Consent Agenda Item:

July 2024 DRAFT
Drug – **Synagis** [palivizumab]
2024-2025 RSV Season

Prior authorization is required for all patients

Providers must fax the completed Synagis Prior Authorization (DHS-6428) (PDF) to the MHCP Prescription Drug Prior Authorization Agent.

FDA-approved indications and usage

- Synagis is indicated for the prevention of serious lower respiratory tract disease caused by respiratory syncytial virus (RSV) in pediatric patients at high risk of RSV disease.
- The RSV season is expected to be November 1 to March 31 OR is determined in real time by identifying the first week of two consecutive weeks that RSV RT-PCR test positivity is greater than or equal to 3% or antigen detection positivity is greater than or equal to 10% (according to CDC RSV Surveillance for Minnesota).
- Up to eight doses will be allowed per member over the course of the RSV season. Some patients will be eligible for fewer doses, depending on their gestational and chronological age. The number of requested doses must be clearly stated on the prior authorization request form.
- If a dose was administered in an inpatient setting, the date the dose was administered must be included on the request form.

Dosing allowance policy

The calculated dose of Synagis is 15 mg/kg. Because this drug is available only in 50 mg and 100 mg vials, use **Table 1** to determine dosage. **Table 1** shows a 10% difference in allowed dose from the calculated dose.

Table 1. MN DHS Dosing Allowance - 10% difference from calculated dose

Weight	Calculated dose (max wt) (15mg/kg)	Allowed dose	Dispense
0 to 3.6 kg	54 mg	50 mg	one 50 mg vial
3.7 to 7.3 kg	110 mg	100 mg	one 100 mg vial
7.4 to 11.1 kg	166.5 mg	150 mg	one 100 mg one 50 mg vial
11.2 to 14.6 kg	220 mg	200 mg	two 100 mg vials
14.7 to 18.1 kg	271.5 mg	250 mg	two 100 mg one 50 mg vial

How Supplied

50 mg vial or 100 mg vial

Criteria

Infant or Child with Pulmonary Dysfunction
Any infant or child younger than or equal to 12 months of age born before 32 weeks, 0 days' gestation with a diagnosis of Chronic Lung Disease (CLD) of prematurity (defined as supplemental oxygen for at least 28 days after birth.
Any infant or child younger than or equal to 24 months of age born before 32 weeks, 0 days' gestation that required at least 28 days of supplemental oxygen after birth **AND** having one or more of the following clinical needs during the previous 6 months:

- Supplemental oxygen
- Recent use of corticosteroid therapy
- Regular or intermittent use of diuretics to treat pulmonary disease

Up to eight (8) monthly doses will be approved.

Any infant or child younger than or equal to 12 months of age, at the time of request, with a diagnosis of one or more of the following that impacts pulmonary function:

- Interstitial Lung Disease
- Neuromuscular disease
- Congenital airway abnormality

Up to eight (8) monthly doses will be approved.
Infant with congenital heart disease (CHD) (see also addendum A)
Any infant younger than 12 months of age, at the time of request, who has a diagnosis of hemodynamically significant congenital heart disease (CHD) and meets any of the following criteria:

- Receiving medication to control congestive heart failure (diuretics, antihypertensives)
- Moderate to severe pulmonary hypertension
- Cyanotic heart disease

Up to eight (8) monthly doses will be approved.
Infants with a history of premature birth
Any infant up to 12 months of age, born at less than 29 weeks, 0 days' gestation.

Up to eight (8) monthly doses will be approved.

Infants or children who are profoundly immunocompromised

Any infant or child younger than 24 months of age who will be profoundly immunocompromised during the RSV season.

Up to eight (8) monthly doses will be approved.

Addendum A

Patients with CHD who are NOT candidates for Synagis include:

- Hemodynamically insignificant heart disease
- Secundum ASD
- Small VSD
- Pulmonic stenosis
- Uncomplicated aortic stenosis

- Mild coarctation of the aorta
- Patent ductus arteriosus (PDA)
- Infants with corrected surgical lesions unless they continue to require medication for CHF
- Infants with mild cardiomyopathy who are not receiving medical therapy

Addendum B

There are no guideline or consensus recommendations to support Synagis prophylaxis in patients who have one of the following disorders:

- Hematopoietic stem cell transplant (BMT, peripheral blood, placental or cord blood)
- Severe combined immunodeficiency syndrome
- Children with Down Syndrome
- Advanced AIDS
- Cystic fibrosis
- RSV episode during the current season
- Repeated pneumonia
- Sickle cell disease
- Being one member of a multiple birth, another member of which is approved for Synagis
- Apnea or respiratory failure of newborn

Addendum C

During the 2024-2025 RSV season, prior authorization request may be approved if the patient meets applicable clinical criteria AND one of the following:

- Patient has a contraindication to the RSV immunization (nirsevimab-alip, Beyfortus [Sanofi]) OR
- Patient is unable to receive the RSV immunization (nirsevimab-alip, Beyfortus [Sanofi])

Questions?

