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Oscar Clinical Guidelines - Pharmacy
2025 Q4 (October) P&T Summary of Changes

Revisions/Off-Cycle Reviews

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
(Commercial) Preferred Physician-Administered Specialty Drugs (CG052)	Medical Preferred Drug List	1. Moved Tyruko (natalizumab-sztn) [Q5134] to preferred from non-preferred. 2. Added Lutrate Depot (leuprolide acetate), 7.5 mg [J1954] as NP. 3. Added Bildyos (denosumab-nxxp), Bosaya (denosumab-kyqq), and Enoby (denosumab-qbde) as non-preferred. 4. Added Aukelso (denosumab-kyqq), Bilprevda (denosumab-nxxp), and Xtrenbo (denosumab-qbde) as non-preferred. 5. Removed companion exceptions criteria and replaced with CG052 exceptions criteria for the following as sunsetting these companion policies: a. Antineoplastic and Immunomodulating Agents - Infliximab Products - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG087) b. Antineoplastics - Proteosome Inhibitors (i.e., bortezomib, carfilzomib) - Medical Benefit Preferred Physician-Administered Drug	Yes	1/1/2026

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
		Exceptions Criteria (CG106) c. Antineoplastics - Bendamustine Products - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG102) d. Gaucher's Disease Agents - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG093) e. Botulinum Toxins - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG088) f. Antineoplastic and Immunomodulating Agents - Rituximab Products - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG081)		
	Applicable Billing Codes	1. Updated Imaavy with C code. 2. Added codes for 2-4 above.		
Continuous Glucose Monitors (CGMs) Prescription Products (PG121)	Table 1: Stand-alone Prescription CGM Systems	1. Added Dexcom G7 15 day sensor for adults as a formulary agent.	Yes	12/1/2025
Authorization Duration	Coverage Criteria	1. New Jersey: A1255 - Ensuring Transparency in Prior Authorization Act requiring at least 6	Yes	12/1/2025

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Exception-REG (PG269)		month authorization duration for chronic conditions.		
Tremfya (guselkumab) (PG250)	Coverage Criteria	1. Allow use in pediatric patients 6 years of age and older who also weigh at least 40 kg with moderate-to-severe plaque psoriasis and who are candidates for systemic therapy or phototherapy. 2. Allow use for 6 years of age and older who also weigh at least 40 kg with active psoriatic arthritis.	Yes	1/1/2026
Methotrexate Injectable Solution (PG249)	Coverage Criteria	Removal of Otrexup, now off-market.	Yes	12/1/2025
Aripiprazole oral disintegrating tablet, solution (PG173)	Coverage Criteria	Opipza (oral film) added to policy; approved as adjunct in major depressive disorder, irritability associated with autistic disorder, schizophrenia and tourette's syndrome or chronic tic disorders and added to those indications.	Yes	12/1/2025

New Guidelines

Clinical Guideline	Details	Effective Date
Kerendia (finerenone) (PG263)	See the new Oscar Clinical Guideline on https://www.hioscar.com/clinical-guidelines	3/2/2026
paroxetine 7.5 mg capsule (PG272)		1/1/2026

Annual Reviews

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Phenoxybenzamine Hydrochloride (Dibenzyline) (PG054)	Medical necessity criteria for initial authorization	1. Updated to include the state regulation regarding stage IV advanced, metastatic cancer. 2. Updated to include paragangliomas in addition to pheochromocytoma per NCCN	Yes	12/1/2025
Orgovyx (relugolix) (G089)	Medical necessity criteria for initial authorization	1. Updated to include the state regulation regarding stage IV advanced, metastatic cancer.	Yes	12/1/2025
Ultomiris (ravulizumab-cwvz) (PG189)	Medical necessity criteria for initial authorization	1. Updated to allow for a neuro-ophthalmologist as prescriber for neuromyelitis optica spectrum disorder (NMOSD). 2. NMOSD - changes to require 1 relapse in last 12 months (from 2 or more in last 12 months or 3 or more in last 24 months with at least 1 in last 12 months) consistent with package insert/pivotal trial. This is the same requirement as Soliris (Soliris study criteria based on PREVENT study for Ultomiris).	Yes	12/1/2025
	Medical necessity criteria for reauthorization	1. Updated to allow for a neuro-ophthalmologist as prescriber for neuromyelitis optica spectrum disorder (NMOSD).	Yes	12/1/2025
Auvelity (Dextromethorpha	Medical necessity	1. Reduced trial/failure (t/f) from 3 to 2 therapies.	Yes	12/1/2025

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
n and Bupropion) (PG128)	criteria for initial authorization	2. Updated authorization from 12 months to a lifetime (thus removal of reauthorization criteria).		
	Experimental or Investigational / Not Medically Necessary	1. Added Alzheimer's disease agitation and smoking cessation due to lack of strong, high-quality literature. Additionally 2023 Beers criteria explicitly places a similar product (Nuedexta [dextromethorphan, quinidine]) on the potentially inappropriate medication list due to the increased risk of falls and drug-drug interactions (quinidine, like bupropion, is a CYP2D6 inhibitor). Bupropion on its own is indicated for smoking cessation.	Yes	12/1/2025
Cromolyn Sodium 100mg/5mL Solution (PG087)	Medical necessity criteria for initial authorization	1. Removal of ranitidine - no longer on market 2. Addition of proton pump inhibitor to trial and failure for a gastrointestinal symptoms of systemic mastocytosis per guideline recommendations. 3. Addition of intranasal corticosteroids to systemic corticosteroids for trial and failure of naso-ocular symptoms of systemic mastocytosis - NCCN does not specify which form of steroid is preferred, and intranasal steroids provider a lower risk and high efficacy option for naso-occular symptoms.	Yes	12/1/2025

