EXPRESS SCRIPTS PHARMACY BENEFIT SERVICES

2027 National Preferred Formulary

Exclusion list changes coming January 1, 2027

This is not an all-inclusive list of exclusions for the Express Scripts® Pharmacy Benefit Services National Preferred Formulary. The excluded medications shown below are not covered on the Express Scripts National Preferred Formulary beginning January 1, 2027 unless otherwise noted. If there is a clinical reason, identified by your doctor, that requires you to continue taking your current medication, your doctor can request a coverage review by visiting the Express Scripts online portal at esrx.com/PA.

Single-source brand and generic exclusions

DRUG CLASS	EXCLUDED MEDICATIONS	PREFERRED ALTERNATIVES
AUTONOMIC AND CENTRAL NERVOUS SYSTEM Antimigraine Agents	**zolmitriptan 5mg nasal,** ONZETRA XSAIL, **ZOLMITRIPTAN 2.5MG NASAL, ZOMIG NASAL**	sumatriptan nasal
CARDIOVASCULAR Beta Blockers & Combinations	**HEMANGEOL**	propranolol solution
Calcium Channel Blockers	**diltiazem er tablets, CARDIZEM LA**	diltiazem er capsules
	nisoldipine, SULAR	amlodipine, felodipine er
	verapamil er pm (100 mg, 200mg, 300mg)	verapamil er (120mg, 180mg, 240mg, 360mg)
Fenofibrates	**fenofibrate capsules (130mg), fenofibrate tablets (40mg, 120mg),** FENOFIBRATE CAPSULES (50MG, 150MG), LIPOFEN	fenofibrate capsules (43mg, 67mg,134mg, 200mg), fenofibrate tablets (48mg, 54mg, 145mg, 160mg), fenofibric acid dr
HMG & Cholesterol Inhibitor Combinations	fluvastatin, fluvastatin er, ALTOPREV, ATORVALIQ, LESCOL XL, **ZYPITAMAG**	atorvastatin, lovastatin, pitavastatin, pravastatin, rosuvastatin, simvastatin
Obstructive Hypertrophic Cardiomyopathy Agents	**MYQORZO**	CAMZYOS
Pulmonary Arterial Hypertension (PAH) Agents	**WINREVAIR**	Coverage may be approved for the treatment of Pulmonary Arterial Hypertension (PAH) under certain conditions.
DERMATOLOGICAL Miscellaneous Topical Dermatological Agents	**ZTLIDO**	lidocaine 5% patch
DIABETES Biguanide Agents	**metformin 625mg, 750mg tablets;** METFORMIN 625MG TABLETS	metformin 500mg, 850mg or 1,000mg tablets
Insulins	U-100: ADMELOG, APIDRA, FIASP, HUMALOG VIAL, INSULIN ASPART, KIRSTY, **LYUMJEV,** NOVOLOG, RELION NOVOLOG U-200: **LYUMJEV** Inhalation: AFREZZA	U-100: HUMALOG (CARTRIDGE, KWIKPEN, JUNIOR KWIKPEN), INSULIN LISPRO, MERILOG U-200: HUMALOG KWIKPEN
GASTROINTESTINAL Anti-Ulcer Agents	**sucralfate suspension,** CARAFATE	sucralfate tablets

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Single-source brand and generic exclusions (continued)

DRUG CLASS	EXCLUDED MEDICATIONS	PREFERRED ALTERNATIVES
MUSCULOSKELETAL & RHEUMATOLOGY Gout Therapy	**GLOPERBA**	colchicine, MITIGARE
ONCOLOGY Bruton Tyrosine Kinase Inhibitors	**BRUKINSA,** JAYPIRCA	For Mantle Cell Lymphoma: CALQUENCE For Chronic Lymphocytic Leukemia, Small Lymphocytic Lymphoma: CALQUENCE, IMBRUVICA For BRUKINSA only: Coverage may be approved for treatment of Waldenström's Macroglobulinemia under certain conditions.
OPHTHALMIC Ophthalmic Agents (Vascular Endothelial Growth Inhibitors)	**BYOOVIZ,** LUCENTIS	CIMERLI
Ophthalmic Anti-Inflammatory	BYQLOVI, CLOBETASOL DROPS, FLAREX, FML FORTE, **LOTEMAX OINTMENT, LOTEMAX SM,** MAXIDEX, PRED MILD	dexamethasone drops, difluprednate drops, fluorometholone drops, loteprednol 0.5% drops, prednisolone drops
Ophthalmic Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)	ACUVAIL, **ILEVRO,** NEVANAC	bromfenac drops, diclofenac drops, ketorolac drops
MISCELLANEOUS AGENTS Cardiomyopathy & Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis	**AMVUTTRA**	HTTR-C: VYNDAMAX Coverage may be approved for treatment of Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis (hATTR) under certain conditions.
	ATTRUBY	VYNDAMAX
Hypoactive Sexual Desire Disorder Agents	**ADDYI**	VYLESSI
Immune Globulins	GAMMAKED, **GAMMAPLEX, PANZYGA,** QIVIGY, YIMMUGO	IV: GAMMAGARD LIQUID, GAMMAGARD LIQUID ERC, GAMMAGARD S-D, GAMUNEX-C SC: GAMMAGARD LIQUID, GAMMAGARD LIQUID ERC, GAMUNEX-C, XEMBIFY
Infused Non-TNF Biologics - Ustekinumab Agents	OTULFI IV, PYZCHIVA IV, **SELARSDI IV,** STARJEMZA IV, STELARA IV, STEQEYMA IV, USTEKINUMAB IV, WEZLANA IV	IMULDOSA IV, USTEKINUMAB-TTWE IV (by Quallent), YESINTEK IV, ENTYVIO IV, OMVOH, SKYRIZI, TREMFYA

