DEPARTMENT OF HUMAN SERVICES

Discussion Items:

MHCP Enrolled Providers – Pharmacies

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

(March 2025)

Drug	**Yorvipath® (palopegteriparatide injection) [**Ascendis Pharma Endocrinology, Inc.**]**
Therapeutic Area	Hyperparathyroid Agents

Initial approval criteria:

- **Patient is ≥ 18 years of age; AND**
- Patient has a diagnosis of hypoparathyroidism; AND
- Patient does NOT have acute post-surgical hypoparathyroidism; AND
- Patient does NOT have pseudohypoparathyroidism; AND
- Patient has baseline (prior to therapy with the requested agent) albumin-corrected serum calcium of ≥ 7.8 mg/dL using calcium and active vitamin D treatment; AND
- Patient does NOT have severe hypersensitivity to palopegteriparatide or to any of its excipients; AND
- Patient has baseline (prior to therapy with the requested agent) vitamin D levels above the lower limit of normal; AND
- Patient has tried and had an inadequate response to maximally tolerated calcium AND vitamin D supplements (e.g., calcitriol,
- ergocalciferol, cholecalciferol); AND
- Patient will continue calcium and vitamin D supplementation while titrating to an appropriate dose of the requested agent; AND
- Patient will NOT be using the requested agent in combination with any bisphosphonate (e.g., alendronate, ibandronate, risedronate), denosumab, estrogen, raloxifene, romosozumab, or cinacalcet (Sensipar) for the requested indication; AND
- The prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist, nephrologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis.
- Initial approval is for 6 months

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient has had clinical benefit with the requested agent; AND
- Patient has an albumin-corrected total serum calcium concentration between 8.3 to 10.6 mg/dL; AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., osteosarcoma).
- Renewal approval is for 12 months

Quantity limits

- 2 pens per 28 days. Max dose of 30 mcg once daily.

Background

Limitations of Use:

- Yorvipath was not studied for acute post-surgical hypoparathyroidism.
- Yorvipath's titration scheme was only evaluated in adults who first achieved an albumin-corrected serum calcium of at least 7.8 mg/dL using calcium and active vitamin D treatment

MHCP Enrolled Providers – Pharmacies

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

(March 2025)

Drug	**Duvyzat™ (givinostat) [**ITF Therapeutics**]**
Therapeutic Area	Duchene muscular dystrophy

Initial approval criteria:

- Patient has a diagnosis of Duchenne Muscular Dystrophy confirmed by genetic analysis (i.e., dystrophin deletion or duplication mutation) (genetic test required) AND
- Patient has tried and had an inadequate response after a 6-month duration of therapy with a glucocorticoid used to treat DMD AND
- Patient will continue to be on a glucocorticoid while taking Duvyzat OR
- Patient has an intolerance or hypersensitivity to a glucocorticoid used to treat DMD OR
- Patient has an FDA labeled contraindication to all glucocorticoids used to treat DMD AND
- Patient's age is within FDA labeling for the requested indication for Duvyzat AND
- Patient's baseline (i.e., prior to therapy with Duvyzat) platelet level has been obtained and is greater than or equal to 150 x 10^9/L AND
- Patient's baseline (i.e., prior to therapy with Duvyzat) triglyceride levels have been evaluated AND
- If patient has underlying cardiac disease or is taking concomitant medications that cause QT prolongation, ECGs have been obtained AND
- Patient's platelet levels will continue to be monitored during treatment with Duvyzat AND
- Patient's triglyceride levels will continue to be monitored during treatment with Duvyzat AND
- If patient has underlying cardiac disease or is taking concomitant medications that cause QT prolongation, ECGs will continue to be monitored as clinically indicated AND
- Prescriber is a specialist in the area of patient's diagnosis (e.g., pediatric neurologist), or prescriber has consulted with a specialist in the area of patient's diagnosis AND
- Patient does NOT have any FDA labeled contraindications to Duvyzat

Renewal criteria:

- Patient has had improvements or stabilization with Duvyzat (e.g., slowed disease progression, improved strength, timed motor function, pulmonary function; reduced need for scoliosis surgery) AND
- Patient's platelet level will continue to be monitored during treatment AND
- Patient's triglyceride levels will continue to be monitored during treatment AND
- If patient has underlying cardiac disease or is taking concomitant medications that cause QT prolongation, ECGs will continue to be monitored as clinically indicated AND
- Prescriber is a specialist in the area of patient's diagnosis (e.g., pediatric neurologist), or prescriber has consulted with a specialist in the area of patient's diagnosis AND
- Patient does NOT have any FDA labeled contraindications to Duvyzat

Quantity limits

- 6 mL twice daily
- Patient's weight (in kg) must be submitted at time of request
- Quantity (number of bottles) and corresponding days supplied must be clearly stated on the request form

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(March 2025)

Drug	**Tryvio™ (aprocitentan) [**Idorsia Pharmaceuticals Ltd**]**
Therapeutic Area	Antihypertensives, Other

Initial approval criteria:

- Patient has a diagnosis of hypertension AND
- Patient is at least 18 years of age AND
- Patient is still not at blood pressure goal while on triple agent therapy with 3 different antihypertensive therapy classes OR
- Patient is unable to be on triple antihypertensive therapy with 3 different antihypertensive therapy classes AND
- Patient will continue therapy with another antihypertensive agent in combination with Tryvio AND
- Patient does NOT have any FDA labeled contraindications to Tryvio
- Initial approval is for 3 months