MHCP Provider Resource Center 651-431-2700 or 800-366-5411

Discussion Items:

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Agamree® - DRAFT

(July 2024)

Drug	**Agamree® (vamorolone) [**Catalyst Pharmaceuticals Inc.**]**
Therapeutic Area	Duchene Muscular Dystrophy Treatments

Initial approval criteria:

- Patient must be at least 2 years of age or must meet the age limit in the FDA-approved label AND
- Must be prescribed by a provider specializing in neurology AND
- Prescriber's specialty must be provided at time of request AND
- Patient must have documentation of a confirmed diagnosis of Duchenne muscular dystrophy (DMD) AND
- Patient retains meaningful voluntary motor function (for example, patient is able to speak, manipulate objects using upper extremities, ambulate, and so forth) AND
- Patient will not be taking concurrent deflazocort; AND
- Prescriber attests that multidisciplinary rehabilitation assessments are conducted every 6-12 months AND
- Patient has tried and failed prednisone, having experienced one of the following unacceptable adverse reactions directly attributable to previous therapy with prednisone:
    - Patient has manifested significant behavioral changes negatively impacting function at school, day care, etc. OR
    - Patient has experienced significant weight gain (for example, crossing two percentiles reaching 98th percentile for age and sex, or both)

Renewal criteria:

- Patient retains meaningful voluntary motor function (for example, patient is able to speak, manipulate objects using upper extremities, ambulate, and so forth) AND
- Prescriber attests that multidisciplinary rehabilitation assessments are conducted every 6-12 months AND
- Patient has received benefit from therapy, which may include one or more of the following:
    - Stability or slowing of decline in motor function
    - Stability or slowing of decline in respiratory function
    - Stability or slowing of decline in sequelae related to diminished strength of stabilizing musculature (for example, scoliosis, etc.)

Quantity limits

- Daily quantity limit must not exceed those established in the FDA-approved label.
- Dosing frequency must reflect those established in the FDA-approved label.
- Patient's most up-to-date weight (in kilograms [kg]) AND requested quantity (in mL) must be submitted at time of request.
- If patient is switched from oral corticosteroid treatment (e.g., prednisone or deflazacort), a dosage of prednisone of 0.75 mg/kg/day (or corticosteroid equivalent) corresponds to Agamree 6 mg/kg/day

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Zilbrysq® - DRAFT

(July 2024)

Drug	**Zilbrysq® (zilucopan) [**UCB Inc.**]**
Therapeutic Area	Immunomodulators, Miscellaneous

Initial approval criteria:

- Patient is at least 18 years of age; **AND**
- Patient has a diagnosis of generalized myasthenia gravis (gMG) with a Myasthenia Gravis Foundation of America (MGFA) clinical classification class II to IV; **AND**
- Patient has a positive serologic test for anti-acetylcholine receptor (AChR) antibodies; **AND**
- Prescriber has assessed objective signs of neurological weakness and fatiguability on a baseline neurological examination (e.g., the Quantitative Myasthenia Gravis [QMG] score); **AND**
- Patient has a baseline MG-Activities of Daily Living (MG-ADL) total score of ≥ 6; **AND**
    - Patient had an inadequate response after a minimum 1-year trial of concurrent use with ≥ 2 immunosuppressive therapies (e.g., corticosteroids plus an immunosuppressant such as azathioprine, cyclosporine, mycophenolate); **OR**
    - Patient required chronic treatment with plasmapheresis or plasma exchange (PE) or intravenous immunoglobulin (IVIG) in addition to immunosuppressant therapy; **AND**
- Prescriber is enrolled in the Zilbrysq Risk Evaluation and Mitigation Strategy (REMS) program; **AND**
- Patient has completed or is up to date on meningococcal vaccination (for serogroups A, C, W, and Y [MenACWY], and serogroup B [MenB]) ≥ 2 weeks prior to administering the first dose (unless the risk of delaying therapy outweighs the risk of developing a meningococcal infection) in compliance with the most current Advisory Committee on Immunization Practices (ACIP) recommendations for meningococcal vaccinations in patients receiving a complement inhibitor; **AND**
- Patient does NOT have an unresolved *Neisseria meningitidis* infection; **AND**
- Patient has completed or is up to date on vaccinations for the prevention of *Streptococcus pneumoniae* and *Haemophilus influenzae type b* (Hib) infections according to ACIP guidelines; **AND**
- Prescriber has obtained baseline amylase and lipase levels; **AND**
- Zilbrysq will NOT be used in combination with other immunomodulatory biologic therapies (e.g., efgartigimod, eculizumab, pegcetacoplan, satralizumab, inebilizumab-cdon, ravulizumab-cwvz, rozanolixizumab-noli); **AND**
- Patient will avoid or use caution with medications known to worsen or exacerbate symptoms of MG (e.g., certain antibiotics, beta-blockers, botulinum toxins, hydroxychloroquine); **AND**
- Zilbrysq is prescribed by or in consultation with a neurologist.
- Initial approval is for 3 months

Renewal criteria:

- Patient must continue to meet the above criteria; **AND**
- Patient has had an improvement (e.g., reduction) of ≥ 1-point from baseline in the MG-ADL total score (may substitute an improvement of ≥ 1-point from baseline in the QMG total score, if available); **AND**
- Improvement in muscle strength testing with fatigue maneuvers as evidenced on neurologic examination when compared to baseline; **AND**
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., unresolved meningococcal infection; other infections, especially with encapsulated bacteria; pancreatitis or suspected pancreatitis); **AND**
- Patient should be revaccinated in accordance with ACIP recommendations depending on the duration therapy.
- Renewal approval is for 12 months

