This list of services applies to GHP Family (Medicaid) line of business unless otherwise noted. All drugs newly approved by the FDA should be considered to require prior authorization until such time as they are reviewed by the GHP Pharmacy & Therapeutics Committee. Final determination to require prior authorization for specific drugs will be added to this list as they are made. The following codes are included below for informational purposes and may not be all inclusive. Inclusion of a procedure or device code(s) does not constitute or imply coverage nor does it imply or guarantee provider reimbursement. Coverage is determined by the member specific benefit plan document and any applicable laws regarding coverage of specific services. Drugs indicated as "Statewide Preferred Drug List (PDL) Managed" are part of the Pennsylvania Department of Human Services Statewide Preferred Drug List (PDL). Policies and Prior Authorization requirements for those medications are goverened by the Pennsylvania Department of Human Services and Implemented by GHP. Current Procedural Terminology (CPT©) © American Medical Association: Chicago IL.

Procedure/Service	Effective Date for providers	Comments	Most recent Communication to Providers	Associated Medical Policy #
Abecma® (idecabtagene vicleucel)	**8/15/2021**		**Monthly Provider Update July 2021**	**MBP 235.0**
Q2055				
Abilify Asimtufii®	**9/15/2023**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS-INJECTABLE**
J0402, **Prior authorization is required for any member under 18 years of age**				
Abilify Maintena®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J0401, **Prior authorization is required for any member under 18 years of age**				
Abraxane® (paclitaxel protein bound particles)	**4/1/2006**		**Briefly March 2006**	**MBP 36.0**
J9258, J9264				
Abrysvo™ (respiratory syncytial virus vaccine)	**1/1/2023**	**Abrysvo™ will not require prior auth for patients greater than or equal to 60 years of age. Abrysvo™ will require prior auth for members less than 60 years of age when the applicable diagnosis code is not listed below.**	**Monthly Provider Update December 2022**	**MBP 296.0**
90678, **Prior auth is not required for members less than 60 years of age with any of the following diagnosis codes;** O09, O09.0, O09.00, O09.03, O09.1, O09.10, O09.13, O09.A, O09.A0, O09.A3, O09.2, O09.21, O09.213, O09.219, O09.29, O09.293, O09.299, O09.3, O09.30, O09.33, O09.4, O09.40, O09.43, O09.5. O09.51, O09.513, O09.519, O09.52, O09.523, O09.529, O09.6, O09.61, O09.613, O09.619, O09.62, O09.623, O09.629, O09.7, O09.70, O09.73, O09.8, O09.81, O09.813, O09.819, O09.82, O09.823, O09.829, O09.89, O09.893, O09.899, O09.9, O09.90, O09.93, O30, O30.0, O30.00, O30.003, O30.009, O30.01, O30.013, O30.019, O30.02, O30.023, O30.029, O30.03, O30.033, O30.039, O30.04, O30.043, O30.049, O30.09, O30.093, O30.099, 030.1, O30.10, O30.103, O30.109, O30.11, O30.113, O30.119, O30.12, O30.123, O30.129, O30.13, O30.133, O30.139, O30.19, O30.193, O30.199, O30.2, O30.20, O30.209. O30.21, O30.213, O30.219, O30.22, O30.223, O30.229, O30.8, O30.80, O30.803, O30.809, O30.81, O30.813, O30.819, O30.82, O30.823, O30.829, O30.83, O30.833, O30.839, O30.89, O30.893, O30.899, O30.9, O30.90, O30.93, Z33, Z33.1, Z33.3, Z34, Z34.0, Z34.00, Z34.03, Z34.8, Z34.80, Z34.83, Z34.9, Z34.90, Z34.93, Z3A, Z3A.0, Z3A.00, Z3A.3, Z3A.32, Z3A.33, Z3A.34, Z3A.35, Z3A.36				

Actemra®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**CYTOKINE AND CAM ANTAGONISTS**
J3262				
Adakveo®	**7/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**SICKLE CELL ANEMIA AGENTS**
J0791				
Adcetris® (brentuximab vedotin)	**4/15/2018**		**Monthly Provider Update March 2018**	**MBP 166.0**
J9042				
Adstiladrin® (nadofaragene Firadenov-vncg)	**3/15/2024**		**Monthly Provider Update February 2024**	**MBP 303.0**
J9029				
Advate®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7192				
Adynovate®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7207				
Afstyla®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7210				
Akynzeo®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIEMETICS-ANTIVERTIGO AGENTS**
J1454				
Aldurazyme® (laronidase)	**1/1/2006**		**Briefly March 2006**	**MBP 7.0**
J1931				
Aliqopa® (copanlisib)	**3/15/2018**		**Monthly Provider Update February 2018**	**MBP 161.0**
J9057				

Alpha 1-Antitrypsin Inhibitor Therapy (Aralast®, Glassia®, Prolastin-C®, Zemaira®)	**4/1/2007**		**Briefly March 2007**	**MBP 43.0**
J0256, J0257				
Alphanate®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7186				
AlphaNine® SD	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7193				
Alprolix®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7201				
Ameluz (aminolevulinic acid)	**4/15/2017**		**Postcard March 2017**	**MBP 149.0**
J7345				
Amondys 45® (casimersen)	**10/1/2021**		**Monthly Provider Update September 2021**	**MBP 241.0**
J1426				
Amvuttra™ (vutrisiran)	**1/1/2023**		**Monthly Provider Update December 2022**	**MBP 268.0**
J0225				
Andexxa® (andexanet alfa)	**12/15/2018**		**Monthly Provider Update Nov 2018**	**MBP 183.0**
J7169				
Anjeso™ (meloxicam injection)	**8/15/2022**		**Monthly Provider Update July 2022**	**MBP 261.0**
Currently this drug is reported with an unlisted procedure code.				
Aponvie™ (aprepitant)	**11/15/2023**		**Monthly Provider Update October 2023**	**ANTIEMETICS-ANTIVERTIGO AGENTS**
C9145				

Aralast® (alpha 1-proteinase inhibitor (human)	**4/1/2007**		**Briefly March 2007**	**MBP 43.0**
J0256				
Aranesp®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ERYTHROPOIESIS STIMULATING AGENTS**
J0881, J0882				
Aristada®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J1944, **Prior authorization is required for any member under 18 years of age**				
Aristada Initio®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J1943, **Prior authorization is required for any member under 18 years of age**				
Arranon® (nelarabine)	**4/1/2009**		**Postcard June 2017-Annual Policy Review**	**MBP 64.0**
J9261				
Arzerra® (ofatumumab)	**7/1/2010**		**Briefly June 2010**	**MBP 73.0**
J9302				
Asceniv™ (immune globulin)	**1/1/2021**		**Monthly Provider Update December 2020**	**MBP 4.0**
J1554				
Ativan®	**1/5/2021**		**Statewide Preferred Drug List (PDL) Managed**	**ANXIOLYTICS**
J2060, **Prior authorization is only required for the following NDC numbers;** 00641600001, 00641600010, 00641600101, 00641600125, 54868240701, 60977011201, 60977011202, 60977011271, 60977011281, 60977011601, 60977011602, 00641600201, 00641600210, 00641600301, 00641600325, 60977011301, 60977011302, 60977011371, 60977011381				
Aveed®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANDROGENIC AGENTS**
J3145				
Avsola®	**7/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**CYTOKINE AND CAM ANTAGONISTS**
Q5121				