Renewal criteria:

- Patient has had clinical benefit with Tryvio AND
- Patient will continue therapy with another antihypertensive agent in combination with Tryvio AND
- Patient does NOT have any FDA labeled contraindications to the requested agent
- Renewal approval is for 12 months

Quantity limits

- 30 tablets per 30 days

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(March 2025)

Drug	**Miplyffa™ (arimoclomol) [**Zevra Therapeutics**]**
Therapeutic Area	Niemann-Pick disease type C (NPC)

Initial approval criteria:

- Patient is at least 2 years of age; AND
- Patient has a diagnosis of Niemann-Pick disease Type C; AND
- Genetic analysis confirms mutation in the NPC1 or NPC2 genes; AND
- Patient has disease-related neurological symptoms; AND
- Miplyffa will be used in combination with miglustat; AND
- Patient does not have any FDA labeled contraindications to Miplyffa; AND
- Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist) or prescriber has consulted with a specialist in the area of patient's diagnosis.
- Initial approval is for 6 months

Renewal criteria:

- Patient has had clinical benefit with Miplyffa AND
- Patient does not have any FDA labeled contraindications to Miplyffa; AND
- Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist) or prescriber has consulted with a specialist in the area of patient's diagnosis.
- Renewal approval is for 12 months

Quantity limits

- 3 capsules per 30 days. Maximum 124 mg three times a day.
- Patient's weight (in kg) must be submitted at time of request.

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(March 2025)

Drug	**Aqneursa™ (levacetylleucine) [**IntraBio Inc.**]**
Therapeutic Area	Niemann-Pick disease type C (NPC)

Initial approval criteria:

- Patient has a diagnosis of Niemann-Pick disease Type C; AND
- Genetic analysis confirms mutation in the NPC1 or NPC2 genes; AND
- Patient has disease-related neurological symptoms; AND
- Patient weighs greater than or equal to 15 kg AND
- Patient does not have any FDA labeled contraindications to Aqneursa; AND
- Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist) or prescriber has consulted with a specialist in the area of patient's diagnosis.
- Initial approval is for 6 months

Renewal criteria:

- Patient has had clinical benefit with Aqneursa AND
- Patient does not have any FDA labeled contraindications to Aqneursa; AND
- Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist) or prescriber has consulted with a specialist in the area of patient's diagnosis
- Renewal approval is for 12 months

Quantity limits

- 1-gram levacetylleucine in a unit-dose packet: 136 packets per 34 days
- Patient's weight (in kg) must be submitted at time of request

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(March 2025)

Drug	**Xolremdi® (mavorixafor) [**X4 Pharmaceuticals, Inc.**]**
Therapeutic Area	WHIM syndrome (warts, hypogammaglobulinemia, infections and myelokathexis)

Initial approval criteria:

- Age ≥ 12 years; AND
- Diagnosis of warts, hypogammaglobulinemia, infections, and myelokathexis (WHIM) syndrome; AND
- Genotype-confirmed variant of CXC chemokine receptor 4 (CXCR4) consistent with WHIM syndrome; AND
- Confirmed absolute neutrophil count (ANC) ≤ 400 cells/µL (or total white blood cell [WBC] count ≤ 400 cells/µL if ANC is below lower limit of detection); AND
- Prescriber attestation to assess QTc at baseline and to monitor QTc periodically during treatment for patients with risk factors for QTc prolongation; AND
- Patient is NOT taking the following:
    - Another CXCR4 antagonist (e.g., plerixafor [Mozobil®]); OR
    - Any medication that is highly dependent on cytochrome P450 (CYP) 2D6 for clearance (e.g., amitriptyline, fluoxetine); OR
    - A strong CYP3A4 inducer (e.g., rifampin, phenytoin); AND
- Patients of reproductive potential must have a confirmed negative pregnancy test prior to initiation AND must attest to use effective contraception during treatment and for 3 weeks after the last dose; AND
- Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist) or prescriber has consulted with a specialist in the area of patient's diagnosis.
- Initial approval is for 3 months

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient must have disease improvement (e.g., improvement in ANC and/or absolute lymphocyte counts [ALC], reduction in infections); AND
- Patient has not experienced any treatment-restricting adverse effects (e.g., significant QTc prolongation); AND
- Prescriber is a specialist in the area of the patient's diagnosis (e.g., geneticist) or prescriber has consulted with a specialist in the area of patient's diagnosis.
- Renewal approval is for 12 months

Quantity limits

- 120 capsules per 30 days. Maximum dose is 400 mg daily

Provider Call Center (844) 575-7887

Consent Agenda Item:

Drug - Zolgensma® (onasemnogene abeparvovec-xioi) [AveXis Inc.]
~~January 2020~~ February 2025
Therapeutic area - Spinal Muscular Atrophy (SMA)

Approval criteria

Prescriber Requirements

- Prescriber must be a pediatric neurologist with expertise in the treatment of SMA
- Physician attests that the patient, while under the care of the physician, will be assessed by one of the following exam scales during subsequent office visits for a period not to exceed 3 years
    - Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP INTEND) scale during subsequent office visits while the patient is 2 to 3 years of age or younger; or
    - Hammersmith Functional Motor Scale Expanded (HFMSE) during subsequent office visits while the patient is 2 to 3 years of age or older
- Prescriber agrees that documentation of follow-up patient assessment(s) including, but not necessarily limited to, serial CHOP INTEND or HFMSE assessments while the patient is under the care of the physician, will be made available to Medical Assistance upon request.
- Physician attests that the patient has never received Zolgensma treatment.

