DEPARTMENT OF HUMAN SERVICES

Discussion Items

MHCP Enrolled Providers – Pharmacies

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

(June 2025)

Drug	**Rhofade® (oxymetazoline 1% cream) [**Mayne Pharma Commercial, LLC.**]**
Therapeutic Area	Rosacea Agents, Topical

Initial approval criteria:

- Patient is ≥ 18 years of age; AND
- Patient has a diagnosis of persistent facial erythema associated with a diagnosis of rosacea; AND
- Prescriber attests that if the patient has cardiovascular disease, orthostatic hypotension, and/or uncontrolled hypertension or
  hypotension they will be appropriately monitored and will be counseled to seek medical care if their condition worsens; AND
- Prescriber attests that patient with cerebral or coronary insufficiency, Raynaud's phenomenon, thromboangiitis obliterans,
  scleroderma, or Sjögren's syndrome will receive appropriate monitoring and advised to seek medical care if signs and symptoms of potentiation of vascular insufficiency develop; AND
- Prescriber attests that patient will receive counseling on the signs and symptoms of acute angle closure glaucoma and will be advised to seek immediate care if they develop; AND
- Prescriber has reviewed Rhofade drug interactions and will monitor patient status as appropriate

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient has experienced improvement or resolution of facial erythema associated with rosacea; AND
- Patient has NOT experienced any treatment-restricting adverse effects.

Quantity limits

- 1 fill (one 30-gram tube) per 30 days

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(June 2025)

Drug	**Ryzumvi™ (phentolamine ophthalmic solution) [**Viatris, Inc.**]**
Therapeutic Area	Mydriasis treatment

Approval criteria:

- Age ≥ 3 years; AND
- Patient is undergoing an ophthalmic exam or other procedure involving pharmacologically-induced mydriasis with an adrenergic agonist (e.g., phenylephrine) or parasympatholytic agent (e.g., tropicamide); AND
- Patient does NOT have hypersensitivity to any component of the product; AND
- Patient does NOT have clinically significant ocular disease; AND
- Patient does NOT have ocular infection or inflammation in either eye; AND
- Patient has NOT had ocular trauma, ocular surgery or non-refractive laser treatment within the 6 months prior to use of Ryzumvi

Quantity limits

- One time dose: 2 vials (0.31 mL each)

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(June 2025)

Drug	**Casgevy® (exagamglogene autotemcel) [**Vertex Pharmaceuticals Inc.**]**
Therapeutic Area	Sickle Cell Disease (SCD)

Approval criteria:

- Patient is at least twelve (12) years of age; AND
- Patient has prior use of, or intolerance to hydroxyurea (per health care professional judgement) at any point in the past; AND
- Patient is clinically stable and fit for transplantation; AND
- Patient has been screened and found negative for hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus 1 & 2 (HIV-1/HIV-2) in accordance with clinical guidelines prior to collection of cells (leukapheresis); AND
- Patient has not received other gene therapies for sickle cell disease [e.g., Lyfgenia® (lovotibeglogene autotemcel)]; AND
- Patient does not have a known and suitable 10/10 human leukocyte antigen matched related donor willing to participate in an allogeneic hematopoietic stem cell transplant (HSCT); AND
- Patient is a candidate for autologous HSCT and has not had prior HSCT; AND
- Patient has a confirmed diagnosis of sickle cell disease with confirmatory genetic testing; AND
- Patient has experienced recurrent VOCs* (defined as more than or equal to two (2) documented VOCs per year in the previous twenty-four (24) months, based on provider attestation); AND
- Casgevy is prescribed in consultation with a board-certified hematologist with SCD expertise

*Vaso-Occlusive Crisis (“VOC”): A VOC occurs when sickled red blood cells block blood flow to the point that tissues become deprived of oxygen. This in turn sets in motion an inflammatory response as the body tries to rectify the problem

Duration of approval:

- Prior authorization approval is effective for 12 months from the approval date. Approval may be extended for another 6 months if patient is unable to receive treatment within 12 months from the approval date.

Quantity limits

- 1 administration per lifetime
- Patient’s most current weight (in kg) and the dose to be administered must be provided at time of request

Billing for Casgevy:

- If prescribed for SCD with recurrent VOCs and approved for payment, Casgevy must be billed as a professional claim
- If prescribed for transfusion-dependent β-thalassemia (TDT), Casgevy is covered under an inpatient DRG and is not separately payable.