Avycaz® (cetfazidime/avibactam)	**1/1/2016**		**Postcard August 2017-Annual Policy Review**	**MBP 132.0**
J0714				
Azedra® (iobenguane I 131)	**3/15/2019**		**Monthly Provider Update February 2019**	**MBP 184.0**
A9590				
Bavencio® (avelumab)	**8/15/2017**		**Postcard July 2017**	**MBP 152.0**
J9023				
Baxdela® IV (delafloxacin)	**6/15/2018**		**Monthly Provider Update May 2018**	**MBP 169.0**
C9462				
Beleodaq® (belinostat)	**12/1/2014**		**Postcard June 2017-Annual Policy Review**	**MBP 117.0**
J9032				
Benefix®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7195				
Beovu®	**4/15/2020**		**Statewide Preferred Drug List (PDL) Managed**	**MACULAR DEGENERATION AGENTS**
J0179				
Benlysta® (belimumab)	**10/1/2011**		**Postcard June 2017-Annual Policy Review**	**MBP 90.0**
J0490				
Berinert®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**HEREDITARY ANGIOEDEMA (HAE) AGENTS**
J0597				
Besponsa® (inotuzumab ozogamicin)	**1/1/2018**		**Monthly Provider Update February 2018**	**MBP 160.0**
J9229				

Bevacizumab (Avastin®)	**4/15/2024**	**Intraocular Avastin® for the treatment of exudative macular degeneration, retinal vein occlusion, choroidal neovascularization and macular edema does NOT require prior authorization**	**Monthly Provider Update March 2024**	**MBP 309.0**
C9257, J9035				
Bivigam® (immune globulin)	**1/1/2014**		**Postcard December 2013**	**MBP 4.0**
J1556				
Blincyto® (blinatumomab)	**7/1/2015**		**Postcard June 2015**	**MBP 128.0**
J9039				
Blood Clotting Factors Given in a Nonemergency Outpatient Facility Setting (Advate®, Adynovate®, Afstyla®, Alphanate®, Alphanine SD®, Alprolix®, Benefix®, Eloctate®, Esperoct®, Feiba NF®, Hemlibra®, Hemofil M®, Humate-P®, Idelvion®, Ixinity®, Jivi®, Kcentra®, Koate®, Kogenate FS®, Kovaltry®, Monoclate-P®, Mononine®, Novoeight®, Novoseven RT®, Nuwiq®, Obizur®, Profilnine®, Rebinyn®, Recombinate®, Rixubis®, Sevenfact®, Wilate®, Vonvendi®, Xyntha® / Xyntha Solofuse®)	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7192, J7207, J7210, J7186, J7193, J7201, J7195, J7205, J7204, J7198, J7170, J7190, J7187, J7202, J7213, J7208, J7168, J7211, J7182, J7189, J7209, J7188, J7194, J7203, J7200, J7212, J7183, J7179, J7185				
Boniva®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**BONE DENSITY REGULATORS**
J1740				
Botox®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**BOTULINUM TOXINS**
J0585				
Botulinum Toxin and Derivatives (Botox®, Dysport®, Myobloc®, Xeomin®)	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**BOTULINUM TOXINS**
J0585, J0586, J0587, J0588				

Breyanzi® (lisocabtagene maraleucel)	**6/15/2021**		**Monthly Provider Update May 2021**	**MBP 228.0**
Q2054				
Brineura® (cerliponase alfa)	**1/1/2018**		**Postcard November 2017**	**MBP 157.0**
J0567				
Briumvi®	**9/15/2023**		**Statewide Preferred Drug List (PDL) Managed**	**MULTIPLE SCLEROSIS AGENTS**
J2329				
Byooviz™	**4/1/2022**		**Statewide Preferred Drug List (PDL) Managed**	**MACULAR DEGENERATION AGENTS**
Q5124				
camcevi®	**1/1/2022**		**Statewide Preferred Drug List (PDL) Managed**	**PITUITARY SUPPRESSIVE AGENTS, LHRH**
J1952				
Carimune NF® (immune globulin)	**1/1/2006**		**Postcard June 2017-Annual Policy Review**	**MBP 4.0**
J1566				
Carvykti™ (ciltacabtagene autoleucel)	**7/1/2022**		**Monthly Provider Update June 2022**	**MBP 256.0**
Q2056				
Cerezyme®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ENZYME REPLACEMENTS, GAUCHER DISEASE**
J1786				
Cimerli™	**4/1/2023**		**Statewide Preferred Drug List (PDL) Managed**	**Not Applicable**
Q5128				
Cimzia®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**CYTOKINE AND CAM ANTAGONISTS**
J0717				

Cinqair®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**MONOCLONAL ANTIBODIES (MABs) – ANTI-IL, ANTI-IGE, ANTI-TLSP**
J2786				
Cinryze®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**HEREDITARY ANGIOEDEMA (HAE) AGENTS**
J0598				
Cinvanti®	**1/8/2024**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIEMETICS-ANTIVERTIGO AGENTS**
J0185				
Clolar® (clofarabine)	**4/1/2006**		**Briefly March 2006**	**MBP 38.0**
J9027				
Columvi (glofitamab-gxbm)	**12/15/2023**		**Monthly Provider Update November 2023**	**MBP 298.0**
J9286				
Cosela™ (trilaciclib)	**7/1/2021**		**Monthly Provider Update June 2021**	**MBP 232.0**
J1448				
Cosentyx®	**4/1/2024**		**Statewide Preferred Drug List (PDL) Managed**	**CYTOKINE AND CAM ANTAGONISTS**
C9166				
Cresemba® IV (isavuconazonium sulfate)	**1/1/2016**		**Postcard October 2015**	**MBP 134.0**
J1833				
Crysvita® (burosumab-twza)	**12/15/2018**		**Monthly Provider Update Nov 2018**	**MBP 182.0**
J0584				
Cutaquig® (immune globulin)	**3/15/2020**		**Monthly Provider Update February 2020**	**MBP 4.0**
J1551				

Cuvitru® (immune globulin)	**1/1/2006**		**Postcard June 2017-Annual Policy Review**	**MBP 4.0**
J1555				
Cyramza® (ramucirumab)	**12/1/2014**		**Postcard July 2017-Annual Policy Review**	**MBP 115.0**
J9308				
Dalvance® (dalbavancin)	**3/1/2015**		**Postcard February 2015**	**MBP 121.0**
J0875				
Danyelza® (naxitamab-gqgk)	**6/15/2021**		**Monthly Provider Update May 2021**	**MBP 227.0**
J9348				
Darzalex® (daratumumab)	**7/1/2016**		**Postcard March 2016**	**MBP 139.0**
J9145				
Darzalex Faspro® (daratumumab-hyaluronidase)	**6/15/2021**		**Monthly Provider Update 2021**	**MBP 230.0**
J9144				
Depo-Provera®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**CONTRACEPTIVES, OTHER**
J1050, **Prior authorization is only required for the following NDC numbers;** 00009737611, 50090066500, 54569490400, 54868410000, 54868410001				
Depo-Testosterone®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANDROGENIC AGENTS**
J1071				
Dextenza®	**6/15/2022**		**Statewide Preferred Drug List (PDL) Managed**	**OPHTHALMICS, ANTI-INFLAMMATORIES**
J1096				
Dexycu®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**OPHTHALMICS, ANTI-INFLAMMATORIES**
J1095				

D.H.E 45®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**MIGRAINE ACUTE TREATMENT AGENTS**
J1110				
Diazepam	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANXIOLYTICS**
J3360, **Syringe: Prior authorization is only required for the following NDC numbers;** 69339013632, 69339013602, 69374096502, 11704060001. **Vial: Prior authorization is required for any member under 21 years of age for any of the following NDC numbers;** 00409321312, 00409321310, 00409321309				
Dihydroergotamine Mesylate Ampule	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**MIGRAINE ACUTE TREATMENT AGENTS**
J1110				
dimenhydrinate	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIEMETICS-ANTIVERTIGO AGENTS**
J1240				
Duopa®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPARKINSON'S AGENTS**
J7340				
Durolane®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**INTRA-ARTICULAR HYALURONATES**
J7318				
Durysta™	**11/15/2021**		**Statewide Preferred Drug List (PDL) Managed**	**OPHTHALMICS, GLAUCOMA**
J7351				
Dysport®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**BOTULINUM TOXINS**
J0586				
Elahere™ (mirvetuximab soravtansine-gynx)	**7/1/2023**		**Monthly Provider Update June 2023**	**MBP 277.0**
J9063				
Elaprase® (idursulfase)	**7/1/2007**		**Briefly June 2007**	**MBP 44.0**
J1743				

