



MEDICAL BENEFIT MANAGEMENT PROGRAM SPECIALTY PRIOR AUTHORIZATION DRUG LIST

Effective February 1, 2024

Register at <https://www.express-path.com>. If you have questions, please call (877) 787-8705.



DRUG NAME	GENERIC DESCRIPTION	THERAPY CLASS	REIMBURSEMENT CODE	EFFECTIVE DATE
Actemra IV*	tocilizumab	Inflammatory Conditions	J3262	8/15/2022
Acthar gel	repository corticotropin	Miscellaneous Conditions	J0800	8/1/2022
Adakveo±	crizanlizumab-tmca	Miscellaneous Conditions	J0791	1/1/2020
Aduhelm°	Aducanumab-avwa	Miscellaneous Conditions	J0172	7/1/2022
Aldurazyme±	laronidase	Enzyme Deficiencies	J1931	7/21/2019
Adzynma	ADAMTS13, recombinant-krhn	Enzyme Deficiencies	C9399, J3590	2/1/2024
Amondys-45	casimersen	Muscular Dystrophies	J1426	5/1/2021
Amvuttra±	vutrisiran	Amyloidosis	J0225	9/1/2022
Aphexda	motixafortide	Blood Cell Deficiency	C9399, J3590	2/1/2024
Apretude±	cabotegravir	HIV	J0739	3/1/2022
Aralast NP*	alpha1-proteinase inhibitor	Alpha 1 Deficiency	J0256	8/15/2022
Aranesp*	darbepoetin alfa	Blood Cell Deficiency	J0881	5/1/2019
Asceniv±	immune globulin	Immune Deficiency	J1554	7/21/2019
Atgam	lymphocyte immune globulin	Immune Deficiency	J7504	3/1/2020
Aveed±	testosterone undecanoate	Endocrine Disorders	J3145	5/1/2019
Avsola±	infliximab-axxq	Inflammatory Conditions	Q5121	7/15/2020
Benlysta*	belimumab	Inflammatory Conditions	J0490	8/15/2022
Beovu	brolocizumab-dbll	Ophthalmic Conditions	J0179	11/11/2019
Berinerter±	c1 esterase inhibitor	Hereditary Angioedema	J0597	5/1/2019
Bivigam±	immune globulin	Immune Deficiency	J1556	5/1/2019

* denotes a drug that may be included in the eviCore Oncology Management Program. If the diagnosis is oncology, please contact eviCore at (855) 727-7444 or myportal@evicore.com

° prior authorization applies to Medicare members only. Coverage is a plan exclusion for all Commercial, Healthcare Exchange and State of Wisconsin members.

• prior authorization applies to Medicare members only. Commercial, Healthcare Exchange and State of Wisconsin members require prior authorization through the pharmacy benefit.

x prior authorization applies to IV formulation for Medicare members only. Subcutaneous formulation requires prior authorization through pharmacy benefit for all lines of business.

± indicates the drug may be subject to site of care requirements

^ prior authorization applies to Medicare and State of Wisconsin members only. Coverage is a plan exclusion for all Healthcare Exchange and Commercial members.

Please note that newly approved specialty drugs, not yet identified on this list, may be subject to prior authorization.



MEDICAL BENEFIT MANAGEMENT PROGRAM SPECIALTY PRIOR AUTHORIZATION DRUG LIST

Effective February 1, 2024

Register at <https://www.express-path.com>. If you have questions, please call (877) 787-8705.



