Optum Rx®

Pharmacy Passages

Formulary Update

April 2025

The following formulary decisions and updates apply to **Optum Rx® 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.

Specialty medication coverage

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

Select	Three tier formulary comprised of generics, preferred brands and non-preferred brands. Many Tier 3 drugs have lower-cost options in Tier 1 or 2.
Premium	Three tier formulary comprised of generics, preferred brands and non-preferred brands. Some drugs may be excluded due to a strategic evaluation of the market, utilization, quality outcomes and total cost of care.
Premium Value (PVF)	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 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.

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
Dermatological Agents	Nemluvio (nemolizumab-ilto) auto-injector for SC injection	Brand	**3 > 2**	**EXC > 2**	5/1/25
Diabetes Supplies	Twiist Refill Kit	Brand	**3 > 2**	**EXC > 2**	5/1/25
	Twiist Refill Kit / Infusion Set	Brand	**3 > 2**	**EXC > 2**	5/1/25
	Twiist Starter Kit	Brand	**3 > 2**	**EXC > 2**	5/1/25
Hormonal Agents	Lupron (leuprolide) depot pediatric kit 11.25mg (1 month, 3month) and 45mg (6 month)	Brand	**3 > 2**	**3 > 2**	7/1/25
	Triptodur (triptorelin) ER suspension for IM injection	Brand	**3 > 2**	**3 > 2**	7/1/25

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 be 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
Antilipemic Agents	Tryngolza (olezarsen) auto-injector for SC injection	Brand	**EXC > T4**	3/12/25

EXC: Excluded

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	Select Tier	Premium Tier	PVF Tier	Programs				Effective date
					SP	PA	ST	QL	
Analgesic Agents	Combogesic (ibuprofen-acetaminophen) tablet*	Tier 3	EXC	EXC	—	—	—	—	4/3/25
Antidepressant Agents	Raldesy (trazodone) oral solution*	Tier 3	EXC	EXC	—	—	—	—	3/6/25
Antineoplastic Agents	Abirtega (abiraterone) tablet*	Tier 3	EXC	EXC	X	X	—	—	3/11/25
	Revuforj (revumenib) 25mg tablet*	Tier 3	EXC	EXC	X	X	—	—	3/18/25
	Romvimza (vimseltinib) capsule*	Tier 3	EXC	EXC	X	—	—	—	3/3/25

Therapeutic use	Medication name	Select Tier	Premium Tier	PVF Tier	Programs				Effective date
					SP	PA	ST	QL	
Antineoplastic Agents	Xpovio (selinexor) 10mg [40mg once weekly] therapy pack	Tier 3	Tier 3	EXC	X	X	—	—	3/13/25
Cardiovascular Agents	Inzirqo (hydrochlorothiazide) oral suspension*	Tier 3	EXC	EXC	—	—	—	—	3/11/25
Dermatological Agents	Clobetasol (ABA of Impoyz) 0.025% cream*	Tier 3	EXC	EXC	—	X	---	---	3/5/25
Electrolytic and Renal Agents	Ferric citrate (ABA of Auryxia) tablet*	Tier 3	EXC	EXC	—	—	—	—	3/20/25
Gastrointestinal Agents	Ctexli (chenodiol) tablet*	Tier 3	EXC	EXC	X	X	—	—	3/14/25
	Tremfya (guselkumab) induction pack for Crohn's disease - 200mg/2mL auto injector for SC injection	Tier 2	Tier 2	Tier 3	X	X	—	X	3/26/25
Hematological Agents	Alhemo (concizumab-mtci) 300mg/3mL pen injector for SC injection*	Tier 3	EXC	EXC	X	—	—	—	3/6/25
Hematological Agents	Bkemv (eculizumab-aeeb) IV infusion	Tier 3	EXC	EXC	X	X	—	—	3/3/25
	Epysqli (eculizumab-aagh) IV infusion*	Tier 3	EXC	EXC	X	X	—	—	3/12/25
	Qfitlia (fitusiran) vial and auto-injector for SC injection*	Tier 3	EXC	EXC	X	—	—	—	4/2/25
	Sevenfact (coagulation factor VIIA [recom] -jncw) 2mg IV injection	Tier 3	EXC	EXC	X	—	—	—	4/1/25
Hormonal Agents	Cortrophin (corticotropin) prefilled syringe for SC injection	Tier 2	Tier 2	Tier 4	X	X	—	—	4/1/25
Immunological Agents	Adalimumab-adaz 10mg/0.1mL prefilled syringe for SC injection	Tier 3	EXC	EXC	X	X	—	X	3/31/25
	Otulfi (ustekinumab-aauz) IV infusion and prefilled syringe for SC injection*	Tier 3	EXC	EXC	X	X	—	X^	2/28/25
	Ryoncil (remestemcel-l-rknd) IV infusion*	Tier 3	EXC	EXC	X	—	—	—	3/13/25
	Selarsdi (ustekinumab-aekn) IV infusion*	Tier 3	EXC	EXC	X	X	—	—	3/21/25

