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Formulary *Update*

A PUBLICATION OF THE GEORGIA PHARMACY AND THERAPEUTICS (P&T) COMMITTEE. The Formulary Update contains information regarding formulary additions, deletions, exclusions, brief descriptions of products, and current drug related news. It also lists items to be discussed at upcoming P&T meetings. Please refer to the web pages: KP Georgia Formulary and Drug List OR Drug Formulary for Practitioners for all KPGA Drug Formularies.

Formulary Additions

- Altreno (tretinoin) 0.05% lotion
- Azelaic acid 15% gel
- Zenpep (pancrelipase) 60,000 units DR capsule

Prior Authorization (QRM) Additions

- Anktiva (nogapendekin alfa inbakicept-pmln)
- Ogsiveo (nirogacestat)
- Orserdu (elacestrant)
- Rezdiffra (resmetirom)
- Ryzneuta (efbemalenograstim)
- Xolremdi (mavorixafor)

Prior Authorization (QRM) Updates

- Adalimumab products
- Benlysta (belimumab)
- Bimzelx (bimekizumab)
- Cosentyx (secukinumab)
- Dupixent (dupilumab)
- Enbrel (etanercept)
- Entyvio (vedolizumab)
- GLP-1 RAs (semaglutide)
- Ilumya (tidrakizumab)
- Jynarque (tolvaptan)
- Kesimpta (ofatumumab)
- Kevzara (sarilumab)
- Mounjaro (tirzepatide)
- Myfembree (relugolix, estradiol, and norethindrone)
- Nucala (mepolizumab)
- Ocrevus (ocrelizumab)
- Orilissa (elagolix)
- Otezla (apremilast)
- SQ Immune Globulins
- Siliq (brodalumab)
- Simponi (golimumab)
- Skyrizi (risankizumab)
- Spevigo (spesolimab)
- Stelara (ustekinumab)
- Taltz (ixekizumab)
- Tezspire (tezepelumab)
- Tremfya (guselkumab)
- Tysabri (natalizumab)
- Unbranded Infliximab
- Xolair (omalizumab)
- Zurzuvae (zuranolone)

Upcoming Formulary Items:

An important aspect of the formulary process is the involvement of all clinicians. Please contact your P&T Committee representative or your clinical department chief by September 24, if you wish to comment on any of the medications, class reviews, or other agenda items under consideration. To make formulary addition requests, you must submit a Formulary Additions/Deletions Form and Conflict of Interest Form to Drug Information Services or call (404) 439-4417.

Medication Class Review
October 2024

- Analgesics – Anti-Inflammatory
- Analgesics – Non-Narcotic
- Analgesics - Opioids
- Anticoagulants
- Antiseptics & Disinfectants
- Diagnostic Products
- Endocrine and Metabolic Agents - Misc
- Hematopoietic Agents
- Hemostatics
- Minerals & Electrolytes
- Mouth / Throat / Dental
- Multi-Vitamins
- Musculoskeletal Therapy Agents
- Otic
- Vitamins

Commercial HMO/Closed Formulary Additions

The following medication will be ADDED to the Commercial Formulary effective September 11, 2024:

Note: Commercial Formulary additions may result in tier changes on the QHP (ACA)/Open Formulary.

Altreno (tretinoin) 0.05% lotion	Indicated for the topical treatment of acne vulgaris in patients 9 years of age and older.
Azelaic acid 15% gel	Indicated for the treatment of mild to moderate rosacea.
Zenpep 60,000 units DR capsule	Indicated for the treatment of exocrine pancreatic insufficiency in adult and pediatric patients.

QHP-ACA/Open Formulary Step Therapy Additions

The following medications will have step therapy ADDED effective January 1, 2025:

Brand Sexual Dysfunction Medications	Indicated for treatment of erectile dysfunction.

Day Supply Additions

The following medication has temporary 30-day supply restrictions due to drug shortage effective August 19, 2024:

Phenytoin ER 100mg capsules

Interregional Practice Recommendations

The Emerging Therapeutics Strategy Program (ETSP) is a centralized effort that applies our evidence-based model to develop interregional practice recommendations with KP physician specialists, coordinates KP HealthConnect clinical content for decision support, and monitors outcomes to measure uptake of the clinical and strategy recommendations. Through the collaboration of Pharmacy, Permanente physicians, and Federation partners, the ETSP offers a unified approach in the provision and management of specialty drugs to help ensure that our members derive the greatest value from these products.

