Q1 2025 Pharmacy and Therapeutics Committee Criteria Summary Table		
Reference ID	**Criteria Title**	**Revision**
CP.PHAR.01	Omalizumab (Xolair)	1Q 2025 annual review: for asthma initial approval criteria, added allowance for ER visit; for immune checkpoint inhibitor-related severe pruritis, added requirement for no response to 1 month of gabapentinoid therapy per NCCN; updated Appendix D to include information about atopic dermatitis; references reviewed and updated.
CP.PHAR.101	Mifepristone (Korlym)	1Q 2025 annual review: per December SDC, added redirection to generic 300 mg tablet for brand Korlym requests; revised policy/criteria section to also include generic mifepristone; references reviewed and updated.
CP.PHAR.114	Teduglutide (Gattex)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.115	Pegloticase (Krystexxa)	1Q 2025 annual review: no significant changes; references reviewed and updated
CP.PHAR.123	Evolocumab (Repatha)	1Q 2025 annual review: RT4: revised FDA approved indication wording to align CV disease wording with PI; for HoFH, lowered untreated LDL requirement to 400 mg/dL and revised evidence of HeFH in both parents to evidence of familial hypercholesterolemia in at least one parent per 2022 ACC expert consensus decision pathway; in Appendix B, added pravastatin and fluvastatin as therapeutic alternatives; in Section VI, clarified non-latex and latex formulations; references reviewed and updated.
CP.PHAR.124	Alirocumab (Praluent)	1Q 2025 annual review: for HoFH, lowered untreated LDL requirement to 400 mg/dL and revised evidence of HeFH in both parents to evidence of familial hypercholesterolemia in at least one parent per 2022 ACC expert consensus decision pathway; for all indications, revised continued therapy criteria to require provider attestation rather than documentation; in Appendix B, added pravastatin and fluvastatin as therapeutic alternatives; references reviewed and updated.
CP.PHAR.160	Alglucosidase Alfa (Lumizyme)	1Q 2025 annual review: moving forward to 1Q annual review cycle to consolidate with the Opfolda+Pombiliti annual review cycle; added increased lysosomal glycogen as an additional option for confirming a Pompe disease diagnosis; references reviewed and updated.
CP.PHAR.164	Miglustat (Zavesca)	Added criteria for use in NPC.
CP.PHAR.165	Ferumoxytol (Feraheme)	1Q 2025 annual review: no significant changes; revised policy/criteria section to also include brand ferumoxytol; references reviewed and updated.
CP.PHAR.168	Repository Corticotropin Injection (Acthar Gel, Purified Cortrophin Gel)	1Q 2025 annual review: no significant changes; for infantile spasm added requirement for documentation of member's current body surface area (BSA) in m2; references reviewed and updated.
CP.PHAR.179	Romiplostim (Nplate)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.180	Eltrombopag (Alvaiz, Promacta)	1Q 2025 annual review: added disclaimer that for HIM line of business Alvaiz is non-formulary; per NCCN Compendium, for MDS removed that request must be for Promacta and for MDS with symptomatic anemia removed requirement for no del(5q) and serum erythropoietin; references reviewed and updated.
CP.PHAR.181	Hemin (Panhematin)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.184	Aflibercept (Eylea, Eylea HD), Aflibercept-yszy (Opuviz), Aflibercept-jbvf (Yesafili), Aflibercept-mrbb (Ahzantive), Aflibercept-abzv (Enzeevu), Aflibercept-ayyh (Pavblu)	1Q 2025 annual review: added max dose of 1 vial or syringe to Eylea and Enzeevu criteria; in Appendix B per Clinical Pharmacology, updated dosing regimens and clarified off-label indications; references reviewed and updated.
CP.PHAR.186	Ranibizumab (Byooviz, Cimerli, Lucentis, Susvimo)	1Q 2025 annual review: simplified FDA approved indications to show Lucentis and Cimerli are additionally indicated from Byooviz for DME and DR; added quantity limit of 1 vial/syringe for Lucentis and biosimilars; revised Susvimo maximum dose to 100 mg (1 vial) per 6 months per PI; in Appendix B per Clinical Pharmacology, removed dosing for neovascular glaucoma, updated dosing regimens, clarified off-label indications; removed Lucentis single-use glass vials in Section VI per PI, references reviewed and updated.
CP.PHAR.187	Verteporfin (Visudyne)	1Q 2025 annual review: for CNV due to pathologic myopia, revised failure of Avastin or Lucentis to bevacizumab and ranibizumab; in Appendix B, added aflibercept and ranibizumab biosimilars; references reviewed and updated.
CP.PHAR.188	Teriparatide (Forteo, Bonsity)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.189	Ibandronate Injection (Boniva)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.190	Ambrisentan (Letairis)	1Q 2025 annual review: in Policy/Criteria, clarified criteria also applies to brand Letairis; in Appendix B per Clinical Pharmacology, removed commercially unavailable branded products, updated dosing regimens; clarified drugs used for off-label indications; references reviewed and updated.
CP.PHAR.191	Bosentan (Tracleer)	1Q 2025 annual review: in Policy/Criteria, clarified criteria also applies to brand Tracleer; in Appendix B per Clinical Pharmacology, removed commercially unavailable branded products, updated dosing regimens; clarified drugs used for off-label indications; references reviewed and updated.
CP.PHAR.192	Epoprostenol (Flolan, Veletri)	1Q 2025 annual review: in Policy/Criteria, clarified criteria also applies to brand Flolan and Veletri; in Appendix B per Clinical Pharmacology, removed commercially unavailable branded products, updated dosing regimens; clarified drugs used for off-label indications; references reviewed and updated.
CP.PHAR.193	Iloprost (Ventavis)	1Q 2025 annual review: in Appendix B per Clinical Pharmacology, removed commercially unavailable branded products, updated dosing regimens; clarified drugs used for off-label indications; references reviewed and updated.