Patient Requirements

- Patient must be < 2 years of age; AND
- Patient has a diagnosis of spinal muscular atrophy (SMA) confirmed by either bi-allelic deletion or dysfunctional point mutation of the SMN1 gene; AND
- ~~Patient must have SMA phenotype 1 confirmed by ≥ 1 of the following:~~
    - ~~Patient must have 1 or 2 copies of the SMN2 gene; OR~~
    - ~~Patient has 3 copies of the SMN2 gene in the absence of the c.859G>C single base substitution modification in exon 7; AND~~
- Patient must have a baseline anti-AAV9 antibody titer of ≤ 1:50 measured by ELISA; AND
- Patient does not have pre-existing hepatic insufficiency; AND
- Patient must not have advanced disease (e.g., complete limb paralysis, permanent ventilation support); AND
- ~~The treatment of pre-symptomatic patients diagnosed by newborn screening who are unlikely to develop Type I or II SMA will not be approved; OR~~
- The treatment of symptomatic later-onset SMA older than 2 years of age will not be approved; AND
- Zolgensma must be used concomitantly with ~~parenteral~~ corticosteroids; AND
- If the request is for a neonatal patient born prematurely, the patient must have reached full gestational age; AND
- The combination treatment of SMA with concomitant SMN modifying therapy/therapies will not be approved; OR
- Zolgensma must not be used in combination with nusinersen or any SMN modifying therapy;
    - Current authorization for any SMN modifying therapy (e.g., nusinersen) will be discontinued upon Zolgensma approval
    - If approved for Zolgensma, any subsequent request for SMN modifying therapy (e.g., nusinersen) will not be approved
        - Current authorization for nusinersen may be continued if the prescribing practitioner provides published peer-reviewed clinical research documenting a superior clinical outcome with the combination therapy of Zolgensma and nusinersen vs. monotherapy with Zolgensma.

Quantity limits

- 1 kit per lifetime
- Patient's most current weight (in kg) must be provided at time of request and the dose to be administered does not exceed one kit
- Authorization will be for up to 14 days from approval or until 2 years of age, whichever comes first

Billing for Zolgensma
Zolgensma is not covered through the MHCP fee-for-service pharmacy benefit and must be billed as a medical claim.

Background information
Zolgensma is an adeno-associated virus (AAV) vector-based gene therapy indicated for the treatment of pediatric patients less than 2 years of age with spinal muscular atrophy (SMA) with bi-allelic mutations in the *survival motor neuron 1 (SMN1) gene*. The safety and effectiveness of repeat administration of Zolgensma have not been evaluated. The use of Zolgensma in patients with advanced SMA (e.g., complete paralysis of limbs, permanent ventilator-dependence) has not been evaluated.

Provider Call Center (844) 575-7887

Consent Agenda Items:

ANALGESICS, NARCOTICS LONG section reviewed 3-19-2025

Preferred	Nonpreferred
BELBUCA (BUCCAL) BUPRENORPHINE (TRANSDERM) MORPHINE ER TABLET (ORAL) FENTANYL (25, 50MCG) TRANSDERM	~~ARYMO ER (ORAL)~~ BUPRENORPHINE (BUCCAL) CONZIP (ORAL) ~~DURAGESIC MATRIX (TRANSDERM.)~~ ~~EMBEDA (ORAL)~~ ~~EXALGO (ORAL)~~ FENTANYL (12, 37.5, 62.5, 87.5 MG, 75, 100MCG) (TRANSDERM) HYDROCODONE ER (HYSINGLA ER) (ORAL) HYDROCODONE ER (ZOHYDRO ER) (ORAL) HYDROMORPHONE ER (ORAL) HYSINGLA ER (ORAL) METHADONE TABLET (ORAL) MORPHABOND ER (ORAL) MORPHINE ER CAPSULE (AVINZA) (ORAL) MORPHINE ER CAPSULE (KADIAN) (ORAL) MS CONTIN (ORAL) ~~NUCYNTA ER (ORAL)~~ OPANA ER (ORAL) OXYCONTIN (ORAL) OXYCODONE ER (ORAL) OXYMORPHONE ER (ORAL) TRAMADOL ER (CONZIP) (ORAL) TRAMADOL ER (RYZOLT) (ORAL) TRAMADOL ER (ULTRAM ER) (ORAL) ~~XTAMPZA ER (ORAL)~~ ZOHYDRO ER (ORAL)

ANGIOTENSIN MODULATOR COMBINATIONS section reviewed 3-19-2025 no change

Preferred	Nonpreferred
AMLODIPINE / BENAZEPRIL (ORAL) AMLODIPINE / VALSARTAN (ORAL) AMLODIPINE / VALSARTAN / HCTZ (ORAL)	AMLODIPINE / OLMESARTAN (ORAL) AMLODIPINE / OLMESARTAN / HCTZ (ORAL) AZOR (ORAL) EXFORGE (ORAL) EXFORGE HCT (ORAL)LOTREL (ORAL) LOTREL (ORAL) TELMISARTAN / AMLODIPINE (ORAL) TRANDOLAPRIL/VERAPAMIL (ORAL) TRIBENZOR (ORAL)