MHCP Enrolled Providers – Pharmacies

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

(June 2025)

Drug	**Attruby™ (acoramidis) [**BridgeBio Pharma, Inc.**]**
Therapeutic Area	ATTR-Cardiac Amyloidosis (ATTR-CM)

Initial approval criteria:

- Patient is at least 18 years old AND
- Patient has a diagnosis of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis confirmed by testing (e.g., stannous pyrophosphate [PYP] scanning, monoclonal antibody studies, biopsy, scintigraphy, genetic testing [TTR genotyping]) AND
- Patient has New York Heart Association (NYHA) Functional Class I, II, or III Heart Failure AND
- Patient has clinical manifestations of cardiomyopathy (e.g., dyspnea, fatigue, orthostatic hypotension, syncope, peripheral edema) AND
- The prescriber is a specialist in the area of patient's diagnosis (e.g., cardiologist, geneticist), or the prescriber has consulted with a specialist in the area of patient's diagnosis AND
- Patient will NOT be using Attruby in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Onpattro (patisiran), Tegsedi (inotersen), Vyndaqel/Vyndamax (tafamadis), or Wainua (eplontersen)] AND
- Patient does NOT have any FDA labeled contraindications to Attruby.

Renewal criteria:

- Patient has had clinical benefit with Attruby AND
- Patient has New York Heart Association (NYHA) Functional Class I, II, or III Heart Failure AND
- The prescriber is a specialist in the area of patient's diagnosis (e.g., cardiologist, geneticist), or the prescriber has consulted with a specialist in the area of patient's diagnosis AND
- Patient will NOT be using Attruby in combination with an RNA-targeted therapy for ATTR amyloidosis [i.e., Amvuttra (vutrisiran), Onpattro (patisiran), Tegsedi (inotersen), Vyndaqel/Vyndamax (tafamadis), or Wainua (eplontersen)] AND
- Patient does NOT have any FDA labeled contraindications to Attruby

Quantity limits

- 112 tablets (4 blister cards) per 28 days

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(June 2025)

Drug	**Hympavzi™ (marstacimab-hncq) [**Pfizer, Inc.**]**
Therapeutic Area	Hemophilia treatments

Initial approval criteria:

- Age ≥ 12 years; AND
- ONE of the following:
  - Diagnosis of hemophilia A (congenital factor VIII deficiency) without factor VIII inhibitors confirmed by blood coagulation testing, OR
  - Diagnosis of hemophilia B (congenital factor IX deficiency, Christmas disease) without factor IX inhibitors confirmed by blood coagulation testing; AND
- ONE of the following:
  - Severe hemophilia (factor activity < 1%); OR
  - Secondary prophylaxis in patients with ≥ 2 documented episodes of spontaneous bleeding into joints; AND
- Patient has not previously received treatment with a gene therapy product (e.g., Hemgenix, Roctavian) for the treatment of hemophilia A or B; AND
- Hympavzi must be used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes; AND
- Hympavzi will NOT be used in combination with prophylactic factor replacement therapy (e.g., factor VIII or factor IX inhibitors); therapy can be initiated at any time after discontinuing clotting factor concentrates (note: factor VIII or factor IX products can be administered for the treatment of breakthrough bleeds during Hympavzi treatment); AND
- Patient will initiate maintenance therapy at the lower range of dosing (150 mg weekly); AND
- Hympavzi will NOT be used for treatment of breakthrough bleeds (note: factor VIII or factor IX products may be administered on an as-needed basis for treatment of breakthrough bleeds in patients being treated with Hympavzi); AND
- Patient of reproductive potential must have a negative pregnancy test prior to initiation of Hympavzi and must use effective
  contraception during treatment and for 2 months after the last dose.
- Initial approval is for 6 months

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient has demonstrated a beneficial response to therapy (e.g., frequency of bleeding episodes has decreased from pre-treatment baseline); OR
- Patient requires dose escalation* (up to the maximum dose and frequency specified below) provided that the patient meets ALL of the following criteria:
  - Body weight ≥ 50 kg
  - Inadequate control of bleeding events (e.g., patient has experienced ≥ 2 breakthrough bleeds while on maintenance therapy at the lower dose)
  - Full adherence to maintenance therapy for ≥ 6 months at the lower dose; AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., thromboembolic events, severe hypersensitivity
  reactions).
- Renewal approval is for 12 months

Quantity limits

- 8 prefilled 150 mg/mL single-dose syringes or pens/28 days
- Max dose: 300 mg SC weekly

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(June 2025)

Drug	**Alhemo® (concizumab-mtci) [**Novo Nordisk, Inc.**]**
Therapeutic Area	Hemophilia treatments

Initial approval criteria:

- Patient is ≥ 12 years of age; AND
- Must be used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes; AND
- Patient has hemophilia A (congenital factor VIII deficiency) with inhibitors; AND
    - Diagnosis of congenital factor VIII deficiency has been confirmed by blood coagulation testing; AND
    - Patient has inhibitors to factor VIII with a current or historical titer of ≥ 5 Bethesda Units (BU)*; AND
    - Used as treatment in one of the following:
        - Primary prophylaxis in patients with severe factor VIII deficiency (factor VIII level of <1%); OR
        - Secondary prophylaxis in patients with ≥ 2 documented episodes of spontaneous bleeding into joints; OR
- Patient has hemophilia B (congenital factor IX deficiency, also known as Christmas Disease) with inhibitors; AND:
    - Diagnosis of congenital factor IX deficiency has been confirmed by blood coagulation testing; AND
    - Patient has inhibitors to factor IX with a current or historical titer of ≥ 5 Bethesda Units (BU)*; AND
    - Used as treatment in one of the following:
        - Primary prophylaxis in patients with severe factor IX deficiency (factor IX level of <1%); OR
        - Secondary prophylaxis in patients with ≥ 2 documented episodes of spontaneous bleeding into joints; AND
- Patient has not previously received treatment with a gene therapy product (e.g., Hemgenix, Roctavian) for the treatment of hemophilia A or B; AND
- Patient does NOT have a history of known serious hypersensitivity to Alhemo or its components or the inactive ingredient; AND
- Will NOT be used for the treatment of breakthrough bleeds (Note: bypassing agents [e.g., recombinant activated factor VII (rFVIIa) or activated prothrombin complex concentrate (aPCC)] may be administered on an as needed basis for the treatment of breakthrough bleeds in patients being treated with concizumab); AND
- Will NOT be used in combination with any of the following (Note: factor VIII or factor IX products can be administered for the treatment of breakthrough bleeds while receiving concizumab):
    - Hemophilia bypassing agents (e.g., factor VIIa or anti-inhibitor coagulant complex); AND
    - Immune tolerance induction in combination with clotting factor products (e.g., factor VIII or factor IX concentrates) as prophylactic therapy; AND
    - Emicizumab-kxwh (Hemlibra) for hemophilia A with inhibitors;AND
- Patients of reproductive potential are NOT pregnant prior to initiating therapy with concizumab and will use a highly effective form of contraception during treatment with Alhemo and for 7 weeks after ending treatment
- Initial approval is for 8 weeks

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient has demonstrated a beneficial response to therapy (e.g., the frequency of bleeding episodes has decreased from pre-treatment baseline); AND
- Patient measurement of concizumab plasma concentrations is ≥ 200 ng/mL**; AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., thromboembolic events, hypersensitivity).
- Renewal approval is for 12 months

*Note: Patients with inhibitor titer levels > 0.6 BU to < 5 BU who are not responding to or are not a candidate for standard factor replacement, will be evaluated on a case-by-case basis.
**Note: Requests for patients with measurements of concizumab plasma concentrations that remain < 200 ng/mL at 2 consecutive measurements, will be reviewed on a case-by-case basis

Quantity limits

- Loading dose and maintenance dose will NOT exceed those recommended in the FDA-approved label
- Patient's weight (in kg) will be submitted at time of request

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(June 2025)

Drug	**Alyftrek™ (vanzacaftor/tezacaftor/deutivacaftor) [**Vertex Pharmaceuticals, Inc.**]**
Therapeutic Area	Cystic fibrosis, Oral

Initial approval criteria:

- Age ≥ 6 years; AND
- Diagnosis of cystic fibrosis (CF); AND
- Patient has ≥ 1 F508del mutation or other responsive mutation in the cystic fibrosis transmembrane conductance regulator (CFTR) gene, as confirmed by genetic testing (medical records required); AND
- Alyftrek will NOT be used in combination with another CFTR modulator; AND
- Liver function tests (e.g., alanine aminotransferase [ALT], aspartate aminotransferase [AST], alkaline phosphatase, bilirubin) have been assessed prior to initiation of Alyftrek and will be monitored regularly during treatment; AND
- Patient does NOT have severe hepatic impairment (Child-Pugh Class C); AND
- The prescriber is a specialist in the area of the patient's diagnosis (e.g., CF, pulmonologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis.
- Initial approval is for 6 months

Transition criteria:

- If patient is currently stable on another CFTR modulator, request to transition to Alyftrek may be approved if all of the following conditions are met:
    - the patient meets initial approval criteria AND
    - approved request for Alyftrek will not be effective until at least 85% of patient's current supply of another CFTR modulator has been depleted (based on pharmacy claims data)
- Transition approval is for 6 months

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient must have disease improvement or stabilization with treatment (e.g., improvement or stabilization of any of the following: forced expiratory volume in one second [FEV1], sweat chloride concentration, weight/body mass index [BMI], Cystic Fibrosis Questionnaire-Revised [CFQ-R] respiratory domain score, respiratory symptoms related to cystic fibrosis [e.g., cough, sputum production, difficulty breathing], number of pulmonary exacerbations); AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., severe liver injury or liver failure, severe hypersensitivity reactions).
- Renewal approval is for 12 months