CP.PHAR.194	Macitentan (Opsumit)	1Q 2025 annual review: in Appendix B per Clinical Pharmacology, removed commercially unavailable branded products, updated dosing regimens, clarified drugs used for off-label indications, and clarified drug classes of recommended redirections; references reviewed and updated.
CP.PHAR.195	Riociguat (Adempas)	1Q 2025 annual review: in Appendix B per Clinical Pharmacology, removed commercially unavailable branded products, updated dosing regimens; clarified drugs used for off-label indications; references reviewed and updated.
CP.PHAR.196	Selexipag (Uptravi)	1Q 2025 annual review: in Appendix B per Clinical Pharmacology, removed commercially unavailable branded products, updated dosing regimens, clarified drugs used for off-label indications; references reviewed and updated.
CP.PHAR.197	Sildenafil (Revatio, Liqrev)	1Q 2025 annual review: in Policy/Criteria, clarified criteria also applies to brand Revatio and Liqrev; in Appendix B per Clinical Pharmacology, removed commercially unavailable branded products and clarified drugs used for off-label indications; references reviewed and updated.
CP.PHAR.198	Tadalafil (Adcirca, Alyq, Tadliq)	1Q 2025 annual review: in Policy/Criteria, clarified criteria also applies to brand Adcirca, Alyq, and Tadliq; in Appendix B per Clinical Pharmacology, removed commercially unavailable branded products, updated dosing regimens; clarified drugs used for off-label indications; references reviewed and updated.

CP.PHAR.199	Treprostinil (Orenitram, Remodulin, Tyvaso, Tyvaso DPI)	1Q 2025 annual review: clarified Tyvaso and Tyvaso DPI are also indicated for PH-ILD; in Policy/Criteria, clarified criteria also applies to brand Orenitram, Remodulin, Tyvaso, and Tyvaso DPI; in Appendix B per Clinical Pharmacology, removed commercially unavailable branded products, updated dosing regimens; clarified drugs used for off-label indications; in Dosage and Administration, updated maximum dose for Orenitram per PI; references reviewed and updated
CP.PHAR.200	Mepolizumab (Nucala)	1Q 2025 annual review: for asthma initial approval criteria, added allowance for ER visit; references reviewed and updated. Per December SDC: HIM line of business removed as separate criteria is required; added statement disclaimer that California Exchange Plans should not be approved using these criteria and should use applicable HIM criteria; for asthma removed intubation option for alignment purposes as a hospital admission would encompass intubation.
CP.PHAR.203	Cosyntropin (Cortrosyn)	1Q 2025 annual review: added Commercial line of business; updated maximum dosing in those age 2 years and older to 0.25 mg as a single-dose per updated prescribing information; references reviewed and updated.
NH.PHAR.206	Carglumic Acid (Carbaglu)	Policy created
NH.PHAR.207	Glycerol Phenylbutyrate (Ravicti)	Policy created
NH.PHAR.208	Sodium Phenylbutyrate (Buphenyl, Pheburane, Olpruva)	Policy created
CP.PHAR.214	Desmopressin Acetate (DDAVP, Stimate, Nocdurna)	1Q 2025 annual review: added the generic versions of DDAVP and Stimate to the “Policy/Criteria” section to clarify that criteria are applicable to the generic versions; for brand DDAVP injection requests, added redirection to generic desmopressin injection for both initial and continued criteria; added Appendix D reference for Stimate brand shortage; references reviewed and updated.
CP.PHAR.215	Factor VIII (Human, Recombinant)	1Q 2025 annual review: for Medicaid and HIM lines of business, continued approval duration revised from 6 months to 12 months for prophylaxis and ITI; for Commercial line of business, all prophylaxis approval durations revised to “6 months or to the member’s renewal date, whichever is longer;” references reviewed and updated.
CP.PHAR.216	Factor VIII/von Willebrand Factor Complex (Human – Alphanate, Humate-P, Wilate); von Willebrand Factor (Recombinant – Vonvendi)	1Q 2025 annual review: revised desmopressin acetate trial to apply only for age ≥ 2 years; for Medicaid and HIM lines of business, initial therapy approval durations revised to from 3 months to 3 months for surgical/acute bleeding and to 6 months for prophylaxis, and continued therapy approval durations revised from 3 months to 3 months for surgical/acute bleeding and 12 months for prophylaxis; for Commercial line of business, all prophylaxis approval durations revised to “6 months or to the member’s renewal date, whichever is longer;” references reviewed and updated.
CP.PHAR.217	Anti-Inhibitor Coagulant Complex, Human (Feiba)	1Q 2025 annual review: for Medicaid and HIM lines of business, continued approval duration revised from 6 months to 12 months for prophylaxis; for Commercial line of business, all prophylaxis approval durations revised to “6 months or to the member’s renewal date, whichever is longer;” references reviewed and updated.
CP.PHAR.218	Factor IX (Human, Recombinant)	1Q 2025 annual review: for Medicaid and HIM lines of business, continued approval duration revised from 6 months to 12 months for prophylaxis; for Commercial line of business, all prophylaxis approval durations revised to “6 months or to the member’s renewal date, whichever is longer;” references reviewed and updated.
CP.PHAR.219	Factor IX Complex, Human (Profilnine)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.220	Factor VIIa, Recombinant (NovoSeven RT, SevenFact)	1Q 2025 annual review: clarified that acquired hemophilia indication is applicable to NovoSeven RT only; updated HCPCS code; references reviewed and updated.
CP.PHAR.221	Factor XIII, Human (Corifact)	1Q 2025 annual review: for Medicaid and HIM lines of business, continued approval duration revised from 6 months to 12 months for prophylaxis; for Commercial line of business, all prophylaxis approval durations revised to “6 months or to the member’s renewal date, whichever is longer”; references reviewed and updated.