The following IR Practice Recommendation ADDITIONs were recently approved:

Duvyzat (givinostat hcl)	Indicated for the treatment of Duchenne muscular dystrophy (DMD) in patients 6 years of age and older.
Filsuvez (birch triterpenes)	Indicated for the treatment of wounds associated with Dystrophic epidermolysis bullosa (DEB) and Junctional epidermolysis bullosa (JEB) in adult and pediatric patients six months of age and older.
Vyjuvek (beremagene geperpavec-scdt)	Indicated for the treatment of wounds in patients six months of age and older with DEB with mutation(s) in the *COL7A1 gene*.

ETSP recommendations as well as pipeline candidates can be found here: ETSP Home Page

Please note: Newly marketed medications requiring ETSP review will also receive prior authorization (PA) review. These medications will not be eligible for consideration of drug benefit coverage until completion of drug specific ETSP and PA criteria review processes.

Approved Floor Stock List Changes

Medication	Department
Approved Floor Stock List Additions	
Naloxone 0.4 mg / 0.1 mL nasal liquid	Behavioral Health
Naloxone 0.4 mg / 0.1 mL nasal liquid	Behavioral Health Crisis Intervention Clinic
COVID-19 (Adult) mRNA	Employee Health
Influenza Vaccine (6 mons-Adult)	Employee Health
Rhophylac (Rho(D) Immune Globulin, prefilled syringe injection)	OB/GYN
Doxycycline 100 mg IV injection	Radiology
Approved Floor Stock List Removals	
Aspirin 325 mg tablet	Employee Health
Glucose gel 3 X 15 gm (Insta-Glucose)	Employee Health
Form Prescription Tamper Proof Paper 8.5 X 11 for printers 1	Employee Health
Diphenhydramine 50 mg / mL, 1 mL vial (Benadryl)	Employee Health
Epinephrine 0.15 mg kit (Epipen Jr)	Employee Health
Nitroglycerin 0.4 mg (1/150 gr) sublingual tab (Nitrostat)	Employee Health
Diphenhydramine 50 mg / mL syringe	Employee Health
Menactra vaccine (1dose) SDV 0.5 mL 5/bx	Employee Health
Pneumovax 23 SDV 0.5 mL 10/bx	Employee Health
Tuberculin PPD 5TU / 0.1 mL 10 test MDV 1 mL	Employee Health
Tubersol PPD 5TU 50 test MDV 1 mL	Employee Health
Energix B Adult 20 mcg / 1 mL, SDV	Employee Health
Bexsero PFS 0.5 mL	Employee Health
Lucentis (ranibizumab)	Ophthalmology

Information Concerning Coverage Determinations

Medicare Part D: Medicare Part D Plan Non Formulary and Prior Authorization criteria and coverage determination are made externally by the Pharmacy Benefit Manager Optum Rx.

Prescriber completes the .NFRequestForm when entering drug order. Your documentation is used by OptumRx to determine whether the prescribed drug is eligible for drug benefit coverage. No documentation = No coverage.

The KP Pharmacy Consult Service will send your documentation to OptumRx for their coverage determination decision within the labeled time frame (standard: 72 hours; urgent: 24 hours). If not received by the deadline, the PBM will deny the request. If OptumRx has further questions, you will be contacted for responses. You may phone OptumRx at 1-888-791-7255 to address any patient / drug coverage specific questions. To see the MPD Formulary, please visit: Medicare Part D Formulary.

Dual Choice: Dual Choice Plan Non Formulary and Prior Authorization criteria and coverage determination are made externally by the Pharmacy Benefit Manager MedImpact.

Prescriber completes the .NFRequestForm when entering drug order. Your documentation is used by MedImpact to determine whether the prescribed drug is eligible for drug benefit coverage. No documentation = No coverage.

The KP Pharmacy Consult Service will send your documentation to MedImpact for their coverage determination decision within the labeled time frame (standard: 72 hours; urgent: 24 hours). If not received by the deadline, the PBM will deny the request. If MedImpact has further questions, you will be contacted to provide responses. You may phone MedImpact at 1-888-336-2676 to address any patient / drug coverage specific questions. The Dual Choice formulary differs from the KPHC formulary (i.e. DOACs, ADHD, asthma). Please visit: Choice Formulary.

