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Oscar Clinical Guidelines - Pharmacy
2025 Q3 (August) P&T Summary of Changes

Revisions/Off-Cycle Reviews

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Benzodiazepines for Acute Repetitive Seizures or Seizure Clusters (PG254)	Clinical Indication	1. Removed diazepam rectal gel as generic PA was removed. Branded diazepam rectal gel (Diastat, Diastat AcuDial) will be reviewed against Non-Formulary policy. 2. Revised criteria that product is being used for acute treatment of potential seizure activity. 3. Revised criteria that member will be or is currently on antiepileptic maintenance therapy. 4. Revised reauthorization criteria that member will continue to benefit with acute treatment on hand to treat potential seizure activity. 5. Added that compendia or evidenced based published guidelines is allowed for dosing and age.	Yes	10/1/2025
Tremfya (guselkumab) (PG250)	Clinical Indications	1. For new starts with Crohn's Disease or Ulcerative Colitis, if the request is for Tremfya IV, the member is unable to use, or has tried and failed ustekinumab IV.	Yes	1/1/2026

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Amvuttra (vutrisiran) (PG264)	Clinical Indications - Polyneuropathy of Hereditary Transthyretin-mediated Amyloidosis (hATTR-PN)	1. Added the member is unable to use, or has tried and failed Wainua (eplontersen).	Yes	1/1/2026
Dupixent (dupilumab) (PG026)	Clinical Indications	1. Added expanded indication that member is 18 years or older, diagnosis of bullous pemphigoid, and unable to use or has tried and failed one (1) oral systemic corticosteroid (e.g., prednisone or prednisolone).	Yes	10/1/2025
Tarpeyo (budesonide delayed release capsules) (PG116)	Clinical Indications	1. Removed that member has had prior treatment with systemic immunosuppressive medications within the last 12 months. 2. Added that the member has tried and failed generic systemic methylprednisolone with or without prednisolone or prednisone, or prednisone, for 6 to 9 months; or the member is unable to use methylprednisolone or prednisone due to an adverse event or contraindication that would not exist or be reasonably expected to occur with Tarpeyo (budesonide delayed release capsules). 3. For concurrent use with ACE inhibitor or ARB allow the member to have an exception if	Yes	1/1/2026

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
		unable to use all. 4. Extended authorization duration to 42 weeks to allow for 2 week tapering after finishing the 9 month treatment course.		
	Experimental or Investigational / Not Medically Necessary	1. Added that subsequent courses of Tarpeyo after the initial treatment course as safety and efficacy of treatment with subsequent courses have not been established.		
Vyvgart (efgartigimod alfa-fcab) and Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) (PG191)	Clinical Indications	1. For all indications, if the request is for Vyvgart (efgartigimod alfa) or Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) vial, the member has tried and failed the self-administered Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) prefilled syringe or there is reason to use a provider-administered product (vial) over the self-administered product (prefilled syringe).	Yes	1/1/2026
Commercial Preferred Physician-Administered Specialty Drugs (CG052)	Medical Preferred Drug List	1. The following preferred drug list changes were made for 1/1/26 for the preferred for non-preferred (NP) section: a. Added Nypozi as NP. b. Moved Kanjinti and Trazimera to NP, Added Hercessi and Trazimera to NP, Moved Herzuma and Ogivri to preferred.	Yes	1/1/2026

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
		c. Added Jobevne as NP. d. Moved Aranesp to NP, moved Mircera to preferred. e. Added Jubbonti and Stoboclo as preferred, added Prolia, Ospomyv , Conexxence (denosumab-bnht), and unbranded denosumab-bnht to NP f. Added Wyost and Osenvelt as preferred, added Xgeva, Xbryk, Bomyntra, and unbranded denosumab - bnht to NP. g. Moved Stelara to NP within the biologics. Moved Steqeyma and Yesintek to preferred within the ustekinumab products. Added Wezlana, Selarsdi, Pyzchiva, Imuldosa, and Otulfi as NP within ustekinumab products. h. Added Avtozma as NP. i. Moved Idelvion to NP. j. Moved Kogenate to NP. k. Moved Paragard and Liletta to preferred. l. Added Tyruko as NP. m. Added Tyvaso and Yutrepia to NP. n. Moved Imaavy to preferred, moved Rystiggo to NP.		

