



# Summary of Updates

## Partnership P & T Committee, January 15, 2026 Effective Date: April 1, 2026

The following TAR criteria, coverage requirements, &/or restrictions, apply to Partnership's Medical Drug Benefit (also referred to as Physician Administered Drugs). These are drugs that are (1) purchased by a medical office, clinic or hospital, (2) administered to the member in a medical setting (not for use at home), and (3) billed directly to Partnership as a medical claim using HCPCS codes (and NDCs where appropriate). For pharmacy drug coverage, please refer to Medi-Cal Rx documents on the [State's Medi-Cal Rx web pages](#).

*NOTE: Brand names are for reference only. Criteria and billing requirements apply to the drug itself (active ingredient) regardless of the manufacturer/brand, unless otherwise specified.*

**Effective Date for all changes below:** April 1<sup>st</sup>, 2026, unless otherwise specified.

### Class Review: ADHD/Anti-Narcolepsy /Anti-Obesity/Anorexiants Agents

HCPCS	HCPCS Description	Summary of Updates
• No updates		

### Class Review: Analgesic/Anti-Inflammatory/Migraine/Gout Agents/Anesthetics

HCPCS	HCPCS Description	Summary of Updates
J3262	Injection, tocilizumab, 1 mg for IV use (Actemra™)	• Added criteria for indication of giant cell arteritis
Q5156	Injection, tocilizumab-anoh, biosimilar, 1 mg (Avtozma™)	• Added criteria for indication of giant cell arteritis
Q5133	Injection, tocilizumab-bavi, biosimilar, 1 mg (Tofidence™)	• Added criteria for indication of giant cell arteritis
Q5135	Injection, tocilizumab-aazg, biosimilar, 1 mg (Tyenne™)	• Added criteria for indication of giant cell arteritis

### Class Review: Cardiovascular Agents

HCPCS	HCPCS Description	Summary of Updates
J1305	Injection, evinacumab-dgnb, 5 mg (Evkeeza™)	• Age limit now 1 year and older, prescriber restriction added diabetologist or endocrinologist and removed lipid specialist
J1306	Injection, inclisiran, 1 mg (Leqvio™)	• Indication updated based on FDA label change, required medical information re-aligned to match recommendations for Leqvio use found in the 2022 ACC Expert Consensus Decision Pathway on the Role of Nonstatin Therapies for LDL-C lowering: covered for

		<p>patients with baseline LDL-C &gt;190mg/dl or a history of clinical ASCVD</p> <ul style="list-style-type: none"> <li>• Addition of requirement to try and fail ezetimibe</li> </ul>
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Class Review: Central Nervous System Agents		
HCPCS	HCPCS Description	Summary of Updates
No updates		

Class Review: Neuromuscular Agents		
HCPCS	HCPCS Description	Summary of Updates
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose (Elevidys™)	<ul style="list-style-type: none"> <li>• Updates to criteria to reflect FDA label change</li> <li>• Excluded in pre-existing liver impairment and active viral hepatitis infection</li> <li>• Must not have signs or symptoms of infection within 4 weeks of receiving Elevidys</li> </ul>
J3590 (NOC)	Injection, onasemnogene abeparvovec-brve, per treatment, up to 5x10 <sup>15</sup> vector genomes (Iltivisma™)	<ul style="list-style-type: none"> <li>• New criteria for SMA (Spinal Muscular Atrophy)</li> </ul>

Miscellaneous Changes Falling Outside of Scheduled Drug Class Reviews		
HCPCS	HCPCS Description	Summary of Updates
J3389	Topical administration, prademagene zamikeracel, per treatment (Zevaskyn™)	<ul style="list-style-type: none"> <li>• New criteria for dystrophic epidermolysis bullosa, requiring diagnosis confirmation,</li> </ul>
Q2054	Lisocabtagene maraleucel (Breyanzi™)	<ul style="list-style-type: none"> <li>• Added criteria for new indication of Marginal Zone Lymphoma</li> </ul>

New CMS & DHCS HCPCS Codes, Effective 1/1/2026		
HCPCS	HCPCS Code & Drug Descriptions	Coverage Status
<b>Analgesic, Anti-inflammatory, Migraine, Gout, Anesthetics</b>		
J1736	Injection, meloxicam (delova), 1 mg (Qamzova™)	TAR required: case by case criteria
J1737	Injection, meloxicam (azurity), 1 mg (Xifyrm™)	TAR required: case by case criteria
<b>Anti-Infective Agents</b>		
J2516	Injection, pentamidine isethionate, 1 mg (Pentam™)	Covered with no limits
J3376	Injection, vancomycin hcl (hikma), not therapeutically equivalent to J3373, 10 mg	Covered with no limits
J1837	Injection, posaconazole, 1 mg (Noxafil™)	TAR required: drug specific criteria

