



# Pharmacy Passages

## Premium Formulary Update

April 2025

The following formulary decisions and updates apply to **Western Health Advantage Premium Formulary**.

The Optum Rx Business Committee meets monthly to evaluate tier placements and new prescription products approved by the Food and Drug Administration (FDA). This committee makes decisions based on information and recommendations from the Optum Rx National Pharmacy & Therapeutics Committee, comprised of independent physician providers and pharmacists.

The following are the strategic clinical decisions made in the past month. Your actual plan’s copays and/or coinsurance may differ from those indicated depending on the selected plan design, which determines coverage and pharmacy provider(s). Refer to your benefit plan documents to make sure the listed medications are included in your benefit.

Premium Formulary Tiers	
Generic/Preferred Brand = Tier 1	
Preferred Brand/Non-Preferred Generic = Tier 2	
Non-Preferred Brand = Tier 3	
Specialty = Tier 4	
Excluded = EXC	
Office Administered = OA	
Include preventive (PV) drugs which may have \$0 when health care reform requirements are met.	
<b>Notes:</b>	Four tier formulary comprised of generics, preferred brands, non-preferred brands, and Specialty. Some drugs may be excluded due to a strategic evaluation of the market, utilization, quality outcomes and total cost of care.
<b>Key</b>	<b>SP:</b> Specialty Pharmacy <b>PA:</b> Prior Authorization <b>ST:</b> Step Therapy <b>QL:</b> Quantity Limits

## FDA approves orphan drug Vykat XR for Prader-Willi syndrome

On Mar. 26, 2025, the FDA approved Vykat XR (diazoxide choline) tablets for the treatment of hyperphagia in adults and pediatric patients 4 years of age and older with Prader-Willi syndrome (PWS).

PWS is a rare genetic neurodevelopmental disorder that is estimated to affect 1 in every 15,000 live births. Hyperphagia, or excessive eating from excess hunger or increased appetite, is a defining symptom of PWS. Individuals with hyperphagia experience intense sensations of hunger and extreme drive to consume food, leading to a diminished quality of life, increased mortality, and longer-term comorbidities.

The Optum Rx National Pharmacy & Therapeutics Committee is thoroughly assessing Vykat XR for clinical value and safety. Afterwards, Optum Rx will determine its place on Optum Rx standard formularies.

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## Down-tiers

Medications may move to a lower tier throughout the year, helping members take immediate advantage of cost savings. Utilization management strategies such as Step Therapy, Quantity Limits or Prior Authorization may apply.

Therapeutic use	Medication name	Brand/Generic	Premium Tier	Effective date
Dermatological Agents	Nemluvio (nemolizumab-ilto) auto-injector for SC injection	Brand	EXC → Tier 4	5/1/25

EXC: Excluded

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## Up-tiers

Medications typically move to a higher tier on Jan. 1 and July 1 to help reduce member disruption. Brand medications may move to a higher tier at any time when a generic equivalent becomes available. Utilization management strategies such as Step Therapy, Quantity Limits or Prior Authorization may apply.

*Please note there are no up-tiers at this time.*

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## New brand launches

New brand name medications launch throughout the year. A change in coverage status may be determined after medications are thoroughly reviewed by the Optum Rx National Pharmacy & Therapeutics Committee and Optum Rx Business Committee. New brand launches may include Authorized Brand Alternatives.

Therapeutic use	Medication name	Premium Tier	Programs				Effective date
			SP	PA	ST	QL	
Analgesic Agents	Combogesic (ibuprofen-acetaminophen) tablet*	EXC	—	—	—	—	4/3/25
Antidepressant Agents	Raldesy (trazodone) oral solution*	EXC	—	—	—	—	3/6/25