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
		o. Added Ahzantive, Enzzevu, Opuviz, and Yesafili to NP. p. Added Gamastan S/D to NP. q. Moved Ruconest to NP. r. Added Cinvanti to NP. s. Added Avgemsi to NP. t. Added Sandoz cyclophosphamide to NP. u. Added Alphanate to preferred, added Humate-P and Wilate to NP. v. Added Faslodex and fulvestrant (Teva) to preferred, added fulvestrant (Fresenius Kabi) to NP.		

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
	Exceptions	1. Added exception for drug shortage for all preferred products and allow for an authorization of 3 months that may be extended based on continued shortage. 2. Added exception if guidelines support the preferential use of the requested product over all preferred products. 3. Added exception for hypersensitivity to excipients in all preferred products. 4. Added exception that all preferred products have not received the requested FDA approval, is not supported by evidence-based guidelines, or is not clinically appropriate for the member's diagnosis. 5. The required dosing or administration cannot be achieved using all preferred products. 6. Documented facility or treatment requirements that cannot be met with all preferred products. 7. Added authorization duration of 12 months or 3 months for drug shortage with allowance of extension.		
	Preferred Drug List	1. Added Nypozi as NP.	Yes	1/1/2026

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Short-Acting Granulocyte Colony-Stimulating Factors - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG080)	Exceptions	1. Added exception if guidelines support the preferential use of the requested product over ALL preferred products.		
Erythropoiesis-Stimulating Agent (ESA) - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG084)	Preferred Drug List	1. Moved Aranesp to NP, moved Mircera to preferred.	Yes	1/1/2026
	Exceptions	1. Added exception for drug shortage for ALL preferred products and allow for an authorization of 3 months that may be extended based on continued shortage. 2. Added exception if guidelines support the preferential use of the requested product over ALL preferred products.		
Antineoplastic and Immunomodulating Agents - Biologics for Autoimmune and Inflammatory	Preferred Drug List	1. Moved Stelara to NP within the biologics. 2. Moved Steqeyma and Yestintek to preferred within the ustekinumab products. 3. Added Wezlana, Selarsdi, Pyzchiva, Imuldosa, and Otulfi as NP within ustekinumab products.	Yes	1/1/2026

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Conditions - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG086)	Exceptions	1. Added exception for drug shortage for ALL preferred products and allow for an authorization of 3 months that may be extended based on continued shortage. 2. Added criteria that if request is for a non-preferred ustekinumab product the member has tried ALL preferred ustekinumab products unless exception met.		
	Preferred Drug List	1. Added Avtozma as NP.	Yes	1/1/2026

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Antineoplastic and Immunomodulating Agents - Tocilizumab Products - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG108)	Exceptions	1. Updated that if the preferred product has not received FDA approval, is not supported by evidence-based guidelines, or is not clinically appropriate for the member's diagnosis or the required dosing or administration cannot be achieved using the preferred product then the non-preferred product is eligible for coverage. 2. Added exception if dosing or administration cannot be achieved using the preferred product. Added exception if guidelines support the preferential use of the requested product over the preferred product. 3. Clarified that members are required to use Tyenne (tocilizumab-aazg) SC injection formulation for therapy first when requesting Tyenne (tocilizumab-aazg) IV, Actemra (tocilizumab) IV, or Tofidence (tocilizumab-bavi) IV unless exception is met.		
	Preferred Drug List	1. Moved Kogenate to NP.	Yes	1/1/2026