CP.PHAR.222	Factor XIII A-Subunit, Recombinant (Tretten)	1Q 2025 annual review: for Commercial line of business, revised initial and continued approval durations to be “6 months or to the member’s renewal date, whichever is longer;” for Medicaid and HIM lines of business, continued approval duration revised from 6 months to 12 months; references reviewed and updated.
CP.PHAR.223	Reslizumab (Cinqair)	1Q 2025 annual review: for initial approval criteria, added allowance for ER visit; references reviewed and updated.
NH.PHAR.224	Enoxaparin (Lovenox)	Policy created
NH.PHAR.225	Dalteparin (Fragmin)	Policy created
NH.PHAR.226	Fondaparinux (Arixtra)	Policy created
CP.PHAR.234	Ferric Carboxymaltose (Injectafer)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.24	Fostamatinib (Tavalisse)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.282	Parathyroid Hormone (Natpara)	1Q 2025 annual review: no significant changes; Takeda plans to discontinue global manufacturing of Natpara by the end of 2024; references reviewed and updated.
CP.PHAR.283	Lomitapide (Juxtapid)	1Q 2025 annual review: per 2022 ACC expert consensus decision pathway, lowered untreated LDL requirement to 400 mg/dL and revised evidence of HeFH in both parents to evidence of familial hypercholesterolemia in at least one parent; references reviewed and updated.
NH.PHAR.285	Nintedanib (Ofev)	Policy created
CP.PHAR.286	Pirfenidone (Esbriet)	Per December SDC, revised generic redirection to generic tablet or capsule by removing specific formulations.
CP.PHAR.288	Eteplirsen (Exondys 51)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.289	Buprenorphine Injection (Sublocade, Brixadi)	1Q 2025 annual review: added pain management to section III as diagnoses/indication for which coverage is not authorized; references reviewed and updated.
CP.PHAR.300	Bezlotoxumab (Zinplava)	1Q 2025 annual review: no significant changes; references reviewed and updated.
NH.PHAR.327	Nusinersen (Spinraza)	Policy created
CP.PHAR.329	Siltuximab (Sylvant)	1Q 2025 annual review: in CRS initial criteria, added Sylvant may be used to replace the second dose of Tyenne per NCCN and added Carvykti as an additional example of a CAR-T therapy; references reviewed and updated.
CP.PHAR.330	Protein C Concentrate, Human (Ceprotin)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.331	Deflazacort (Emflaza)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.336	Dupilumab (Dupixent)	1Q 2025 annual review: for immunotherapy-related pruritus per NCCN, removed “refractory” for G3 pruritus, added requirement for no response to 1 month of gabapentinoid therapy for severe pruritus, removed requirement for increased IgE level, and added indication for immunotherapy-related bullous dermatitis; references reviewed and updated. Per December SDC, commercial line of business removed as separate criteria is required; for CRSwNP, added disclaimer statement “Refer to NY.HIM.SP69 for NY CHIP Plans.”

CP.PHAR.345	Abaloparatide (Tymlos)	1Q 2025 annual review: no significant changes; for Commercial continuation of therapy modified approval duration to 6 months or to the member's renewal date, whichever is longer; added Appendix E to provide clarity on the interpretation of bone mineral density T-scores; references reviewed and updated.
CP.PHAR.361	Tisagenlecleucel (Kymriah)	1Q 2025 annual review: per NCCN Compendium for LBCL added off-label use for disease relapsed more than 12 months after completion of first-line therapy and partial response following second-line therapy; added the following to Appendix C per updated prescribing information: T cell malignancies have occurred following treatment of hematologic malignancies with BCMA- and CD19- directed genetically modified autologous T cell immunotherapies, including Kymriah. Kymriah is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Kymriah REMS; references reviewed and updated.
CP.PHAR.362	Axicabtagene Ciloleucel (Yescarta)	1Q 2025 annual review: per NCCN Compendium for LBCL added off-label use for disease relapsed more than 12 months after completion of first-line therapy and partial response following second-line therapy; consolidated extranodal marginal zone lymphoma of the stomach with gastric MALT lymphoma and extranodal marginal zone lymphoma of nongastric sites with nongastric MALT lymphoma as they refer to the same condition; added the following to Appendix C per updated prescribing information: T cell malignancies have occurred following treatment of hematologic malignancies with BCMA- and CD19-directed genetically modified autologous T cell immunotherapies, including Yescarta; references reviewed and updated.
CP.PHAR.367	Letermovir (Prevymis)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.370	Emicizumab-kxwh (Hemlibra)	1Q 2025 annual review: respective diagnosis criterion for each Hemlibra indication was clarified further to add "WITH inhibitors" and "WITHOUT inhibitors" to help prevent reviewer confusion; revised Commercial line of business approval duration to "6 months or to the member's renewal date, whichever is longer;" revised continued approval duration for Medicaid and HIM lines of business from 6 months to 12 months; references reviewed and updated.
CP.PHAR.371	Triamcinolone ER Injection (Zilretta)	1Q 2025 annual review: added requirement that member is not receiving re-treatment of knee(s) previously treated with Zilretta; clarified approval duration for one dose per knee lifetime; references reviewed and updated.
CP.PHAR.372	Voretigene Neparvovec-rzyl (Luxturna)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.373	Benralizumab (Fasenra)	1Q 2025 annual review: no significant changes; references reviewed and updated. Per December SDC: added statement disclaimer that NY CHIP Plans should not be approved using these criteria and should use NY.HIM.PA.SP70 criteria; for asthma, removed intubation option for alignment purposes as a hospital admission would encompass intubation.
CP.PHAR.40	Octreotide Acetate (Sandostatin, Sandostatin LAR Depot, Mycapssa)	1Q 2025 annual review: for Sandostatin, added must use generic octreoide language to continued therapy; for Sandostatin LAR, added must use generic octrotide language, if available to both initial and continued therapy; references reviewed and updated.