Elelyso®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ENZYME REPLACEMENTS, GAUCHER DISEASE**
J3060				
Elevidys (delandistrogene moxeparvovec-rokl)	**1/1/2024**		**Monthly Provider Update December 2023**	**MBP 307.0**
J1413				
Elfabrio® (pegunigalsidase alfa-iwxj)	**10/15/2023**		**Monthly Provider Update September 2023**	**MBP 289.0**
J2508				
Eligard®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**PITUITARY SUPPRESSIVE AGENTS, LHRH**
J9217				
Elitek® (rasburicase)	**3/1/2005**		**Briefly March 2006**	**MBP 29.0**
J2783				
Eloctate®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7205				
Elrexfio™ (elranatamab-bcmm)	**1/1/2024**		**Monthly Provider Update December 2023**	**MBP 301.0**
J1323				
Elzonris® (Tagraxofusp-erzs)	**8/15/2019**		**Provider Monthly Update July 2019**	**MBP 197.0**
J9269				
Empaveli™ (pegcetacoplan)	**1/15/2022**		**Monthly Provider Update December 2021**	**MBP 245.0**
Currently this drug is reported with an unlisted procedure code.				
Empliciti® (elotuzumab)	**4/15/2016**		**Postcard March 2016**	**MBP 140.0**
J9176				

Enhertu® (fam-trastuzumab deruxtecan-nxki)	**6/15/2020**		**Monthly Provider Update May 2020**	**MBP 208.0**
J9358				
Enjaymo® (sutimlimab-jome)	**10/15/2022**		**Monthly Provider Update September 2022**	**MBP 264.0**
J1302				
Entyvio®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**CYTOKINE AND CAM ANTAGONISTS**
J3380				
Epkinly™ (epcoritamab-bysp)	**10/1/2023**		**Monthly Provider Update September 2023**	**MBP 290.0**
J9321				
Epogen®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ERYTHROPOIESIS STIMULATING AGENTS**
J0885, Q4081				
Eraxis® (anidulafungin)	**1/1/2008**		**Briefly December 2007**	**MBP 53.0**
J0348				
Erwinaze® (asparaginase)	**7/1/2013**		**Postcard June 2017-Annual Policy Review**	**MBP 95.0**
J9019				
Erythropoietin and Darbepoetin Therapy (Aranesp®, Epogen®, Mircera®, Procrit®, Retacrit®)	**6/15/2007**	**darbepoetin alfa, epoetin alfa, epoetin alfa-epbx, epoetin beta**	**Statewide Preferred Drug List (PDL) Managed**	**ERYTHROPOIESIS STIMULATING AGENTS**
J0881, J0882, J0885, Q4081, J0887, J0888, Q5105, Q5106				
Esperoct®	**7/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7204				
Euflexxa®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**INTRA-ARTICULAR HYALURONATES**
J7323				

Evenity®	**10/1/2019**		**Statewide Preferred Drug List (PDL) Managed**	**BONE DENSITY REGULATORS**
J3111				
Evkeeza™	**10/1/2021**		**Statewide Preferred Drug List (PDL) Managed**	**LIPOTROPICS, OTHER**
J1305				
Exondys 51® (eteplirsen)	**4/1/2017**		**Postcard June 2017**	**MBP 148.0**
J1428				
Eylea®, Eylea® HD (aflibercept hd)	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**MACULAR DEGENERATION AGENTS**
J0177, J0178				
Fabrazyme® (agalsidase beta)	**1/1/2006**		**Briefly March 2006**	**MBP 18.0**
J0180				
Fasenra® Prefilled Syringes	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**MONOCLONAL ANTIBODIES (MABs) – ANTI-IL, ANTI-IGE, ANTI-TLSP**
J0517				
Feiba NF®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7198				
Fensolvi®	**1/5/2021**		**Statewide Preferred Drug List (PDL) Managed**	**PITUITARY SUPPRESSIVE AGENTS, LHRH**
J1951				
Feraheme	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**IRON, PARENTERAL**
Q0138, Q0139				
Fetroja® (cefiderocol)	**1/1/2021**		**Monthly Provider Update December 2021**	**MBP 219.0**
J0699				

Flebogamma® / Flebogamma DIF® (immune globulin)	**1/1/2006**		**Postcard June 2017-Annual Policy Review**	**MBP 4.0**
J1572				
Flolan® or Veletri® (epoprostenol)	**1/1/2009**		**Postcard July 2017-Annual Policy Review**	**MBP 61.0**
J1325				
Fluphenazine Decanoate	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J2680, **Prior authorization is required for any member under 18 years of age**				
Fulphila®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**COLONY STIMULATING FACTORS**
Q5108				
Fyarro™ (sirolimus protein-bound particles for injectable suspension) (albumin-bound)	**8/15/2022**		**Monthly Provider Update July 2022**	**MBP 262.0**
J9331				
Fylnetra®	**4/1/2023**		**Statewide Preferred Drug List (PDL) Managed**	**COLONY STIMULATING FACTORS**
Q5130				
Gamifant® (emapalumab-lzsg)	**8/15/2019**		**Monthly Provider Update July 2019**	**MBP 198.0**
J9210				
Gammagard Liquid® (immune globulin)	**1/1/2008**		**Postcard December 2007**	**MBP 4.0**
J1569				
Gammagard S/D® (immune globulin)	**1/1/2006**		**Postcard June 2017-Annual Policy Review**	**MBP 4.0**
J1566				
Gammaplex® (immune globulin)	**1/1/2012**		**Postcard December 2011**	**MBP 4.0**
J1557				

Gammaked® / Gamunex / Gamunex-C® (immune globulin)	**1/1/2006**		**Postcard June 2017-Annual Policy Review**	**MBP 4.0**
J1561				
Gazyva® (obinutuzumab)	**8/1/2014**		**Postcard July 2017-Annual Policy review**	**MBP 113.0**
J9301				
Gel-One®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**INTRA-ARTICULAR HYALURONATES**
J7326				
Gelsyn-3®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**INTRA-ARTICULAR HYALURONATES**
J7328				
GenVisc 850®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**INTRA-ARTICULAR HYALURONATES**
J7320				
Geodon®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J3486				
Givlaari® (givosiran)	**7/1/2020**		**Monthly Provider Update June 2020**	**MBP 211.0**
J0223				
Glassia® (alpha 1 proteinase inhibitor (human)	**1/1/2012**		**Briefly March 2007**	**MBP 43.0**
J0257				
Granix®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**COLONY STIMULATING FACTORS**
J1447				
Halaven® (eribulin mesylate)	**7/1/2011**		**Posted May 2016-Annual Policy Review**	**MBP 88.0**
J9179				

Haldol®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J1630, **Prior authorization is required for any member under 18 years of age**				
Haldol Decanoate	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J1631, **Prior authorization is only required for the following NDC numbers;** 50458025414, 50458025303				
Haloperidol Decanoate	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J1631, **Prior authorization is required for any member under 18 years of age for any of the following NDC numbers;** 70069003105, 10147092205, 70069003101, 70069003001, 10147092103, 70069003003, 25021083301, 00703702301, 00703702103, 67457040913, 67457038158, 67457040900, 00703702101, 67457038100, 63323047141, 63323047105, 63323047101, 00703701103, 00703701101, 63323046901, 63323046905, 67457041013, 25021083101,00703701301, 67457041000				
Haloperidol Lactate	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J1630, **Prior authorization is required for any member under 18 years of age**				
Helixate FS®	**1/1/2020**		**Statewide PDL Managed**	**Not Applicable**
J7192				
Hemgenix® (etranacogene dezaparvovec-drlb)	**10/15/2023**		**Monthly Provider Update September 2023**	**MBP 286.0**
J1411				
Hemlibra®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7170				
Hemofil M®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7190				
Hizentra® (immune globulin)	**1/1/2011**		**Postcard June 2017-Annual Policy Review**	**MBP 4.0**
J1559				
Humate P®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7187				