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Factor VIII Antihemophilic Agents - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG091)	Exceptions	1. Added exception for drug shortage for ALL preferred products and allow for an authorization of 3 months that may be extended based on continued shortage.		
Prostacyclin Analogs/Receptor Agonists for Pulmonary Hypertension (PAH) - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG097)	Preferred Drug List	1. Added Tyvaso and Yutrepia to NP.	Yes	1/1/2026
	Exceptions	1. Added exception for drug shortage for ALL preferred products and allow for an authorization of 3 months that may be extended based on continued shortage.		
Vascular Endothelial Growth Factor (VEGF) Inhibitor Ophthalmic	Preferred Drug List	1. Added Ahzantive, Enzzevu, Opuviz, and Yesafili to NP. 2. Coverage of Eylea (aflibercept) or Eylea HD (aflibercept) requires trial and failure of Pavblu (aflibercept-ayyh).	Yes	1/1/2026

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Agents - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG099)	Exceptions	1. Added exception for drug shortage for ALL preferred products and allow for an authorization of 3 months that may be extended based on continued shortage.		
Antiemetics - Substance P/Neurokinin 1 (NK1) Antagonist (i.e., Fosaprepitant Products) - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG103)	Preferred Drug List	1. Added Cinvanti to NP.	Yes	1/1/2026
	Exceptions	1. Added exception if guidelines support the preferential use of the requested product over the preferred product.		
	Preferred Drug List	1. Added Sandoz cyclophosphamide to NP.	Yes	1/1/2026

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Antineoplastics - Cyclophosphamide Products - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG120)	Exceptions	1. Added exception for contraindication that would not occur with non-preferred product.		

New Guidelines

Clinical Guideline	Details	Effective Date
Skyrizi (risankizumab) (PG266)	1. General criteria asking for 18 years and older, negative tuberculosis test, not receiving in combination with other biologic or targeted disease-modifying antirheumatic drug (DMARD) for the same indication. 2. Initial review asking for prescriber specialty, diagnosis of Crohn's Disease, Plaque Psoriasis, Psoriatic Arthritis, or Ulcerative Colitis. For new starts with Crohn's Disease or Ulcerative Colitis, if the request is for Tremfya IV, the member is unable to use, or has tried and failed ustekinumab IV. For new starts with Psoriatic Arthritis or Plaque Psoriasis, member	1/1/2026

Clinical Guideline	Details	Effective Date
	has tried and failed conventional synthetic drug or previously received a biologic (or phototherapy if for Plaque Psoriasis). 3. Continued care asking for a positive response. 4. Crohn's Disease and Ulcerative Colitis maintenance dose escalation to show that lower dose provided inadequate response.	
Vykat XR (diazoxide choline) (PG267)	1. General criteria asking for prescriber specialty, age 4 years and older, 20 kg or greater, member's current weight, and prescribed at dose and frequency within FDA label. 2. Initial review asking for diagnosis of Prader-Willi syndrome (PWS), diagnosis supported by genetic testing documentation in chromosome 15 region, moderate to severe hyperphagia supported two (2) characteristics, assessed for hyperglycemia, and no evidence of contraindications and specific populations. 3. Continued care asking for improvement in hyperphagia, body fat mass, or levels of leptin, and no evidence of unacceptable toxicity or adverse reactions.	1/1/2026
Non-Formulary Antiretroviral Products Criteria (PG268)	1. General authorization supported by FDA approved or compendia supported indication, diagnosis for Human Immunodeficiency Virus-1 (HIV-1), and age, weight dosing, frequency, duration of therapy, and site of administration	1/1/2026