Indication-based management

DRUG CLASS	EXCLUDED MEDICATIONS	PREFERRED ALTERNATIVES
Adalimumab Products for Inflammatory Conditions‡	ADALIMUMAB-AACF, IDACIO ADALIMUMAB-AATY, YUFLYMA ADALIMUMAB-BWW ADADALIMUMAB-FKJP, HULIO ADALIMUMAB-RYVK (by Teva) ABRILADA AMJEVITA CYLTEZO HADLIMA HUMIRA HYRIMOZ YUSIMRY	ADALIMUMAB-ADAZ ADALIMUMAB-ADBM (by Boehringer Ingelheim & Quallent) SIMLANDI
Tocilizumab Products for Inflammatory Conditions‡	ACTEMRA SC, AVTOZMA SC	TYENNE SC**

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Indication-based management (continued)

DRUG CLASS	EXCLUDED MEDICATIONS	PREFERRED ALTERNATIVES
Ustekinumab Products for Inflammatory Conditions‡	OTULFI SC, PYZCHIVA SC, **SELARSDI SC,** STARJEMZA SC, STELARA SC, STEQEYMA SC, USTEKINUMAB SC, USTEKINUMAB-AAUZ SC, USTEKINUMAB-AEKN SC, WEZLANA SC	IMULDOSA SC, USTEKINUMAB-TTWE SC (by Quallent), YESINTEK SC
Referenced excluded medications for Inflammatory Conditions‡ as indicated	KINERET, SILIQ	See below for Preferred Alternatives

DRUG CLASS	OTHER MEDICATIONS	PREFERRED ALTERNATIVES
Inflammatory Conditions‡	All other Brand Name medications for Inflammatory Conditions may require a trial of one or more Preferred medications as part of the Formulary exceptions process.	Preferred: ADALIMUMAB-ADAZ, ADALIMUMAB-ADBM (by Boehringer Ingelheim & Quallent), COSENTYX SC, ENBREL, ICOTYDE, IMULDOSA SC, OMVOH SC, OTEZLA, OTEZLA XR, RINVOQ ER, RINVOQ LQ, SIMLANDI, SKYRIZI SC, SOTYKTU, TALTZ, TREMFYA SC, tofacitinib, tofacitinib er, USTEKINUMAB-TTWE SC (by Quallent), VELSIPITY, YESINTEK SC, ZYMFENTRA Preferred for Non-Radiographic Axial Spondyloarthritis (nr-axSpA) only: CIMZIA, COSENTYX SC, TALTZ **Preferred after use of one Preferred Medication: CIMZIA (for Crohn's Disease only), SIMPONI 100MG, TYENNE SC

Multi-source brand exclusions

The generic equivalents of the following brand-name medications are covered on the National Preferred Formulary FDA-approved generic medications meet strict standards and contain the same active ingredients as their corresponding brand-name medications, although they may have a different appearance.

XELJANZ
XELJANZ XR

Excluded to Preferred

LEDIPASVIR-SOFOSBUVIR
SOFOSBUVIR/VELPATASVIR

Bolded Excluded Medications are new for 01/01/2027

‡ Please note that PDL and product placement for treatment of Inflammatory and Atopic Conditions in the Inflammatory and Atopic Conditions Care Value (IACCV) Program are subject to change throughout the year based upon changes in market dynamics, new indications for existing products, biosimilar and new product launches.

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