Provider Update

Trillium Community Health Plan

August 1, 2025

Pharmacy Information and Preferred Drug List Changes –3rd Quarter 2025

This update applies to Trillium Community Health Plan's Oregon Health Plan

TRILLIUM COMMUNITY HEALTH PLAN PREFERRED BLOOD GLUCOSE TESTING SUPPLIES

As of July 1st, Trillium has added Accu-Chek blood glucose testing supplies to the preferred drug list (PDL). OneTouch Verio and Ultra supplies will remain on the PDL until October 1st at which time continued utilization will require prior authorization for coverage.

Trillium members and their prescribers will start receiving notices informing them of the need to transition to Accu-Chek supplies starting at the beginning of August. Please prescribe a new Accu-Check blood glucose meter and test strips for all your patients that test their blood glucose to help ensure that your patients with Trillium coverage have minimal impact to their care. Please have all your members transitioned to the preferred product by October 1st.

TRILLIUM COMMUNITY HEALTH PLAN PREFERRED LONG-ACTING INSULIN COVERAGE

Trillium's Preferred long-acting insulin is insulin glargine-yfgn. In February the manufacturer of insulin glargine-yfgn announced that they were anticipating a shortage of the branded and unbranded pens which they expected to be resolved the first week of March. In response to this announcement Trillium entered overrides for Latus for members currently utilizing insulin glargine-yfgn through March 31, 2025. Unfortunately, the impact of the insulin glargine-yfgn shortage is ongoing and many pharmacies within our service area continue to have difficulty obtaining insulin glargine-yfgn.

As of April 21st, Lantus (insulin glargine) vials and SoloStar pens have been added to Trillium's Preferred Drug List temporarily to address the continued shortage of insulin glargine-yfgn. Lantus and insulin glargine-yfgn are interchangeable and thus members do not require a new prescription for pharmacies to dispense. Please continue to prescribe insulin glargine-yfgn to help promote utilization of the lowest cost agent when available. Any pharmacy unable to obtain insulin glargine-yfgn should be instructed to run the claim for Lantus.

TRILLIUM COMMUNITY HEALTH PLAN PREFERRED DRUG LIST CHANGES

Trillium's Preferred Drug List (PDL) is updated monthly and is available online.

- See the table below for a summary of the PDL changes made in the third quarter of 2025. For the most current preferred drug list, visit the Pharmacy section of our website.

Medication	Effective Date
Additions	

ACCU-CHEK GUIDE (Blood Glucose Monitoring Kit w/ Device) Added to PDL. Meter should be billed directly to manufacturer: BIN 610524, PCN 1016, ID 029318512, Group 40026479	07.01.25
ACCU-CHEK GUIDE CONTROL (Blood Glucose Calibration Liquid) Added to PDL; QL: max 1 package per 90 days	07.01.25
ACCU-CHEK GUIDE TEST (Glucose Blood Test Strip) Added to PDL; QL: max 450/90days for insulin utilizers; non-insulin utilizers max 100/90 days	07.01.25
Adalimumab-adaz 10 MG/0.1ML Soln Prefilled Syringe Added to PDL; PA required	05.21.25
Adalimumab-fkjp 20 MG/0.4ML, 40 MG/0.8ML Prefilled Syringe and Auto-injector Kit Added to PDL; PA required	08.01.25
EMBECTA PEN NEEDLE (Insulin Pen Needle) 29 G X 12.7 MM, 30 G X 5 MM (1/5" or 3/16"), 31 G X 5 MM (3/16"), 31 G X 8 MM (1/3" or 5/16"), 32 G X 4 MM (5/32"), 32 G X 4 MM (5/32"), 32 G X 6 MM (1/4") Added to PDL; QL: max 6/day	03.31.25
Exenatide 10 MCG/0.04ML Soln Pen-injector Added to PDL; QL: 0.08/day; AL: min age of 18 years	05.01.25
Exenatide 5 MCG/0.02ML Soln Pen-injector Added to PDL; QL: 0.04/day; AL: min age of 18 years	07.01.25
SIMLANDI (adalimumab-ryvk) 20 MG/0.2ML, 80 MG/0.8ML Auto-injector Kit Added to PDL; PA required	05.21.25
Sirolimus 1 MG, 2 MG Tab Added to PDL	10.01.25
Ticagrelor 60 MG & 90 MG Tab Added to PDL; QL: max 2/day	06.01.25
Removals	
Adalimumab-adbm 40 MG/0.4ML Prefilled Syringe and Auto-injector Kit Removed from PDL	08.01.25
Cherry Syrup Removed from PDL. All compounds require PA unless containing at least one formulary agent	08.01.25
Flavoring Agent – Liquid Removed from PDL. All compounds require PA unless containing at least one formulary agent	08.01.25
Gelatin Capsules (Empty) Removed from PDL. All compounds require PA unless containing at least one formulary agent	08.01.25
Glycerin Liquid Removed from PDL. All compounds require PA unless containing at least one formulary agent	08.01.25
Levocarnitine 1 GM/10ML Oral Soln Removed from PDL	05.13.25
Methylparaben Powder Removed from PDL. All compounds require PA unless containing at least one formulary agent	08.01.25
Propylparaben Powder Removed from PDL. All compounds require PA unless containing at least one formulary agent	08.01.25
Simple – Syrup Removed from PDL. All compounds require PA unless containing at least one formulary agent	08.01.25