Additions to the QRM Prior Authorization Review List of Medications for the Commercial/HMO Closed Formularies & QHP-ACA/Open Formularies

Note: The updates below DO NOT APPLY to Medicare Part D or Dual Choice Prescription Benefit Plans. Optum and MedImpact are the external PBMs for each of these plans, respectively, externally administering all non-formulary or prior authorization criteria and coverage review.

The following medications will be ADDED to the QRM PA Review List effective September 11, 2024:

Anktiva (nogapendekin alfa inbakicept-pmln)	Indicated with BCG for the treatment of adult patients with BCG-unresponsive non-muscle invasive bladder cancer (NMIBC) with carcinoma in situ (CIS) with or without papillary tumors.
Ogsiveo (nirogacestat)	Indicated for the treatment of adult patients with progressing desmoid tumors who require systemic treatment.
Orserdu (elacestrant)	Indicated for the treatment of postmenopausal women or adult men, with estrogen receptor positive (ER+), human epidermal growth factor 2 negative (HER2-), estrogen receptor 1 (*ESR1*)-mutated advanced or metastatic breast cancer with disease progression following at least one line of endocrine therapy.
Rezdiffra (resmetirom)	Indicated in conjunction with diet and exercise for the treatment of adults with noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis).
Ryzneuta (efbemalenograstim)	Indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in adult patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.
Xolremdi (mavorixafor)	Indicated for use in patients 12 years of age and older with WHIM syndrome to increase the number of circulating mature neutrophils and lymphocytes.

QRM Prior Authorization Review Criteria Updates

Note: The updates below DO NOT APPLY to Medicare Part D or Dual Choice Prescription Benefit Plans. Optum and MedImpact are the external PBMs for each of these plans, respectively, externally administering all non-formulary or prior authorization criteria and coverage review.