ANTICONVULSANTS section reviewed 3-19-2025

Preferred	Nonpreferred
CARBAMAZEPINE CHEWABLE TABLET (ORAL) CARBAMAZEPINE SUSPENSION (ORAL) CARBAMAZEPINE TABLET (ORAL) CARBAMAZEPINE XR (ORAL) CELONTIN (ORAL)	APTIOM (ORAL) BANZEL SUSPENSION (ORAL) BANZEL TABLET (ORAL) BRIVIACT SOLUTION (ORAL) BRIVIACT TABLET (ORAL)

Preferred	Nonpreferred
CLOBAZAM TABLET (ORAL)	CARBAMAZEPINE ER (GENERIC CARBATROL) (ORAL)
CLOBAZAM SUSPENSION (ORAL)	DEPAKOTE (ORAL)
DILANTIN (ORAL)	DEPAKOTE ER (ORAL)
DILANTIN 30 MG CAPSULE (ORAL)	DEPAKOTE SPRINKLE (ORAL)
DIVALPROEX ER (ORAL)	DIACOMIT (ORAL)
DIVALPROEX SPRINKLE (ORAL)	DILANTIN INFATAB (ORAL)
DIVALPROEX TABLET (ORAL)	DILANTIN SUSPENSION (ORAL)
ETHOSUXIMIDE CAPSULE (ORAL)	ELEPSIA XR TABLET (ORAL)
ETHOSUXIMIDE SYRUP (ORAL)	EPIDIOLEX SOLUTION (ORAL)
FELBAMATE SUSPENSION (ORAL)	EPRONTIA SOLUTION (ORAL)
FELBAMATE TABLET (ORAL)	EQUETRO (ORAL)
LACOSAMIDE TABLET (ORAL)	FELBATOL TABLET (ORAL)
LACOSAMIDE SUSPENSION (ORAL)	FINTEPLA (ORAL)
LAMOTRIGINE CHEWABLE TABLET (ORAL)	FYCOMPA SUSPENSION (ORAL)
LAMOTRIGINE TABLET (ORAL)	FYCOMPA TABLET (ORAL)
LAMOTRIGINE XR (ORAL)	FYCOMPA TABLET DOSE PACK (ORAL)
LEVETIRACETAM ER (ORAL)	KEPPRA SOLUTION (ORAL)
LEVETIRACETAM SOLUTION (ORAL)	KEPPRA TABLETS (ORAL)
LEVETIRACETAM TABLETS (ORAL)	KEPPRA XR (ORAL)
OXCARBAZEPINE SUSPENSION (ORAL)	LAMICTAL CHEWABLE TABLET (ORAL)
OXCARBAZEPINE TABLETS (ORAL)	LAMICTAL ODT (ORAL)
PHENYTEK (ORAL)	LAMICTAL ODT DOSE PACK (ORAL)
PHENYTOIN CAPSULE (ORAL)	LAMICTAL TABLET (ORAL)
PHENYTOIN CHEWABLE TABLET (ORAL)	LAMICTAL TABLET DOSE PACK (ORAL)
PHENYTOIN EXT CAPSULE (GENERIC PHENYTEK) (ORAL)	LAMICTAL XR (ORAL)
PHENYTOIN SUSPENSION (ORAL)	LAMICTAL XR DOSE PACK (ORAL)
PRIMIDONE (ORAL)	LAMOTRIGINE ODT (ORAL)
QUDEXY XR (ORAL)	LAMOTRIGINE ODT DOSE PACK (ORAL)
ROWEEPRA TABLET (ORAL)	LAMOTRIGINE TABLET DOSE PACK (ORAL)
ROWEEPRA XR (ORAL)	LEVETIRACETAM TABLETS (AG) (ORAL)
TOPIRAMATE SPRINKLE (ORAL)	METHSUXIMIDE (ORAL)
TOPIRAMATE TABLETS (ORAL)	MOTPOLY XR (ORAL)
VALPROIC ACID CAPSULE (ORAL)	MYSOLINE (ORAL)
VALPROIC ACID SOLUTION (ORAL)	ONFI SUSPENSION (ORAL)
ZONISAMIDE (ORAL)	ONFI TABLET (ORAL)
	OXTELLAR XR (ORAL)
	RUFINAMIDE SUSPENSION (ORAL)
	RUFINAMIDE TABLET (ORAL)
	SABRIL POWDER PACK (ORAL)
	SABRIL TABLET (ORAL)
	SPRITAM (ORAL)
	SYMPAZAN (ORAL)
	TEGRETOL SUSPENSION (ORAL)
	TEGRETOL TABLET (ORAL)
	TEGRETOL XR (ORAL)
	TIAGABINE (ORAL)
	TOPAMAX SPRINKLE (ORAL)
	TOPAMAX TABLETS (ORAL)
	TOPIRAMATE ER (QUDEXY) (ORAL)
	TOPIRAMATE ER (TROKENDI) (ORAL)
	TRILEPTAL SUSPENSION (ORAL)
	TRILEPTAL TABLETS (ORAL)

Preferred	Nonpreferred
	TROKENDI XR (ORAL) VIGABATRIN POWDER PACK (ORAL) VIGABATRIN TABLET (ORAL) VIMPAT SOLUTION (ORAL) VIMPAT TABLET (ORAL) VIMPAT TABLET DOSE PACK (ORAL) XCOPRI TABLET (ORAL) XCOPRI TITRATION PAK (ORAL) ZARONTIN CAPSULE (ORAL) ZARONTIN SYRUP (ORAL) ZONISADE (ORAL) ZTALMY (ORAL)