Clinical Guideline	Details	Effective Date
	being prescribed per prescribing information, compendia, or medical literature. 2. Initial authorization requires appropriate patient characteristics per FDA labeling, trial and failure of three appropriate formulary alternatives, and if the request is for a brand-name product with a generic or biosimilar available then trial and failure of the corresponding generic or biosimilar. No contraindications. 12 month approval. 3. For reauthorization or continued care, the member is stable on requested product, if request is for a brand-name product with a generic or biosimilar available then trial and failure of the corresponding generic or biosimilar, has seen an improvement such as reduction in HIV-1 RNA copies, and no evidence of significant adverse reaction or unacceptable toxicity. Lifetime approval.	
Authorization Duration Exception-REG (PG269)	1. Created for Illinois: (215 ILCS 200/) Prior Authorization Reform Act, Oklahoma: Bill No. 1808. Ensuring Transparency in Prescription Drugs Prior Authorization Act, and Texas: HB755 Sec. 1369.654. Prohibition On Multiple Prior Authorizations regarding authorization durations.	10/1/2025

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Annual Reviews

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Beyfortus (nirsevimab-alip) and Enflonsia (clesrovimab-cfor) (PG180)	Clinical Indications	1. Added Enflonsia (clesrovimab-cfor) asking that administration is before or during the Respiratory syncytial virus (RSV) season, request is for prevention of RSV, has not previously received any RSV prophylaxis unless undergoing cardiac surgery or have not completed palivizumab regimen, and does not have active RSV or prior RSV infection in current season. 2. Additionally, Enflonsia (clesrovimab-cfor) is covered for infants aged <8 months during or entering their first RSV season and dodge and administration is within FDA approved labeling or supported by compendia. Additional dose covered after cardiac bypass surgery.	Yes	10/1/2025

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
	Medical Necessity Criteria for Clinical Review	1. Included language per package insert regarding prior administration and second dosage recommendations.	No	
	Additional Billing Codes	1. Updated CPT/HCPCS codes	Yes	
	Appendix A	1. Dosing/administration recommended moved to Appendix A	No	
Testosterone replacement therapy (PG122)	Medical Necessity Criteria for Authorization	1. Additional criteria allowing for indications in which serum testosterone level monitoring may not be clinically warranted with proper documentation (e.g., Klinefelter's syndrome) 2. Removal of requirement for hand and wrist radiographic examinations every 6 months, changed to an assessment of bone maturation prior to treatment. 3. Increased duration of authorization to: a. Hypogonadism: 36 months b. Hormone therapy for transgender and gender diverse individuals: lifetime c. Hypogonadism associated with HIV: 36 months d. Palliative treatment of breast cancer: lifetime	Yes	10/1/2025

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
CeQur Simplicity Insulin Delivery System (PG192	Medical Necessity Criteria for Initial Authorization	1. Amended language around diabetes education program to allow for a documented treatment plan and documentation that member or caregiver can be trained to use the device. 2. Amended requirement for at least 3 blood glucose checks daily to the member requiring blood glucose checks daily (without a specific number requirement). 3. Additional criteria to define suboptimal glycemic control including hypoglycemic episodes, wide swings in blood glucose, pregnancy or planning pregnancy, and complications associated with inadequate glycemic control.	Yes	10/1/2025
Aripiprazole oral disintegrating	Summary	1. Addition of Mezofy (oral film) product	Yes	10/1/2025

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
tablet, solution (PG173)	Medical Necessity Criteria for Authorization	1. With addition of Mefozy, clarification of which product is approved for each indication. 2. Removal of postpartum psychosis clinical documentation consistent with the American College of Obstetricians and Gynecologists (ACOG). 3. Additional off-label uses including delusional disorder. 4. Increase of authorization duration from 12 months to member's lifetime 5. Removal of reauthorization criteria given lifetime authorization.	Yes	
Caplyta (lumateperone) (PG175)	Medical Necessity Criteria for Authorization	1. Removal of postpartum psychosis clinical documentation consistent with guidelines (ACOG). 2. Additional antipsychotics added for trial/failure for the following indications: bipolar disorder, schizoaffective disorder, schizophrenia. This is consistent with available Bipolar disorder guidelines (2023 Veterans Affairs/Department of Defense [VA/DoD]), schizophrenia guidelines (2020 American Psychiatric Association, 2024 VA/DoD). 3. Increase of authorization duration from 12 months to member's lifetime 4. Removal of reauthorization criteria given	Yes	10/1/2025