DRUG NAME	GENERIC DESCRIPTION	THERAPY CLASS	REIMBURSEMENT CODE	EFFECTIVE DATE
Botox	onabotulinumtoxinA	Neuromuscular Conditions	J0585	5/1/2019
Brineura	cerliponase alfa	Enzyme Deficiencies	J0567	5/1/2019
Briumvi±	ublituximab-xiyy	Multiple Sclerosis	J2329	3/1/2023
Byooviz	ranibizumab-nuna	Ophthalmic Conditions	Q5124	6/8/2022
Cabenuva±	cabotegravir/rilpivirine extended-release injection	HIV	J0741	5/1/2021
Cablivi	caplacizumab-yhdp	Blood Cell Deficiency	C9047	7/21/2019
Carimune NF	immune globulin	Immune Deficiency	J1566	5/1/2019
Cerezyme±	imiglucerase	Enzyme Deficiencies	J1786	11/1/2023
Cimzia*	certolizumab pegol	Inflammatory Conditions	J0717	8/15/2022
Cimerli	ranibizumab-eqrn	Ophthalmic Conditions	Q5128	8/10/2022
Cinqair±	reslizumab	Asthma & Allergy	J2786	5/1/2019
Cinryze±	c1 esterase inhibitor	Hereditary Angioedema	J0598	5/1/2019
Cortrophin gel	repository corticotropin	Miscellaneous Conditions	J0800	8/1/2022
Cosentyx IV	secukinumab	Inflammatory Conditions	C9399, J3590	1/1/2024
Crysvita±	burosumab-twza	Endocrine Disorders	J0584	10/1/2019
Cutaquig±	immune globulin	Immune Deficiency	J1551, 90284	4/1/2022
Cuvitru±	immune globulin	Immune Deficiency	J1555	4/1/2022
Cytogam±	cytomegalovirus immune globulin	Immune Deficiency	J0850	3/1/2020
Daxxify	daxibotulinumtoxinA-lanm	Neuromuscular Conditions	C9399, J3590	11/1/2023
Depo-Testosterone	testosterone cypionate	Endocrine Disorders	J1071	2/1/2022

* denotes a drug that may be included in the eviCore Oncology Management Program. If the diagnosis is oncology, please contact eviCore at (855) 727-7444 or myportal@evicore.com

° prior authorization applies to Medicare members only. Coverage is a plan exclusion for all Commercial, Healthcare Exchange and State of Wisconsin members.

● prior authorization applies to Medicare members only. Commercial, Healthcare Exchange and State of Wisconsin members require prior authorization through the pharmacy benefit.

x prior authorization applies to IV formulation for Medicare members only. Subcutaneous formulation requires prior authorization through pharmacy benefit for all lines of business.

± indicates the drug may be subject to site of care requirements

^ prior authorization applies to Medicare and State of Wisconsin members only. Coverage is a plan exclusion for all Healthcare Exchange and Commercial members.

Please note that newly approved specialty drugs, not yet identified on this list, may be subject to prior authorization.



MEDICAL BENEFIT MANAGEMENT PROGRAM SPECIALTY PRIOR AUTHORIZATION DRUG LIST

Effective February 1, 2024

Register at <https://www.express-path.com>. If you have questions, please call (877) 787-8705.



DRUG NAME	GENERIC DESCRIPTION	THERAPY CLASS	REIMBURSEMENT CODE	EFFECTIVE DATE
Durysta	bimatoprost	Ophthalmic Conditions	J7351	5/1/2020
Dysport	abobotulinumtoxinA	Neuromuscular Conditions	J0586	5/1/2019
Elaprase±	idursulfase	Enzyme Deficiencies	J1743	7/21/2019
Elelyso±	taliglucerase alfa	Enzyme Deficiencies	J3060	11/1/2023
Elevidys^	delandistrogene moxeparvovec-rokl	Muscular Dystrophies	C9399, J3590	11/1/2023
Elfabrio	pegunigalsidase alfa-iwxj	Enzyme Deficiencies	C9399, J3590	9/1/2023
Enjaymo±	sutimlimab – jome	Miscellaneous Conditions	J1302	4/1/2022
Entyvio±	vedolizumab	Inflammatory Conditions	J3380	5/1/2019
Epogen*	epoetin alfa	Blood Cell Deficiency	J0885	5/1/2019
Epoprostenol	epoprostenol	Pulmonary Hypertension	J1325	5/1/2019
Evenity±	romosozumab	Osteoporosis	J3111	10/1/2019
Evkeeza±	evinacumab-dgnb	High Blood Cholesterol	J1305	5/1/2021
Exondys 51	eteplirsen	Muscular Dystrophies	J1428	5/1/2019
Eylea	aflibercept	Ophthalmic Conditions	J0178	5/1/2019
Eylea HD	aflibercept	Ophthalmic Conditions	C9399, J3590	8/18/2023
Fabrazyme±	agalsidase beta	Enzyme Deficiencies	J0180	7/21/2019
Fasenra*	benralizumab	Asthma & Allergy	J0517	8/15/2022
Fensolvi±	leuprolide acetate	Endocrine Disorders	J1951	6/1/2020
Feraheme	ferumoxytol	Anemia	Q0138	3/1/2021
Flebogamma Dif±	immune globulin	Immune Deficiency	J1572	5/1/2019

* denotes a drug that may be included in the eviCore Oncology Management Program. If the diagnosis is oncology, please contact eviCore at (855) 727-7444 or myportal@evicore.com

° prior authorization applies to Medicare members only. Coverage is a plan exclusion for all Commercial, Healthcare Exchange and State of Wisconsin members.

