



The following formulary decisions and updates apply to **Optum Rx<sup>®</sup> commercial business**.

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.

**Please note:**

If your plan includes Specialty Pharmacy (SP), your members may obtain specialty products from Optum Specialty Pharmacy for your plan's designated copay or coinsurance. If your plan does not include SP, your members may purchase self-injectable and oral specialty medications from retail pharmacies, or specialty products may be covered under your medical plan. Specialty program medications may be limited to a 30-day supply depending on plan design. Please consult your plan coverage documents.

### Available formularies

<b>Select</b>	Three tier formulary with generic drugs included in Tier 1, preferred brand name drugs included in Tier 2 and non-preferred drugs included in Tier 3. Many Tier 3 drugs have lower-cost options in Tier 1 or 2.
<b>Premium</b>	Three tier formulary with generic drugs included in Tier 1. Some drugs may be excluded from the Premium Formulary due to a strategic evaluation of the market, utilization, quality outcomes and total cost of care.
<b>Premium Value (PVF)</b>	Four-tiered, closed formulary with tiering based on net cost, regardless if the drug is a brand or generic. Drugs are added to PVF after a strategic evaluation of the market, utilization, quality outcomes and total cost of care.

**Key**    **SP:** Specialty Pharmacy    **PA:** Prior Authorization    **ST:** Step Therapy    **QL:** Quantity Limits

---

## FDA approves first Solaris biosimilar for two rare disorders

On May 28, 2024, the FDA approved Bkemy (eculizumab-aeab), administered as a weekly injectable, to treat two rare diseases:

- Paroxysmal nocturnal hemoglobinuria (PNH) to reduce hemolysis
- Atypical hemolytic uremic syndrome (aHUS) to inhibit complement-mediated thrombotic microangiopathy

**Bkemy is the first FDA-approved biosimilar for Solaris (eculizumab) and was approved as an interchangeable biosimilar.** As an interchangeable biosimilar, Bkemy is highly similar with no clinically meaningful differences to Solaris and may be substituted for the reference product without consulting the prescriber. Solaris has FDA-approval for four indications. Bkemy currently carries two of the Solaris indications: PNH and aHUS. At this time, Bkemy is not indicated for the two additional Solaris indications, generalized myasthenia gravis (gMG) and neuromyelitis optica spectrum disorder (NMOSD).

PNH and aHUS are rare diseases that afflict fewer than 200,000 people in the U.S. Both diseases lead to the destruction of red blood cells, which may result in severe symptoms such as low blood cell counts, blood clot formations, and kidney failure. Bkemy is a monoclonal antibody that works by interfering with the triggering of the complement system, a part of the body's immune system, by binding to the complement C5 protein. This binding prevents the destruction of red blood cells in the bloodstream of patients with PNH and aHUS.

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

---

## 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	Select Tier	Premium Tier	Effective date
Ophthalmic Agents	Cequa (cyclosporine) ophthalmic solution	Brand	3 (N/C)	EXC > 3	8/1/24

N/C: No change  
EXC: Excluded

---

## 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.*

## Premium Value Up-tiers/Down-tiers

Medications may move to a lower tier or added to the formulary throughout the year, helping members take immediate advantage of cost savings. Medications typically move to a higher tier on Jan. 1 and July 1 to help reduce member disruption. Utilization management strategies such as Step Therapy, Quantity Limits or Prior Authorization may apply.

Therapeutic use	Medication name	Brand/ Generic	PVF Tier	Effective date
Antineoplastic Agents	Rybrevent (amivantamab-vmjw) IV injection	Brand	EXC > 4	6/3/24
Neurological Agents	Ingrezza (valbenazine) capsule	Brand	EXC > 4	6/3/24

EXC: Excluded

## New Brand Launches

New brand name medications launch throughout the year. Final coverage status is determined after medications are thoroughly reviewed by the Optum Rx National Pharmacy & Therapeutics Committee. New brand launches may include Authorized Brand Alternatives.