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
		lifetime authorization.		
Combination products for treatment of helicobacter pylori (PG199)	Medical Necessity Criteria for General Authorization	1. Created a general authorization section	Yes	10/1/2025
	Medical Necessity Criteria for Initial Authorization	1. Reorganized by indication: treatment-naive and treatment-experienced therapy for *H. Pylori* based on The 2024 American College of Gastroenterology (ACG) guidelines 2. Removal of requirement of trial and failure of individual products to better align with 2024 ACG guidelines regarding recommended therapies based on indication.	Yes	
	Appendix	1. Updated table 1 to include products recommended by 2024 ACG guideline for treatment-naive and treatment-experienced.	Yes	
Xdemvy (lotilaner) (PG161)	Medical Necessity Criteria for Initial Authorization	1. Clarified symptoms and expanded symptoms to be more consistent with diagnostic criteria for Demodex blepharitis.	No	10/1/2025

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Xifaxan (rifaximin) 550 mg Tablets (PG022	Medical Necessity Criteria for Initial Clinical Review	1. For the management of small intestinal bacterial overgrowth (SIBO), removed the requirement to be 18 years of age or older, as dosing supported by evidence for pediatric population.	Yes	10/1/2025
oxiconazole (Oxistat 1%) (PG100)	Medical Necessity Criteria for Authorization	1. Updated trial and failure requirement from three (3) to two (2) products.	Yes	10/1/2025
brimonidine/timolol (Combigan) (PG103)	Medical Necessity Criteria for Initial Authorization	1. Re-organized criteria regarding trial and failure to allow for trial and failure of 2 products (from at least 2 different classes). 2. Allowed for trial and failure of ophthalmic prostaglandins, which are first line for the management of open-angle glaucoma and ocular hypertension.	Yes	10/1/2025
Allergen Sublingual Immunotherapy (SLIT) (PG093)	Medical Necessity Criteria for Initial Authorization	1. Expanded age range for Odactra from 12 to 65 years to 5 to 65 years of age consistent with package insert dosing. 2. Removal of criteria which are not true contraindications per prescribing information in package insert.	Yes	10/1/2025

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Velphoro (sucroferric oxyhydroxide) (PG179)	Medical Necessity Criteria for Initial Authorization	1. For pediatric members 9-17 years, the dosing for sevelamer carbonate (Renvela) trial and failure was updated to include that sevelamer carbonate (Renvela) would only be appropriate in those with a body surface area of 0.75m^2 or more.	No	10/1/2025
Carvykti (ciltacabtagene autoleucel; cilta-cel) (CG067)	Summary	1. Removal of Risk Evaluation and Mitigation Strategies (REMS) language, as the FDA removed requirement of a REMS program for all CAR-T therapies.	No	1/1/2026
	Medical Necessity Criteria for Initial Authorization	1. Removal of REMS program requirement, and changed to language which indicates that the facility/providers attest to the ability to manage potential serious adverse events.	No	
Kymriah (tisagenlecleucel) (CG058)	Summary	1. Removal of Risk Evaluation and Mitigation Strategies (REMS) language, as the FDA removed requirement of a REMS program for all CAR-T therapies.	No	1/1/2026
	Medical Necessity Criteria for Initial Authorization	1. Additional language to require that the facility/providers attest to the ability to manage potential serious adverse events.	No	
	Summary	1. Removal of Risk Evaluation and Mitigation Strategies (REMS) language, as the FDA	No	1/1/2026