Therapeutic use	Medication name	Select Tier	Premium Tier	PVF Tier	Programs				Effective date
					SP	PA	ST	QL	
Immunological Agents	Simlandi (adalimumab-ryvk) 80mg/0.8mL auto injector single pen kit	Tier 3	EXC	EXC	X	X	—	X	4/8/25
Metabolic Agents	Vykat XR (diazoxide choline)* ER tablet	Tier 3	EXC	EXC	X	—	—	—	3/31/25
Ophthalmic Agents	Encelto (revakinagene taroretcel-lwey) intravireal implant*	Tier 3	EXC	EXC	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 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	
Antineoplastic Agents	mercaptopurine oral suspension	Purixan	Tier 1	Tier 1	Tier 3	X	—	—	—	3/3/25
Antiparasitic Agents	ivermectin 6mg tablet	N/A	Tier 1	Tier 1	EXC	—	—	—	—	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	Select Tier	Premium Tier	PVF Tier	Programs				Effective date
						SP	PA	ST	QL	
Antineoplastic Agents	Itovebi (inavolisib) tablet	Brand	Tier 3	Tier 3	EXC	X	X	—	X*	5/1/25

Therapeutic use	Medication name	Brand/ Generic	Select Tier	Premium Tier	PVF Tier	Programs				Effective date
						SP	PA	ST	QL	
Antiparkinson Agents	Vyalev (foslevodopa-foscabidopa) auto-injector for SC injection	Brand	Tier 3	Tier 3	EXC	X	X	—	—	4/19/25
Antipsychotic Agents	Erzofri (paliperidone palmitate) ER prefilled syringe for SC injection	Brand	Tier 3	Tier 3	EXC	—	—	—	—	5/5/25
Devices	Vyafuser Pump	Brand	Tier 3	Tier 3	EXC	—	—	—	—	4/19/25
Hematological Agents	Hympavzi (marstacimab-hncq) auto-injector for SC injection	Brand	Tier 3	Tier 3	Tier 4	X	—	—	—	5/7/25
Ophthalmic Agents	Pavblu (aflibercept-ayyh) vial and prefilled syringe for intravitreal injection	Brand	Tier 3	Tier 3	EXC	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
Antineoplastic Agents	Datroway (datopotamab deruxtecan-dlnk) IV injection	Add	4/1/25
	Gomekli (mirdametinib) capsule	Add	4/1/25
Antiviral Agents	Cabenuva (cabotegravir) ER IM injection	Remove	4/1/25
Cystic Fibrosis Agents	Alyftrek (vanzacaftor-tezacaftor-deutivacaftor) tablet	Add	4/1/25
Immunological Agents	Niktimvo (axatilimab-csfr) IV injection	Add	4/1/25

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 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
Antidiabetic Agents	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
Antineoplastic Agents	Khapzory (levoleucovorin) IV injection	Remove	4/1/25
Antipsychotic Agents	Erzofri (paliperidone palmitate) ER prefilled syringe for SC injection	Remove	5/1/25
Hematological Agents	Sevenfact (coagulation factor VIIA [recom] -jncw) 2mg IV injection	Remove	4/1/25
Respiratory Agents	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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At Optum, we help create a healthier world, one insight, one connection, one person at a time.