● prior authorization applies to Medicare members only. Commercial, Healthcare Exchange and State of Wisconsin members require prior authorization through the pharmacy benefit.

x prior authorization applies to IV formulation for Medicare members only. Subcutaneous formulation requires prior authorization through pharmacy benefit for all lines of business.

± indicates the drug may be subject to site of care requirements

^ prior authorization applies to Medicare and State of Wisconsin members only. Coverage is a plan exclusion for all Healthcare Exchange and Commercial members.

Please note that newly approved specialty drugs, not yet identified on this list, may be subject to prior authorization.



MEDICAL BENEFIT MANAGEMENT PROGRAM SPECIALTY PRIOR AUTHORIZATION DRUG LIST

Effective February 1, 2024

Register at <https://www.express-path.com>. If you have questions, please call (877) 787-8705.



DRUG NAME	GENERIC DESCRIPTION	THERAPY CLASS	REIMBURSEMENT CODE	EFFECTIVE DATE
Flolan	epoprostenol	Pulmonary Hypertension	J1325	5/1/2019
Gamifant	emapalumab-lzsg	Miscellaneous Conditions	J9210	5/1/2019
Gammagard±	immune globulin	Immune Deficiency	J1569	5/1/2019
Gammagard SD±	immune globulin	Immune Deficiency	J1566	5/1/2019
Gammaked±	immune globulin	Immune Deficiency	J1561	5/1/2019
Gammaplex±	immune globulin	Immune Deficiency	J1557	5/1/2019
Gamunex-C±	immune globulin	Immune Deficiency	J1561	5/1/2019
Givlaari±	givosiran	Miscellaneous Conditions	J0223	1/1/2020
Glassia*	alpha1-proteinase inhibitor	Alpha 1 Deficiency	J0257	8/15/2022
Hemgenix^	etranacogene dezaparvovec-drlb	Hemophilia	J1411	3/1/2023
Hizentra±	immune globulin	Immune Deficiency	J1559	4/1/2022
Hyqvia±	immune globulin	Immune Deficiency	J1575	4/1/2022
Ilaris±	canakinumab	Inflammatory Conditions	J0638	5/1/2019
Ilumya±	tildrakizumab	Inflammatory Conditions	J3245	5/1/2020
Inflectra±	infliximab-dyyb	Inflammatory Conditions	Q5103	5/1/2019
Injectafer	ferric carboxymaltose	Anemia	J1439	3/1/2021
Izervay	avacincaptad pegol	Ophthalmic Conditions	C9399, J3590	11/1/2023
Kanuma±	sebelipase alfa	Enzyme Deficiencies	J2840	7/21/2019
Krystexxa±	pegloticase	Gout	J2507	5/1/2019
Lanreotide	lanreotide	Endocrine Disorders	J1932	3/9/2022

* denotes a drug that may be included in the eviCore Oncology Management Program. If the diagnosis is oncology, please contact eviCore at (855) 727-7444 or myportal@evicore.com

° prior authorization applies to Medicare members only. Coverage is a plan exclusion for all Commercial, Healthcare Exchange and State of Wisconsin members.

● prior authorization applies to Medicare members only. Commercial, Healthcare Exchange and State of Wisconsin members require prior authorization through the pharmacy benefit.

x prior authorization applies to IV formulation for Medicare members only. Subcutaneous formulation requires prior authorization through pharmacy benefit for all lines of business.

± indicates the drug may be subject to site of care requirements

^ prior authorization applies to Medicare and State of Wisconsin members only. Coverage is a plan exclusion for all Healthcare Exchange and Commercial members.

Please note that newly approved specialty drugs, not yet identified on this list, may be subject to prior authorization.



MEDICAL BENEFIT MANAGEMENT PROGRAM SPECIALTY PRIOR AUTHORIZATION DRUG LIST

Effective February 1, 2024

Register at <https://www.express-path.com>. If you have questions, please call (877) 787-8705.