ANTICONVULSANTS, OTHER section reviewed 3-19-2025 no change

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

ANTIDEPRESSANTS, OTHER section reviewed 3-19-2025 no change

Preferred	Nonpreferred
BUPROPION (ORAL) BUPROPION SR (ORAL) BUPROPION XL (ORAL) DESVENLAFAXINE ER (NO BRAND) (ORAL) DESVENLAFAXINE ER (PRISTIQ) (ORAL) MIRTAZAPINE ODT (ORAL) MIRTAZAPINE TABLET (ORAL) NEFAZODONE (ORAL) TRAZODONE (ORAL) VENLAFAXINE (ORAL) VENLAFAXINE ER CAPSULES (ORAL) VIIBRYD (ORAL)	APLENZIN (ORAL) AUVELITY (ORAL) BUPROPION XL (FORFIVO XL) (AG) (ORAL) EFFEXOR XR (ORAL) FETZIMA (ORAL) FORFIVO XL (ORAL) PRISTIQ (ORAL) REMERON ODT (ORAL) REMERON TABLET (ORAL) TRINTELLIX (ORAL) VENLAFAXINE ER TABLETS (ORAL) VILAZODONE (ORAL) WELLBUTRIN SR (ORAL) WELLBUTRIN XL (ORAL) ZURZUVAE (ORAL)

ANTIDEPRESSANTS, SSRIs section reviewed 3-19-2025

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)

Preferred	Nonpreferred
	PAROXETINE SUSPENSION (ORAL) PAXIL (ORAL) PAXIL CR (ORAL) PAXIL SUSPENSION (ORAL) ~~PEXEVA (ORAL)~~ PROZAC CAPSULE (ORAL) SERTRALINE CAPSULE (ORAL) ZOLOFT CONC (ORAL) ZOLOFT TABLET (ORAL)

ANTIEMETIC/ANTIVERTIGO AGENTS section reviewed 3-19-2025

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)~~

ANTIHISTAMINES, MINIMALLY SEDATING section reviewed 3-19-2025

Preferred	Nonpreferred
CETIRIZINE SOLUTION (ORAL) CETIRIZINE SOLUTION OTC (ORAL) CETIRIZINE TABLETS OTC (ORAL) CETIRIZINE-D OTC (ORAL) FEXOFENADINE 60 MG, 180 MG OTC (ORAL) FEXOFENADINE SUSPENSION (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)

ANTIMIGRAINE AGENTS, OTHER section reviewed 3-19-2025

Preferred	Nonpreferred
AIMOVIG (SUBCUTANE.) AJOVY (SUBCUTANE.) AJOVY AUTOINJECTOR (SUBCUTANE.) EMGALITY 120 MG/ML (PEN) (SUBCUTANE.)	ELYXYB SOLUTION (ORAL) NURTEC ODT (ORAL) QULIPTA (ORAL) REYVOW (ORAL)

Preferred	Nonpreferred
EMGALITY 120 MG/ML (SYRINGE) (SUBCUTANE.) UBRELVY (ORAL)	~~TRUDHESA (NASAL)~~ VYEPTI (INTRAVENOUS) ZAVZPRET (NASAL)

ANTIMIGRAINE AGENTS, TRIPTANS section reviewed 3-19-2025

Preferred	Nonpreferred
IMITREX KIT (SUBCUTANE.) IMITREX VIAL (SUBCUTANE.) RELPAX (ORAL) RIZATRIPTAN ODT (ORAL) RIZATRIPTAN TABLET (ORAL) SUMATRIPTAN (ORAL) ZOLMITRIPTAN TABLET (ORAL) ZOMIG (NASAL)	ALMOTRIPTAN (ORAL) ~~AMERGE (ORAL)~~ ELETRIPTAN (ORAL) FROVA (ORAL) FROVATRIPTAN (ORAL) IMITREX (ORAL) MAXALT MLT (ORAL) MAXALT TABLET (ORAL) NARATRIPTAN (ORAL) SUMATRIPTAN (NASAL) SUMATRIPTAN KIT (SUBCUTANE.) SUMATRIPTAN DISP SYRINGE (SUBCUTANE.) SUMATRIPTAN VIAL (SUBCUTANE.) SUMATRIPTAN/NAPROXEN (ORAL) TOSYMRA (NASAL) TREXIMET (ORAL) ZEMBRACE SYMTOUCH (SUBCUTANE.) ZOLMITRIPTAN ODT (ORAL) ZOLMITRIPTAN SPRAY (NASAL) ZOMIG TABLET (ORAL)