Sodium Benzoate Powder Removed from PDL. All compounds require PA unless containing at least one formulary agent	08.01.25
Xanthan Gum Powder Removed from PDL. All compounds require PA unless containing at least one formulary agent	08.01.25
Key: AL = age Limit; PA = prior authorization; PDL = preferred drug list; QL = quantity limit	

PRIOR AUTHORIZATION CHANGES TO SPECIALIZED MEDICATIONS GIVEN IN OFFICE

See the table below for list of new HCPC codes. These codes now require prior authorization for coverage for Trillium Oregon Health Plan members.

Brand (Generic Name)	HCPC Code	Description
Ahzantive (aflibercept-mrbb)	Q5150	INJECTION AFLIBERCEPT MRBB AHZANTIVE BS 1 MG
Aucatzyl (obecabtagene autoleucel)	C9301	OBECABTAGENE AUTOLEUCEL POS T CELLS Q THER D
Azmiro (testosterone cypionate)	J1072	INJECTION TESTOSTERONE CYPIONATE AZMIRO 1 MG
Bkemv (eculizumab-aeeb)	Q5152	INJECTION ECULIZUMAB AEEB BKEMV BIOSIMILAR 2 MG
Boruzu (bortezomib)	J9054	INJECTION BORTEZOMIB BORUZU 0.1 MG
Enzeevu (aflibercept-abzv)	Q5149	INJECTION AFLIBERCEPT ABZV ENZEEVU BS 1 MG
Epysqli (eculizumab-aagh)	Q5151	INJECTION ECULIZUMAB AAGH EPYSQLI BS 2 MG
Erzofri (paliperidone palmitate)	J2428	INJECTION PALIPERIDONE PAL EXT REL ERZOFRI 1 MG
Hympavzi (marstacimab-hncq)	C9304	INJECTION MARSTACIMAB HNCQ 0.5 MG
Lymphir (denileukin diftitox-cxdl)	J9161	INJECTION DENILEUKIN DIFTITOX CXDL 1 MCG
Niktimvo (axatilimab-csfr)	J9038	INJECTION AXATILIMAB CSFR 0.1 MG
Nypozi (filgrastim-txid)	Q5148	INJECTION FILGRASTIM TXID NYPOZI BS 1 MCG
Ocrevus zunovo (ocrelizumab-hyaluronidase-ocsq)	J2351	INJECTION OCRELIZUMAB 1 MG AND HYALURONIDASE OCSQ
Otulfi (ustekinumab-aauz)	Q9999	INJECTION USTEKINUMAB AAUZ OTULFI BS 1 MG
Pavblu (aflibercept-ayyh)	Q5147	INJECTION AFLIBERCEPT AYYH PAVBLU BS 1 MG
Prograf (tacrolimus)	J7521	TACROLIMUS GRANULES ORAL SUSPENSION 0.1 MG
Soliris (eculizumab)	J1299	INJECTION ECULIZUMAB 2 MG
Tecelra (afamitresgene autoleucel)	Q2057	AFAMITRESGENE AUTOLEUCEL PER THERAPEUTIC DOSE
Tecentriq hybreza (atezolizumab-hyaluronidase-tqjs)	J9024	INJECTION ATEZOLIZUMAB 5 MG AND HYALURONIDASE TQJS
Vyloy (zolbetuximab-clzb)	C9303	INJECTION ZOLBETUXIMAB CLZB 1 MG
Ziihera (zanidatamab-hrii)	C9302	INJECTION ZANIDATAMAB HRII 2 MG

QUARTERLY UPDATE ON PHARMACY COVERAGE GUIDELINES

The P&T Committee determines updates to coverage guidelines (criteria) based on quarterly, comprehensive reviews. Criteria serves as a reference for providers to use when prescribing pharmaceutical products for Trillium members with pharmacy coverage. Prior authorization (PA) does not guarantee payment. PA determination is based on multiple factors in conjunction to the criteria posted in drug coverage guidelines. These factors include but are not limited to: treatment of a funded vs non-funded condition as defined by the Oregon Prioritized List and applicable guidelines; prior trial and failure of agents on the PDL; comparative costs of available treatment options.