DRUG NAME	GENERIC DESCRIPTION	THERAPY CLASS	REIMBURSEMENT CODE	EFFECTIVE DATE
Lemtrada±	alemtuzumab	Multiple Sclerosis	J0202	5/1/2019
Lamzedo	velmanase alfa-tycv	Enzyme Deficiencies	C9399, J3590	6/1/2023
Leqembi	lecanemab-irmb	Miscellaneous Conditions	C9399, J3590	9/15/2023
Leqvio±	inclisiran	High Blood Cholesterol	J1306	3/1/2022
Lucentis	ranibizumab	Ophthalmic Conditions	J2778	5/1/2019
Lumizyme±	alglucosidase alfa	Enzyme Deficiencies	J0221	7/21/2019
Lupaneta Pack*	leuprolide acetate/norethindrone	Endocrine Disorders	J3490	5/1/2019
Lupron Depot*±	leuprolide acetate	Endocrine Disorders	J9217	5/1/2019
Lupron Depot-Ped	leuprolide acetate	Endocrine Disorders	J1950	5/1/2019
Luxturna^	voretigene neparvovec-rzyl	Ophthalmic Conditions	J3398	5/1/2019
Macugen	pegaptanib sodium	Ophthalmic Conditions	J2503	5/1/2019
Mepsevii±	vestronidase alfa-vjvk	Enzyme Deficiencies	J3397	7/21/2019
Mircera	methoxy peg-epoetin beta	Blood Cell Deficiency	J0888	5/1/2019
Monoferic	ferric derisomaltose	Anemia	J1437	3/1/2021
Myobloc	rimabotulinumtoxinB	Neuromuscular Conditions	J0587	5/1/2019
Naglazyme±	galsulfase	Enzyme Deficiencies	J1458	7/21/2019
Neupogen*	filgrastim	Blood Cell Deficiency	J1442	5/1/2019
Nexvzyme±	avalglucosidase alfa-ngpt	Enzyme Deficiencies	J0219	10/1/2021
Nivestym*	filgrastim-aafi	Blood Cell Deficiency	Q5110	7/21/2019
Nplate±	romiplostim	Blood Cell Deficiency	J2796	5/1/2019

* denotes a drug that may be included in the eviCore Oncology Management Program. If the diagnosis is oncology, please contact eviCore at (855) 727-7444 or myportal@evicore.com

° prior authorization applies to Medicare members only. Coverage is a plan exclusion for all Commercial, Healthcare Exchange and State of Wisconsin members.

● prior authorization applies to Medicare members only. Commercial, Healthcare Exchange and State of Wisconsin members require prior authorization through the pharmacy benefit.

x prior authorization applies to IV formulation for Medicare members only. Subcutaneous formulation requires prior authorization through pharmacy benefit for all lines of business.

± indicates the drug may be subject to site of care requirements

^ prior authorization applies to Medicare and State of Wisconsin members only. Coverage is a plan exclusion for all Healthcare Exchange and Commercial members.

Please note that newly approved specialty drugs, not yet identified on this list, may be subject to prior authorization.



MEDICAL BENEFIT MANAGEMENT PROGRAM SPECIALTY PRIOR AUTHORIZATION DRUG LIST

Effective February 1, 2024

Register at <https://www.express-path.com>. If you have questions, please call (877) 787-8705.



DRUG NAME	GENERIC DESCRIPTION	THERAPY CLASS	REIMBURSEMENT CODE	EFFECTIVE DATE
Nucala*	mepolizumab	Asthma & Allergy	J2182	8/15/2022
Nulibry±	fosdenopterin	Enzyme Deficiencies	C9399, J3590	6/1/2021
Nulojix±	belatacept	Transplant	J0485	5/1/2019
Ocrevus±	ocrelizumab	Multiple Sclerosis	J2350	5/1/2019
Octagam±	immune globulin	Immune Deficiency	J1568	5/1/2019
OmvoH	mirikizumab-mrkz	Inflammatory Conditions	C9399, J3590	1/1/2024
Onpattro±	patisiran	Amyloidosis	J0222	10/1/2019
Orencia^	abatacept	Inflammatory Conditions	J0129	8/15/2022
Oxlumo±	lumasiran	Metabolic Disorders	J0224	3/1/2021
Panzyga±	immune globulin	Immune Deficiency	J1599	5/1/2019
Pombiliti	cipaglucosidase alfa-atga	Enzyme Deficiencies	C9399, J3590	12/1/2023
Privigen±	immune globulin	Immune Deficiency	J1459	5/1/2019
Procrit*	epoetin alfa	Blood Cell Deficiency	J0885	5/1/2019
Prolastin-C	alpha1-proteinase inhibitor	Alpha 1 Deficiency	J0256	5/1/2019
Qalsody	tofersen	Enzyme Deficiencies	C9399, J3590	8/1/2023
Radicava±	edaravone	Muscular Dystrophies	J1301	5/1/2019
Reblozyl	luspatercept-aamt	Blood Cell Deficiency	J0896	1/1/2020
Remicade±	infliximab	Inflammatory Conditions	J1745	5/1/2019
Remodulin	treprostinil	Pulmonary Hypertension	J3285	5/1/2019
Renflexis±	infliximab-abda	Inflammatory Conditions	Q5104	5/1/2019

