

Lupus Prior Authorization with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date
11-01-2025

Date of Origin

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Benlysta	belimumab subcutaneous solution auto-injector	200 MG/ML	M ; N ; O ; Y	N		
Benlysta	belimumab subcutaneous solution prefilled syringe	200 MG/ML	M ; N ; O ; Y	N		
Lupkynis	voclosporin cap	7.9 MG	M ; N ; O ; Y	N		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
Benlysta	belimumab subcutaneous solution auto-injector	200 MG/ML	4	Syringes	28	DAYS			
Benlysta	belimumab subcutaneous solution prefilled syringe	200 MG/ML	4	Syringes	28	DAYS			
Lupkynis	Voclosporin Cap	7.9 MG	180	Capsules	30	DAYS			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Benlysta	belimumab subcutaneous solution auto-injector	200 MG/ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ;

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Benlysta	belimumab subcutaneous solution prefilled syringe	200 MG/ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Lupkynis	voclosporin cap	7.9 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Benlysta	belimumab subcutaneous solution auto-injector	200 MG/ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ;

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Benlysta	belimumab subcutaneous solution prefilled syringe	200 MG/ML	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods
Lupkynis	Voclosporin Cap	7.9 MG	IL HMO Performance Annual ; Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; HIM Quarterly 2026 ; IL HIM Annual 2025 ; IL HIM Annual 2026 ; IL non-HMO Performance Full ; Jade ; MT Performance Full ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM HIM Annual 2026 ; NM Performance Full ; OK Performance Full ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; TX HIM Annual 2025 ; TX HIM Annual 2026 ; Topaz ; Whole Foods

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
PA	<p>Initial Evaluation</p> <p>Target Agent(s) will be approved when ALL of the following are met:</p> <p>1. ONE of the following:</p>

Module	Clinical Criteria for Approval
	<p>A. The requested agent is eligible for continuation of therapy AND the following:</p> <div style="border: 1px solid black; padding: 5px; margin: 10px auto; width: fit-content;"> <p style="text-align: center;">Agents Eligible for Continuation of Therapy</p> <p style="text-align: center;">All target agents are eligible for continuation of therapy</p> </div> <p>1. The prescriber states the patient has been treated with the requested agent (starting on samples is not approvable) within the past 90 days AND is at risk if therapy is changed OR</p> <p>B. BOTH of the following:</p> <p>1. ONE of the following:</p> <p>A. The patient has a diagnosis of active systemic lupus erythematosus (SLE) disease WITHOUT active lupus nephritis (LN) AND BOTH of the following:</p> <ol style="list-style-type: none"> 1. The requested agent is FDA labeled or compendia supported for SLE AND 2. BOTH of the following: <ol style="list-style-type: none"> A. ONE of the following: <ol style="list-style-type: none"> 1. The patient has ONE of the following: <ol style="list-style-type: none"> A. Has tried and had an inadequate response to hydroxychloroquine OR B. Has an intolerance or hypersensitivity to hydroxychloroquine OR 2. The patient has an FDA labeled contraindication to hydroxychloroquine AND B. ONE of the following: <ol style="list-style-type: none"> 1. The patient has ONE of the following: <ol style="list-style-type: none"> A. Has tried and had an inadequate response to ONE corticosteroid OR immunosuppressive agent (i.e., azathioprine, methotrexate, mycophenolate, cyclophosphamide) OR B. Has an intolerance or hypersensitivity to ONE corticosteroid OR immunosuppressive agent (i.e., azathioprine, methotrexate, mycophenolate, cyclophosphamide) OR 2. The patient has an FDA labeled contraindication to ALL corticosteroids AND immunosuppressive agents (i.e., azathioprine, methotrexate, mycophenolate, cyclophosphamide) OR <p>B. The patient has a diagnosis of active lupus nephritis (LN) AND BOTH of the following:</p> <ol style="list-style-type: none"> 1. The requested agent is FDA labeled or compendia supported for LN AND 2. The patient has Class III, IV, or V lupus nephritis confirmed via kidney biopsy OR <p>C. The patient has another FDA labeled indication for the requested agent and route of administration AND</p> <p>2. If the patient has an FDA labeled indication, then ONE of the following:</p> <ol style="list-style-type: none"> A. The patient's age is within FDA labeling for the requested indication for the requested agent and route of administration OR B. There is support for using the requested agent for the patient's age for the requested indication and route of administration OR <p>C. The patient has another indication that is supported in compendia for the requested agent and route of administration AND</p>