Therapeutic use	Medication name	Premium Tier	Programs				Effective date
			SP	PA	ST	QL	
Antineoplastic Agents	Abirtega (abiraterone) tablet*	EXC	X	X	—	—	3/11/25
	Revuforj (revumenib) 25mg tablet*	EXC	X	X	—	—	3/18/25
	Romvimza (vimseltinib) capsule*	EXC	X	—	—	—	3/3/25
	Xpovio (selinexor) 10mg [40mg once weekly] therapy pack	Tier 4	X	X	—	—	3/13/25
Cardiovascular Agents	Inzirqo (hydrochlorothiazide) oral suspension*	EXC	—	—	—	—	3/11/25
Dermatological Agents	Clobetasol (ABA of Impoyz) 0.025% cream*	EXC	—	X	---	---	3/5/25
Electrolytic and Renal Agents	Ferric citrate (ABA of Auryxia) tablet*	EXC	—	—	—	—	3/20/25
Gastrointestinal Agents	Ctexli (chenodiol) tablet*	EXC	X	X	—	—	3/14/25
	Tremfya (guselkumab) induction pack for Crohn's disease - 200mg/2mL auto injector for SC injection	Tier 4	X	X	—	X	3/26/25
Hematological Agents	Alhemo (concizumab-mtci) 300mg/3mL pen injector for SC injection*	EXC	X	—	—	—	3/6/25
Hematological Agents	Bkemv (eculizumab-aeab) IV infusion	OA	X	X	—	—	3/3/25
	Epysqli (eculizumab-aagh) IV infusion*	OA	X	X	—	—	3/12/25
	Qfitlia (fitusiran) vial and auto-injector for SC injection*	EXC	X	—	—	—	4/2/25
	Sevenfact (coagulation factor VIIA [recom] -jncw) 2mg IV injection	EXC	X	—	—	—	4/1/25
Hormonal Agents	Cortrophin (corticotropin) prefilled syringe for SC injection	Tier 2	X	X	—	—	4/1/25
Immunological Agents	Adalimumab-adaz 10mg/0.1mL prefilled syringe for SC injection	EXC	X	X	—	X	3/31/25
	Otulfi (ustekinumab-aauz) IV infusion and prefilled syringe for SC injection*	EXC	X	X	—	X^	2/28/25

Therapeutic use	Medication name	Premium Tier	Programs				Effective date
			SP	PA	ST	QL	
Immunological Agents	Ryoncil (remestemcel-l-rknd) IV infusion*	OA	X	—	—	—	3/13/25
	Selarsdi (ustekinumab-aekn) IV infusion*	OA	X	X	—	—	3/21/25
	Simlandi (adalimumab-ryvk) 80mg/0.8mL auto injector single pen kit	EXC	X	X	—	X	4/8/25
Metabolic Agents	Vykat XR (diazoxide choline)* ER tablet	EXC	X	—	—	—	3/31/25
Ophthalmic Agents	Encelto (revakinagene taroretcel-lwey) intravireal implant*	OA	X	—	—	—	3/26/25

\* Medications or products added to the New Drugs to Market exclusion list can remain excluded for up to six months. Updates for these products will be listed in the **New benefit coverage for medications no longer on the New Drugs to Market exclusion list** section.

^ QL applies to subcutaneous route only.

EXC: Excluded

## New generic launches

New generic medication launches occur throughout the year. Generic medications will typically be placed in Tier 1. Brand medications may move to a higher tier at any time when a generic equivalent becomes available.

Therapeutic use	Generic medication name	Brand medication name	Premium Tier	Programs				Effective date
				SP	PA	ST	QL	
Antineoplastic Agents	mercaptopurine oral suspension	Purixan	Tier 1	X	—	—	—	3/3/25
Antiparasitic Agents	ivermectin 6mg tablet	N/A	Tier 1	—	—	—	—	3/18/25

EXC: Excluded

## New benefit coverage for medications no longer on the **New Drugs to Market** exclusion list

New Drugs to Market updates apply to all plans that have this exclusion list in place. New drugs can be maintained on this list for up to six months after which a medication may be added from the list and have new benefit coverage as shown below, or remain excluded.