ANTIPARASITICS, TOPICAL section reviewed 3-19-2025 no change

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

LIPOTROPICS, OTHER section reviewed 3-19-2025

Preferred	Nonpreferred
CHOLESTYRAMINE/ASPARTAME (ORAL) CHOLESTYRAMINE/SUCROSE (ORAL) COLESTIPOL GRANULES (ORAL) COLESTIPOL TABLET (ORAL) EZETIMIBE (ORAL) FENOFIBRATE CAPSULE (LOFIBRA) (ORAL) FENOFIBRATE TABLET (LOFIBRA) (ORAL) FENOFIBRATE TABLET (TRICOR) (ORAL) GEMFIBROZIL (ORAL) ~~NIASPAN (ORAL)~~ NIACIN TABLET OTC (ORAL) NIACIN CAPSULE ER OTC (ORAL)	ANTARA (ORAL) COLESEVELAM (ORAL) COLESEVELAM POWDER PACK (ORAL) COLESTID TABLET (ORAL) EVKEEZA (INTRAVENOUS) FENOFIBRATE (ANTARA) (ORAL) FENOFIBRATE (FENOGLIDE) (ORAL) FENOFIBRATE (TRIGLIDE) (ORAL) FENOFIBRATE CAPSULE (LIPOFEN) (ORAL) FENOFIBRIC ACID (FIBRICOR) (ORAL) FENOFIBRIC ACID (TRILIPIX) (ORAL) FENOGLIDE (ORAL)

Preferred	Nonpreferred
NIACIN ER (ORAL)	FIBRICOR (ORAL)
NIACIN TABLET ER OTC (ORAL)	ICOSAPENT ETHYL (ORAL)
OMEGA-3 ACID ETHYL ESTERS (LOVAZA) (ORAL)	LEQVIO (SUBCUTANEOUS)
	LIPOFEN (ORAL)
	LOPID
	LOVAZA (ORAL)
	NEXLETOL (ORAL)
	NEXLIZET (ORAL)
	~~NIACOR (ORAL)~~
	PRALUENT PEN (SUBCUTANEOUS)
	QUESTRAN (ORAL)
	QUESTRAN LIGHT (ORAL)
	REPATHA PUSHTRONEX (SUBCUTANEOUS)
	REPATHA SURECLICK (SUBCUTANEOUS)
	REPATHA SYRINGE (SUBCUTANEOUS)
	TRICOR (ORAL)
	~~TRIGLIDE (ORAL)~~
	TRILIPIX (ORAL)
	~~VASCEPA (ORAL)~~
	WELCHOL POWDER PACK (ORAL)
	WELCHOL TABLET (ORAL)
	ZETIA (ORAL)

OPIATE DEPENDENCE TREATMENTS section reviewed 3-19-2025 no change

Preferred	Nonpreferred
KLOXXADO SPRAY (NASAL)	BRIXADI MONTHLY (SUBCUTANEOUS)
NALOXONE SYRINGE (INJECTION)	BRAXADI WEEKLY (SUBCUTANEOUS)
NALOXONE VIAL (INJECTION)	BUPRENORPHINE HCL (SUBLINGUAL)
NARCAN SPRAY (RX) (NASAL)	BUPRENORPHINE/NALOXONE FILM (SUBLINGUAL)
NARCAN SPRAY (OTC) (NASAL)	NALOXONE SPRAY (NASAL)
REXTOVY SPRAY (NASAL)	OPVEE SPRAY (NASAL)
SUBOXONE FILM (SUBLINGUAL)	SUBLOCADE (SUBCUTANEOUS)
BUPRENORPHINE/NALOXONE TAB (SUBLINGUAL)	ZIMHI (INJECTION)
	ZUBSOLV (SUBLINGUAL)

Discussion Items:

ANTIPARKINSON'S AGENTS section reviewed 3-19-2025

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 ER (ORAL)
PRAMIPEXOLE (ORAL)	NEUPRO (TRANSDERM)
ROPINIROLE (ORAL)	NOURIANZ (ORAL)
	ONGENTYS (ORAL)
	PRAMIPEXOLE ER (ORAL)
	REQUIP (ORAL)
	REQUIP XL (ORAL)
	ROPINIROLE ER (ORAL)
	RYTARY (ORAL)
	SINEMET (ORAL)
	STALEVO (ORAL)
	TASMAR (ORAL)
	TOLCAPONE (ORAL)
	VYALEV (SUBCUTANE.)
	XADAGO (ORAL)

ANTIPSYCHOTICS section reviewed 3-19-2025

Preferred	Nonpreferred
ABILIFY MAINTENA (INTRAMUSC.)	ABILIFY TABLET (ORAL)
ABILIFY ASIMTUFII (INTRAMUSC)	ABILIFY MYCITE (ORAL)
ARIPIPRAZOLE SOLUTION (ORAL)	ARIPIPRAZOLE ODT (ORAL)
ARIPIPRAZOLE TABLET (ORAL)	ARISTADA (INTRAMUSC)
CLOZAPINE (ORAL)	ARISTADA INITIO (INTRAMUSC)
CLOZAPINE ODT (AG) (ORAL)	ASENAPINE (SUBLINGUAL)
CLOZAPINE ODT (ORAL)	ASENAPINE (AG) (SUBLINGUAL)
INVEGA HAFYERA (INTRAMUSC)	CAPLYTA (ORAL)
INVEGA SUSTENNA (INTRAMUSC)	CLOZARIL (ORAL)
INVEGA TRINZA (INTRAMUSC)	COBENFY (ORAL)
LURASIDONE	ERZOFRI (INTRAMUSC.)
OLANZAPINE (INTRAMUSC)	FANAPT TABLET (ORAL)
OLANZAPINE TABLET (ORAL)	FANAPT TITRATION PACK (ORAL)
PALIPERIDONE (ORAL)	~~FAZACLO (ORAL)~~
QUETIAPINE ER (ORAL)	GEODON (INTRAMUSC)
QUETIAPINE TABLETS (ORAL)	GEODON (ORAL)
RISPERDAL CONSTA (INTRAMUSC.)	INVEGA (ORAL)
RISPERIDONE ODT (ORAL)	LATUDA (ORAL)
RISPERIDONE SOLUTION (ORAL)	LYBALVI (ORAL)
RISPERIDONE TABLET (ORAL)	NUPLAZID (ORAL)
ZIPRASIDONE CAPSULE (ORAL)	OLANZAPINE ODT (ORAL)
	OLANZAPINE/FLUOXETINE (ORAL)
	OPIPZA FILM (ORAL)
	REXULTI (ORAL)
	~~RISPERDAL ODT (ORAL)~~
	RISPERDAL SOLUTION (ORAL)
	RISPERDAL TABLET (ORAL)