Quantity limits

- 28 single-dose prefilled syringes/28 days for any of the 3 product strengths (16.6 mg/0.416 mL, 23 mg/0.574 mL, 32.4 mg/0.81 mL)
- max dose 32.4 mg once daily for patients with an actual body weight ≥ 77 kg

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Fabhalta® - DRAFT

(July 2024)

Drug	**Fabhalta® (iptacopan) [**Novartis Pharmaceuticals Corporation**]**
Therapeutic Area	PNH Agents

Initial approval criteria:

- Patient is ≥ 18 years of age; **AND**
- Patient has a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by detection of PNH clones of at least 10% by flow cytometry diagnostic testing; **AND**
    - Demonstrate the presence of at least 2 different glycosylphosphatidylinositol (GPI) protein deficiencies (e.g., CD55, CD59, etc.) within at least 2 different cell lines (e.g., granulocytes, monocytes, erythrocytes); **AND**
- Patient's hemoglobin (Hb) is < 10 g/dL (lab tests required); **AND**
- If the patient has NOT received prior treatment with complement inhibitor therapy (e.g., pegcetacoplan, eculizumab, or ravulizumab-cwvz) BOTH of the following (lab tests required) must be met:
    - Patient has RBC clone size ≥ 10%; **AND**
    - Patient has a lactate dehydrogenase (LDH) level > 1.5 times the upper limit of normal (ULN); **AND**
- Patient will NOT use Fabhalta in combination with another complement inhibitor (e.g., pegcetacoplan, eculizumab, or ravulizumab); **AND**
- Patient does NOT have an unresolved serious infection caused by an encapsulated bacteria, including *Streptococcus pneumoniae, Neisseria meningitidis*, or *Haemophilus influenzae* type B; **AND**
- Patient does NOT have serious hypersensitivity to iptacopan or any of the excipients; **AND**
- Patient has complete or updated vaccination for encapsulated bacteria (based on ACIP recommendations for patients receiving a complement inhibitor) ≥ 2 weeks prior to the first dose of Fabhalta, unless the risks of delaying Fabhalta outweigh the risk of developing a serious infection; **AND**
- Patient is NOT on concomitant cytochrome P450 2C8 (CYP2C8) inhibitors (e.g., gemfibrozil); **AND**
- Patient does NOT have severe renal impairment (estimated glomerular filtration rate [eGFR] < 30 mL/min/1.73 m^2) with or without hemodialysis; **AND**
- Patient does NOT have severe hepatic impairment (Child-Pugh class C); **AND**
- Fabhalta has been prescribed by or in consultation with a specialist in the area of the patient's diagnosis (e.g., hematologist); **AND**
- Prescriber will monitor total cholesterol, low-density lipoprotein-cholesterol (LDL-C), and serum triglycerides during Fabhalta treatment; **AND**
- Prescriber will monitor for signs of hemolysis for ≥ 2 weeks after Fabhalta discontinuation.
- Initial approval is for 6 months

Renewal criteria:

- Patient must continue to meet the above criteria; **AND**
- Patient has demonstrated improvement or stabilization of PNH from baseline (e.g., decreased requirement of RBC transfusions, Hb stabilization or improvement, LDH reduction, symptom improvement or stabilization, reduction in thrombotic events); **AND**
- Patient has not experienced treatment restricting adverse effects (e.g., encapsulated bacterial infection, uncontrolled hyperlipidemia).
- Renewal approval is for 12 months

Quantity limits

- 200 mg capsules: 68 capsules per 34 days

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Eohilia™ - DRAFT

(July 2024)

Drug	**Eohilia™ (budesonide oral suspension) [**Takeda Pharmaceuticals, Inc.**]**
Therapeutic Area	Glucocorticoids, Oral

Approval criteria:

- Patient is at least 11 years of age; AND
- Eohilia is prescribed by a gastroenterologist, allergist or immunologist; AND
- Patient has a diagnosis of eosinophilic esophagitis as confirmed in patient's chart notes; AND
- Patient has received at least 8 weeks of therapy with a proton pump inhibitor; AND
- Patient has tried dietary modifications to managed eosinophilic esophagitis.
- Approval is for 90 days

Quantity limits

- 60 unit-dose packets per 30 days per fill
- Maximum of 3 fills

Background

Eohilia is a corticosteroid indicated for 12 weeks of treatment in adult and pediatric patients 11 years of age and older with eosinophilic esophagitis (EoE). Eohilia has not been shown to be safe and effective for the treatment of EoE for longer than 12 weeks.

MHCP Provider Resource Center (651) 431-2700 or 1-800-366-5411

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Wainua™ - DRAFT

(July 2024)

Drug	**Wainua™ (eplontersen) [**AstraZeneca Pharmaceuticals LP**]**
Therapeutic Area	Transthyretin Agents

Initial approval criteria:

- Patient is ≥ 18 years of age; AND
- Patient has a diagnosis of polyneuropathy of hereditary transthyretinmediated amyloidosis confirmed by testing (e.g., genetic testing, biopsy); AND
- The patient has clinical manifestations of polyneuropathy (e.g., neuropathic pain, altered sensation, numbness, tingling, impaired balance, motor disability); AND
- The patient will NOT be using in combination with inotersen (Tegsedi®), tafamidis (Vyndamax®), tafamidis meglumine (Vyndaqel®), patisiran (Onpattro®) or vutrisiran (Amvuttra®); AND
- Prescriber will supplement vitamin A at the recommended daily allowance as appropriate and refer to an ophthalmologist if ocular symptoms suggestive of vitamin A deficiency (e.g., night blindness, dry eyes) occur; AND
- The patient has NOT received a liver transplant; AND
- The prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist, geneticist, neurologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis.