Module	Clinical Criteria for Approval
	<p>2. If the patient has a diagnosis of active systemic lupus erythematosus (SLE) WITHOUT active LN, then BOTH of the following:</p> <ul style="list-style-type: none"> A. The patient is currently treated with standard SLE therapy (i.e., corticosteroids, hydroxychloroquine, azathioprine, methotrexate, mycophenolate, cyclophosphamide) AND B. The patient will continue standard SLE therapy (i.e., corticosteroids, hydroxychloroquine, azathioprine, methotrexate, mycophenolate, cyclophosphamide) in combination with the requested agent AND <p>3. If the patient has a diagnosis of active LN, the patient will be using background immunosuppressive LN therapy (e.g., Lupkynis requests: corticosteroids plus mycophenolate; Benlysta requests: corticosteroids plus mycophenolate, azathioprine, or cyclophosphamide) in combination with the requested agent AND</p> <p>4. The prescriber is a specialist in the area of the patient’s diagnosis (e.g., rheumatologist, nephrologist), or the prescriber has consulted with a specialist in the area of the patient’s diagnosis AND</p> <p>5. If the requested agent is Benlysta, then ALL of the following:</p> <ul style="list-style-type: none"> A. The patient does NOT have severe active central nervous system (CNS) lupus AND B. ONE of the following: <ul style="list-style-type: none"> 1. The patient will NOT be using the requested agent in combination with Lupkynis OR 2. BOTH of the following: <ul style="list-style-type: none"> A. The patient has a diagnosis of active LN AND B. The patient has tried and had an inadequate response to TWO standard therapy courses (e.g., corticosteroids and Benlysta plus mycophenolate, azathioprine, or cyclophosphamide; corticosteroids and Lupkynis plus mycophenolate) and will be using Benlysta in combination with Lupkynis plus mycophenolate (medical records required) AND C. ONE of the following (Please refer to “Agents NOT to be used Concomitantly” table): <ul style="list-style-type: none"> 1. The patient will NOT be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) OR 2. The patient will be using the requested agent in combination with another immunomodulatory agent AND BOTH of the following: <ul style="list-style-type: none"> A. The prescribing information for the requested agent does NOT limit the use with another immunomodulatory agent AND B. There is support for the use of combination therapy (submitted copy of clinical trials, phase III studies, or guidelines required) AND <p>6. If the requested agent is Lupkynis, then BOTH of the following:</p> <ul style="list-style-type: none"> A. The patient will NOT be using the requested agent in combination with cyclophosphamide OR Saphnelo AND B. ONE of the following: <ul style="list-style-type: none"> 1. The patient will NOT be using the requested agent in combination with Benlysta OR 2. BOTH of the following: <ul style="list-style-type: none"> A. The patient has a diagnosis of active LN AND B. The patient has tried and had an inadequate response to TWO standard therapy courses (e.g., corticosteroids and Benlysta plus mycophenolate, azathioprine, or cyclophosphamide; corticosteroids and Lupkynis plus mycophenolate) and will be using Lupkynis in combination with Benlysta plus mycophenolate (medical records required) AND <p>7. The patient does NOT have any FDA labeled contraindications to the requested agent</p> <p>Compendia Allowed: AHFS, or DrugDex 1, 2a, or 2b level of evidence</p> <p>Length of Approval:</p>

Module	Clinical Criteria for Approval
	<p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p>The requested agent will also be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The request is for a BCBS MT Fully Insured or MT HIM member AND <ol style="list-style-type: none"> A. The patient is under the age of 18 years old AND B. The patient does NOT have any FDA labeled contraindications to the requested agent AND C. The patient has an indication that is supported in TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] AND D. There is support for an age in the patient’s given age bracket in TWO articles from major peer-reviewed professional medical journals as generally safe and effective. The age brackets are: 1. infancy (birth up to, but not including, 2 years of age), 2. childhood (2 years of age through 11 years of age), 3. adolescence (12 years of age through 17 years of age). Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] OR 2. ALL of the following: <ol style="list-style-type: none"> A. The member resides in Ohio AND B. The plan is Fully Insured or HIM Shop (SG) AND C. The patient does NOT have any FDA labeled contraindications to the requested agent AND D. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR 3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required] <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p>