* denotes a drug that may be included in the eviCore Oncology Management Program. If the diagnosis is oncology, please contact eviCore at (855) 727-7444 or myportal@evicore.com

° prior authorization applies to Medicare members only. Coverage is a plan exclusion for all Commercial, Healthcare Exchange and State of Wisconsin members.

● prior authorization applies to Medicare members only. Commercial, Healthcare Exchange and State of Wisconsin members require prior authorization through the pharmacy benefit.

x prior authorization applies to IV formulation for Medicare members only. Subcutaneous formulation requires prior authorization through pharmacy benefit for all lines of business.

± indicates the drug may be subject to site of care requirements

^ prior authorization applies to Medicare and State of Wisconsin members only. Coverage is a plan exclusion for all Healthcare Exchange and Commercial members.

Please note that newly approved specialty drugs, not yet identified on this list, may be subject to prior authorization.



MEDICAL BENEFIT MANAGEMENT PROGRAM SPECIALTY PRIOR AUTHORIZATION DRUG LIST

Effective February 1, 2024

Register at <https://www.express-path.com>. If you have questions, please call (877) 787-8705.



DRUG NAME	GENERIC DESCRIPTION	THERAPY CLASS	REIMBURSEMENT CODE	EFFECTIVE DATE
Retacrit*	epoetin alfa-epbx	Blood Cell Deficiency	Q5106	5/1/2019
Revcovi±	elapegademase-lvlr	Enzyme Deficiencies	J3590	5/1/2019
Riabni*±	rituximab-arrx	Inflammatory Conditions	Q5123	3/1/2021
Rivfloza	nedosiran	Miscellaneous Diseases	C9399, J3590	2/1/2024
Rituxan*±	rituximab	Inflammatory Conditions	J9312	5/1/2019
Roctavian^	valoctocogene roxaparvovec	Hemophilia	C9399, J3590	11/1/2023
Ruconest±	c1 esterase inhibitor	Hereditary Angioedema	J0596	5/1/2019
Ruxience*±	rituximab-pvvr	Inflammatory Conditions	Q5119	3/1/2020
Ryplazim	plasminogen, human-tvmh	Miscellaneous Conditions	J2998	3/1/2022
Rystiggo	rozanolixizumab-noli	Miscellaneous Conditions	C9399, J3590	9/1/2023
Sandostatin LAR*±	Octreotide	Endocrine Disorders	J2353	1/1/2022
Saphnelo±	anifrolumab	Inflammatory Conditions	J0491	10/1/2021
Scenese	afamelanotide	Miscellaneous Conditions	J7352	1/1/2020
Signifor LAR±	pasireotide pamoate	Endocrine Disorders	J2502	1/1/2022
Simponi Aria±	golimumab	Inflammatory Conditions	J1602	5/1/2019
Skyrizi IV±	risankizumab-rzaa	Inflammatory Conditions	J2327	9/1/2022
Skysona^	elivaldogene automovel	Neurologic Conditions	C9399	1/1/2023
Soliris±	eculizumab	Blood Modifying Agents	J1300	5/1/2019
Somatuline Depot*±	lanreotide	Endocrine Disorders	J1930	1/1/2022
Spevigo	spesolimab-sbzo	spesolimab-sbzo	J1747	11/1/2022

* denotes a drug that may be included in the eviCore Oncology Management Program. If the diagnosis is oncology, please contact eviCore at (855) 727-7444 or myportal@evicore.com

° prior authorization applies to Medicare members only. Coverage is a plan exclusion for all Commercial, Healthcare Exchange and State of Wisconsin members.