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient has demonstrated a clinical benefit based on improvement in clinical manifestations of polyneuropathy from baseline (e.g., neuropathic pain, altered sensation, numbness, tingling, impaired balance, motor disability); AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., severe ocular symptoms related to vitamin A deficiency).

Quantity limits

- 1 pen per 30 days (max dose of 45 mg once monthly)

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Rivfloza™ - DRAFT

(July 2024)

Drug	**Rivfloza™ (nedosiran) [**Novo Nordisk Inc.**]**
Therapeutic Area	Hyperoxaluria Treatments

Initial approval criteria:

- Patient is ≥ 9 years of age; AND
- Patient has a definitive diagnosis of primary hyperoxaluria type 1 (PH1) as evidenced by 1 of the following:
    - Patient has a biallelic pathogenic mutation in the alanine: glyoxylate aminotransferase (AGXT) gene as identified on molecular genetic testing; OR
    - Identification of alanine: glyoxylate aminotransferase (AGT) enzyme deficiency on liver biopsy; AND
- Patient has a baseline for ≥ 1 of the following:
    - Urinary oxalate excretion level (corrected for BSA)
    - Spot urinary oxalate: creatinine ratio
    - Estimated glomerular filtration rate (eGFR)
    - Plasma oxalate level; AND
- Rivfloza will be used to lower urinary oxalate levels; AND
- Patient does not have renal impairment defined as an estimated glomerular filtration rate (eGFR) <30 mL/min/1.73 m^2; AND
- Patient has NOT had a liver transplant; AND
- Rivfloza will NOT be used in combination with other urinary oxalate reducing agents (e.g., lumasiran); AND
- Rivfloza is prescribed by, or in consultation with, a specialist in genetics, nephrology or urology.
- Initial approval is for 6 months

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient has experienced disease response as evidenced by a decrease in urinary oxalate excretion from baseline, a reduction in spot urinary oxalate: creatinine ratio from baseline, stabilization of glomerular filtration rate and/or a decrease in plasma oxalate level from baseline; AND
- Patient is absent of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: severe injection site reactions, etc.
- Renewal approval is for 12 months

Quantity limits

- Maximum 160 mg once per month
    - 80 mg single-dose vial: 2 vials per month
    - 128 mg prefilled-syringe: 1 syringe per month
    - 160 mg prefilled-syringe: 1 syringe per month

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Filsuvez™ - DRAFT

(July 2024)

Drug	**Filsuvez™ (birch triterpenes) [**Chiesi USA**]**
Therapeutic Area	Dystrophic epidermolysis bullosa

Initial approval criteria:

- Age ≥ 6 months; AND
- Diagnosis of dystrophic or junctional epidermolysis bullosa (EB) as confirmed by one of the following (medical records required):
    - Immunofluorescence mapping (IFM); OR
    - Transmission electron microscopy (TEM); OR
    - Genetic testing; AND
- The patient does NOT have current evidence or a history of squamous cell carcinoma in the area that will undergo treatment; AND
- The patient does NOT have an active infection in the area that will undergo treatment; AND
- The prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist, geneticist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis.
- Initial approval is for 4 months

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient must have clinical benefit with use; AND
- Patient has not experienced any treatment-restricting adverse effects (e.g., local or systemic hypersensitivity).
- Renewal approval is for 6 months

Quantity limits

- 30 tubes per 30 days. If a supply of more than 30 tubes per 30 days is required, provide the following information at time of request**:**
    - Estimated affected area size; 1 tube covers the same area as a business envelop (4 1/8" X 9 ½")l; AND
    - Frequency of application or wound dressing

MHCP Provider Resource Center (651) 431-2700 or 1-800-366-5411

Discussion Items:

ANTICONVULSANTS, OTHER section reviewed 7-17-2024

Preferred	Nonpreferred
DIASTAT (RECTAL) DIAZEPAM (RECTAL) DIAZEPAM DEVICE (RECTAL) VALTOCO (NASAL) NAYZILAM (NASAL)	LIBERVANT (BUCCAL)

ANTIEMETIC/ANTIVERTIGO AGENTS section reviewed 7-17-2024

Preferred	Nonpreferred
DICLEGIS (ORAL) ONDANSETRON ODT (ORAL) ONDANSETRON SOLUTION (ORAL) ONDANSETRON TABLETS (ORAL) TRANSDERM-SCOP (TRANSDERM)	AKYNZEO (ORAL) ANZEMET (ORAL) BONJESTA (ORAL) CESAMET (ORAL) DOXYLAMINE SUCCINATE/VIT B6 (DICLEGIS) (ORAL) GIMOTI (NASAL) GRANISETRON (ORAL) METOCLOPRAMIDE ODT (ORAL) SANCUSO (TRANSDERMAL) SCOPOLAMINE (TRANSDERM) ZOFRAN ODT (ORAL) ZOFRAN SOLUTION (ORAL) ZOFRAN TABLETS (ORAL)