Preferred	Nonpreferred
	RISPERIDONE (INTRAMUSC.) RYKINDO (INTRAMUSC.) SAPHRIS (SUBLINGUAL) SECUADO (TRANSDERMAL) SEROQUEL (ORAL) SEROQUEL XR (ORAL) ~~SYMBYAX (ORAL)~~ UZEDY (SUBCUTANEOUS) VERSACLOZ (ORAL) VRAYLAR (ORAL) ZIPRASIDONE (INTRAMUSC) ZYPREXA (INTRAMUSC) ZYPREXA (ORAL) ZYPREXA RELPREVV (INTRAMUSC) ZYPREXA ZYDIS (ORAL)

CYTOKINE AND CAM ANTAGONISTS section reviewed 3-19-2025

Preferred	Nonpreferred
ENBREL KIT (INJECTION)	ABRILADA SYRINGE (SUBCUTANE.)
ENBREL MINI CARTRIDGE (SUBCUTANE.)	ABRILADA PEN (SUBCUTANE.)
ENBREL PEN (INJECTION)	ADALIMUMAB-AACF SYRINGE (SUBCUTANE.)
ENBREL SYRINGE (INJECTION)	ADALIMUMAB-AACF PEN (SUBCUTANE.)
ENBREL VIAL (SUBCUTANE.)	ADALIMUMAB-AATY SYRINGE (SUBCUTANE.)
HUMIRA KIT (INJECTION)	ADALIMUMAB-AATY PEN (SUBCUTANE.)
HUMIRA PEN KIT (INJECTION)	ADALIMUMAB-ADAZ SYRINGE (SUBCUTANE.)
INFLIXIMAB (INJECTION)	ADALIMUMAB-ADAZ PEN (SUBCUTANE.)
OTEZLA (ORAL)	ADALIMUMAB-ADBM SYRINGE (SUBCUTANE.)
XELJANZ (ORAL)	ADALIMUMAB ADBM PEN (SUBCUTANE.)
	ADALIMUMAB-FKJP SYRINGE (SUBCUTANE.)
	ADALIMUMAB-FKJP PEN (SUBCUTANE.)
	ADALIMUMAB-RYVK AUTOINJECT (SUBCUTANE.)
	AMJEVITA SYRINGE (SUBCUTANE.)
	AMJEVITA AUTOINJECTOR (SUBCUTANE.)
	ACTEMRA PEN (SUBCUTANE.)
	ACTEMRA SYRINGE (SUBCUTANE.)
	ACTEMRA VIAL (INJECTION)
	ARCALYST (SUBCUTANE.)
	AVSOLA (INJECTION)
	BIMZELX SYRINGE (SUBCUTANE.)
	BIMZELX AUTOINJECTOR (SUBCUTANE.)
	CIMZIA KIT (INJECTION)
	CIMZIA SYRINGE KIT (INJECTION)
	COSENTYX PEN INJECTER (SUBCUTANE.)
	COSENTYX SYRINGE (SUBCUTANE.)
	COSENTYX VIAL (INTRAVENOUS)
	CYLTEZO SYRINGE (SUBCUTANE.)
	CYLTEZO PEN (SUBCUTANE.)
	ENSPRYNG (SUBCUTANEOUS)
	ENTYVIO (INJECTION)
	ENTYVIO PEN (SUBCUTANE.)
	HADLIMA SYRINGE (SUBCUTANE.)
	HADLIMA PUSHTOUCH (SUBCUTANE.)
	HULIO SYRINGE (SUBCUTANE.)
	HULIO PEN (SUBCUTANE.)
	HYRIMOZ SYRINGE(SUBCUTANE.)
	HYRIMOZ PEN (SUBCUTANE.)
	IDACIO SYRINGE (SUBCUTANE.)
	IDACIO PEN (SUBCUTANE.)
	ILARIS (SUBCUTANE.)
	ILUMYA SYRINGE (SUBCUTANE.)
	INFLECTRA VIAL (INTRAVEN.)
	KEVZARA (SUBCUTANE.)
	KINERET (INJECTION)
	OLUMIANT (ORAL)
	OMVOH PEN (SUBCUTANE.)
	OMVOH SYRINGE (SUBCUTANE.)
	OMVOH VIAL (INJECTION)
	ORENCIA CLICKJECT (SUBCUTANE.)
	ORENCIA SYRINGE (SUBCUTANE.)