Hyalgan®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**INTRA-ARTICULAR HYALURONATES**
J7321				
Hydroxyprogesterone Caproate	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**PROGESTATIONAL AGENTS**
J1726, J1729				
Hymovis®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**INTRA-ARTICULAR HYALURONATES**
J7322				
Hyqvia® (immune globulin/hyaluronidase)	**1/1/2016**		**Postcard June 2017-Annual Policy Review**	**MBP 4.0**
J1575				
Ibandronate sodium	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**BONE DENSITY REGULATORS**
J1740				
Idelvion®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7202				
Igalmi™	**9/15/2022**		**Statewide Preferred Drug List (PDL) Managed**	**SEDATIVE HYPNOTICS**
J1105				
Ilaris®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**CYTOKINE AND CAM ANTAGONISTS**
J0638				
Ilumya®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**CYTOKINE AND CAM ANTAGONISTS**
J3245				
Iluvien®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**OPHTHALMICS, ANTI-INFLAMMATORIES**
J7313				

Imfinzi® (durvalumab)	**10/1/2017**		**Postcard September 2017**	**MBP 156.0**
J9173				
Imjudo® (tremelimumab-actl)	**3/15/2023**		**Monthly Provider Update February 2023**	**MBP 270.0**
J9347				
Imlygic® (talimogene laherparepvec)	**4/15/2016**		**Postcard March 2016**	**MBP 136.0**
J9325				
Inflectra®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**CYTOKINE AND CAM ANTAGONISTS**
Q5103				
Injectafer®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**IRON, PARENTERAL**
J1439				
Injectable Antipsychotic Medications (Abilify Asimtufii®, Abilify Maintena®, Aristada®, Aristada Initio®, Invega Hafyera™, Invega Sustenna®, Invega Trinza®, Perseris®, Risperdal Consta®, Uzedy™, Zyprexa Relprevv®)	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J0402, J0401, J1944, J1943, J2427, J2426, J2798, J2794, J2799, J2358				
Intravenous Immune Globulin (IVIG) (Asceniv™, Bivigam®, Carimune NF®, Cutaquig®, Cuvitru®, Flebogamma®, Flebogamma DIF®, Gammagard Liquid®, Gammagard S/D®, Gammaked®, Gammaplex®, Gamunex, Gamunex-C®, Hizentra®, Hyqvia®, Octagam®, Panzyga®, Privigen®, Xembify®)	**1/1/2006**		**Postcard June 2017-Annual Policy Review**	**MBP 4.0**
J1554, J1556, J1566, J1551, J1555, J1572, J1569, J1561, J1557, J1559, J1575, J1568, J1576, J1459, J1558				
Invega Hafyera™	**3/15/2022**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J2427**, Prior authorization is required for any member under 18 years of age**				

Invega Sustenna®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J2426, **Prior authorization is required for any member under 18 years of age**				
Invega Trinza®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J2427, **Prior authorization is required for any member under 18 years of age**				
Istodax® (romidepsin)	**10/1/2010**		**Briefly September 2010**	**MBP 78.0**
J9318, J9319				
Ixempra® (ixabepilone)	**10/1/2008**		**Postcard June 2017-Annual Policy Review**	**MBP 63.0**
J9207				
Ixinity®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7213				
Izervay™	**4/1/2024**		**Statewide Preferred Drug List (PDL) Managed**	**Not Applicable**
J2782				
Jelmyto® (mitomycin ureteral gel)	**2/15/2023**		**Monthly Provider Update January 2023**	**MBP 266.0**
J9281				
Jemperli® (dostarlimab-gxly)	**10/15/2021**		**Monthly Provider Update September 2021**	**MBP 236.0**
J9272				
Jevtana® (cabazitaxel)	**1/1/2011**		**Briefly December 2010**	**MBP 82.0**
J9043				
Jivi®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7208				

Kadcyla® (ado-trastuzumab emtansine	**9/1/2013**		**Postcard June 2017-Annual Policy Review**	**MBP 108.0**
J9354				
Kalbitor®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**HEREDITARY ANGIOEDEMA (HAE) AGENTS**
J1290				
Kanuma® (sebelipase alfa)	**1/1/2017**		**Monthly Provider Update December 2016**	**MBP 180.0**
J2840				
Kcentra®	**7/1/2021**		**Statewide Preferred Drug List (PDL) Managed**	**Not Applicable**
J7168				
Keytruda® (pembrolizumab)	**3/1/2015**		**Postcard July 2017-Annual Policy Review**	**MBP 119.0**
J9271				
Khapzory® (Levoleucovorin)	**4/15/2020**		**Monthly Provider Update March 2020**	**MBP 206.0**
J0642				
Kimmtrak® (tebentafusp-tebn)	**5/15/2022**		**Monthly Provider Update April 2022**	**MBP 250.0**
J9274				
Kimyrsa™ (oritavancin)	**3/15/2022**		**Monthly Provider Update February 2022**	**MBP 247.0**
J2406				
Koate®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7190				
Kogenate FS®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7192				

Korsuva™ (difelikefalin)	**7/15/2023**		**Monthly Provider Update June 2023**	**MBP 279.0**
J0879				
Kovaltry®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7211				
Krystexxa®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHYPERURICEMICS**
J2507				
Kymriah® (tisagenlecleucel)	**1/1/2018**		**Monthly Provider Update February 2018**	**MBP 159.0**
Q2042				
Kyprolis® (carfilzomib)	**1/1/2013**		**Postcard August 2016-Annual Policy Review**	**MBP 97.0**
J9047				
Lamzede® (velmanase alfa-tycv)	**10/15/2023**		**Monthly Provider Update September 2023**	**MBP 291.0**
J0217				
Lemtrada®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**MULTIPLE SCLEROSIS AGENTS**
J0202				
Leukine®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**COLONY STIMULATING FACTORS**
J2820				
Leuprolide acetate	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**PITUITARY SUPPRESSIVE AGENTS, LHRH**
J9218				
Leuprolide acetate depot	**1/1/2023**		**Statewide Preferred Drug List (PDL) Managed**	**PITUITARY SUPPRESSIVE AGENTS, LHRH**
J1954				

Leqembi™ (lecanemab-irmb)	**7/15/2023**		**Monthly Provider Update June 2023**	**MBP 288.0**
J0174				
Leqvio®	**6/15/2022**		**Statewide Preferred Drug List (PDL) Managed**	**LIPOTROPICS, OTHER**
J1306				
Levothyroxine	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**THYROID HORMONES**
J0650, J0651, J0652				
Libtayo® (cemiplimab-rwlc)	**4/1/2019**		**Monthly Provider Update March 2019**	**MBP 186.0**
J9119				
Liothyronine	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**THYROID HORMONES**
Currently this drug is billed with and unlisted procedure code				
Lorazepam	**1/5/2021**		**Statewide Preferred Drug List (PDL) Managed**	**ANXIOLYTICS**
J2060, **Prior authorization is required for any member under 21 years of age for any of the following NDC numbers;** 00409198505, 00409198510, 00409198530, 00409677802, 00409677805, 00409677811, 00409677815, 00409677862, 00409678002, 00409678011, 00641604401, 00641604425, 00641604601, 00641604610, 00641604801, 00641604825, 00641605001, 00641605010, 00641620701, 00641620725, 10019010201, 10019010237, 10019010210, 10019010239, 10019010501, 10019010502, 10019010544, 10019010571, 17478004001, 54868356600, 54868356601, 54868356602, 55390016810, 55390017010, 72572038001, 72572038025, 76329826100, 76329826101, 00074153901, 00074153921, 00409153931, 00409677902, 00409677911, 00409678102, 00641604501, 00641604525, 00641604701, 00641604710, 00641604901, 00641604925, 00641604925, 00641605101, 00641605110, 10019010301, 10019010310, 10019010337, 10019010339, 10019010601, 10019010602, 10019010644, 10019010671, 55390016910, 55390017110				
Lucentis®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**MACULAR DEGENERATION AGENTS**
J2778				
Lumizyme® (alglucosidase alfa)	**1/1/2011**		**Postcard June 2017-Annual Policy Review**	**MBP 83.0**
J0221				
Lumoxiti® (moxetumomab pasudotox-tdfk)	**4/1/2019**		**Monthly Provider Update March 2019**	**MBP 189.0**
J9313				

