none"> Updates to current criteria: Require trial of an IL-23 inh in addition to TNFi and minor changes to wording
J1747	Injection, spesolimab-sbzo, 1 mg (Spevigo™)	<ul style="list-style-type: none"> Update to specify IV formulation, added age limit to ≥12 and up and ≥40 kg
C9166 (J3247)	Injection, secukinumab, intravenous, 1 mg (Cosentyx™ IV)	<ul style="list-style-type: none"> Add drug-specific criteria
J3401	Beremagene geperpavec-svdt for topical administration (Vyjuvek™)	<ul style="list-style-type: none"> Add drug-specific criteria
J2778	Injection, ranibizumab, 0.1 mg (Lucentis™)	<ul style="list-style-type: none"> Update existing criteria, previously shared with Cimerli™, now with drug-specific criteria. Updates to required info
Q5128	Injection, ranibizumab-eqrn, biosimilar, 0.1 mg (Cimerli™)	<ul style="list-style-type: none"> Update existing criteria, previously shared criteria with Lucentis™, now with drug-specific criteria. Updates to required info
J0177	Injection, aflibercept hd, 1 mg (Eylea HD™)	<ul style="list-style-type: none"> Add drug-specific criteria
J2777	Injection, faricimab-svoa, 0.1 mg (Vabysmo™)	<ul style="list-style-type: none"> Add new FDA approved indication: RVO
J3299	Injection, triamcinolone acetonide, 1 mg (Xipere™)	<ul style="list-style-type: none"> Update qty limit from 40 units per day to 36 units per day
J7351	Injection, bimatoprost, intracameral implant, 1 microgram (Durysta™)	<ul style="list-style-type: none"> Add drug-specific criteria
J7355	Unclassified drugs (Injection, travoprost, intracameral implant, 1 microgram) (iDOSE TR™)	<ul style="list-style-type: none"> Add drug-specific criteria
J2787	Riboflavin 5'-phosphate, ophthalmic solution, up to 3	<ul style="list-style-type: none"> Update to no TAR required

	ml (Photrexa Viscous™)	with QL
J3398	Injection, voretigene neparvovec-rzyl, 1 billion vector genomes (Luxturna™)	<ul style="list-style-type: none"> • Add drug-specific criteria

Class Review: Endocrine and Metabolic Agents

HCPCS	HCPCS Description	Summary of Updates
J3241	Injection, teprotumumab-trbw, 10 mg (Tepezza™)	<ul style="list-style-type: none"> • Add drug-specific criteria
J0218	Injection, olipudase alfa-rpcp, 1 mg (Xenpozyme™)	<ul style="list-style-type: none"> • Add to existing criteria for enzyme replacement drugs
J0219	Injection, avalglucosidase alfa-ngpt, 4 mg (Nexviazyme™)	<ul style="list-style-type: none"> • Add to existing criteria for enzyme replacement drugs

Class Review: Gastrointestinal Agents

HCPCS	HCPCS Description	Summary of Updates
C9168	Mirikizumab-mrkz (Omvoh™)	<ul style="list-style-type: none"> • Add drug-specific criteria
J3358	Ustekinumab (Stelara™)	<ul style="list-style-type: none"> • Update existing criteria: Remove requirement for trial of TNFi or vedolizumab
J3380	Vedolizumab (Entyvio™)	<ul style="list-style-type: none"> • Update existing criteria: Remove requirement for trial of immunomodulators, corticosteroids, or 5 aminosalicylates for UC and add trial of ustekinumab as qualifying option to TNFi
Q5121	Infliximab-axxq, biosimilar (Avsola™)	<ul style="list-style-type: none"> • Update existing criteria: Avsola™ is group 2 non-preferred biosimilar and only require trial of 1 SUBQ TNFi
Q5103	Infliximab-dyyb, biosimilar (Inflectra™)	<ul style="list-style-type: none"> • Update existing criteria: Inflectra™ is preferred group 1 biosimilar and only required trial of 1 SUBQ TNFi
Q5104	Infliximab-abda, biosimilar (Renflexis™)	<ul style="list-style-type: none"> • Update existing criteria: Renflexis™ is group 2 non-preferred biosimilar and only required trial of 1 SUBQ TNFi
J1745	Infliximab (Remicade™)	<ul style="list-style-type: none"> • Updated existing criteria: Only require trial of 1 SUBQ TNFi

Class Review: Miscellaneous Products

HCPCS	HCPCS Description	Summary of Updates
J0879	Injection, difelikefalin, 0.1 microgram, (for ESRD on dialysis) (Korsuva™)	<ul style="list-style-type: none"> • Add drug-specific criteria
J0775	Injection, collagenase, clostridium histolyticum, 0.01 mg (Xiaflex™)	<ul style="list-style-type: none"> • Update existing criteria: remove requirement for trial of

		glucocorticoid
J9332	Injection, efgartigimod alfa-fcab, 2mg (Vyvgart™)	<ul style="list-style-type: none"> Update existing criteria to include Vyvgart Hytrulo™
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc (Vyvgart Hytrulo™)	<ul style="list-style-type: none"> Add to Vyvgart™ criteria
J9333	Injection, rozanolixizumab-noli, 1 mg (Rystiggo™)	<ul style="list-style-type: none"> Add drug-specific criteria
J0485	Injection, belatacept, 1 mg (Nulojix™)	<ul style="list-style-type: none"> Update to no TAR required with QL and required ICD10 of Z94.0