ANTIFUNGALS, TOPICAL section reviewed 7-17-2024

Preferred	Nonpreferred
CICLOPIROX SUSPENSION (TOPICAL)	~~BENSAL HP (TOPICAL)~~
CICLOPIROX CREAM (TOPICAL)	CICLOPIROX GEL (TOPICAL)
CICLOPIROX SOLUTION (TOPICAL)	CICLOPIROX SHAMPOO (TOPICAL)
CLOTRIMAZOLE-BETAMETHASONE CREAM (TOPICAL)	CLOTRIMAZOLE-BETAMETHASONE LOTION (TOPICAL)
CLOTRIMAZOLE CREAM OTC (TOPICAL)	CLOTRIMAZOLE SOLUTION OTC (TOPICAL)
CLOTRIMAZOLE CREAM RX(TOPICAL)	ERTACZO (TOPICAL)
CLOTRIMAZOLE SOLUTION RX (TOPICAL)	~~EXELDERM CREAM (TOPICAL)~~
ECONAZOLE CREAM (TOPICAL)	~~EXELDERM SOLUTION (TOPICAL)~~
KETACONAZOLE CREAM (TOPICAL)	JUBLIA (TOPICAL)
KETOCONAZOLE SHAMPOO (TOPICAL)	KERYDIN (TOPICAL)
MICONAZOLE CREAM OTC (TOPICAL)	KETOCONAZOLE FOAM (TOPICAL)
MICONAZOLE POWDER OTC (TOPICAL)	LOPROX (TOPICAL)
NYSTATIN CREAM (TOPICAL)	LULICONAZOLE (TOPICAL)
NYSTATIN OINTMENT (TOPICAL)	LUZU (TOPICAL)
NYSTATIN POWDER (TOPICAL)	MICONAZOLE NITRATE/ZINC OXIDE/PETROLATUM (VUSION) (TOPICAL)
NYSTATIN-TRIAMCINOLONE CREAM (TOPICAL)	~~NAFTIFINE CREAM (TOPICAL)~~
TERBINAFINE CREAM OTC (TOPICAL)	NAFTIFINE GEL (TOPICAL)
TOLNAFTATE CREAM OTC (TOPICAL)	NAFTIN CREAM (TOPICAL)
	NAFTIN GEL (TOPICAL)
	NYSTATIN-TRIAMCINOLONE OINTMENT (TOPICAL)
	OXICONAZOLE CREAM (TOPICAL)
	OXISTAT LOTION (TOPICAL)
	~~OXISTAT CREAM (TOPICAL)~~
	~~PENLAC (TOPICAL)~~
	~~SULCONAZOLE NITRATE CREAM (TOPICAL)~~
	~~SULCONAZOLE NITRATE SOLUTION (TOPICAL)~~
	TAVABOROLE (TOPICAL)
	TOLNAFTATE SOLUTION OTC (TOPICAL)
	VUSION (TOPICAL)

ANTIMIGRAINE AGENTS, OTHER section reviewed 7-17-2024

Preferred	Nonpreferred
AIMOVIG (SUBCUTANE.)	~~AIMOVIG (SUBCUTANE.)~~
AJOVY (SUBCUTANE.)	ELYXYB SOLUTION (ORAL)
AJOVY AUTOINJECTOR (SUBCUTANE.)	NURTEC ODT (ORAL)
EMGALITY 120 MG/ML (PEN) (SUBCUTANE.)	QULIPTA (ORAL)
EMGALITY 120 MG/ML (SYRINGE) (SUBCUTANE.)	REYVOW (ORAL)
UBRELVY (ORAL)	TRUDHESA (NASAL)
	VYEPTI (INTRAVENOUS)
	ZAVZPRET (NASAL)

ANTIPARKINSON'S AGENTS section reviewed 7-17-2024

Preferred	Nonpreferred
CARBIDOPA / LEVODOPA (ORAL)	DHIVY TABLET (ORAL)
CARBIDOPA / LEVODOPA ER (ORAL)	GOCOVRI (ORAL)
CARBIDOPA / LEVODOPA ODT (ORAL)	INBRIJA (ORAL)
CARBIDOPA/LEVODOPA/ENTACAPONE (ORAL)	KYNMOBI (SUBLINGUAL)
ENTACAPONE (ORAL)	~~MIRAPEX (ORAL)~~
PRAMIPEXOLE (ORAL)	MIRAPEX ER (ORAL)
ROPINIROLE (ORAL)	NEUPRO (TRANSDERM)

Preferred	Nonpreferred
	NOURIANZ (ORAL) ONGENTYS (ORAL) PRAMIPEXOLE ER (ORAL) REQUIP (ORAL) REQUIP XL (ORAL) ROPINIROLE ER (ORAL) RYTARY (ORAL) SINEMET (ORAL) ~~SINEMET CR (ORAL)~~ STALEVO (ORAL) TASMAR (ORAL) TOLCAPONE (ORAL) XADAGO (ORAL)

ANTIVIRALS, TOPICAL section reviewed 7-17-2024

Preferred	Nonpreferred
ACYCLOVIR OINTMENT (TOPICAL) DENAVIR (TOPICAL)	ACYCLOVIR CREAM (TOPICAL) PENCICLOVIR (TOPICAL) XERESE (TOPICAL) ZOVIRAX CREAM (TOPICAL) ZOVIRAX OINTMENT (TOPICAL)