Lunsumio™ (mosunetuzumab-axgb)	**7/1/2023**		**Monthly Provider Update June 2023**	**MBP 280.0**
J9350				
Lupron Depot®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**PITUITARY SUPPRESSIVE AGENTS, LHRH**
J1950				
Lupron Depot-Ped®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**PITUITARY SUPPRESSIVE AGENTS, LHRH**
J1950				
Lutathera® (lutetium Lu 177 dotatate)	**6/15/2018**		**Monthly Provider Update May 2018**	**MBP 170.0**
A9513				
Lutrate®	**1/1/2023**		**Statewide Preferred Drug List (PDL) Managed**	**Not Applicable**
J1954				
Luxturna® (voretigene-neparvovec-rzyl)	**8/15/2018**		**Monthly Provider Update July 2018**	**MBP 174.0**
J3398				
Macugen®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**Not Applicable**
J2503				
Margenza™ (margetuximab-cmkb)	**7/1/2021**		**Monthly Provider Update June 2021**	**MBP 231.0**
J9353				
Mepsevii® (vestronidase alfa-vjbk)	**8/15/2018**		**Monthly Provider Update July 2018**	**MBP 175.0**
J3397				
Mircera®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ERYTHROPOIESIS STIMULATING AGENTS**
J0887, J0888				

Monjuvi® (tafasitamab-cxix)	**11/15/2020**		**Monthly Provider Update October 2020**	**MBP 221.0**
J9349				
Monoclate-P®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**Not Applicable**
J7190				
Monoferric®	**10/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**IRON, PARENTERAL**
J1437				
Mononine®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**Not Applicable**
J7193				
Monovisc®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**INTRA-ARTICULAR HYALURONATES**
J7327				
Mylotarg® (gemtuzumab ozogamicin)	**4/15/2018**		**Monthly Provider Update March 2018**	**MBP 163.0**
J9203				
Myobloc®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**BOTULINUM TOXINS**
J0587				
Naglazyme® (galsulfase)	**10/1/2006**		**Briefly September 2006**	**MBP 39.0**
J1458				
Neulasta® / Neulasta Onpro®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**COLONY STIMULATING FACTORS**
J2506				
Neupogen®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**COLONY STIMULATING FACTORS**
J1442				

Nexviazyme® (avalglucosidase alfa-ngpt)	**4/15/2022**		**Monthly Provider Update March 2022**	**MBP 248.0**
J0219				
Nivestym®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**COLONY STIMULATING FACTORS**
Q5110				
NovoEight®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7182				
NovoSeven RT®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7189				
Nplate®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**THROMBOPOIETICS**
J2796				
Nucala® vial	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**MONOCLONAL ANTIBODIES (MABs) – ANTI-IL, ANTI-IGE, ANTI-TLSP**
J2182				
Nulibry™ (fosdenopterin)	**9/15/2021**		**Monthly Provider Update August 2021**	**MBP 238.0**
Currently this drug is reported with an unlisted procedure code.				
Nulojix® (belatacept)	**1/1/2012**		**Postcard June 2017-Annual Policy Review**	**MBP 93.0**
J0485				
Nuwiq®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7209				
Nuzyra® (omadacycline) Injection	**3/15/2020**		**Monthly Provider Update February 2020**	**MBP 203.0**
J0121				

Nyvepria™	**1/1/2021**		**Statewide Preferred Drug List (PDL) Managed**	**COLONY STIMULATING FACTORS**
Q5122				
Obizur®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7188				
Octagam® (immune globulin)	**1/1/2006**		**Postcard June 2017-Annual Policy Review**	**MBP 4.0**
J1568				
Ocrevus®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**MULTIPLE SCLEROSIS AGENTS**
J2350				
Olanzapine	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J2358, J2359				
Olinvyk™ (oliceridine)	**6/15/2021**		**Monthly Provider Update May 2021**	**MBP 229.0**
C9101				
Omisirge® (omidubicel-onlv)	**10/15/2023**		**Monthly Provider Update September 2023**	**MBP 292.0**
Currently this drug is reported with an unlisted procedure code.				
Omvoh™	**4/1/2024**		**Statewide Preferred Drug List (PDL) Managed**	**Not Applicable**
C9168				
Onivyde® (irinotecan liposome injection)	**4/15/2016**		**Postcard March 2016**	**MBP 138.0**
J9205				
Onpattro® (patisiran)	**4/15/2019**		**Monthly Provider Update March 2019**	**MBP 188.0**
J0222				

Opdivo® (nivolumab)	**7/1/2015**		**Postcard July 2017-Annual Policy Review**	**MBP 126.0**
J9299				
Opdualag™ (nivolumab and relatlimab-rmbw)	**7/15/2022**		**Monthly Provider Update June 2022**	**MBP 257.0**
J9298				
Orencia®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**CYTOKINE AND CAM ANTAGONISTS**
J0129				
Orthovisc®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**INTRA-ARTICULAR HYALURONATES**
J7324				
Oxlumo® (lumasiran)	**7/1/2021**		**Monthly Provider Update June 2021**	**MBP 234.0**
J0224				
Ozurdex®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**OPHTHALMICS, ANTI-INFLAMMATORIES**
J7312				
Paclitaxel Protein-Bound Particles	**7/1/2023**		**Monthly Provider Update June 2023**	**MBP 36.0**
J9259				
Padcev® (enfortumab vedotin-ejfv)	**6/15/2020**		**Monthly Provider Update May 2020**	**MBP 209.0**
J9177				
Panzyga® (immune globulin)	**1/1/2006**		**Postcard June 2017-Annual Policy Review**	**MBP 4.0**
J1576				
Parsabiv® (etelcalcetide)	**6/15/2018**		**Monthly Provider Update May 2018**	**MBP 168.0**
J0606				

Pedmark (sodium thiosulfate)	**4/1/2023**		**Monthly Provider Update March 2023**	**MBP 275.0**
J0208				
Pepaxto® (melphalan flufenamide)	**7/1/2021**		**Monthly Provider Update June 2021**	**MBP 233.0**
J9247				
Perseris®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J2798, **Prior authorization is required for any member under 18 years of age**				
Phenergan®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIEMETICS-ANTIVERTIGO AGENTS**
J2550 **Prior authorization is only required for the following NDC numbers;** 00641608425, 00641608401, 00641608525, 00641608501, 00641608225, 00641608201, 00641608301, 00641608				
Pluvicto™ (lutetium Lu 177 vipivotide tetraxetan)	**9/15/2022**		**Monthly Provider Update August 2022**	**MBP 263.0**
A9607				
Polivy® (polatuzumab vedotin-piiq)	**11/15/2019**		**Monthly Provider Update October 2019**	**MBP 200.0**
J9309				
Portrazza® (necitumumab)	**6/15/2016**		**Postcard May 2016-Annual Policy Review**	**MBP 142.0**
J9295				
Poteligeo® (mogamulizumab-kpkc)	**3/15/2019**		**Monthly Provider Update February 2019**	**MBP 185.0**
J9204				
Praxbind® (idarucizumab)	**6/15/2016**		**Postcard May 2016-Annual Policy Review**	**MBP 143.0**
Currently this drug is billed with and unlisted procedure code				
Premarin®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ESTROGENS**
J1410				