Therapeutic use	Medication name	Select Tier	Premium Tier	PVF Tier	Programs				Effective date
					SP	PA	ST	QL	
Antineoplastic Agents	Imdelltra (tarlatamab-dlle) IV infusion*	Tier 3	EXC	EXC	X	---	---	---	5/21/24
Hematological Agents	Beqvez (fidanacogene elaparvovec-dzkt) IV infusion*	Tier 3	EXC	EXC	X	---	---	---	5/10/24
	Xolremdi (mavorixafor) capsule*	Tier 3	EXC	EXC	X	---	---	---	5/7/24
Immunological Agents	Adalimumab-adbm auto-injector & prefilled syringe 40mg/0.4mL*	Tier 3	EXC	EXC	X	X	---	X	5/17/24
	OmvoH (mirikizumab-mrkz) SC prefilled syringe 100mg/mL	Tier 3	Tier 3	EXC	X	X	---	X	6/5/24
Neurological Agents	Ingrezza (valbenazine) sprinkle capsule	Tier 3	Tier 3	EXC	X	X	---	X	5/29/24

<b>Opioid Antagonist Agents</b>	Rextovy (naloxone) nasal spray*	Tier 3	EXC	EXC	---	---	---	---	5/8/24
<b>Potassium Removing Agents</b>	Kionex (sodium polystyrene sulfonate) oral suspension	Tier 3	Tier 3	Tier 1	---	---	---	---	5/21/24
<b>Respiratory Agents</b>	Fasenra (benralizumab) SC prefilled syringe 10mg/0.5mL	Tier 2	Tier 2	Tier 4	X	X	---	---	5/16/24

\*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 Removed from the New Drugs to Market Exclusion List** section below.

Authorized Brand Alternatives (ABA), also referred to as Authorized Generics, are approved brand name medications marketed by either the brand company or another company. Although it does not have the brand name on its label, it is the exact same drug product as the brand product.

EXC: Excluded

## New Generic Launches

New generic medication launches occur throughout the year. Generic medications will be placed in Tier 1 on the Select and Premium Formularies. 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	Select Tier	Premium Tier	PVF Tier	Programs				Effective date
						SP	PA	ST	QL	
<b>Antineoplastic Agents</b>	eribulin IV injection	Halaven	Tier 1	Tier 1	Tier 4	X	X	---	---	5/3/24
<b>Corticosteroid Agents</b>	deflazacort oral suspension	Emflaza	Tier 1	Tier 1	EXC	X	X	---	---	5/29/24

## New Benefit Coverage for Medications Removed from 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. Medications that are removed from this exclusion list have new benefit coverage as shown below.

Therapeutic use	Medication name	Brand/ Generic	Select Tier	Premium Tier	PVF Tier	Programs				Effective date
						SP	PA	ST	QL	
<b>Antineoplastic Agents</b>	Bosulif (bosutinib) capsule	Brand	Tier 3	Tier 3	EXC	X	X	---	---	7/5/24

Therapeutic use	Medication name	Brand/ Generic	Select Tier	Premium Tier	PVF Tier	Programs				Effective date
						SP	PA	ST	QL	
<b>Antineoplastic Agents</b>	Iwifin (eflornithine) tablet	Brand	Tier 3	Tier 3	EXC	X	X	---	---	6/22/24
<b>Corticosteroid Agents</b>	Agamree (vamorolone) oral suspension	Brand	Tier 3	Tier 3	EXC	X	X	---	---	7/5/24
<b>Genitourinary Agents</b>	Rivfloza (nedosiran) SC injection	Brand	Tier 3	Tier 3	EXC	X	X	---	X	7/24/24
<b>Hematological Agents</b>	Casgevay (exagamglogene autotemcel) IV infusion	Brand	Tier 3	Tier 3	EXC	X	X	---	---	6/15/24
	Lyfgenia (lovotibeglogene autotemcel) IV infusion	Brand	Tier 3	Tier 3	EXC	X	X	---	---	6/15/24
<b>Neurological Agents</b>	Lenmeldy (atidarsagene autotemcel) IV infusion	Brand	Tier 3	Tier 3	EXC	X	X	---	---	7/1/24
	Wainua (eplontersen) SC injection	Brand	Tier 3	Tier 3	EXC	X	X	---	X	6/28/24

## 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>Hematological Agents</b>	Voydeya (danicopan) tablet	Add	6/1/24
<b>Neurological Agents</b>	Lenmeldy (atidarsagene autotemcel) IV infusion	Add	6/1/24

## ST Step Therapy

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 have 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
Thyroid Agents	Adthyza (levothyroxine) tablet	Remove	6/1/24
	Armour (levothyroxine) tablet	Remove	6/1/24
	Niva Thyroid (levothyroxine) tablet	Remove	6/1/24
	Synthroid (levothyroxine) tablet	Remove	6/1/24

## 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
Hematological Agents	Voydeya (danicipan) tablet	Add	6/1/24



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

At Optum, we help create a healthier world, one insight, one connection, one person at a time.

All Optum trademarks and logos are owned by Optum, Inc., in the U.S. and other jurisdictions. All other trademarks are the property of their respective owners.

© 2024 Optum, Inc. All rights reserved. OPT6773729\_Optum Rx direct and UMR June2024

**Optum Rx**<sup>®</sup>