CALCIUM CHANNEL BLOCKERS section reviewed 7-17-2024

Preferred	Nonpreferred
AMLODIPINE (ORAL) DILTIAZEM CAPSULE ER (ORAL) DILTIAZEM TABLET (ORAL) FELODIPINE ER (ORAL) ~~ISRADIPINE (ORAL)~~ ~~NICARDIPINE (ORAL)~~ NIFEDIPINE ER (ORAL) NIFEDIPINE IR (ORAL) ~~VERAPAMIL 360 MG CAPSULE (ORAL)~~ VERAPAMIL CAPSULE ER (ORAL) ~~VERAPAMIL ER PM (ORAL)~~ VERAPAMIL TABLET (ORAL) VERAPAMIL TABLET ER (ORAL)	ADALAT CC (ORAL) CALAN (ORAL) CALAN SR (ORAL) CARDIZEM (ORAL) CARDIZEM CD (ORAL) CARDIZEM CD 360 MG (ORAL) CARDIZEM LA (ORAL) DILTIAZEM TABLET ER (LA) (ORAL) ISRADIPINE (ORAL) KATERZIA (ORAL) LEVAMLODIPINE MALEATE (ORAL) MATZIM LA (ORAL) NICARDIPINE (ORAL) NIMODIPINE (ORAL) NISOLDIPINE (ORAL) NORLIQVA (ORAL) NORVASC (ORAL) NYMALIZE (ORAL) PROCARDIA (ORAL) PROCARDIA XL (ORAL) SULAR (ORAL) TIAZAC (ORAL) TIAZAC 420 MG (ORAL) VERAPAMIL 360 MG CAPSULE (ORAL) VERAPAMIL ER PM (ORAL) ~~VERELAN (ORAL)~~ VERELAN PM (ORAL)

GLUCAGON AGENTS section added and reviewed 7-17-2024

Preferred	Nonpreferred
BAQSIMI (NASAL) GLUCAGON (INJECTION) GLUCAGON EMERGENCY KIT (AMPHASTAR) (INJECTION)	GLUCAGON EMERGENCY KIT (FRESENIUS) (INJECTION) GVOKE VIAL (SUBCUTANEOUS) GVOKE SYRINGE (SUBCUTANEOUS) GVOKE PEN (SUBCUTANEOUS) ZEGALOGUE SYRINGE (SUBCUTANEOUS) ZEGALOGUE AUTOINJECTOR (SUBCUTANEOUS)

LIPOTROPICS, STATINS section reviewed 7-17-2024

Preferred	Nonpreferred
ATORVASTATIN (ORAL) LOVASTATIN (ORAL) PRAVASTATIN (ORAL) SIMVASTATIN (ORAL) ROSUVASTATIN (ORAL)	ALTOPREV (ORAL) AMLODIPINE-ATORVASTATIN (ORAL) ATORVALIQ (ORAL) CADUET (ORAL) CRESTOR (ORAL) EZALLOR SPRINKLE (ORAL) EZETIMIBE-SIMVASTATIN (ORAL) FLUVASTATIN (ORAL) FLUVASTATIN ER (ORAL) LESCOL XL (ORAL) LIPITOR (ORAL) LIVALO (ORAL) ~~PRAVACHOL (ORAL)~~ VYTORIN (ORAL) ZOCOR (ORAL) ZYPITAMAG (ORAL)

OPHTHALMICS, ANTI-INFLAMMATORY/IMMUNOMODULATOR section added and reviewed 7-17-2024

Preferred	Nonpreferred
RESTASIS (OPHTHALMIC) RESTASIS MULTIDOSE (OPHTHALMIC) XIIDRA (OPHTHALMIC)	CEQUA (OPHTHALMIC) CYCLOSPORIN (OPHTHALMIC) EYSUVIS (OPHTHALMIC) MIEBO (OPHTHALMIC) TYRVAYA SPRAY (NASAL) VERKAZIA (OPHTHALMIC) VEVYE (OPHTHALMIC)

PROTON PUMP INHIBITORS section reviewed 7-17-2024

Preferred	Nonpreferred
ESOMEPRAZOLE CAPSULES (ORAL) LANSOPRAZOLE CAPSULES (ORAL) NEXIUM SUSPENSION (ORAL) OMEPRAZOLE (ORAL) PANTOPRAZOLE (ORAL) * Prilosec OTC, Prevacid OTC, Zegerid (omeprazole sodium bicarb) excluded from coverage	~~ACIPHEX SPRINKLE (ORAL)~~ ACIPHEX TABLETS (ORAL) DEXILANT (ORAL) DEXLANSOPRAZOLE CAPSULE (ORAL) ESOMEPRAZOLE SUSPENSION (ORAL) KONVOMEP (ORAL) LANSOPRAZOLE SOLUTAB (ORAL) NEXIUM (ORAL) OMEPRAZOLE / SODIUM BICARBONATE (ORAL) PANTOPRAZOLE SUSPENSION (ORAL) PREVACID CAPSULES (ORAL)

Preferred	Nonpreferred
	PREVACID SOLUTAB (ORAL) PRILOSEC SUSPENSION (ORAL) PROTONIX (ORAL) PROTONIX SUSPENSION (ORAL) RABEPRAZOLE TABLETS (ORAL) ZEGERID (ORAL)