Therapeutic use	Medication name	Brand/ Generic	Premium Tier	Programs				Effective date
				SP	PA	ST	QL	

<b>Antineoplastic Agents</b>	Itovebi (inavolisib) tablet	Brand	Tier 3	X	X	--	X*	5/1/25
<b>Antiparkinson Agents</b>	Vyalev (foslevodopa-foscabidopa) auto-injector for SC injection	Brand	Tier 4	X	X	--	--	4/19/25
<b>Antipsychotic Agents</b>	Erzofri (paliperidone palmitate) ER prefilled syringe for SC injection	Brand	Tier 3	--	--	--	--	5/5/25
<b>Devices</b>	Vyafuser Pump	Brand	Tier 3	--	--	--	--	4/19/25
<b>Hematological Agents</b>	Hympavzi (marstacimab-hncq) auto-injector for SC injection	Brand	Tier 4	X	--	--	--	5/7/25
<b>Ophthalmic Agents</b>	Pavblu (aflibercept-ayyh) vial and prefilled syringe for intravitreal injection	Brand	Tier 3	X	X	--	--	4/25/25

\*QL applies to 3mg strength only

EXC: Excluded

## SP Specialty updates

Specialty medication updates include existing medications being added to or removed from the Specialty Pharmacy Program.

*Please note there are no specialty medication updates at this time.*

## PA Prior Authorization

Prior Authorization requires physicians to provide additional clinical information to verify member benefit coverage. This table only shows Prior Authorizations that have been added or removed. Existing utilization management such as Step Therapy and Quantity Limits may still apply.

Therapeutic use	Medication name	Add/Remove	Effective date
<b>Antineoplastic Agents</b>	Datroway (datopotamab deruxtecan-dlnk) IV injection	Add	4/1/25
	Gomekli (mirdametinib) capsule	Add	4/1/25
<b>Antiviral Agents</b>	Cabenuva (cabotegravir) ER IM injection	Remove	4/1/25
<b>Cystic Fibrosis Agents</b>	Alyftrek (vanzacaftor-tezacaftor-deutivacaftor) tablet	Add	4/1/25
<b>Immunological Agents</b>	Niktimvo (axatilimab-csfr) IV injection	Add	4/1/25

## Step Therapy

**ST**

Step Therapy directs members to try a lower-cost alternative (Step 1) before a higher-cost medication (Step 2) may be eligible for coverage. This table only shows Step Therapy that has been added or removed. Existing utilization management such as Prior Authorizations and Quantity Limits may still apply.

Therapeutic use	Medication name	Add/Remove	Effective date
<b>Antidiabetic Agents</b>	Janumet (sitagliptin-metformin) tablet	Remove	5/1/25
	Janumet XR (sitagliptin-metformin) ER tablet	Remove	5/1/25
	Januvia (sitagliptin) tablet	Remove	5/1/25
	Jentadueto (linagliptin-metformin) tablet	Remove	5/1/25
	Jentadueto XR (linagliptin-metformin) ER tablet	Remove	5/1/25
	saxagliptin tablet	Remove	5/1/25
	saxagliptin/metformin ER tablet	Remove	5/1/25
	Tradjenta (linagliptin) tablet	Remove	5/1/25
<b>Antineoplastic Agents</b>	Khapzory (levoleucovorin) IV injection	Remove	4/1/25
<b>Antipsychotic Agents</b>	Erzofri (paliperidone palmitate) ER prefilled syringe for SC injection	Remove	5/1/25
<b>Hematological Agents</b>	Sevenfact (coagulation factor VIIA [recom] -jncw) 2mg IV injection	Remove	4/1/25
<b>Respiratory Agents</b>	zileuton ER tablet	Remove	4/1/25
	Zyflo (zileuton) tablet	Remove	4/1/25

**QL**

**Quantity Limits**

Quantity limits establish the maximum quantity of a drug that is covered within a specified timeframe. This table only shows Quantity Limits that have been added or removed. Existing utilization management such as Prior Authorizations and Step Therapy may still apply.

Therapeutic use	Medication name	Add/Remove	Effective date
Cystic Fibrosis Agents	Alyftrek (vanzacaftor-tezacaftor-deutivacaftor) tablet	Add	4/1/25



**If you would like additional information that is not listed, please contact your Optum Rx representative.**



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