Prevymis™ IV (letermovir)	**8/15/2018**		**Monthly Provider Update July 2018**	**MBP 177.0**
Currently this drug is billed with and unlisted procedure code				
Prialt® (ziconotide intrathecal infusion)	**1/1/2008**		**Briefly December 2007**	**MBP 58.0**
J2278				
Privigen® (immune globulin)	**1/1/2006**		**Postcard June 2017-Annual Policy Review**	**MBP 4.0**
J1459				
Probuphine®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**Not Applicable**
J0570				
Procrit®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ERYTHROPOIESIS STIMULATING AGENTS**
J0885, Q4081				
Profilnine®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7194				
Prolastin-C® (alpha 1-proteinase inhibitor (human)	**4/1/2007**		**Briefly March 2007**	**MBP 43.0**
J0256				
Prolia®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**BONE DENSITY REGULATORS**
J0897				
Prolixin® (fluphenazine hcl)	**1/1/2024**		**Monthly Provider Update December 2023**	**Not Applicable**
J2679				
Promethazine HCl	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIEMETICS-ANTIVERTIGO AGENTS**
J2550, **Prior authorization is required for any member under 6 years of age for any of the following NDC numbers;** 00641092821, 00641095521, 00703219104, 00641620825, 00641095525, 00641092825, 00641620801, 00641095621, 00703220104, 00641092921, 00641092925, 00641095625, 39822552502, 00641149535, 00641094831, 39822552503, 00641149531, 00641094835, 39822555006, 00641094935, 00641149635, 00641094931, 39822555005, 00641149631				

Provenge® (sipuleucel-T)	**1/1/2011**		**Postcard June 2017-Annual Policy Review**	**MBP 79.0**
Q2043				
Qalsody™ (tofersen)	**10/1/2023**		**Monthly Provider Update September 2023**	**MBP 293.0**
J1304				
Qutenza®	**2/15/2023**		**Statewide Preferred Drug List (PDL) Managed**	**NEUROPATHIC PAIN AGENTS**
J7336				
Radicava® (edaravone)	**10/1/2017**		**Postcard September 2017**	**MBP 154.0**
J1301				
Rapivab®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIVIRALS, INFLUENZA**
J2547				
Rebinyn®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7203				
Reblozyl® (luspatercept-aamt)	**7/1/2020**		**Monthly Provider Update June 2020**	**MBP 210.0**
J0896				
Rebyota™ (fecal microbiota, live-jslm)	**7/1/2023**		**Monthly Provider Update June 2023**	**MBP 281.0**
J1440				
Recarbrio™ (imipenem/cilastatin/relebactam)	**7/1/2020**		**Monthly Provider Update June 2020**	**MBP 215.0**
J0742				
Reclast®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**BONE DENSITY REGULATORS**
J3489, **Prior authorization is only required for the following NDC number;** 00078043561				

Recombinate®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7192				
Releuko®	**7/1/2022**		**Statewide Preferred Drug List (PDL) Managed**	**COLONY STIMULATING FACTORS**
Q5125				
Remicade®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**CYTOKINE AND CAM ANTAGONISTS**
J1745				
Remodulin® IV (treprostinil sodium)	**1/1/2009**		**Briefly December 2008**	**MBP 62.0**
J3285				
Renflexis®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**CYTOKINE AND CAM ANTAGONISTS**
Q5104				
Retacrit®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ERYTHROPOIESIS STIMULATING AGENTS**
Q5105, Q5106				
Retisert®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**OPHTHALMICS, ANTI-INFLAMMATORIES**
J7311				
Revcovi® (elapegademase-lvlr)	**6/15/2019**		**Monthly Provider Update May 2019**	**MBP 193.0**
Currently this drug is billed with and unlisted procedure code				
Rezzayo™ (rezafungin)	**4/15/2024**		**Monthly Provider Update March 2024**	**MBP 313.0**
J0349				

Riabni™ (rituximab-arrx)	**7/1/2021**	**Per policy, Riabni™ does not require prior auth for Non-Hodgkin's Lymphoma (C82.00-C88.9), Chronich Lymphocytic Leukemia (C91.10-C91.12), and Multiple Sclerosis (G35)**	**Monthly Provider Update June 2021**	**MBP 48.0**
Q5123				
Risperdal Consta®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J2794, **Prior authorization is required for any member under 18 years of age**				
Rituxan Hycela® (rituximab-hyaluronidase)	**4/1/2018**		**Monthly Provider Update March 2018**	**MBP 165.0**
J9311				
Rituxan® (rituximab)	**10/1/2007**		**Monthly Provider Update September 2018**	**MBP 48.0**
J9312				
Rixubis®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7200				
Roctavian™ (valoctocogene roxaparvovec-rvox)	**1/1/2024**		**Monthly Provider Update December 2023**	**MBP 308.0**
J1412				
Rolvedon™ (eflapegrastim-xnst)	**4/1/2023**		**Monthly Provider Update March 2023**	**COLONY STIMULATING FACTORS**
J1449				
Ruconest®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**HEREDITARY ANGIOEDEMA (HAE) AGENTS**
J0596				

Ruxience® (rituximab-pvvr)	**7/1/2020**	**Per policy, Ruxience® does not require prior auth for Non-Hodgkin's Lymphoma (C82-00-C88.9), Chronic Lymphocytic Leukemia (C91.10-C91.12), and Multiple Sclerosis (G35)**	**Monthly Provider Update June 2020**	**MBP 48.0**
Q5119				
Rybrevant® (amivantamab-vmjw)	**9/15/2021**		**Monthly Provider Update August 2021**	**MBP 239.0**
J9061				
Rylaze™ (asparaginase erwinia chrysanthemi (recombinant)- rywn)	**11/15/2021**		**Monthly Provider Update October 2021**	**MBP 244.0**
J9021				
Ryplazim® (plasminogen, human-tvmh)	**7/1/2022**		**Monthly Provider Update June 2022**	**MBP 258.0**
J2998				
Rystiggo® (rozanolixizumab-noli)	**1/1/2024**		**Monthly Provider Update December 2024**	**MBP 305.0**
J9333				
Sandostatin LAR® (Octreotide acetate)	**4/1/2013**		**Briefly March 2013**	**MBP 99.0**
J2353				
Saphnelo™ (anifrolumab-fnia)	**4/15/2022**		**Monthly Provider Update March 2022**	**MBP 249.0**
J0491				
Sarclisa® (isatuximab-irfc)	**9/15/2020**		**Monthly Provider Update August 2020**	**MBP 213.0**
J9227				
Scenesse® (afamelanotide)	**1/1/2021**		**Monthly Provider Update December 2020**	**MBP 220.0**
J7352				

Sevenfact®	**1/1/2021**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7212				
Signifor LAR® (pasireotide LAR)	**1/1/2016**		**Postcard July 2017-Annual Policy Review**	**MBP 133.0**
J2502				
Simponi Aria®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**CYTOKINE AND CAM ANTAGONISTS**
J1602				
Sinuva™	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**INTRANASAL RHINITIS AGENTS**
J7402				
Site of Care Review Guidelines for Infusion Drugs and Specialty Medications	**10/15/2018**		**Statewide Preferred Drug List (PDL) Managed**	**Not Applicable**
Specific intravenous and injectable drugs must meet applicable medical necessity criteria for coverage.				
Sivextro® (tedizolid phosphate) IV	**3/1/2015**		**Postcard February 2015**	**MBP 122.0**
J3090				
Skyrizi® IV (risankizumab intravenous)	**1/15/2023**		**Monthly Provider Update December 2022**	**MBP 267.0**
J2327				
Skysona® (elivaldogene autotemcel)	**7/15/2023**		**Monthly Provider Update June 2023**	**MBP 282.0**
Currently this drug is billed with and unlisted procedure code				
Soliris® (eculizumab)	**10/1/2008**		**Postcard May 2016-Annual Policy Review**	**MBP 54.0**
J1300				
Spevigo®	**4/15/2023**		**Statewide Preferred Drug List (PDL) Managed**	**CYTOKINE AND CAM ANTAGONISTS**
J1747				