- **Adalimumab products:** Criteria updated to 1) ensure all non-preferred products are listed under the same level of preference, and 2) to require additional therapeutic alternatives including etanercept (Enbrel) prior to approval of brand Humira for rheumatoid arthritis, psoriatic arthritis, spondyloarthropathy and polyarticular JIA indications.
- **Benlysta (belimumab):** Criteria updated to reflect subcutaneous formulation has now been approved for both pediatric systemic lupus erythematosus and lupus nephritis indications.
- **Cosentyx (secukinumab):** Criteria updated to 1) reflect biologics order of preference for pediatric patients, 2) reflect Cosentyx 150mg pens or prefilled syringes are preferred, 2) add language to ensure that the Cosentyx 300mg UnoReady pens are not approved unless patient has a documented latex allergy or severe injection site reactions, 3) add language to reflect trial of phototherapy is required as appropriate in patients with plague psoriasis diagnosis, 4) add language to reflect Cosentyx will be approved without requiring topical and oral medications if patient is currently on biologic treatment in patients with hidradenitis suppurativa, and 5) clarify that pediatric patients with plaque psoriasis should meet all criteria unless contraindicated or clinical reason to avoid treatment.
- **Dupixent (dupilumab):** Criteria updated to 1) include patient has diagnosis of severe persistent asthma in the past 12 months along with clear parameters for diagnosis of asthma, 2) provide criteria to cover those patients with asthma without peripheral eosinophilia, 3) require patient is on an aggressive drug therapy regimen for uncontrolled severe asthma, 4) require that Dupixent will be used as an add on therapy with certain medication classes, 5) clarify the time period for use of systemic corticosteroids is updated to within the last 12 months for diagnosis of nasal polyposis, 6) clarify that alternative biologics that should not be concurrently used for diagnosis of nasal polyposis and patient is required to continue nasal corticosteroids with Dupixent unless contraindicated or intolerant, and 7) to reflect continued approval criteria is added for existing members on therapy.
- **Entyvio (vedolizumab):** Criteria updated to 1) include expanded indication to cover Crohn's disease (CD) and ulcerative colitis (UC), 2) clarify approval of Entyvio subcutaneous formulation for 6 months only where appropriate for inflammatory bowel disease (IBD) patients with missed doses of Entyvio due to organizational staffing limitations or members outside of KP network, and 3) provide information to support coverage for patients where trial of an additional anti-TNF agent is inappropriate due to class/mechanism failure.
- **GLP-1 RAs (semaglutide):** Criteria updated for cardiovascular disease indication to require all standards of care treatment listed in criteria prior to approval. Criteria updated for type 2 diabetes mellitus indication to 1) reflect adherence update for Jardiance in criteria, 2) include MedTAC update in notes, and 3) reflect A1C requirement update for new and current KP members with atherosclerotic cardiovascular disease (ASCVD).
- **Gonadotropin Releasing Hormone Antagonists (Orilissa (elagolix) and Myfembree (relugolix, estradiol, and norethindrone):** Criteria updated to no longer require Lupron as a trial agent.
- **Jynarque (tolvaptan):** Criteria updated to ensure Jynarque is utilized for patients at high risk of disease progression as defined by Mayo autosomal dominant polycystic kidney disease (ADPKD) Classification.
- **Kevzara (sarilumab):** Criteria updated to include recent FDA approved indication polymyalgia rheumatica (PMR).
- **Mounjaro (tirzepetide):** Criteria for adherence updated for type 2 diabetes mellitus.
- **Multiple Sclerosis/Rheumatology - Kesimpta (ofatumumab), Ocrevus (ocrelizumab), Skyrizi (risankizumab), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab):** Criteria updated to reflect changed TB test look back from 12 months to 24 months; **Otezla (apremilast), Tysabri (natalizumab):** Criteria updated to define continuation criteria as adequate response or optimizing therapy to achieve adequate response.
- **Nucala (mepolizumab):** Criteria updated to 1) clarify time period for use of systemic corticosteroids, 2) note alternative biologics that should not be concurrently used, 3) reflect patient is required to continue nasal corticosteroids, and 4) add continued approval criteria for existing members on therapy stating patient must have completed an appointment with an otolaryngologist or allergist with documented clinically significant benefit within the last 12 months.
- **Plaque Psoriasis - Adalimumab Products, Bimzelx (bimekizumab), Enbrel (etanercept), Ilumya (tidrakizumab), Siliq (brodalumab), Skyrizi (risankizumab), Stelara (ustekinumab), Taltz (ixekizumab), Tremfya (guselkumab):** Criteria updated to 1) add language to reflect trial of phototherapy is required as appropriate in patients with plague psoriasis diagnosis, 2) clarify no longer requiring non-biologic systemic treatment in the QRM criteria for peds, 3) reflect removal of biologics order of preference for pediatrics.
- **Simponi (golimumab):** Criteria updated to include addition of required trial of Velsipity.
- **Spevigo (spesolimab):** Criteria updated to include criteria for generalized pustular psoriasis (GPP) treatment.
- **SQ Immune Globulins:** Criteria updated to 1) reflect change to prescriber documenting intolerability to IV dose due to volume, 2) reflect documented risk of thromboembolic events or hemolysis, and 3) incorporate the expanded indication for Hyqvia for chronic inflammatory demyelinating polyneuropathy (CIDP).

QRM Prior Authorization Review Criteria Updates (continued)

Note: The updates below DO NOT APPLY to Medicare Part D or Dual Choice Prescription Benefit Plans. Optum and MedImpact are the external PBMs for each of these plans, respectively, externally administering all non-formulary or prior authorization criteria and coverage review.

- **Tezspire (tezepelumab):** Criteria updated to allow coverage for non-eosinophilic, non-allergic, and oral corticosteroid dependent severe persistent asthma population that are eligible for treatment.
- **Unbranded infliximab:** Criteria updated to include information for patients who have had one preferred infliximab product infusion with a reported intolerance.
- **Xolair (omalizumab):** Criteria updated for food allergies to remove required trial of Palforzia, and for nasal polyposis to 1) clarify time period for use of systemic corticosteroids, 2) note alternative biologics that should not be concurrently used, 3) require patient continue nasal corticosteroids, and 4) continued approval criteria added for existing members on therapy.
- **Zeposia (ozanimod):** Criteria updated to include addition of required trial of Velsipity.
- **Zurzuvae (zuranolone):** Criteria updated to remove requirement to use the PHQ-9 screening tool.