• prior authorization applies to Medicare members only. Commercial, Healthcare Exchange and State of Wisconsin members require prior authorization through the pharmacy benefit.

x prior authorization applies to IV formulation for Medicare members only. Subcutaneous formulation requires prior authorization through pharmacy benefit for all lines of business.

± indicates the drug may be subject to site of care requirements

^ prior authorization applies to Medicare and State of Wisconsin members only. Coverage is a plan exclusion for all Healthcare Exchange and Commercial members.

Please note that newly approved specialty drugs, not yet identified on this list, may be subject to prior authorization.



MEDICAL BENEFIT MANAGEMENT PROGRAM SPECIALTY PRIOR AUTHORIZATION DRUG LIST

Effective February 1, 2024

Register at <https://www.express-path.com>. If you have questions, please call (877) 787-8705.



DRUG NAME	GENERIC DESCRIPTION	THERAPY CLASS	REIMBURSEMENT CODE	EFFECTIVE DATE
Spinraza	nusinersen	Muscular Dystrophies	J2326	5/1/2019
Spravato	esketamine	Miscellaneous Conditions	S0013	7/21/2019
Stelara IV	ustekinumab	Inflammatory Conditions	J3358	5/1/2019
Sunlenca±	lenacapavir	HIV	J1961	3/1/2023
Supprelin LA*	Histrelin implant	Endocrine Disorders	J9226	5/1/2019
Syfovre	pegcetacoplan	Ophthalmic Conditions	C9399, J3590	6/1/2023
Synagis	palivizumab	Respiratory Syncytial Virus	90378	5/1/2019
Tepezza±	teprotumumab	Ophthalmic Conditions	J3241	3/1/2020
Testopel	testosterone implant	Endocrine Disorders	S0189	5/1/2019
Testosterone enanthate	testosterone enanthate	Endocrine Disorders	J3121	2/1/2022
Tezspire±	tezepelumab-ekko	Asthma & Allergy	J2356	7/1/2023
Treprostinil	treprostinil	Pulmonary Hypertension	J3285	7/21/2019
Triptodur±	triptorelin	Endocrine Disorders	J3316	5/1/2019
Trogarzo±	lbalizumab-uiy	HIV	J1746	9/1/2022
Truxima*±	rituximab-abbs	Inflammatory Conditions	Q5115	7/21/2019
Tysabri±	natalizumab	Multiple Sclerosis	J2323	5/1/2019
Tzield	teplizumab-mzwv	Diabetes	C9399, J3590	3/1/2023
Ultomiris±	ravulizumab-cwvz	Blood Modifying Agents	J1303	5/1/2019
Uplizna±	inebilizumab-cdon	Miscellaneous Conditions	J1823	7/15/2020
Vabysmo	faricimab-svoa	Ophthalmic Conditions	J2777	5/1/2022

* denotes a drug that may be included in the eviCore Oncology Management Program. If the diagnosis is oncology, please contact eviCore at (855) 727-7444 or myportal@evicore.com

° prior authorization applies to Medicare members only. Coverage is a plan exclusion for all Commercial, Healthcare Exchange and State of Wisconsin members.

• prior authorization applies to Medicare members only. Commercial, Healthcare Exchange and State of Wisconsin members require prior authorization through the pharmacy benefit.

x prior authorization applies to IV formulation for Medicare members only. Subcutaneous formulation requires prior authorization through pharmacy benefit for all lines of business.

± indicates the drug may be subject to site of care requirements

^ prior authorization applies to Medicare and State of Wisconsin members only. Coverage is a plan exclusion for all Healthcare Exchange and Commercial members.

Please note that newly approved specialty drugs, not yet identified on this list, may be subject to prior authorization.



MEDICAL BENEFIT MANAGEMENT PROGRAM SPECIALTY PRIOR AUTHORIZATION DRUG LIST

Effective February 1, 2024

Register at <https://www.express-path.com>. If you have questions, please call (877) 787-8705.



