



Synergie Medication Collective

Select Med+ Medical Drug List - Effective 1/1/2024

Select Med+ Medical Drug List is part of Synergie's Select Med+ program to achieve lowest net cost savings. As part of the program, the following Select Med+ Medical Drug List for selected products will be effective 1/1/2024. Highlights of the Select Med+ Medical Drug List include:

- Combines clinical and cost-effectiveness evaluation to make selection of preferred medical drugs in an effort to control the rising cost of healthcare for the 100 million members that are part of Synergie;
- Clients use the guidance to apply strategies for their plans to achieve net-cost savings for their insured lives, employer groups and members; and
- Strong adoption of recommendations and net-cost savings will result across several condition-categories that have selected preferred medical drugs, particularly in areas with direct competition such as biosimilars.

At a minimum, Synergie will update the medical drug list annually and as needed throughout the calendar year. ***This list is solely based on recommendations made by Synergie to its participants. Product coverage and medical policy and guideline decisions are made by each health plan independently, in their sole discretion.***

Category	Preferred	Non-Preferred	Excluded
Infliximab	Avsola infliximab Remicade		Inflectra Renflexis
Oncology - Bevacizumab	Mvasi Zirabev		Alymsys Vegzelma
Oncology - Rituximab	Riabni Truxima		Ruxience
Oncology - Trastuzumab	Kanjinti Ogivri		Herzuma Ontruzant Trazimera
Pegfilgrastim	Only 2 products (1 of 2): Fulphila Neulasta Nyvepria Udenyca	Stimufend	Flyntera Rolvedon Ziextenzo

Preferred = Medical drugs that should be used first; Non-Preferred = Medical drugs that require use of a Preferred drug first; Excluded = Medical drugs that are not covered by a plan or considered not medically necessary.

Not all products or positions are represented for all categories. All coverage and policy decisions will be made by the health plan and will affect rebate eligibility, and in addition to the three categories represented above, may include options such as coverage parity, exclusive coverage, among others.

Category	Preferred	Non-Preferred	Excluded
Viscosupplements	Preferred Recommendation: Euflexxa Synvisc/Synvisc One	Alternative Options: Durolane Gelsyn-3 Hyalgan Hymovis Monovisc Orthovisc Supartz FX Triluron	1% Sodium Hyaluronate Gel-One Genvisc Visco-3
Acute Hepatic Porphyria	Givlaari		
Amyloidosis	Amyvtra Onpattro		Tegsedi
Asthma (Injectable)	Fasenra Nucala Tezspire Xolair		Cinqair
Autoimmune	Entyvio Ilumya Simponi Simponi Aria Stelara	Cimzia Skyrizi Tremfya	Actemra Orencia
Erythropoietin	Aranesp Procrit Retacrit	Mircera	Epogen
Filgrastim	Zarxio	Granix Releuko	Leukine Neupogen Nivestym
Gaucher's Disease	Cerezyme		Elelyso VPRIV
Generalized Myasthenia Gravis (gMG)	Vyvgart Vyvgart Hytrulo	Rystiggo Soliris Ultomiris	
GnRH – Central Precocious Puberty (CPP)	Fensolvi Supprelin LA Triptodur	Lupron Ped	

Preferred = Medical drugs that should be used first; Non-Preferred = Medical drugs that require use of a Preferred drug first; Excluded = Medical drugs that are not covered by a plan or considered not medically necessary.

Not all products or positions are represented for all categories. All coverage and policy decisions will be made by the health plan and will affect rebate eligibility, and in addition to the three categories represented above, may include options such as coverage parity, exclusive coverage, among others.

Category	Preferred	Non-Preferred	Excluded
Gout	3-month trial of BOTH: 1) allopurinol or febuxostat 2) Probenecid		Krystexxa
Hemophilia A	Altuviio Eloctate Jivi Kogenate Nuwiq Xyntha	Alphanate Advate Adynovate Afstyla Esperoct Hemlibra Hemofil M Humate-P Koate Kovaltry Novoeight Recombinate Wilate	
Hemophilia B	Alprolix Benefix	Alphanine Idelvion Ixinity Profilnine Rebinyn Rixubis	
Immune Globulin	Asceniv Bivigam Cutaqig Octagam Panzyga	Cuvitru Flebogamma Gamastan Gammagard Gammaked Gammaplex Gamunex-C Hizentra Hyqvia Privigen Xembify	

Preferred = Medical drugs that should be used first; Non-Preferred = Medical drugs that require use of a Preferred drug first; Excluded = Medical drugs that are not covered by a plan or considered not medically necessary.

Not all products or positions are represented for all categories. All coverage and policy decisions will be made by the health plan and will affect rebate eligibility, and in addition to the three categories represented above, may include options such as coverage parity, exclusive coverage, among others.

Category	Preferred	Non-Preferred	Excluded
Infertility	Cetrotide Gonal-F Ovidrel		Follistim ganirelix Novarel Pregnyl
Multiple Sclerosis	Ocrevus Briumvi		Tysabri
Ocular VEGF (after Avastin/ bevacizumab)	Byooviz Cimerli Lucentis		Beovu Eylea Eylea HD Susvimo
Primary Hyperoxaluria Type 1	Oxlumo		
Somatostatin Analogs	Sandostatin LAR Somatuline Depot		lanreotide (Cipla)
Thyroid Eye Disease	History of intolerance/failure/ contraindication to oral AND IV glucocorticoid steroids		Tepezza
Toxins (Cervical Dystonia/ Spasticity)	Dysport Xeomin	Botox Myobloc	

Preferred = Medical drugs that should be used first; Non-Preferred = Medical drugs that require use of a Preferred drug first; Excluded = Medical drugs that are not covered by a plan or considered not medically necessary.

Not all products or positions are represented for all categories. All coverage and policy decisions will be made by the health plan and will affect rebate eligibility, and in addition to the three categories represented above, may include options such as coverage parity, exclusive coverage, among others.



Select Med+ Cell & Gene Medical Drug List - Effective 1/1/2024

Select Med+ Cell & Gene Medical Drug List is part of Synergie's Cell & Gene+ program to obtain total value and cost savings with very expensive cell- and gene-based therapies. As part of the program, the following Select Med+ Cell & Gene Medical Drug List for selected products will be effective 1/1/2024.

Highlights of the Cell & Gene+ program include:

- Risk Protection – alleviates drug costs for payers, with lowest fee;
- Patient Navigation – national program for navigating patients to highest quality sites at lowest cost; and
- Outcomes - scalable VBCs, with longitudinal patient tracking to provide payer value certainty.

At a minimum, Synergie will update the Cell & Gene Medical Drug List annually and as needed throughout the calendar year. ***This list is solely based on recommendations made by Synergie to its participants. Product coverage and medical policy and guideline decisions are made by each health plan independently, in their sole discretion.***

Cell & Gene Category	Preferred	Excluded
Beta Thalassemia	Zynteglo	
Duchenne Muscular Dystrophy (DMD)		Elevidys
Dystrophic Epidermolysis Bullosa (DEB)	Vyjuvek	
Hemophilia A	Roctavian	
Hemophilia B	Hemgenix	
Sickle Cell Disease	Casgevy Lyfgenia	
Spinal Muscular Atrophy (SMA)	Zolgensma	

Preferred = Medical drugs that should be used first; Excluded = Medical drugs that are not covered by a plan, considered not medically necessary, or clinical profile deemed investigational.

Not all products or positions are represented for all categories. All coverage and policy decisions will be made by the health plan and will affect rebate eligibility, and in addition to the three categories represented above, may include options such as coverage parity, exclusive coverage, among others.