WEIGHT MANAGEMENT AGENTS section reviewed 7-17-2024

Preferred	Nonpreferred
SAXENDA (SUBCUTANEOUS) WEGOVY (SUBCUTANEOUS)	ORLISTAT (ORAL) XENICAL (ORAL) ZEPBOUND (SUBCUTANEOUS)

Consent Agenda Items:

ANTIBIOTICS, TOPICAL section reviewed 7-17-2024 no change

Preferred	Nonpreferred
MUPIROCIN OINTMENT (TOPICAL)	CENTANY (TOPICAL) CENTANY KIT (TOPICAL) MUPIROCIN CREAM (TOPICAL) XEPI (TOPICAL)

ANTIDEPRESSANTS, SSRIs section reviewed 7-17-2024

Preferred	Nonpreferred
CITALOPRAM SOLUTION (ORAL) CITALOPRAM TABLET (ORAL) ESCITALOPRAM TABLET (ORAL) FLUOXETINE CAPSULE (ORAL) FLUOXETINE SOLUTION (ORAL) FLUVOXAMINE (ORAL) PAROXETINE TABLET (ORAL) SERTRALINE CONC (ORAL) SERTRALINE TABLET (ORAL)	BRISDELLE (ORAL) CELEXA TABLET (ORAL) CITALOPRAM CAPSULE (ORAL) ESCITALOPRAM SOLUTION (ORAL) FLUOXETINE CAPSULE DR (ORAL) FLUOXETINE TABLET (ORAL) FLUOXETINE 60 MG (ORAL) FLUVOXAMINE ER (ORAL) LEXAPRO TABLET (ORAL) PAROXETINE (BRISDELLE) (AG) (ORAL) PAROXETINE (BRISDELLE) (ORAL) PAROXETINE CR (ORAL) PAROXETINE SUSPENSION (ORAL) PAXIL (ORAL) PAXIL CR (ORAL) PAXIL SUSPENSION (ORAL) PEXEVA (ORAL) PROZAC CAPSULE (ORAL) ~~SARAFEM (ORAL)~~ SERTRALINE CAPSULE (ORAL) ZOLOFT CONC (ORAL) ZOLOFT TABLET (ORAL)

ANTIHISTAMINES, MINIMALLY SEDATING section reviewed 7-17-2024 no change

Preferred	Nonpreferred
CETIRIZINE SOLUTION (ORAL) CETIRIZINE SOLUTION OTC (ORAL) CETIRIZINE TABLETS OTC (ORAL) CETIRIZINE-D OTC (ORAL) LEVOCETIRIZINE SOLUTION (ORAL) LEVOCETIRIZINE TABLETS (ORAL) LORATADINE ODT OTC (ORAL) LORATADINE SOLUTION OTC (ORAL) LORATADINE TABLETS OTC (ORAL) LORATADINE-D OTC (ORAL) * Not all OTC products are covered. Please consult the NDC lookup website for specific NDC coverage information	CETIRIZINE CHEWABLE OTC (ORAL) CLARINEX SYRUP (ORAL) CLARINEX TABLET (ORAL) CLARINEX-D 12 HOUR (ORAL) DESLORATADINE (ORAL) DESLORATADINE ODT (ORAL)

ANTIPARASITICS, TOPICAL section reviewed 7-17-2024

Preferred	Nonpreferred
NATROBA (TOPICAL)	CROTAN (TOPICAL)
PERMETHRIN CREAM (TOPICAL)	EURAX LOTION (TOPICAL)
PERMETHRIN OTC (TOPICAL)	LINDANE LOTION (TOPICAL)
PIPERONYL BUTOXIDE/PYRETHRINS SHAMPOO OTC (TOPICAL)	LINDANE SHAMPOO (TOPICAL)
	MALATHION BRAND (TOPICAL)
	OVIDE (TOPICAL)
	~~PIP BUTOXIDE/PYRETHRINS/PERMETHRIN KIT OTC (TOPICAL)~~
	~~SKLICE (TOPICAL)~~
	SPINOSAD (TOPICAL)

ANTIVIRALS, ORAL section reviewed 7-17-2024

Preferred	Nonpreferred
ACYCLOVIR CAPSULE (ORAL)	FAMCICLOVIR (ORAL)
ACYCLOVIR SUSPENSION (ORAL)	SITAVIG (BUCCAL)
ACYCLOVIR TABLET (ORAL)	TAMIFLU CAPSULE (ORAL)
VALACYCLOVIR (ORAL)	TAMIFLU SUSPENSION (ORAL)
OSELTAMIVIR CAPSULE (ORAL)	VALTREX (ORAL)
OSELTAMIVIR SUSPENSION (ORAL)	XOFLUZA (ORAL)
RELENZA (INHALATION)	~~ZOVIRAX CAPSULE (ORAL)~~
~~TAMIFLU CAPSULE (ORAL)~~	~~ZOVIRAX SUSPENSION (ORAL)~~
~~TAMIFLU SUSPENSION (ORAL)~~	~~ZOVIRAX TABLET (ORAL~~)

BPH TREATMENTS section reviewed 7-17-2024

Preferred	Nonpreferred
ALFUZOSIN (ORAL)	AVODART (ORAL)
DOXAZOSIN (ORAL)	CARDURA (ORAL)
DUTASTERIDE (ORAL	CARDURA XL (ORAL)
FINASTERIDE (ORAL)	DUTASTERIDE/TAMSULOSIN (ORAL)
TAMSULOSIN (ORAL)	ENTADFI (ORAL)
TERAZOSIN (ORAL)	FLOMAX (ORAL)
	JALYN (ORAL)
	PROSCAR (ORAL)
	RAPAFLO (ORAL)
	SILODOSIN (ORAL)