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Yescarta (axicabtagene ciloleucel) (CG063)		removed requirement of a REMS program for all CAR-T therapies.		
	Medical Necessity Criteria for Initial Authorization	1. Additional language to require that the facility/providers attest to the ability to manage potential serious adverse events.	No	
Sirturo (bedaquiline) (PG242)	Medical Necessity Criteria for Authorization	1. Updated age and weight requirement consistent with most recent updates to the FDA-approved labeling in the package insert (now approved in those 2 years of age and older and weighing at least 8 kg)	Yes	10/1/2025
Vemlidy (tenofovir alafenamide) (PG010)	Medical Necessity Criteria for Initial Authorization	Treatment of Chronic hepatitis B infection: 1. Added language consistent with package insert regarding appropriate management if co-infection with HIV or Hepatitis C occurs (tenofovir should not be used as monotherapy in these cases). 2. Removal of requirement for a trial and failure of lamivudine. Lamivudine is not a first-line agent for this indication (unlike tenofovir and entecavir). 3. Added criteria for when a trial/failure of entecavir would not be appropriate: in the setting of lamivudine-resistant strain, tenofovir is considered first-line).	Yes	10/1/2025

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
		Hepatitis B Virus Reactivation Prophylaxis 1. Added language consistent with American Gastroenterology Association (AGA) regarding risk stratification for when tenofovir would be appropriate.		
	Appendix	1. Added an appendix to highlight risk stratification in the setting of Hepatitis B reactivation prophylaxis management per the AGA guidelines.	Yes	
Niktimvo (axatilimab) (PG252)	Medical Necessity Criteria for Initial Authorization	1. Updated to clarify steroid-refractory chronic graft versus host disease (cGVHD) to be more consistent with guidelines and lack of explicit definition. 2. Removal of age requirement as dosing is only weight based. 3. Re-organized to clarify systemic corticosteroid has first-line therapy to trial and fail, and allowed for additional therapy other than Jakafi (as the additional second systemic therapy required per package insert) in the event the member is unable to use Jakafi. 4. Additional language to avoid concomitant use with other targeted therapy.	Yes	10/1/2025

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Vesicular Monoamine Transporter Type 2 (VMAT2) Inhibitors (PG144)	Medical Necessity Criteria for Initial Authorization	1. Re-worded trial and failure explicit for prescribing Xenazine (branded tetrabenazine) or Austedo or Austedo XR (deutetrabenazine) for clarity and consistency with prior policies. 2. Re-organized section to include all initiation authorization criteria first, followed by all reauthorization criteria. 3. Updated past monoamine oxidase inhibitor (MAOI) to be within the past 30 days vs. past 90 days, as the goal is only 14 day wash-out between therapies. 4. Updated trial and failure options for Tourette's Syndrome (Gilles de la Tourette's syndrome, including additional antipsychotics and topiramate.	Yes	10/1/2025
Oscar Clinical Guidelines	Clinical Indication	List of criteria that have completed the annual review process. No clinical changes. 1. Miebo (perfluorohexyloctane) (PG166) 2. Xiidra (lifitegrast) (PG197) 3. Ivermectin 1% Topical Cream (PG239) 4. Lanthanum carbonate chewable tablets (Fosrenal) (PG177)	No	1/1/2026
Oscar Clinical Guidelines	Clinical Indication	List of Criteria that will be sunset: 1. Clomid (clomiphene PG104)	No	9/1/2025

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Oscar Clinical Guidelines	Clinical Indication	List of Criteria that will be sunset as exceptions criteria is captured in Commercial Preferred Physician-Administered Specialty Drugs (CG052): 1. Antineoplastics - Trastuzumab Products - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG082) 2. Antineoplastics - Bevacizumab for Cancer Indications - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG083) 3. Long-Acting Reversible Contraceptives - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG095) 4. Factor IX Antihemophilic Agents - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG089) 5. Multiple Sclerosis Agents - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG096) 6. Antineoplastics - Gemcitabine Products - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG104)	No	1/1/2026