Additions to the QRM Prior Authorization Review List of Medications for the Commercial/HMO Closed Formularies & QHP-ACA/Open Formularies

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Ogsiveo (nirogacestat)	Indicated for the treatment of adult patients with progressing desmoid tumors who require systemic treatment.
Orserdu (elacestrant)	Indicated for the treatment of postmenopausal women or adult men, with estrogen receptor positive (ER+), human epidermal growth factor 2 negative (HER2-), estrogen receptor 1 (*ESR1*)-mutated advanced or metastatic breast cancer with disease progression following at least one line of endocrine therapy.
Rezdiffra (resmetirom)	Indicated in conjunction with diet and exercise for the treatment of adults with noncirrhotic nonalcoholic steatohepatitis (NASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis).
Ryzneuta (efbemalenograstim)	Indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in adult patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.
Xolremdi (mavorixafor)	Indicated for use in patients 12 years of age and older with WHIM syndrome to increase the number of circulating mature neutrophils and lymphocytes.

Medicare Part D Formulary Removal of Brand Drugs

During the year, Kaiser Permanente may make changes to our Medicare Part D Formulary (Drug List). The list below is intended to inform you of these changes. The following table lists all products recently removed from the Medicare Part D Formulary to be replaced with the generic.

Brand Medication	Brand Drug Current Tier	Generic Alternative	Generic Drug Tier	Effective Date
KEVEYIS TABS 50 MG	5	ORMALVI TABS 50 MG	5	8/1/2024

Questions and Concerns?

If you have any questions or concerns, please contact any of the following P&T Committee members and designated alternates:

P&T Committee Voting Members:

Debbi Baker, PharmD, BCPS
Clinical Pharmacy

Hector Clarke, PharmD, BCOP
Ambulatory Pharmacy

Halima Daboiko, MD
Obstetrics and Gynecology

Carole Gardner, MD
P&T Chair/Geriatrics

Pierson Gladney, MD
Hematology/Oncology

Ramin Haddad, MD
Adult Hospitalist

Larry Kang, MD
Adult Primary Care

Mary Kangoma, RN, MSN
Clinical Services

Craig Kaplan, MD
Adult Primary Care

Christine Kofman, MD
Pediatrics

Amy Levine, MD
Pediatrics

Sophie Lukashok, MD
Infectious Disease

Chad Madill, PharmD, MBA
Executive Director of Pharmacy Operations

Jennifer Marrast-Host, MD
Emergency Medicine/ ACC

Felecia Martin, PharmD
Pharmacy/Geriatrics

Shayne Mixon, PharmD
Pharmacy Operations

Jennifer Rodriguez, MD
Behavioral Health

P&T Committee Non-Voting Physician Members

Elizabeth Greco, MD
Physician Lead, Pharmacy Safety and Systems

Daniel Robitshek, MD
CDU/Hospital Services

Designated Alternates:

Jacqueline Anglade, MD
Obstetrics and Gynecology

Lesia Jackson, RN
Clinical Services

Satya Jayanthi, MD
Hospitalist

Medications Reviewed But Not Accepted to the Commercial HMO Formulary

Note: Medications that can be dispensed via the outpatient pharmacy benefit, but are not accepted to the closed Commercial HMO formulary, will be placed on a tier for the QHP-ACA/ Open formularies.

Medication	Commercial HMO/Closed Formulary Status	QHP-ACA/ Open Formulary Status
Anktiva (nogapendekin alfa inbakicept-pmln)	• Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage	
Exblifep (cefepime-enmetazobactam)	• Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage	
GLP-1 RA and GLP-1/GIP RA for weight management	• Non-Formulary • Continue to require QRM PA review • Excluded for benefits without a Class III rider	• Specialty Tier 5 • Continue to require QRM PA review • Excluded for benefits without a Class III rider
Ogsiveo (nirogacestat)	• Non-Formulary • Require QRM PA review • 30-day supply limits	• Specialty Tier 5 • Require QRM PA review • 30-day supply limits
Orserdu (elacestrant)	• Non-Formulary • Require QRM PA review	• Specialty Tier 5 • Require QRM PA review
Rezdiffra (resmetirom)	• Non-Formulary • Require QRM PA review	• Specialty Tier 5 • Require QRM PA review
Ryzneuta (efbemalenograstim)	• Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage • Require QRM PA review	
Tofidence (tocilizumab-bavi)	• Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage	
Tyenne (tocilizumab-aazg) IV Formulation	• Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage	
Xolremdi (mavorixafor)	• Non-Formulary • Require QRM PA review	• Specialty Tier 5 • Require QRM PA review
Zevtera (ceftobiprole medocaril sodium)	• Not accepted – clinic administered medication • Approve for clinic administration under medical benefit coverage	

In the News....