<b>Antineoplastic and Adjunctive Agents</b>		
C9308	Injection, carboplatin (avyxa), 1 mg (Kyxata™)	TAR required: case by case
C9307	Injection, linvoseltamab-gcpt, 1 mg (Lynozytic™)	TAR required: case by case
J9184	Injection, gemcitabine hydrochloride (avyxa), 200 mg (Avgemsi™)	TAR required: case by case
J9282	Mitomycin, intravesical instillation, 1 mg (Zusduri™)	TAR required: case by case
J9326	Injection, telisotuzumab vedotin-tllv, 1 mg (Emrelis™)	TAR required: drug specific criteria
Q5160	Injection, bevacizumab-nwgd (jobevne), biosimilar, 10 mg	TAR required: case by case
<b>Cardiovascular Agents</b>		
J0162	Injection, epinephrine (fresenius), not therapeutically equivalent to J0165, 0.1 mg	Covered with no limits
<b>Central Nervous System Agents</b>		
J0013	Esketamine, nasal spray, 1 mg (Spravato™)	TAR required: drug specific criteria
<b>Dermatological, Anorectal, Mouth-Throat, Dental, Eye, Ear</b>		
J3389	Topical administration, prademagene zamikeracel, per treatment (Zevaskyn™)	TAR required: drug specific criteria
<b>Endocrine and Metabolic Agents</b>		
J0654	Injection, liothyronine, 1 mcg (Triostat™)	TAR required: case by case
J1073	Testosterone pellet, implant, 75 mg (Testopel™)	Covered, with limits
J2596	Injection, vasopressin (long grove), not therapeutically equivalent to J2598, 1 unit	Covered with no limits
J7299	Intrauterine copper contraceptive (Miudella™)	Covered with no limits
<b>Hematological Agents</b>		
J3291	Injection, tranexamic acid in sodium chloride, 5 mg	Covered with no limits
<b>Miscellaneous Products</b>		
J2711	Injection, neostigmine methylsulfate 0.1 mg and glycopyrrolate 0.02 mg (Prevduo™)	Covered with limits (no UA/UB)
J7528	Mycophenolate mofetil, for suspension, oral, 100 mg (CellCept™)	Covered with no limits
J9256	Injection, nipocalimab-aahu, 3 mg (Imaavy™)	TAR required: drug specific criteria
<b>Neuromuscular Agents</b>		
J3379	Injection, valproate sodium, 5 mg (Depacon™)	Covered with no limits
<b>Psychotherapeutic and Neurological Misc. Agents</b>		
J3387	Injection, elivaldogene autotemcel, per treatment (Skysona™)	TAR required: drug specific criteria

### New CMS & DHCS HCPCS Codes, Effective 1/1/2025

HCPCS	HCPCS Code & Drug Descriptions	Coverage Status
<b>Gastrointestinal Agents</b>		
Q0155	Dronabinol (syndros), 0.1 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	TAR required: Self-administered drug criteria

### New CMS & DHCS HCPCS Codes, Effective 4/1/2025

HCPCS	HCPCS Code & Drug Descriptions	Coverage Status
<b>Hematological Agents</b>		
Q5148	Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram	TAR: case by case criteria

### New CMS & DHCS HCPCS Codes, Effective 7/1/2025

HCPCS	HCPCS Code & Drug Descriptions	Coverage Status
<b>Antineoplastic and Adjunctive Agents</b>		
J9174	Injection, docetaxel (beizray), 1 mg	TAR Required: case by case
J9275	Injection, cosibelimab-ipdl, 2 mg (Unloxcyt™)	TAR Required: case by case
J9382	Injection, zenocutuzumab-zbco, 1 mg (Bizengri™)	TAR required: drug specific criteria
<b>Cardiovascular Agents</b>		
J0166	Injection, epinephrine (bpi), not therapeutically equivalent to J0165, 0.1 mg	Covered with no limits

### New CMS & DHCS HCPCS Codes, Effective 10/1/2025

HCPCS	HCPCS Code & Drug Descriptions	Coverage Status
<b>Anti-Infective Agents</b>		
J0681	Injection, ceftobiprole medocaril sodium, 3 mg (Zevtera™)	TAR: case by case criteria
<b>Endocrine and Metabolic Agents</b>		
Q5159	Injection, denosumab-dssb (ospomyv/xbryk), biosimilar, 1 mg	TAR required: drug specific criteria

### Changes made to mirror the State's Medi-Cal provider manual billing requirements

HCPCS	HCPCS Code & Drug Descriptions	Coverage Status
<b>Hematological Agents</b>		
J9309	Injection, polatuzumab vedotin-piiq, 1 mg (Polivy™)	Covered with no limits (ICD-10 requirements)