Spinraza® (nusinersen)	**7/1/2017**		**Postcard June 2017**	**MBP 151.0**
J2326				
Spravato®	**1/1/2021**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIDEPRESSANTS, OTHER**
G2082, G2083, S0013				
Stelara® IV	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**CYTOKINE AND CAM ANTAGONISTS**
J3357, J3358				
Stimufend®	**4/1/2023**		**Statewide Preferred Drug List (PDL) Managed**	**COLONY STIMULATING FACTORS**
Q5127				
Supartz FX®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**INTRA-ARTICULAR HYALURONATES**
J7321				
Supprelin LA®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**PITUITARY SUPPRESSIVE AGENTS, LHRH**
J1675, J9226				
Sunlenca®	**7/1/2023**		**Statewide Preferred Drug List (PDL) Managed**	**HIV/AIDS ANTIRETROVIRALS – MISCELLANEOUS**
J1961				
Sustol®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIEMETICS-ANTIVERTIGO AGENTS**
J1627, **Prior authorization is only required for the following NDC number;** 47426010106				
Susvimo™	**4/1/2022**		**Statewide Preferred Drug List (PDL) Managed**	**MACULAR DEGENERATION AGENTS**
J2779				
Syfovre™	**6/15/2023**		**Statewide Preferred Drug List (PDL) Managed**	**MACULAR DEGENERATION AGENTS**
J2781				

Sylvant® (siltuximab)	**3/1/2015**		**Postcard February 2015**	**MBP 120.0**
J2860				
Synagis® (palivizumab)	**10/1/2005**		**Briefly March 2006**	**MBP 2.0**
90378				
Synojoynt®	**10/15/2023**		**Statewide Preferred Drug List (PDL) Managed**	**INTRA-ARTICULAR HYALURONATES**
J7331				
Synribo® (omacetaxine mepesuccinate)	**4/1/2013**		**Postcard June 2017-Annual Policy Review**	**MBP 102.0**
J9262				
Synvisc® / Synvisc One®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**INTRA-ARTICULAR HYALURONATES**
J7325				
Talvey™ (talquetamab-tgvs)	**1/1/2024**		**Monthly Provider Update December 2023**	**MBP 302.0**
J3055				
Tecartus® (brexucabtagene autoleucel)	**3/15/2021**		**Monthly Provider Update February 2021**	**MBP 224.0**
Q2053				
Tecentriq™ (atezolizumab)	**10/15/2016**		**Postcard July 2017-Annual Policy Review**	**MBP 144.0**
J9022				
Tecvayli™ (teclistamab-cqyv)	**4/1/2023**		**Monthly Provider Update March 2023**	**MBP 273.0**
J9380				
Tepadina® (thiotepa)	**12/15/2017**		**Postcard November 2017**	**MBP 158.0**
J9340				

Tepezza® (teprotumumab-trbw)	**10/1/2020**		**Monthly Provider Update September 2020**	**MBP 217.0**
J3241				
Terlivaz® (terlipressin)	**3/15/2023**		**Monthly Provider Update February 2023**	**MBP 271.0**
Currently this drug is billed with and unlisted procedure code				
Testopel®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANDROGENIC AGENTS**
S0189				
Testosterone cypionate	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANDROGENIC AGENTS**
J1071				
Testosterone enanthate	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANDROGENIC AGENTS**
J3121				
Tezspire®	**7/1/2022**		**Statewide Preferred Drug List (PDL) Managed**	**MONOCLONAL ANTIBODIES (MABs) – ANTI-IL, ANTI-IGE, ANTI-TLSP**
J2356				
Tigan®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIEMETICS-ANTIVERTIGO AGENTS**
J3250				
Tivdak™ (tisotumab vedotin-tftv)	**3/15/2022**		**Monthly Provider Update February**	**MBP 246.0**
J9273				
Tofidence™	**4/1/2024**		**Statewide Preferred Drug List (PDL) Managed**	**CYTOKINE AND CAM ANTAGONISTS**
Q5133				
Torisel® (temsirolimus)	**4/1/2009**		**Postcard May 2016-Annual Policy Review**	**MBP 65.0**
J9330				

Trastuzumab (Herceptin®)	**9/15/2023**		**Monthly Provider Update August 2023**	**MBP 294.0**
J9355				
Trelstar®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**PITUITARY SUPPRESSIVE AGENTS, LHRH**
J3315				
Triesence®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**OPHTHALMICS, ANTI-INFLAMMATORIES**
J3300				
Triferic® AVNU	**10/1/2021**		**Statewide Preferred Drug List (PDL) Managed**	**Not Applicable**
J1445				
Triostat	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**THYROID HORMONES**
Currently this drug is billed with and unlisted procedure code				
Triptodur®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**PITUITARY SUPPRESSIVE AGENTS, LHRH**
J3316				
Trisenox® (arsenic trioxide)	**6/15/2018**		**Monthly Provider Update May 2018**	**MBP 172.0**
J9017				
Trivisc®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**INTRA-ARTICULAR HYALURONATES**
J7329				
Triluron™	**1/5/2021**		**Statewide Preferred Drug List (PDL) Managed**	**INTRA-ARTICULAR HYALURONATES**
J7332				
Trodelvy® (sacituzumab govitecan-hziy)	**10/1/2020**		**Monthly Provider Update Septemeber 2020**	**MBP 216.0**
J9317				

Trogarzo®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**HIV/AIDS ANTIRETROVIRALS – MISCELLANEOUS**
J1746				
Truxima® (rituximab-abbs)	**4/15/2020**	**Per policy, Truxima® does not require prior auth for Non-Hodgkin's Lymphoma (C82-00-C88.9), Chronic Lymphocytic Leukemia (C91.10-C91.12), and Multiple Sclerosis (G35)**	**Monthly Provider Update March 2020**	**MBP 48.0**
Q5115				
Tyruko®	**4/1/2024**		**Statewide Preferred Drug List (PDL) Managed**	**MULTIPLE SCLEROSIS AGENTS**
Q5134				
Tysabri®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**MULTIPLE SCLEROSIS AGENTS**
J2323				
Tzield™ (teplizumab-mzwv)	**7/1/2023**		**Monthly Provider Update June 2023**	**MBP 283.0**
J9381				
Udenyca®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**COLONY STIMULATING FACTORS**
Q5111				
Ultomiris® (Ravulizumab-cwvz)	**8/15/2019**		**Monthly Provider Update July 2019**	**MBP 196.0**
J1303				
Unituxin® (dinutuximab)	**1/1/2016**		**Postcard October 2015**	**MBP 135.0**
J1246				
Uplizna® (inebilizumab-cdon)	**3/15/2021**		**Monthly Provider Update February 2021**	**MBP 225.0**
J1823				

Uzedy™ (risperidone)	**9/15/2023**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS-INJECTABLE**
J2799, **Prior authorization is required for any member under 18 years of age**				
Vabomere® (meropenem/vaborbactam)	**6/15/2018**		**Monthly Provider Update May 2018**	**MBP 167.0**
J2186				
Vabysmo®	**5/15/2022**		**Statewide Preferred Drug List (PDL) Managed**	**MACULAR DEGENERATION AGENTS**
J2777				
Varubi® IV	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**Not Applicable**
J2797				
Vectibix® (panitumumab)	**7/1/2007**		**Briefly June 2007**	**MBP 50.0**
J9303				
Velcade® (bortezomib)	**8/1/2004**		**Briefly March 2006**	**MBP 23.0**
J9041,J9046, J9048, J9049				
Veopoz™ (pozelimab-bbfg)	**4/1/2024**		**Monthly Provider Update March 2024**	**MBP 312.0**
J9376				
Viltepso® (viltolarsen)	**4/1/2021**		**Monthly Provider Update March 2021**	**MBP 226.0**
J1427				
Vimizim® (elosulfase alfa)	**12/1/2014**		**Postcard November 2014**	**MBP 114.0**
J1322				
Visco-3®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**INTRA-ARTICULAR HYALURONATES**
J7321				