CP.PHAR.402	Emapalumab-lzsg (Gamifant)	1Q 2025 annual review: no significant changes; added additional vial sizes per updated prescribing information; references reviewed and updated; references reviewed and updated.
CP.PHAR.407	Lusutrombopag (Mulpleta)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.411	Amifampridine (Firdapse)	1Q 2025 annual review: no significant changes; modified maximum dose per updated prescribing information; references reviewed and updated.
CP.PHAR.428	Romosozumab-aqqg (Evenity)	1Q 2024 annual review: no significant changes; added Appendix E to provide clarity on the interpretation of bone mineral density T-scores; references reviewed and updated.
CP.PHAR.444	Afamelanotide (Scenesse)	1Q 2025 annual review: removed requirement for gene sequencing per consensus guidelines as not required for primary diagnosis and recommended as follow-up tests; references reviewed and updated.
CP.PHAR.445	Brolucizumab-dbll (Beovu)	1Q 2025 annual review: revised initial approval duration to 6 months for all indications; revised initial criteria maximum dosage to include dosing schedule after loading doses; revised continued therapy to only apply to requests for dose increase; in Appendix B per Clinical Pharmacology, updated dosing regimens and clarified off-label indications; references reviewed and updated.
CP.PHAR.449	Crizanlizumab-tmca (Adakveo)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.450	Luspatercept-aamt (Reblozyl)	1Q 2025 annual review: for MDS, removed requirement for ineligibility, inadequate response, or failure of an ESA for serum erythropoietin ≤ 500 mU/mL per NCCN; added criteria for myelofibrosis-associated anemia per NCCN Compendium; references reviewed and updated.
CP.PHAR.451	Voxelotor (Oxbryta)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.453	Golodirsen (Vyondys 53)	1Q 2025 annual review: no significant changes; updated Appendix C with new contraindication per PI; references reviewed and updated.
CP.PHAR.455	Enfortumab Vedotin-ejfv (Padcev)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.457	Givosiran (Givlaari)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.459	Iobenguane I-131 (Azedra)	1Q 2025 annual review: removed initial approval criteria due to manufacturer discontinuation; added information regarding manufacturer discontinuation to Appendix E; references reviewed and updated.
CP.PHAR.464	Selumetinib (Koselugo)	1Q 2025 annual review: for all indications, added weight-based limitation (25 mg/m2) to max dose requirement per PI; for off-label NCCN compendium recommended indications, updated the following per NCCN: added PXA and NF-1 mutated circumscribed glioma as coverable diagnoses; specified that BRAF fusion or BRAF V600E activating mutation applies only to circumscribed glioma and that Langerhans cell histiocytosis must be MAP kinase positive or have no detectable/actionable mutation unless testing is not available; added that Koselugo must be prescribed as a single agent; references reviewed and updated.
CP.PHAR.465	Teprotumumab (Tepezza)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.466	Valoctocogene Roxaparvovec-rvox (Roctavian)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.467	Zanubrutinib (Brukinsa)	1Q 2025 annual review: for MCL, added option to be prescribed in combination with Gazyva and Venclexta; for WM/LPL, added criterion prescribed as a single agent or in combination with rituximab; for CLL/SLL, added option to be prescribed with Tevimbra® for histolotic (Richter) transformation to difusse large B-cell lymphoma; for hairy cell leukemia, added criterion that disease is relapsed or refractory per NCCN; references reviewed and updated.
CP.PHAR.470	Casimersen (Amondys 45)	1Q 2025 annual review: no significant changes; updated Appendix C with new contraindication per PI; references reviewed and updated.
CP.PHAR.472	Brexucabtagene Autoleucel (Tecartus)	1Q 2025 annual review: no significant changes; added the following to Appendix C per updated prescribing information: T cell malignancies have occurred following treatment of hematologic malignancies with BCMA- and CD19- directed genetically modified autologous T cell immunotherapies. Tecartus is available only through a restricted program under a Risk Evaluation and Mitigation Strategy (REMS) called the Tecartus REMS; references reviewed and updated.
CP.PHAR.473	Lumasiran (Oxlumo)	1Q 2025 annual review: for initial criteria, added medical geneticist; references reviewd and updated.
CP.PHAR.477	Risdiplam (Evrysdi)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.484	Viltolarsen (Viltepso)	1Q 2025 annual review: no significant changes; references reviewed and updated.

CP.PHAR.491	Setmelanotide (Imcivree)	1Q 2025 annual review: for BBS initial criteria, added standard approval language for Commercial line of business of "6 months or to the member's renewal date, whichever is longer"; updated contraindications section to include hypersensitivity to setmelanotide or any of its excipients per PI; references reviewed and updated.
CP.PHAR.492	Teplizumab-mzwv (Tzield)	1Q 2025 annual review: added ZnT8A and IA-2A as additional diabetes-related autoantibody options per pivotal study design and specialist feedback; removed requirement for familial history of T1D as lack of familial history does not preclude the diagnosis; added information about PROTECT trial to Appendix D; references reviewed and updated.
CP.PHAR.499	Lonafarnib (Zokinvy)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.510	Arimoclomol (Miplyffa)	Drug is now FDA approved – criteria updated per FDA labeling: for the diagnostic criteria, the criterion for oxysterols elevated at > 2 times the upper limit of normal was revised to include more examples reflecting the consensus guideline; added neurologist and geneticist specialists and removed psychiatrist per external specialist feedback; removed upper limit of 18 years as age requirement for therapy initiation; revised ≥ 1 neurologic symptom to include option of neurologic sign; added requirement that Miplyffa is prescribed in combination with miglustat to initial and continued criteria; added exclusion for concurrent therapy with Aqneursa to initial and continued criteria; clarified continued therapy positive response criterion to improvement or stabilization in a domain affected by NPC; references reviewed and updated.