Preferred	Nonpreferred
	ORENCIA VIAL (INJECTION) REMICADE (INJECTION) RENFLEXIS (INTRAVEN.) RINVOQ ER (ORAL) RINVOQ LQ SOLUTION (ORAL) SIMLANDI AUTOINJECTOR (SUBCUTANE.) SIMLANDI SYRINGE (SUBCUTANE.) SILIQ (SUBCUTANE.) SIMPONI ARIA VIAL (INTRAVEN.) SIMPONI PEN INJECTER (INJECTION) SIMPONI SYRINGE (INJECTION) SKYRIZI (SUBCUTANE.) SKYRIZI VIAL (INTRAVEN.) SOTYKTU (ORAL) SPEVIGO (INTRAVEN.) SPEVIGO SYRINGE (SUBCUTANE.) STELARA SYRINGE (INJECTION) STELARA VIAL (INJECTION) STEQEYMA SYRINGE (SUBCUTANEOUS) TALTZ AUTOINJECTOR (SUBCUTANE.) TALTZ SYRINGE (SUBCUTANE.) TYENNE VIAL (INTRAVENOUS) TYENNE PEN (SUBCUTANE.) TYENNE SYRINGE (SUBCUTANE.) TOFIDENCE (INTRAVENOUS) TREMFYA (SUBCUTANE.) UPLIZNA (INTRAVEN.) VELSIPITY (ORAL) WEZLANA VIAL (SUBCUTANE.) WEZLANA VIAL (INTRAVENOUS) WEZLANA SYRINGE (SUBCUTANE.) XELJANZ SOLUTION (ORAL) XELJANZ XR (ORAL) YESINTEK SYRINGE (SUBCUTANE.) YESINTEK VIAL (SUBCUTANE.) YUFLYMA SYRINGE (SUBCUTANE.) YUFLYMA AUTOINJECTOR (SUBCUTANE.) YUSIMRY PEN (SUBCUTANE.) ZYMFENTRA PEN (SUBCUTANE.) ZYMFENTRA SYRINGE (SUBCUTANE.)

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS section reviewed 3-19-2025

Preferred	Nonpreferred
~~BYDUREON BCISE (SUBCUTANE.)~~	ALOGLIPTIN (AG) (ORAL)
~~BYETTA PENS (SUBCUTANE.)~~	ALOGLIPTIN/METFORMIN (ORAL)
JANUMET (ORAL)	ALOGLIPTIN/PIOGLITAZONE (ORAL)
JANUMET XR (ORAL)	EXENATIDE PEN (SUBCUTANE.)
JANUVIA (ORAL)	GLYXAMBI (ORAL)
JENTADUETO (ORAL)	LIRAGLUTIDE (SUBCUTANE.)
JENTADUETO XR (ORAL)	MOUNJARO (SUBCUTANE.)
OZEMPIC (SUBCUTANE.)	QTERN (ORAL)
SYMLIN PENS (SUBCUTANE.)	RYBELSUS (ORAL)
TRADJENTA (ORAL)	SAXAGLIPTIN (ORAL)
VICTOZA (SUBCUTANE.)	SAXAGLIPTIN/METFORMIN ER (ORAL)
	SITAGLIPTIN (ORAL)
	SITAGLIPTIN/METFORMIN (ORAL)
	SOLIQUA (SUBCUTANE.)
	STEGLUJAN (ORAL)
	TRIJARDY XR (ORAL)
	TRULICITY (SUBCUTANE.)
	XULTOPHY (SUBCUTANE.)
	ZITUVIO (ORAL)

MULTIPLE SCLEROSIS AGENTS section reviewed 3-19-2025

Preferred	Nonpreferred
AVONEX (INTRAMUSC.)	AMPYRA (ORAL)
AVONEX PEN (INTRAMUSC.)	AUBAGIO (ORAL)
BETASERON KIT (SUBCUTANE.)	BAFIERTAM (ORAL)
BETASERON VIAL (SUBCUTANE.)	BRIUMVI (INTRAVEN.)
COPAXONE 20 MG/ML (SUBCUTANE.)	COPAXONE 40 MG/ML (SUBCUTANE.)
DIMETHYL FUMARATE DR (ORAL)	DALFAMPRIDINE ER (ORAL)
FINGOLIMOD (ORAL)	DIMETHYL FUMARATE DR STARTER PACK (ORAL)
REBIF (SUBCUTANE.)	~~EXTAVIA KIT (SUBCUTANE.)~~
REBIF REBIDOSE PEN INJCTR (SUBCUTANE.)	~~EXTAVIA VIAL (SUBCUTANE.)~~
TERIFLUNOMIDE TABLET (ORAL)	GILENYA (ORAL)
	GLATIRAMER 20 MG/ML (SUBCUTANE.)
	GLATIRAMER 40 MG/ML (SUBCUTANE.)
	GLATOPA 20 MG/ML (SUBCUTANE.)
	GLATOPA 40 MG/ML (SUBCUTANE.)
	KESIMPTA PEN (SUBCUTANE.)
	LEMTRADA (INTRAVEN.)
	MAVENCLAD (ORAL)
	MAYZENT (ORAL)
	OCREVUS (INTRAVEN.)
	OCREVUS ZUNOVO (SUBCUTANE.)
	PLEGRIDY (SUBCUTANE.)
	PONVORY (ORAL)
	TASCENSO ODT (ORAL)
	TECFIDERA (ORAL)
	TYSABRI (INTRAVEN.)
	VUMERITY (ORAL)
	ZEPOSIA (ORAL)