Module	Clinical Criteria for Approval
	<p data-bbox="232 180 1076 212">NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p> <p data-bbox="232 310 498 342">Renewal Evaluation</p> <p data-bbox="232 375 1081 407">Target Agent(s) will be approved when ALL of the following are met:</p> <ol data-bbox="280 443 1409 1976" style="list-style-type: none"> <li data-bbox="280 443 1357 527">1. The patient has been previously approved for the requested agent through the plan's Prior Authorization process [Note: patients not previously approved for the requested agent will require initial evaluation review] AND <li data-bbox="280 531 1127 562">2. The patient has had clinical benefit with the requested agent AND <li data-bbox="280 567 1409 1976">3. ONE of the following: <ol style="list-style-type: none"> <li data-bbox="354 590 1409 821">A. The patient has a diagnosis of active systemic lupus erythematosus (SLE) WITHOUT active lupus nephritis (LN) AND BOTH of the following: <ol style="list-style-type: none"> <li data-bbox="472 646 1300 730">1. The patient is currently treated with standard SLE therapy (i.e., corticosteroids, hydroxychloroquine, azathioprine, methotrexate, mycophenolate, cyclophosphamide) AND <li data-bbox="472 735 1341 821">2. The patient will continue standard SLE therapy (i.e., corticosteroids, hydroxychloroquine, azathioprine, methotrexate, mycophenolate, cyclophosphamide) in combination with the requested agent OR <li data-bbox="354 825 1409 1108">B. The patient has a diagnosis of active lupus nephritis (LN) AND BOTH of the following: <ol style="list-style-type: none"> <li data-bbox="472 882 1385 995">1. The patient is currently treated with background immunosuppressive LN therapy (e.g., Lupkynis requests: corticosteroids plus mycophenolate; Benlysta requests: corticosteroids plus mycophenolate, azathioprine, or cyclophosphamide) AND <li data-bbox="472 999 1377 1108">2. The patient will continue background immunosuppressive LN therapy (e.g., Lupkynis requests: corticosteroids plus mycophenolate; Benlysta requests: corticosteroids plus mycophenolate, azathioprine, or cyclophosphamide) in combination with the requested agent OR <li data-bbox="354 1113 1252 1144">C. The patient has a diagnosis other than active SLE OR active LN AND <li data-bbox="280 1148 1409 1232">4. The prescriber is a specialist in the area of the patient's diagnosis (e.g., rheumatologist, nephrologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND <li data-bbox="280 1236 1409 1976">5. If the requested agent is Benlysta, then ALL of the following: <ol style="list-style-type: none"> <li data-bbox="354 1260 1289 1316">A. The patient does NOT have severe active central nervous system (CNS) lupus AND <li data-bbox="354 1320 1409 1625">B. ONE of the following: <ol style="list-style-type: none"> <li data-bbox="472 1344 1370 1400">1. The patient will NOT be using the requested agent in combination with Lupkynis OR <li data-bbox="472 1404 1409 1625">2. BOTH of the following: <ol style="list-style-type: none"> <li data-bbox="565 1428 1162 1459">A. The patient has a diagnosis of active LN AND <li data-bbox="565 1463 1409 1625">B. The patient has tried and had an inadequate response to TWO standard therapy courses (e.g., corticosteroids and Benlysta plus mycophenolate, azathioprine, or cyclophosphamide; corticosteroids and Lupkynis plus mycophenolate) and will be using Benlysta in combination with Lupkynis plus mycophenolate (medical records required) AND <li data-bbox="354 1629 1409 1976">C. ONE of the following (Please refer to "Agents NOT to be used Concomitantly" table): <ol style="list-style-type: none"> <li data-bbox="472 1686 1409 1770">1. The patient will NOT be using the requested agent in combination with another immunomodulatory agent (e.g., TNF inhibitors, JAK inhibitors, IL-4 inhibitors) OR <li data-bbox="472 1774 1409 1976">2. The patient will be using the requested agent in combination with another immunomodulatory agent AND BOTH of the following: <ol style="list-style-type: none"> <li data-bbox="565 1831 1365 1890">A. The prescribing information for the requested agent does NOT limit the use with another immunomodulatory agent AND <li data-bbox="565 1894 1377 1976">B. There is support for the use of combination therapy (submitted copy of clinical trials, phase III studies, or guidelines required) AND