CP.PHAR.511	Evinacumab-dgnb (Evkeeza)	1Q 2025 annual review: per 2022 ACC expert consensus decision pathway, lowered untreated LDL requirement to 400 mg/dL and revised evidence of HeFH in both parents to evidence of familial hypercholesterolemia in at least one parent; modified redirection to Praluent to apply only to age ≥ 18 years old per Praluent FDA-approved indication for HoFH; references reviewed and updated.
CP.PHAR.515	Avacopan (Tavneos)	1Q 2025 annual review: added nephrologist, immunologist, and pulmonologist to specialists; removed criterion for documentation of baseline BVAS and added requirement for a diagnosis of severe active ANCA-associated vasculitis per competitor analysis; revised positive response criteria from BVAS of 0 and no glucocorticoid use to improvement in at least one objective measure from baseline; references reviewed and updated.
CP.PHAR.516	Fostemsavir (Rukobia)	1Q 2025 annual review: revised FDA approved indication language to align with wording in prescribing information; in Appendix B, included additional generic drug examples to NRTIs, NNRTIs, and PIs drug classes; references reviewed and updated.
CP.PHAR.52	Interferon Gamma- 1b (Actimmune)	1Q 2025 annual review: for CGD, added immunologist as an additional prescriber specialist option; for mycosis fungoides and Sezary syndrome, added hematologist as an additional prescriber specialist option; references reviewed and updated.
CP.PHAR.521	Avalglucosidase Alfa-ngpt (Nexviazyme)	1Q 2025 annual review: moving forward to 1Q annual review cycle to consolidate with the Opfolda+Pombiliti annual review cycle; added increased lysosomal glycogen as an additional option for confirming a Pompe disease diagnosis; references reviewed and updated.
CP.PHAR.522	Margetuximab-cmkb (Margenza)	1Q 2025 annual review: added criteria for fourth-line use for recurrent unresectable disease and for patients with no response to preoperative systemic therapy to align with NCCN 2A recommendations; references reviewed and updated.
CP.PHAR.523	Naxitamab-gqgk (Danyelza)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.525	Vosoritide (Voxzogo)	1Q 2025 annual review: added HCPCS code for unclassified drugs or biologicals [J3490, C9399]; references reviewed and updated.
CP.PHAR.555	Efgartigimod Alfa-fcab, Efgartigimod/Hyaluronidase-qvfc (Vyvgart, Vyvgart Hytrulo)	1Q 2025 annual review: for gMG, added exclusion for concurrent therapy with Bkemv, Epysqli, Zilbrysq, and an FcRn antagonist; for CIDP, added exclusion for concurrent therapy with a complement inhibitor or FcRn antagonist; references reviewed and updated.
CP.PHAR.562	Allogeneic Cultured Keratinocytes and Dermal Fibroblasts in Murine Collagen-dsat (StrataGraft)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.563	Allogenic Processed Thymus Tissue-agdc (Rethymic)	1Q 2025 annual review: no significant changes; corrected "CDXH7" mutation to "CHD7"; references reviewed and updated.
CP.PHAR.564	Antithrombin III (ATryn, Thrombate III)	1Q 2025 annual review: for Commercial line of business, revised initial and continued approval durations for prevention from "6 months" to "6 months or to the member's renewal date, whichever is longer;" references reviewed and updated.
CP.PHAR.567	Cipaglucosidase Alfa-atga + Miglustat (Pombiliti + Opfolda)	1Q 2025 annual review: added criteria for off-label use of Opfolda for NPC to align with coverage guidelines in the Zavesca (miglustat) and Miplyffa criteria; added increased lysosomal glycogen as an additional option for confirming a Pompe disease diagnosis; references reviewed and updated.
CP.PHAR.568	Inclisiran (Leqvio)	1Q 2025 annual review: added contraindication for hypersensitivity per PI; references reviewed and updated.
CP.PHAR.570	Ropeginterferon Alfa-2b-njft (BESREMi)	1Q 2025 annual review: for Commercial line of business, added standard approval duration language "6 months or duration of request, whichever is less"; references reviewed and updated.
CP.PHAR.572	Budesonide (Tarpeyo)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.573	Cabotegravir (Apretude), Cabotegravir/Rilpivirine (Cabenuva)	1Q 2025 annual review: revised FDA approved indication language for Apretude to align with wording in PI; in Appendix C, added Apretude contraindication for UGT enzyme inducing drugs; in Appendix D, updated wording in panel's recommendation for Cabenuva per US Department of Health and Human Services guideline; references reviewed and updated.
CP.PHAR.574	Sirolimus Protein-Bound Particles (Fyarro), Topical Gel (Hyftor)	1Q 2025 annual review: for PEComa continued therapy, updated commercial duration to "6 months or to the member's renewal date, whichever is longer"; references reviewed and updated.
CP.PHAR.576	Tezepelumab (Tezspire)	1Q 2025 annual review: for initial approval criteria, added allowance for ER visit; references reviewed and updated. Per December SDC: HIM line of business removed as separate criteria is required; added statement disclaimer that California Exchange Plans should not be approved using these criteria and should use applicable HIM criteria; removed intubation option for alignment purposes as a hospital admission would encompass intubation.
CP.PHAR.58	Denosumab (Prolia, Xgeva), Denosumab-bbdz (Jubbonti, Wyost)	1Q 2025 annual review: per updated prescribing information for Prolia and Jubbonti added boxed warnings for severe hypocalcemia in patients with advanced kidney disease; for prostate and breast cancer added requirement that member does not have bone metastasis; for giant cell tumor of bone localized disease removed option for combination use with interferon alfa per NCCN; references reviewed and updated.