- See the table below for all the updated or new Trillium Community Health Plan coverage guidelines that were approved by P&T in the third quarter of 2025. All coverage guidelines will go

into effect October 1, 2025 and will become available to view in their entirety at our website approximately 2 weeks prior to their implementation date.

Clinically Significant Change(s)	
CP.PHAR.11 Burosumab-twza (Crysvita)	CP.PHAR.440 Elexacaftor/Ivacaftor/Tezacaftor; Ivacaftor (Trikafta)
CP.PHAR.121 Nivolumab, Nivolumab Hyaluronidase-nvhy	CP.PHAR.495 Mitomycin for Pyelocalyceal Solution (Jelmyto)
CP.PHAR.132 Nitisinone (Orfadin, Nityr, Harliku)	CP.PHAR.496 Pemigatinib (Pemazyre)
CP.PHAR.145 Deferasirox (Exjade, Jadenu)	CP.PHAR.524 Pegcetacoplan (Empaveli, Syfovre)
CP.PHAR.146 Deferoxamine (Desferal)	CP.PHAR.540 Dostarlimab-gxly (Jemperli)
CP.PHAR.147 Deferiprone (Ferriprox)	CP.PHAR.542 Talimogene laherepvec (Imlygic)
CP.PHAR.188 Teriparatide (Forteo, Bonsity)	CP.PHAR.543 Maralixibat (Livmarli)
CP.PHAR.189 Ibandronate Injection (Boniva)	CP.PHAR.544 Amivantamab-vmjw (Rybrevant)
CP.PHAR.209 Aztreonam (Cayston)	CP.PHAR.592 Beremagene geperpavec-svdt (Vyjuvek)
CP.PHAR.210 Ivacaftor (Kalydeco)	CP.PHAR.609 Prademagene Zamikeracel (Zevaskyn)
CP.PHAR.211 Tobramycin (Bethkis, Kitabis Pak, TOBI, TOBI Podhaler)	CP.PHAR.61 Cinacalcet (Sensipar)
CP.PHAR.213 Lumacaftor/Ivacaftor (Orkambi)	CP.PHAR.634 Epcoritamab-bysp (Epkinly)
CP.PHAR.27 Tolvaptan (Jynarque, Samsca)	CP.PHAR.636 Glofitamab-gxbm (Columvi)
CP.PHAR.270 Paricalcitol Injection (Zemplar)	CP.PHAR.638 Nalmefene (Opvee, Zurnai)
CP.PHAR.290 Aripiprazole Long-Acting Injections (Abilify Maintena, Abilify Asimtufii, Aristada, Aristada Initio)	CP.PHAR.656 Iptacopan (Fabhalta)
CP.PHAR.293 Risperidone Long-Acting Injection (Perseris, Risperdal Consta, Risvan, Rykindo, Uzedy)	CP.PHAR.664 Crovalimab-akkz (PiaSky)
CP.PHAR.295 Sargramostim (Leukine)	CP.PHAR.665 Danicopan (Voydeya)
CP.PHAR.296 Pegfilgrastim/Biosimilars, Eflapegrastim, Efbemalenograstim	CP.PHAR.687 Tislelizumab-jsgr (Tevimbra)
CP.PHAR.297 Filgrastim (Neupogen), Filgrastim-sndz (Zarxio), Tbo-filgrastim (Granix), Filgrastim-aafi (Nivestym), Filgrastim-ayow (Releuko), Filgrastim-txid (Nypozi)	CP.PHAR.81 Pazopanib (Votrient)
CP.PHAR.302 Ixazomib (Ninlaro)	CP.PHAR.83 Vorinostat (Zolinza)
CP.PHAR.303 Brentuximab Vedotin (Adcetris)	CP.PHAR.89 Peginterferon Alfa-2a (Pegasys)
CP.PHAR.310 Daratumumab (Darzalex), Daratumumab/Hyaluronidase-fihj (Darzalex Faspro)	CP.PHAR.97 Eculizumab (Soliris)
CP.PHAR.312 Blinatumomab (Blincyto)	CP.PMN.08 Lidocaine Transdermal (Lidoderm, ZTlido)
CP.PHAR.322 Pembrolizumab (Keytruda)	CP.PMN.132 Tadalafil BPH - ED (Cialis, Chewtadzy)
CP.PHAR.345 Abaloparatide (Tymlos)	CP.PMN.144 Epinephrine (Auvi-Q, EpiPen, EpiPen Jr) Quantity Limit Override
CP.PHAR.377 Tezacaftor/Ivacaftor; Ivacaftor (Symdeko)	CP.PMN.152 Lofexidine (Lucemyra)
CP.PHAR.379 Etelcalcetide (Parsabiv)	CP.PMN.159 Dronabinol (Marinol, Syndros)
CP.PHAR.381 Mechlorethamine Gel (Valchlor)	CP.PMN.19 Aprepitant (Aponvie, Emend, Cinvanti), Fosaprepitant (Emend for injection, Focinvez)
CP.PHAR.384 Lutetium Lu 177 Dotatate (Lutathera)	CP.PMN.205 Patiromer (Veltassa)
CP.PHAR.385 Corticosteroids for Ophthalmic Injection (Dextenza, Iluvien, Ozurdex, Retisert, Xipere, Yutiq)	CP.PMN.215 Non-preferred blood glucose monitors and test strips
CP.PHAR.402 Emapalumab-lzsg (Gamifant)	CP.PMN.239 Chenodiol (Chenodal)
CP.PHAR.415 Ravulizumab-cwvz (Ultomiris)	CP.PMN.240 Gabapentin ER (Gralise, Horizant)
CP.PHAR.423 Erdafitinib (Balversa)	CP.PMN.243 Progesterone (Crinone, Endometrin)
CP.PHAR.424 Fulvestrant (Faslodex Injection)	CP.PMN.247 Rivaroxaban (Xarelto)
CP.PHAR.425 Metreleptin (Myalept)	CP.PMN.263 Estradiol Vaginal Ring (Femring)
CP.PHAR.428 Romosozumab-aqqg (Evenity)	CP.PMN.268 Tenofovir Alafenamide Fumarate (Vemlidy)
CP.PHAR.430 Alpelisib (Piqray, Vijoice)	CP.PMN.269 Ivermectin (Stromectol, Sklice)
CP.PHAR.433 Polatuzumab Vedotin-piiq (Polivy)	CP.PMN.289 Fezolinetant (Veozah)
CP.PHAR.449 Crizanlizumab-tmca (Adakveo)	CP.PMN.44 Pyrimethamine (Daraprim)