Miscellaneous Changes Falling Outside of Scheduled Drug Class Reviews

HCPSC	HCPSC Description	Summary of Updates
Q5126	Injection, bevacizumab-maly, biosimilar, 10 mg (Alymsys™)	<ul style="list-style-type: none"> Add drug-specific criteria with Vegzelma™: non-preferred biosimilar
Q5129	Injection, bevacizumab-adcd, biosimilar, 10 mg (Vegzelma™)	<ul style="list-style-type: none"> Add drug-specific criteria with Alymsys™: non-preferred biosimilar
Q2055	Idecabtagene vicleucel (Abecma™)	<ul style="list-style-type: none"> Updated existing criteria: Require only 2 prior lines of therapy
Q2056	Ciltacabtagene autoleucel (Carvykti™)	<ul style="list-style-type: none"> Updated existing criteria: Require only 1 prior line of therapy

New CMS & DHCS HCPSC Codes, Effective 7/1/2023

HCPSC	HCPSC Code & Drug Descriptions	Coverage Status
Antibiotics/Antifungals		
J0687	Injection, cefazolin sodium (WG Critical Care), not therapeutically equivalent to J0690, 500 mg	Covered, no restrictions
J0872	Injection, daptomycin (Xellia), unrefrigerated, not therapeutically equivalent to J0878 or J0873, 1 mg	TAR required
J2183	Injection, meropenem (WG Critical Care), not therapeutically equivalent to J2185, 100 mg	TAR required
J2246	Injection, micafungin in sodium (Baxter), not therapeutically equivalent to J2248, 1 mg	Covered, no restrictions
Antineoplastic Agents & Adjunctive Therapies		
J3263	Injection, toripalima-btpzi, 1 mg	TAR required
J8611	Methotrexate (jylamvo), oral, 2.5 mg (solution, 2 mg/ml)	TAR required
J8612	Methotrexate (xatmep), oral, 2.5 mg (solution, 2.5 mg/ml)	TAR required
Cardiovascular Agents		
J2373	Injection, phenylephrine hydrochloride (Immphentiv™), 20 micrograms	Covered, no restrictions
Dermatological/Anorectal/Mouth-Throat/Dental/Ophthalmic/Otic		
J3247	Injection, secukinumab, intravenous, 1 mg	TAR required

J7355	Injection, travoprost, intracameral implant, 1 mcg	TAR required
Gastrointestinal Agents		
J1597	Injection, glycopyrrolate (Glyrx™-PF), 0.1 mg	Covered with limits: not allowed with UA/UB modifier for anesthesia use
J1598	Injection, glycopyrrolate (Fresenius Kabi), not therapeutically equivalent to J1596, 0.1 mg	Covered with limits: not allowed with UA/UB modifier for anesthesia use
J1748	Injection, infliximab-dyyb (Zymfentra™), 10 mg	TAR required
J2267	Injection, mirikizumabmrkz, 1 mg	TAR required
J2468	Injection, palonosetron hydrochloride (Avyxa), not therapeutically equivalent to J2469, 25 mcg's	Covered, no restrictions
J2470	Injection, pantoprazole sodium, 40 mg	Covered, no restrictions
J2471	Injection, pantoprazole (Hikma), not therapeutically equivalent to J2470, 40 mg	Covered, no restrictions
Q5137	Injection, ustekinumab-auub (Wezlana™), biosimilar, subcutaneous, 1 mg	TAR required
Q5138	Injection, ustekinumab-auub (Wezlana™), biosimilar, intravenous, 1 mg	TAR required
Hematologic Agents		
J3393	Injection, betibeglogene autotemcel, per treatment	TAR required
J3394	Injection, lovitibeglogene autotemcel, per treatment	TAR required
J7171	Injection, adamts13, recombinant-krhn, 10 iu	TAR required

Additions to J3490/Z7610 Unclassified NDC Coverage

Brand names are listed for reference only; coverage information also applies to generics.

Generic (Brand)	Coverage Requirements/Limits
Antihistamine/Nasal agents/Cough-Cold/Respiratory	
Roflumilast 250 mg, 500 mg tablets (Daliresp™)	Addition, no restriction
Endocrine & Metabolic	
Potassium acetate, 2 mEq/1 ml, IV solution; 20, 50 & 100 ml vials	Addition, no restriction
Hematologic	
Deferasirox 90, 180, 360 mg tabs (Jadenu™)	Addition, no restriction
	Addition, no restriction