Module	Clinical Criteria for Approval
	<p>6. If the requested agent is Lupkynis, then BOTH of the following:</p> <ul style="list-style-type: none"> A. The patient will NOT be using the requested agent in combination with cyclophosphamide OR Saphnelo AND B. ONE of the following: <ul style="list-style-type: none"> 1. The patient will NOT be using the requested agent in combination with Benlysta OR 2. BOTH of the following: <ul style="list-style-type: none"> A. The patient has a diagnosis of active LN AND B. The patient has tried and had an inadequate response to TWO standard therapy courses (e.g., corticosteroids and Benlysta plus mycophenolate, azathioprine, or cyclophosphamide; corticosteroids and Lupkynis plus mycophenolate) and will be using Lupkynis in combination with Benlysta plus mycophenolate (medical records required) AND <p>7. The patient does NOT have any FDA labeled contraindications to the requested agent</p> <p>Length of Approval:</p> <p>BCBSOK: 36 months</p> <p>ALL other plans: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p>

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Quantity limit for the Target Agent(s) will be approved when ONE of the following is met:</p> <ul style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the program quantity limit OR 2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: <ul style="list-style-type: none"> A. BOTH of the following: <ul style="list-style-type: none"> 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication OR B. BOTH of the following: <ul style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication AND 2. There is support for why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit <p>Length of Approval: 12 months</p> <p>Note: If approving initial loading dose for Benlysta, approve the loading dose per FDA labeling for 1 month, followed by maintenance dosing for the remainder of the length of approval.</p>

CONTRAINDICATION AGENTS

Contraindicated as Concomitant Therapy
<p>Agents NOT to be used Concomitantly</p> <p>Abrilada (adalimumab-afzb) Actemra (tocilizumab) Adalimumab</p>

Contraindicated as Concomitant Therapy

Adbry (tralokinumab-ldrm)
Amjevita (adalimumab-atto)
Arcalyst (rilonacept)
Avsola (infliximab-axxq)
Avtozma (tocilizumab-anoh)
Benlysta (belimumab)
Bimzelx (bimekizumab-bkzx)
Cibinqo (abrocitinib)
Cimzia (certolizumab)
Cinqair (reslizumab)
Cosentyx (secukinumab)
Cyltezo (adalimumab-adbm)
Dupixent (dupilumab)
Ebglyss (lebrikizumab-lbkz)
Enbrel (etanercept)
Entyvio (vedolizumab)
Fasenra (benralizumab)
Hadlima (adalimumab-bwwd)
Hulio (adalimumab-fkjp)
Humira (adalimumab)
Hyrimoz (adalimumab-adaz)
Idacio (adalimumab-aacf)
Ilaris (canakinumab)
Ilumya (tildrakizumab-asmn)
Imuldosa (ustekinumab-srlf)
Inflectra (infliximab-dyyb)
Infliximab
Kevzara (sarilumab)
Kineret (anakinra)
Leqselvi (deuruxolitinib)
Litfulo (ritlecitinib)
Nemluvio (nemolizumab-ilto)
Nucala (mepolizumab)
Olumiant (baricitinib)
Omyclo (omalizumab-igec)
OmvoH (mirikizumab-mrkz)
Opzelura (ruxolitinib)
Orencia (abatacept)
Otezla (apremilast)
Otulfi (ustekinumab-aaaz)
Pyzchiva (ustekinumab-ttwe)
Remicade (infliximab)
Renflexis (infliximab-abda)
Riabni (rituximab-arrx)
Rinvoq (upadacitinib)
Rituxan (rituximab)
Rituxan Hycela (rituximab/hyaluronidase human)
Ruxience (rituximab-pvvr)
Saphnelo (anifrolumab-fnia)
Selarsdi (ustekinumab-aekn)
Siliq (brodalumab)
Simlandi (adalimumab-ryvk)
Simponi (golimumab)
Simponi ARIA (golimumab)
Skyrizi (risankizumab-rzaa)
Sotyktu (deucravacitinib)
Spevigo (spesolimab-sbzo) subcutaneous injection
Stelara (ustekinumab)
Steqeyma (ustekinumab-stba)
Taltz (ixekizumab)
Tezspire (tezepelumab-ekko)
Tofidence (tocilizumab-bavi)

Contraindicated as Concomitant Therapy

Tremfya (guselkumab)
Truxima (rituximab-abbs)
Tyenne (tocilizumab-aazg)
Tysabri (natalizumab)
Ustekinumab
Velsipity (etrasimod)
Wezlana (ustekinumab-auub)
Xeljanz (tofacitinib)
Xeljanz XR (tofacitinib extended release)
Xolair (omalizumab)
Yesintek (ustekinumab-kfce)
Yuflyma (adalimumab-aaty)
Yusimry (adalimumab-aqvh)
Zeposia (ozanimod)
Zymfentra (infliximab-dyyb)