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Myrbetriq (mirabegron) (PG181)	Medical necessity criteria for initial authorization	1. For pediatric neurogenic detrustor overactivity - added oral tablets (previously only granules) for dosing in those ≥35 kg; granules if unable to swallow.	Yes	3/2/2026
Asenapine (Saphris) (PG058)	Medical necessity criteria for initial authorization	1. Reduction of trial and failure from two to one agent consistent with higher tiered Caplyta 2. Removal of clinical documentation requirements (with specifications inconsistent with current guidelines) for postpartum psychosis. This is consistent with other policies we have for with this clinical indication. 3. Removal of requirement of clinical documentation for all other indications. 4. Addition of luradisone (Latuda) for trial and failure in schizoaffective disorder. 5. Increase authorization from 12 months to a lifetime, subsequent removal of re-authorization criteria (except for agitation/aggression associated with psychiatric disorders, substance intoxication or other organic causes as this only for acute management). 6. Addition of intramuscular (IM) ziprasidone for trial and failure for agitation/aggression associated with psychiatric disorders, substance intoxication or other organic causes	Yes	12/1/2025

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
		consistent with guidelines.		
Lacosamide (Vimpat) (PG056)	Medical necessity criteria for initial authorization	Partial-onset (focal) seizures 1. Removed requirement of specialist prescriber. 2. Addition of several agents for trial/failure consistent with guideline recommendations - added ages at which some products are off-label for pediatrics for clarity. Generalized tonic-clonic seizures 1. Updated ages at which some products are off-label for pediatrics for clarity for several agents where applicable. Updated duration of authorization from 12 months to a lifetime. Subsequent removal of reauthorization criteria.	Yes	12/1/2025
Potassium Chloride Oral solution (PG086)	Medical necessity criteria for initial authorization	1. Removal of off-market effervescent potassium chloride tablets.	Yes	3/2/2026
Medical Necessity Prior Authorization Criteria (PG076)	General medical necessity criteria	1. Addition of “age” to the requirement for appropriate dosing and supported by compendia.	Yes	3/2/2026
Lamzede (velmanase alfa-tycv) (PG146)	Medical necessity criteria for initial	1. Changed requirement of alpha-mannose enzyme activity from <5-10% to <10%	No	12/1/2025

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
	authorization	consistent with compendia and pivotal trials.		
Sancuso (granisetron) Patch (PG007)	Necessary criteria for authorization	1. Updated to include the state regulation regarding stage IV advanced, metastatic cancer. 2. Added inability to swallow as indication for use without step therapy.	Yes	12/1/2025
Fetzima (levomilnacipran) (PG063)	Medical necessity criteria for initial authorization	1. Updated trial and failure from three to two consistent with other therapies for depression on similar tier. 2. Increased duration of trial and failure from 1 month to 6 weeks consistent with other therapies for depression on similar tier. 3. Increased duration of authorization from 12 months to lifetime; subsequent removal of reauthorization criteria	Yes	12/1/2025
Antidiabetic Agent - SymlinPen (pramlintide acetate) (PG156)	Coverage criteria	1. Updated authorization and reauthorization criteria from 12 to 24 months consistent with goals of increasing authorization duration when appropriate for chronic disease.	Yes	12/1/2025
Oscar Clinical Guidelines	Clinical Indication	List of criteria that have completed the annual review process. No clinical changes. 1. Palforzia [Peanut (Arachis hypogaea) Allergen Powder-dnfp] (PG245) 2. Non-Formulary Products Criteria (PG069)	No	3/2/2026

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
		3. Hormonal Therapy for Gender Dysphoria Zero Copay Exception-REG (PG184) 4. Difluprednate ophthalmic drops (Durezol) (PG079) 5. Zokinvy (lonafarnib) (PG092)		
Oscar Clinical Guidelines	Clinical Indication	List of criteria that will be sunset: 1. Phenoxybenzamine Hydrochloride (Dibenzyline) (PG054-REG) 2. Orgovyx (relugolix) (PG089-REG) 3. Sancuso (granisetron) Patch (PG007-REG) List of Criteria that will be sunset as exceptions criteria is captured in Commercial Preferred Physician-Administered Specialty Drugs (CG052): 4. Antineoplastic and Immunomodulating Agents - Infliximab Products - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG087) 5. Antineoplastics - Proteosome Inhibitors (i.e., bortezomib, carfilzomib) - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG106)	No	12/1/2025 (#1-3), 1/1/2026 (#4-9)

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		6. Antineoplastics - Bendamustine Products - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG102) 7. Gaucher's Disease Agents - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG093) 8. Botulinum Toxins - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG088) 9. Antineoplastic and Immunomodulating Agents - Rituximab Products - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG081)		