CP.PHAR.580	Etranacogene Dezaparvovec-drlb (Hemgenix)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.581	Faricimab-svoa (Vabysmo)	1Q 2025 annual review: simplified initial approval criteria for DME max dosing to 6 mg every 4 weeks for the first 6 doses per PI; for RVO, removed "for 6 months" from max dosing and clarified Vabysmo treatment for greater than 6 months was not evaluated per PI; simplified continued therapy criteria for DME max dosing to 6 mg every 4 weeks per PI; in Appendix B per Clinical Pharmacology, updated dosing regimens and clarified off-label indications; references reviewed and updated.

CP.PHAR.59	Zoledronic Acid (Reclast)	1Q 2025 annual review: for brand Reclast requests added redirection to generic; for initial requests for oncology indications other than prostate and breast cancer, added clarification that request is for zoledronic acid 4 mg/5 mL or 4 mg/100 mL (formerly Zometa); references reviewed and updated.
CP.PHAR.602	Atidarsagene Autotemcel (Lenmeldy)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.603	Exagamglogene Autotemcel (Casgevy)	1Q 2025 annual review: for both SCD and TDT indications, added criterion for documentation of member's body weight for verification of weight-based dose; references reviewed and updated. To RETIRE NH.PHAR.603 State version as it's a one time infusion and only variation was the approval duration.
CP.PHAR.605	Adagrasib (Krazati)	1Q 2025 annual review: for initial approval criteria, added allowance for ER visit; references reviewed and updated. Per December SDC: HIM line of business removed as separate criteria is required; added statement disclaimer that California Exchange Plans should not be approved using these criteria and should use applicable HIM criteria; removed intubation option for alignment purposes as a hospital admission would encompass intubation.
CP.PHAR.608	Furosemide (Furoscix)	1Q 2025 annual review: no significant changes; added examples of extracellular volume expansion due to CHF; references reviewed and updated.
CP.PHAR.610	Sodium Thiosulfate (Pedmark)	1Q 2025 annual review: for continued therapy, added commercial duration language of "6 months or to the member's renewal date, whichever is longer"; references reviewed and updated.
CP.PHAR.613	Fecal Microbiota, Live-jslm (Rebyota)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.615	Olutasidenib (Rezlidhia)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.616	Zilucoplan (Zilbrysq)	1Q 2025 annual review: no significant changes; added Bkemv, Epysqli, and Rystiggo to the list of therapies that Zilbrysq should not be prescribed concurrently with; references reviewed and updated.
CP.PHAR.617	Mirvetuximab Soravatansine-gynx (Elahere)	1Q 2025 annual review: added platinum-sensitive ovarian cancer option to platinum-resistant cancer criterion per NCCN; Appendix D updated with definitions of platinum-resistant and sensitive cancer per NCCN; references reviewed and updated.
CP.PHAR.618	Mosunetuzumab-axgb (Lunsumio)	1Q 2025 annual review: no significant changes; updated Appendix B with additional therapeutic options per NCCN guidelines; references reviewed and updated.
CP.PHAR.619	Nedosiran (Rivfloza)	1Q 2025 annual review: added HCPC codes [C9399, J3490], added medical geneticist to initial approval criteria; references reviewed and updated.
CP.PHAR.627	Lovotibeglogene Autotemcel (Lyfgenia)	1Q 2025 annual review: added criterion for documentation of member's body weight for verification of weight-based dose; references reviewed and updated.
CP.PHAR.63	Everolimus (Afinitor, Afinitor Disperz, Zortress)	1Q 2025 annual review: for NET, removed bronchopulmonary per NCCN the terms have been revised to lung; for SEGA associated with TSC, removed criterion member is not a candidate for curative surgical resection given that NCCN allows for usage as adjuvant therapy if symptomatic or growing; for GIST, added Qinlock as an additional therapy for disease progression after per NCCN; added off label indication for osteosarcoma prescribed in combination with Nexavar and meningiomas prescribed in combination with bevacizumab or octreotide acetate LAR per NCCN; references reviewed and updated.
CP.PHAR.635	ADAMTS13, Recombinant-krhn (Adzynma)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.657	Sotatercept (Winrevair)	1Q 2025 annual review: added bypass to use Winrevair with PAH monotherapy if intolerant to two or more PAH drug classes; in Appendix B per Clinical Pharmacology, removed commercially unavailable branded products, updated dosing regimens; clarified drugs used for off-label indications; references reviewed and updated.
CP.PHAR.659	Vamorolone (Agamree)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.663	Capivasertib (Truqap)	1Q 2025 annual review: no significant changes; removed the Coding Implications section since this is an oral agent; references reviewed and updated.
CP.PHAR.664	Crovalimab-akkz (PiaSky)	1Q 2025 annual review: no significant changes; for continued therapy added examples of improved extravascular hemolysis to demonstrate positive response to therapy; references reviewed and updated.
CP.PHAR.666	Fruquintinib (Fruzaqla)	1Q 2025 annual review: no significant changes; clarified RAS wild-type is mutation negative; references reviewed and updated.
CP.PHAR.667	Repotrectinib (Augtyro)	1Q 2025 annual review: for NSCLC, added recurrent NSCLC per NCCN compendium recommendation; revised NTRK fusion-positive solid tumor section to NTRK fusion-positive cancer to include off-label non-solid tumor indications; for NTRK fusion-positive cancer, added histiocytic neoplasm indication per NCCN 2A recommendation with allowance for hematology specialty, revised "prescribed as subsequent therapy" to "disease has progressed following treatment", added bypass for gastrointestinal stromal tumors, salivary gland tumors, histiocytic neoplasms, pancreatic adenocarcinoma, soft tissue sarcoma, and anaplastic thyroid carcinoma per NCCN; in Appendix D, updated examples of solid tumors with listed indications from NCCN; references reviewed and updated.