CP.PHAR.458 Inebilizumab-cdon (Uplizna)	CP.PMN.46 Roflumilast (Daliresp, Zoryve)
CP.PHAR.463 Satralizumab-mwge (Enspryng)	CP.PMN.62 Tedizolid (Sivextro)
CP.PHAR.487 Osilodrostat (Isturisa)	CP.PMN.84 Timothy Grass Pollen Allergen Extract (Grastek)
CP.PHAR.488 Apomorphine (Apokyn)	CP.PMN.95 Fluticasone Propionate (Xhance)
CP.PHAR.494 Capmatinib (Tabrecta)	
New Coverage Guidelines	
CP.PHAR.731 Avutometinib, Defactinib (Avmapki Fakzynja Co-Pack)	CP.PHAR.740 Clesrovimab-cfor (Enflonsia)
CP.PHAR.732 Penpulimab-kcqx	CP.PHAR.741 Taletrectinib (Ibtrozi)
CP.PHAR.733 Telisotuzumab Vedotin-tllv (Emrelis)	CP.PHAR.742 Sunvozertinib (Zegfrovy)
CP.PHAR.739 Acoltremon (Tryptyr)	CP.PHAR.743 Linvoseltamab-gcpt (Lynozyfic)

ADDITIONAL INFORMATION

For additional information regarding changes to the Trillium Preferred Drug List (PDL), contact Trillium by telephone at 1-877-600-5472. For the most current version of the PDL, visit the Trillium website.

For additional information on medication coverage guidelines visit the Provider Resources section of Trillium's website.

If you have questions regarding the information contained in this update, contact Trillium Provider Services through the Trillium website or by telephone at 1-877-600-5472.