2024-2025 Flu Season Update: Influenza Vaccine Options and Guidance

Once again, for the 2024–2025 influenza season, the CDC recommends annual vaccination for everyone ≥6 months of age. Influenza vaccination reduces the incidence of influenza and can reduce the risk of serious complications and death associated with influenza illness in children and adults. Updated vaccines for the 2024–2025 influenza season are trivalent, meaning that they contain three strains of influenza virus. In most recent prior years, the vaccines have been quadrivalent, containing four influenza strains. The change was made as a result of recommendations from the World Health Organization (WHO), CDC, and the FDA's Vaccines and Related Biological Products Advisory Committee (VRBPAC) to eliminate the B/Yamagata strain from influenza vaccines based on the absence of detectable circulating B/Yamagata virus strains worldwide over the previous 3 years.

Several vaccines are preferentially recommended by the CDC for people ≥65 years of age. These vaccines are recommended because they may induce greater immunogenicity over standard vaccines, which may lead to better and longer durations of protection in older adults.

• Fluzone High-Dose (HD-IIV3) is a high-dose vaccine that is FDA-approved for people ≥65 years of age and contains four times the antigen dose compared to standard-dose inactivated flu vaccines.

• Flublok (RIV3) is also a higher-dose vaccine. It is approved for use in people ≥18 years of age and contains three times the antigen dose compared with standard-dose inactivated flu vaccines.

• Fluad (aIIV3) is an inactivated influenza vaccine with an adjuvant approved for use in people ≥65 years of age. It contains the same amount of antigen as other standard-dose inactivated flu vaccines plus the adjuvant MF59, which is intended to trigger a greater immune response against flu.

New for the 2024–2025 influenza season is a CDC recommendation for high-dose inactivated (Fluzone HD) and adjuvant-boosted inactivated (Fluad) influenza vaccines as acceptable options for vaccination of solid organ transplant (SOT) recipients 18–64 years of age who are receiving immunosuppressive medication regimens. Because vaccine response can be reduced in the post-transplant setting, the American Society of Transplantation (AST) had previously suggested that high-dose or adjuvant-boosted influenza vaccines may be preferred for patients who are on immunosuppressants after a SOT. However, these vaccines are only FDA-approved for individuals ≥65 years of age, which left younger patients who had SOTs without a high-dose or adjuvant-boosted vaccine option that was available and universally covered by insurance. An Advisory Committee on Immunization Practices (ACIP) Work Group reviewed the literature and performed a meta-analysis of eight studies comparing immunogenicity of the adjuvanted and high-dose vaccines compared to standard inactivated vaccines in patients who had a SOT. They found that seroconversion was higher with adjuvant-boosted and high-dose vaccines, although there was no direct evidence of clinical benefit against hospitalization or disease incidence. No increased risks were seen with the alternative vaccines. The CDC recommendation for use of these vaccines by younger patients post SOT ensures access and coverage by payers. However, the CDC does not recommend the high-dose or adjuvant-boosted vaccines preferentially over other age-appropriate vaccines.

References:

1. IPD Analytics. IPD Analytics Payer and Provider Updates. 2024-2025 Flu Season Update: Influenza Vaccine Options and Guidance. IPD Analytics, LLC. Accessed August 30, 2024. http://www.ipdanalytics.com [Subscription database].
2. Centers for Disease Control and Prevention. ACIP Recommendations. CDC. Accessed September 6, 2024. https://www.cdc.gov/flu/prevent/qa_fluzone.htm
3. Fluzone High-Dose, Flublok. Prescribing Information. Sanofi Pasteur Inc. Accessed September 6, 2024. Trivalent Influenza Vaccines for Influenza Type A and B | Sanofiflu.com.
4. Fluad. Prescribing Information. CSL Seqirus. Accessed September 6, 2024. FLUAD® (Influenza Vaccine, Adjuvanted) for 65+ | CSL Seqirus flu360.