CP.PHAR.668	Toripalimab-tpzi (Loqtorzi)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.669	Birch Triterpenes (Filsuvez)	1Q 2025 annual review: for initial approval criteria, added "member does not have current evidence or history of squamous cell carcinoma in the area that will undergo treatment" per competitor analysis and EASE study trial design; references reviewed and updated.
CP.PHAR.670	Eflornithine (Iwilfin)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.671	Nirogacestat (Ogsiveo)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.672	Travoprost Implant (iDose TR)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.674	Marstacimab-hncq (Hympavzi)	Drug is now FDA approved – criteria updated per FDA labeling: removed requirement for weight ≥ 35 kg; clarified hemophilia B from "moderate" to "moderately severe"; added option of at least one serious spontaneous bleed to the classification criteria of hemophilia A and B; removed option for ≥ 6 acute bleeding episodes in the previous 6 months; added redirection to Hemlibra for hemophilia A per SDC recommendation; added standard adverse effect or contraindication template language to failure of a FVIII or FIX product criterion; for continued therapy, added maximum maintenance dosing option of 300 mg weekly for patients weighing ≥ 50 kg when control of bleeding events is judged to be inadequate by the provider; added Commercial approval duration of 6 months or to the member's renewal date, whichever is longer to both initial and continued therapy criteria; revised continued approval duration for Medicaid & HIM to 12 months; references reviewed and updated.
CP.PHAR.682	Levacetylleucine (Aqneursa)	Drug is now FDA approved – criteria updated per FDA labeling: added neurologist and geneticist specialists and removed psychiatrist per external specialist feedback; removed requirement for age ≥ 4 years; revised neurologic signs and symptoms from ≥ 2 to ≥ 1; added option for baseline severity assessment that member can walk either independently or with assistance; added exclusion for concurrent therapy with Miplyffa to initial and continued criteria; revised continued therapy positive response criterion to improvement or stabilization in a domain affected by NPC; references reviewed and updated.
CP.PHAR.94	Alpha1-Proteinase Inhibitors (Aralast NP, Glassia, Prolastin-C, Zemaira)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.96	Naltrexone (Vivitrol)	1Q 2025 annual review: added standard approval language to Commercial line of business to continued therapy; references reviewed and updated.
CP.PMN.03	Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	1Q 2025 annual review: no significant changes; references reviewed and updated.

CP.PMN.04	Non-Calcium Phosphate Binders	1Q 2025 annual review: no significant changes; for policy/criteria description added references to products available generically; for Fosrenol added contraindication per updated prescribing information for hypersensitivity to Fosrenol or to any ingredient in the formulation; references reviewed and updated.
CP.PMN.05	Rifapentine (Priftin)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.100	Risedronate (Actonel, Atelvia)	1Q 2025 annual review: added generic redirection to continuation of therapy requests; references reviewed and updated.
NH.PMN.101	Rivastigmine (Exelon)	Policy created
CP.PMN.103	Secnidazole (Solosec)	1Q 2025 annual review: no significant changes; references reviewed and updated.
NH.PMN.104	Tasimelteon (Hetlioz, Hetlioz LQ)	Annual Review, no changes.
CP.PMN.105	Tavaborole (Kerydin)	1Q 2025 annual review: added tavaborole to “tavaborole and Kerydin are medically necessary when the following criteria are met” standard template language as generic requires prior authorization; for Appendix B, removed brand Penlac® as branded product is obsolete; references reviewed and updated.
CP.PMN.107	Topical Immunomodulators	1Q 2025 annual review: no significant changes; for Appendix C, updated boxed warning section to align with Protopic PI; references reviewed and updated.
CP.PMN.113	Safinamide (Xadago)	1Q 2025 annual review: no significant changes; references reviewed and updated.
NH.PMN.121	Lisdexamfetamine (Vyvanse)	Removed redirection trial and failure for ADHD to amphetamine products
CP.PMN.123	Colchicine (Colcrys, Lodoco)	1Q 2025 annual review: for cardiovascular event prophylaxis, added options of peripheral aterial disease and acute coronary syndrome per competitor analysis and FDA approved indication of atherosclerotic disease and updated the criteria “ secondary prevention regimen for MI or stroke” to “treatment for atherosclerotic disease” with examples of standard of care therapy; updated cardiovascular risk factor examples in Appendix D; references reviewed and updated.
CP.PMN.129	Pramlintide (Symlin)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.14	Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	1Q 2025 annual review: for CKD, updated eGFR requirement from 25-75 mL/min/1.73 m^2 to at least 20 mL/min/1.73 m^2 per 2024 KDIGO CKD guideline recommendations; references reviewed and updated.
CP.PMN.151	Blood Glucose Test Strip Quantity Limit - Not Receiving Insulin	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.166	Luliconazole Cream (Luzu)	1Q 2025 annual review: added luliconazole to “luliconazole and Luzu are medically necessary when the following criteria are met” standard template language as generic requires prior authorization; references reviewed and updated.
CP.PMN.186	Cenegermin-bkbj (Oxervate)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.187	Icosapent Ethyl (Vascepa)	1Q 2025 annual review: no significant changes; references reviewed and updated
CP.PMN.189	Sarecycline (Seysara)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.194	Prucalopride (Motegrity)	Per December SDC, added the following clarification under the description and initial approval criteria sections: “These criteria do NOT apply to California Exchange Plans. Requests for California Exchange Plans should be reviewed using HIM.PA.159”; for continued therapy added similar step requirements to those listed for initial approval requests
CP.PMN.20	Aspirin/Dipyridamole (Aggrenox)	1Q 2025 annual review: clarified criteria applies to generic aspirin-dipyridamole; removed “member must use generic” requirement because drug is not commercially available as brand; references reviewed and updated.
CP.PMN.212	Bedaquiline (Sirturo)	1Q 2025 annual review: for continuation of therapy added option for up to 9 month approval duration if request is for Sirturo prescribed in combination with linezolid, moxifloxacin, and pyrazinamide per World Health Organization (WHO) updates to the treatment of drug-resistant tuberculosis; references reviewed and updated.