Viscosupplementation using hyaluronan injections (Durolane®, Euflexxa®, Gel-One®, Gelsyn-3®, GenVisc 850®, Hyalgan®, Hymovis®, Monovisc®, Orthovisc®, Supartz FX®, Synojoynt®, Synvisc®, Synvisc One®, Triluron™, Trivisc®, Visco-3)	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**INTRA-ARTICULAR HYALURONATES**
J7318, J7323, J7326, J7328, J7320, J7321, J7322, J7327, J7324, J7331, J7325, J7322, J7329				
Visudyne®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**MACULAR DEGENERATION AGENTS**
J3396				
Vonvendi®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7179				
Voraxaze® (glucarpidase)	**1/1/2014**		**Postcard June 2017-Annual Policy Review**	**MBP 96.0**
C9293				
VPRIV®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ENZYME REPLACEMENTS, GAUCHER DISEASE**
J3385				
Vyepti®	**9/15/2020**		**Statewide Preferred Drug List (PDL) Managed**	**MIGRAINE PREVENTION AGENTS (PREVIOUSLY ANTIMIGRAINE AGENTS, OTHER)**
J3032				
Vyjuvek™ (beremagene geperpavec-svdt)	**1/1/2024**		**Monthly Provider Update December 2023**	**MBP 306.0**
J3401				
Vyondys 53®	**7/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**Not Applicable**
J1429				
Vyvgart® (efgartigimod alfa-fcab), Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase injection)	**7/1/2022**		**Monthly Provider Update June 2022**	**MBP 260.0**
J9332, J9334				

Vyxeos® (daunorubicin/cytarabine liposomal)	**4/15/2018**		**Monthly Provider Update March 2018**	**MBP 164.0**
J9153				
White Blood Cell Stimulating Factors (Fulphila®, Fylnetra®, Granix®, Leukine®, Neulasta®, Neulasta Onpro®, Neupogen®, Nivestym®, Nyvepria™, Releuko®, Rolvedon™, Stimufend®, Udenyca®, Zarxio®, Ziextenzo®)	**4/1/2008**		**Statewide Preferred Drug List (PDL) Managed**	**COLONY STIMULATING FACTORS**
Q5108, Q5130, J1447, J2820, J2506, J1442, Q5110, Q5122, Q5125, J1449, Q5127, Q5111, Q5101, Q5120				
Wilate®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7183				
Xacduro® (sulbactam and durlobactam)	**4/15/2024**		**Monthly Provider Update March 2024**	**MBP 311.0**
Currently this drug is billed with and unlisted procedure code				
Xembify® (immune globulin)	**3/15/2022**		**Monthly Provider Update February 2022**	**MBP 4.0**
J1558				
Xenleta® IV (lefamulin)	**4/15/2020**		**Monthly Provider Update March 2020**	**MBP 207.0**
J0691				
Xenpozyme® (olipudase alfa-rpcp)	**4/1/2023**		**Monthly Provider Update March 2023**	**MBP 284.0**
J0218				
Xeomin®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**BOTULINUM TOXINS**
J0588				
Xerava® (eravacycline)	**6/15/2019**		**Monthly Provider Update May 2019**	**MBP 194.0**
J0122				

Xgeva®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**BONE DENSITY REGULATORS**
J0897				
Xiaflex® (collagenase clostridium histolyticum)	**1/1/2011**		**Briefly December 2010**	**MBP 80.0**
J0775				
Xipere®	**5/17/2022**		**Statewide Preferred Drug List (PDL) Managed**	**OPHTHALMICS, ANTI-INFLAMMATORIES**
J3299				
Xofigo® (radium Ra 223 dichloride)	**9/1/2013**		**Postcard August 2013**	**MBP 110.0**
A9606				
Xolair®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**MONOCLONAL ANTIBODIES (MABs) – ANTI-IL, ANTI-IGE, ANTI-TLSP**
J2357				
Xyntha® / Xyntha Solofuse	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIHEMOPHILIA AGENTS**
J7185				
Ycanth™ (cantharidin)	**4/1/2024**		**Monthly Provider Update March 2024**	**Not Applicable**
J7354				
Yervoy® (ipilimumab)	**10/1/2011**		**Postcard May 2016-Annual Policy Review**	**MBP 91.0**
J9228				
Yescarta® (axicabtagene ciloleucel)	**4/1/2018**		**Monthly Provider Update March 2018**	**MBP 162.0**
Q2041				
Yondelis® (trabectedin)	**7/1/2016**		**Postcard March 2016**	**MBP 137.0**
J9352				

Yutiq®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**OPHTHALMICS, ANTI-INFLAMMATORIES**
J7314				
Zaltrap® (ziv-aflibercept)	**4/1/2013**		**Postcard June 2017-Annual Policy Review**	**MBP 101.0**
J9400				
Zantac®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**Not Applicable**
J2780, **Prior authorization is only required for the following NDC numbers;** 52565009601, 52565010201, 52565010110				
Zarxio®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**COLONY STIMULATING FACTORS**
Q5101				
Zemaira® (alpha 1-proteinase inhibitor (human)	**4/1/2007**		**Briefly March 2007**	**MBP 43.0**
J0256				
Zemdri® (plazomicin)	**4/15/2019**		**Monthly Provider Update March 2019**	**MBP 187.0**
J0291				
Zemplar®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**VITAMIN D ANALOGS**
J2501, **Prior authorization is only required for the following NDC numbers;** 00074165805, 00074463701, 00074165801				
Zepzelca® (lurbinectedin)	**11/15/2020**		**Monthly Provider Update October 2020**	**MBP 222.0**
J9223				
Zerbaxa® (ceftolozane/tazobactam)	**3/15/2020**		**Monthly Provider Update February 2020**	**MBP 205.0**
J0695				
Zevalin® (Ibritumomab)	**1/1/2006**		**Briefly March 2006**	**MBP 15.0**
A9542, A9543				

Ziextenzo®	**4/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**COLONY STIMULATING FACTORS**
Q5120				
Zilretta® (triamcinolone acetonide ER injection)	**8/15/2018**		**Monthly Provider Update July 2018**	**MBP 178.0**
J3304				
Zimhi™	**1/1/2023**		**Statewide Preferred Drug List (PDL) Managed**	**OPIOID OVERDOSE AGENTS**
J2311				
Zinplava®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIBIOTICS, GI AND RELATED AGENTS**
J0565				
Ziprasidone	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J3486				
Zoladex®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**Not Applicable**
J9202				
Zolgensma® (onasemnogene abeparvovec-xioi)	**11/15/2019**		**Monthly Provider Update October 2019**	**MBP 199.0**
J3399				
Zometa®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**Not Applicable**
J3489, **Injection: Prior authorization is only required for the following NDC number;** 00078059061 **Vial: Prior authorization is only required for the following NDC number;** 00078038725				
Zulresso® (brexanolone)	**1/15/2020**		**Monthly Provider Update December 2019**	**MBP 201.0**
J1632				
Zynlonta® (loncastuximab tesirine-lpyl)	**9/15/2021**		**Monthly Provider Update August 2021**	**MBP 237.0**
J9359				

Zynteglo® (betibeglogene autotemcel)	**7/15/2023**		**Monthly Provider Update June 2023**	**MBP 276.0**
Currently this drug is reported with an unlisted procedure code.				
Zynyz™ (retifanlimab-dlwr)	**7/15/2023**		**Monthly Provider Update June 2023**	**MBP 285.0**
J9345				
Zyprexa® / Zyprexa Relprevv®	**1/1/2020**		**Statewide Preferred Drug List (PDL) Managed**	**ANTIPSYCHOTICS – INJECTABLE**
J2358, **Prior authorization is required for any member under 18 years of age**				