DRUG NAME	GENERIC DESCRIPTION	THERAPY CLASS	REIMBURSEMENT CODE	EFFECTIVE DATE
Vantas*	Histrelin implant	Endocrine Disorders	J9225	5/1/2019
Veletri	epoprostenol	Pulmonary Hypertension	J1325	5/1/2019
Veopoz	pozelimab-bbfg	Blood Modifying Agents	C9399, J3590	12/1/2023
Vilteposo	viltolarsen	Muscular Dystrophies	J1427	11/15/2020
Vimizim±	elosulfase alfa	Enzyme Deficiencies	J1322	7/21/2019
VPRIV±	velaglucerase alfa	Enzyme Deficiencies	J3385	11/1/2023
Vyepti±	eptinezumab-jjmr	Miscellaneous Conditions	J3032	5/1/2020
Vyondys-53	golodirsen	Muscular Dystrophies	J1429	3/1/2020
Vyvgart±	efgartigimod alfa-fcab	Miscellaneous Conditions	J9332	3/1/2022
Vyvgart Hytrulo	efgartigimod alfa/hyaluronidase	Miscellaneous Conditions	C9399, J3590	9/1/2023
Vyjuvek^	beremagene-geperpavec-svdt	Miscellaneous Conditions	C9399, J3590	9/1/2023
Xembify±	immune globulin	Immune Deficiency	J1558	4/1/2022
Xenpozyme±	olipudase alfa-rpcp	Enzyme Deficiencies	J0218	11/1/2022
Xeomin	incobotulinumtoxinA	Neuromuscular Conditions	J0588	5/1/2019
Xiaflex	collagenase clostridium histolyticum	Miscellaneous Conditions	J0775	5/1/2019
Xolair*	omalizumab	Asthma & Allergy	J2357	8/15/2022
Xyosted	testosterone enanthate	Endocrine Disorders	J3490	2/1/2022
Zarxio*	filgrastim-sndz	Blood Cell Deficiency	Q5101	5/1/2019
Zemaira*	alpha1-proteinase inhibitor	Alpha 1 Deficiency	J0256	8/15/2022
Zoladex*	goserelin acetate implant	Endocrine Disorders	J9202	5/1/2019

* denotes a drug that may be included in the eviCore Oncology Management Program. If the diagnosis is oncology, please contact eviCore at (855) 727-7444 or myportal@evicore.com

° prior authorization applies to Medicare members only. Coverage is a plan exclusion for all Commercial, Healthcare Exchange and State of Wisconsin members.

• prior authorization applies to Medicare members only. Commercial, Healthcare Exchange and State of Wisconsin members require prior authorization through the pharmacy benefit.

x prior authorization applies to IV formulation for Medicare members only. Subcutaneous formulation requires prior authorization through pharmacy benefit for all lines of business.

± indicates the drug may be subject to site of care requirements

^ prior authorization applies to Medicare and State of Wisconsin members only. Coverage is a plan exclusion for all Healthcare Exchange and Commercial members.

Please note that newly approved specialty drugs, not yet identified on this list, may be subject to prior authorization.



MEDICAL BENEFIT MANAGEMENT PROGRAM SPECIALTY PRIOR AUTHORIZATION DRUG LIST

Effective February 1, 2024

Register at <https://www.express-path.com>. If you have questions, please call (877) 787-8705.

CARECONTINUUM[®]

DRUG NAME	GENERIC DESCRIPTION	THERAPY CLASS	REIMBURSEMENT CODE	EFFECTIVE DATE
Zolgensma [^]	onasemnogene abeparvovec-xioi	Muscular Dystrophies	J3399	6/1/2019
Zulresso	brexanolone	Miscellaneous Conditions	J1632	7/21/2019
Zynteglo [^]	betibeglogene autotemcel	Blood Cell Deficiency	C9399	1/1/2023

* denotes a drug that may be included in the eviCore Oncology Management Program. If the diagnosis is oncology, please contact eviCore at (855) 727-7444 or myportal@evicore.com

° prior authorization applies to Medicare members only. Coverage is a plan exclusion for all Commercial, Healthcare Exchange and State of Wisconsin members.

● prior authorization applies to Medicare members only. Commercial, Healthcare Exchange and State of Wisconsin members require prior authorization through the pharmacy benefit.

× prior authorization applies to IV formulation for Medicare members only. Subcutaneous formulation requires prior authorization through pharmacy benefit for all lines of business.

± indicates the drug may be subject to site of care requirements

^ prior authorization applies to Medicare and State of Wisconsin members only. Coverage is a plan exclusion for all Healthcare Exchange and Commercial members.

Please note that newly approved specialty drugs, not yet identified on this list, may be subject to prior authorization.