CP.PMN.217	Istradefylline (Nourianz)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.218	Lasmiditan (Reyvow)	1Q 2025 annual review: for requests for quantities greater than two doses per month modified to require both specialist prescribing and use of prophylactic therapy to align with criteria requirements of other acute migraine therapy; references reviewed and updated.
NH.PMN.22	Brand Name Override	Annual Review, no changes.
CP.PMN.222	Pretomanid	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.223	Rifabutin (Mycobutin)	1Q 2025 annual review: no significant changes; added Commercial line of business; in policy description added reference to generic to clarify that criteria would apply; references reviewed and updated.
CP.PMN.224	Tenapanor (Ibsrela, Xphozah)	1Q 2025 annual review: removed Xphozah 10 mg strength due to product discontinuation; references reviewed and updated.
CP.PMN.225	Trifarotene (Aklief)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.227	Edoxaban (Savaysa)	1Q 2025 annual review: no significant changes; updated appendix D with current NCCN compendium language; references reviewed and updated.
CP.PMN.231	Cenobamate (Xcopri)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.237	Bempedoic Acid (Nexletol), Bempedoic Acid/Ezetimibe (Nexlizet)	1Q 2025 annual review: in Appendix B, added pravastatin and fluvastatin as hydrophilic statin therapeutic alternatives; revised section V. Dosage and Administration to list Nexletol and Nexlizet dosing regimens separately; references reviewed and updated.
CP.PMN.24	Ciclopirox Topical Solution 8%	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.25	Efinaconazole (Jublia)	1Q 2025 annual review: no significant changes; for Appendix B, removed brand Penlac® as branded product is obsolete; references reviewed and updated.
CP.PMN.257	Clascoterone (Winlevi)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.258	Conjugated Estrogens/Bazedoxifene (Duavee)	1Q 2025 annual review: no significant changes; references reviewed and updated.
NH.PMN.259	Inhaled Agents for Asthma and COPD	Policy created
NH.PMN.260	Loteprednol etabonate (Eysuvis)	Policy created
CP.PMN.261	Dichlorphenamide (Keveyis)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.271	Maribavir (Livtencity)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.274	Diclofenac (Pennsaid)	1Q 2025 annual review: no significant changes; references reviewed and updated.

CP.PMN.286	Glaucoma Agents	1Q 2025 annual review: removed discontinued drug Omlonti from criteria; in initial approval criteria, reformatted therapeutic drug classes into individual rows, added example drugs in each therapeutic class, and revised failure of two generic ophthalmic agents to two formulary ophthalmic agents (generics preferred); in Appendix B, added example drugs for each therapeutic drug class and added example combination ophthalmic agents; references reviewed and updated.
CP.PMN.299	Xanomeline-trospium chloride (Cobenfy)	Policy created
CP.PMN.34	Ranolazine (Ranexa, Aspruzyo Sprinkle)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.52	Omega-3-Acid Ethyl Esters (Lovaza)	1Q 2025 annual review: no significant changes; references reviewed and updated
CP.PMN.57	Febuxostat (Uloric)	1Q 2025 annual review: added febuxostat to “febuxostat and Uloric are medically necessary when the following criteria are met” standard template language as generic requires prior authorization; references reviewed and updated.
CP.PMN.67	Sacubitril/Valsartan (Entresto)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.70	Ivabradine (Corlanor)	1Q 2025 annual review: no significant changes; updated Section V to include specific weight-based maximum doses for pediatric patients per PI; references reviewed and updated.
NH.PMN.72	Metformin ER (Fortamet, Glumetza)	Policy created
NH.PMN.73	Lifitegrast (Xiidra)	Policy created
NH.PMN.81	Buprenorphine/Naloxone (Suboxone, Zubsolv)	Policy created
CP.PMN.82	Buprenorphine (Subutex)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.88	Alendronate (Binosto, Fosamax Plus D)	1Q 2024 annual review: added alendronate oral solution to policy; clarified redirection to generic alendronate should be a formulary/preferred drug list (PDL) product; references reviewed and updated.
CP.PMN.89	Amantadine ER (Gocovri, Osmolex ER)	1Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.90	Benznidazole	1Q 2025 annual review: no significant changes; references reviewed and reviewed.
CP.PMN.92	CNS Stimulants	1Q 2025 annual review: removed Adzenys ER from criteria as drug has been discontinued; for Adhansia XR, removed discontinued strengths [25 mg, 45 mg, 55 mg, 70 mg, 80 mg]; updated Adhansia XR quantity limit to 3 tablets per day; for Adzenys XR-ODT, split dosing based on 6 to 12 years and ≥ 13 years per prescriber information; references reviewed and updated.
CP.PMN.93	Dextromethorphan-Quinidine (Nuedexta)	1Q 2025 annual review: no significant changes; corrected reference to Appendix D for additional information on CNS-LS questionnaire; references reviewed and updated.
CP.PMN.96	Ibandronate Oral (Boniva)	1Q 2025 annual review: removed redirection to generic ibandronate as branded Boniva has been discontinued; references reviewed and updated.
CP.PMN.99	Prasterone (Intrarosa)	1Q 2025 annual review: no significant changes; references reviewed and updated.
NH.PST.01	Step Therapy	Annual Review, no changes.
CC.PHAR.01	72 Hour Emergency Supply	Annual review no changes deemed necessary.
CC.PHAR.13	Pharmacy and Therapeutics Committee	Annual review no changes deemed necessary.
CC.PHAR.23	Clinical Pharmacy Criteria Web Posting	Annual review no changes deemed necessary.
CC.PHAR.24	Split Fill Program	Policy and drug list created. Replaces NH.PHAR.50 Split-Fill Program which will be retired