CEPHALOSPORINS AND RELATED ANTIBIOTICS section reviewed 7-17-2024

Preferred	Nonpreferred
AMOXICILLIN/CLAV SUSPENSION (ORAL)	AMOXICILLIN/CLAV CHEW TABLET (ORAL)
AMOXICILLIN/CLAV TABLET (ORAL)	AMOXICILLIN/CLAV XR (ORAL)
CEFACLOR CAPSULE (ORAL)	AUGMENTIN XR (ORAL)
CEFACLOR SUSPENSION (ORAL)	CEFACLOR TABLET ER (ORAL)
CEFADROXIL CAPSULE (ORAL)	CEFADROXIL TABLET (ORAL)
CEFADROXIL SUSPENSION (ORAL)	~~CEFIXIME CAPSULE (ORAL)~~
CEFDINIR CAPSULE (ORAL)	CEFIXIME SUSPENSION (ORAL)
CEFDINIR SUSPENSION (ORAL)	CEFPODOXIME SUSPENSION (ORAL)
CEFIXIME CAPSULE (ORAL)	CEFPODOXIME TABLET (ORAL)
CEFPROZIL SUSPENSION (ORAL)	CEPHALEXIN TABLET (ORAL)
CEFPROZIL TABLET (ORAL)	KEFLEX (ORAL)
CEFUROXIME TABLET (ORAL)	SUPRAX SUSPENSION (ORAL)

Preferred	Nonpreferred
CEPHALEXIN CAPSULE (ORAL) CEPHALEXIN SUSPENSION (ORAL) ~~SUPRAX CAPSULE (ORAL)~~	SUPRAX TAB CHEW (ORAL)

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS section reviewed 7-17-2024

Preferred	Nonpreferred
ACARBOSE (ORAL)	~~GLYSET (ORAL)~~ MIGLITOL (ORAL) PRECOSE (ORAL)

HYPOGLYCEMICS, TZD section reviewed 7-17-2024

Preferred	Nonpreferred
PIOGLITAZONE (ORAL)	~~AVANDIA (ORAL)~~ DUETACT (ORAL) PIOGLITAZONE/GLIMEPIRIDE (ORAL) PIOGLITAZONE/METFORMIN (ORAL)

LEUKOTRIENE MODIFIERS section reviewed 7-17-2024

Preferred	Nonpreferred
MONTELUKAST CHEWABLE TABLET (ORAL) MONTELUKAST TABLET (ORAL) ZAFIRLUKAST (ORAL)	ACCOLATE (ORAL) MONTELUKAST GRANULES (ORAL) SINGULAIR CHEWABLE TABLET (ORAL) SINGULAIR GRANULES (ORAL) SINGULAIR TABLET (ORAL) ZILEUTON ER (ORAL) ZYFLO (ORAL) ~~ZYFLO CR (ORAL)~~

MACROLIDES/KETOLIDES section reviewed 7-17-2024

Preferred	Nonpreferred
AZITHROMYCIN PACKET (ORAL) AZITHROMYCIN SUSPENSION (ORAL) AZITHROMYCIN TABLET (ORAL) CLARITHROMYCIN TABLET (ORAL) ~~E.E.S. 400 TABLET (ORAL)~~ ERYTHROMYCIN BASE CAPSULE DR (ORAL)	CLARITHROMYCIN ER (ORAL) CLARITHROMYCIN SUSPENSION (ORAL) E.E.S. 200 SUSPENSION (ORAL) ERYPED 200 SUSPENSION (ORAL) ERYPED 400 SUSPENSION (ORAL) ERY-TAB (ORAL) ERYTHROCIN (ORAL) ERYTHROMYCIN BASE TABLET (ORAL) ERYTHROMYCIN BASE TABLET DR (ORAL) ERYTHROMYCIN ETHYLSUCCINATE TABLET 400MG (ORAL) ERYTHROMYCIN ETHYLSUCCINATE SUSPENSION 200MG (ORAL) ERYTHROMYCIN ETHYLSUCCINATE SUSPENSION 400MG (ORAL) ZITHROMAX PACKET (ORAL) ZITHROMAX SUSPENSION (ORAL) ZITHROMAX TABLET (ORAL)

PLATELET AGGREGATION INHIBITORS section reviewed 7-17-2024

Preferred	Nonpreferred
BRILINTA (ORAL)	ASPIRIN/DIPYRIDAMOLE (ORAL)
CLOPIDOGREL (ORAL)	EFFIENT (ORAL)
DIPYRIDAMOLE (ORAL)	PLAVIX (ORAL)
PRASUGREL (ORAL)	~~ZONTIVITY (ORAL)~~

PROGESTINS FOR CACHEXIA section reviewed 7-17-2024

Preferred	Nonpreferred
MEGESTROL SUSPENSION (MEGACE) (ORAL)	~~MEGACE (ORAL)~~
MEGESTROL TABLETS (ORAL)	~~MEGACE ES (ORAL)~~
	MEGESTROL SUSPENSION (MEGACE ES) (ORAL)