Quantity limits

- vanzacaftor 4 mg/tezacaftor 20 mg/deutivacaftor 50 mg tablets: 84 tablets per 28 days
- vanzacaftor 10 mg/tezacaftor 50 mg/deutivacaftor 125 mg tablets: 56 tablets per 28 days

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(June 2025)

Drug	**Crenessity™ (crinecerfont) [**Neurocrine Biosciences, Inc.**]**
Therapeutic Area	Congenital adrenal hyperplasia (CAH)

Initial approval criteria:

- Patient is ≥ 4 years of age; AND
- The patient has a diagnosis of classic congenital adrenal hyperplasia (CAH) due to 21-hydroxylase deficiency as confirmed by ONE of the following:
    - Positive infant screening with secondary tier 2 confirmatory testing; OR
    - Elevated serum 17-hydroxyprogesterone level (17OHP) above the upper limit of normal (ULN); OR
    - Cosyntropin (adrenocorticotropic hormone [ACTH]) stimulation test; OR
    - Genetic testing for mutation in the *CYP21A2* gene consistent with CAH; AND
- Patient does NOT have a hypersensitivity to Crenessity or any excipients of the product; AND
- The patient is currently treated with glucocorticoid replacement therapy (e.g., hydrocortisone, prednisone, prednisolone,
- dexamethasone); AND
- The patient will continue glucocorticoid at a dosage that is required for replacement therapy (e.g., hydrocortisone, prednisone,
- prednisolone, dexamethasone) in combination with Crenessity; AND
- The prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist, geneticist), 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 had clinical benefit with Crenessity; AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., clinically significant hypersensitivity reactions).

Quantity limits

- 25 mg, 50 mg and 100 mg: 60 capsules/30 days
    - If a higher dose is requested due to concomitant use with strong or moderate CYP3A4 inducers, provide the name(s) of concomitant strong or moderate CYP3A4 inducers at time of request
    - For requested quantity based on weight, provide patient's weight (in kg) at the time of request
- 50 mg/mL: 120 mL/30 days
    - If a higher dose is requested due to concomitant use with strong or moderate CYP3A4 inducers, provide the name(s) of concomitant strong or moderate CYP3A4 inducers at time of request
    - For requested quantity based on weight, provide patient's weight (in kg) at the time of request

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(June 2025)

Drug	**Prevymis® (letemovir) [**Merck and Co., Inc.**]**
Therapeutic Area	Antivirals, General

Approval criteria:

- Patient is a kidney transplant recipient AND
- Patient is at high risk for cytomegalovirus (CMV) disease (Donor CMV seropositive/Recipient CMV seronegative [D+/R-])

OR

- Patient is an allogeneic hematopoietic stem cell transplant (HSCT) recipient AND
- Patient is CMV-seropositive (R+)

AND

- Prevymis is being prescribed as prophylaxis and NOT treatment of CMV infection AND
- Patient's age is within FDA labeling for the requested indication for Prevymis AND
- When applicable, the patient's weight is within FDA labeling for the requested indication for Prevymis AND
- Patient does NOT have any FDA labeled contraindications to Prevymis
- Approval is effective for 9 months from approval date

Quantity limits:

- Daily quantity limit and prophylaxis duration will NOT exceed those recommended in the FDA-approved label
- Patient's weight (in kg) must be submitted at time of request, when applicable.

Billing for Prevymis:

- Intravenous infusion: must be billed as a professional claim
- Tablets and oral pellets: must be billed as a pharmacy claim

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(June 2025)

Drug	**Journavx™ (suzetrigine) [**Vertex Pharmaceuticals, Inc.**]**
Therapeutic Area	Neuropathic pain and select agents

Approval criteria:

- Age ≥ 18 years; AND
- Patient has moderate to severe acute pain, as confirmed by a pain score or rating system (e.g. numeric pain rating scale NPRS], verbal categorical rating scale [VRS]); AND
- Journavx will be used for the shortest duration consistent with individual patient treatment goals and will NOT be used beyond 14 days; AND
- Patient is NOT taking a strong cytochrome P450 (CYP) 3A inhibitor (e.g., itraconazole, grapefruit juice); AND
- Patient is NOT taking a moderate or strong CYP3A inducer (e.g., rifampin, carbamazepine, St. John's Wort); AND
- Patient does NOT have severe hepatic impairment (Child-Pugh Class C); AND
- Patients taking hormonal contraceptives containing progestins other than levonorgestrel and norethindrone will use additional
  nonhormonal contraceptives (e.g., condoms) or alternative contraceptives (e.g., combined oral contraceptive containing ethinyl estradiol and levonorgestrel or norethindrone; intrauterine system) during treatment and for 28 days after discontinuation.

Quantity limits

- 30 tablets per 14 days and cannot be renewed

Provider Call Center (844) 575-7887

Discussion Items:

ANGIOTENSIN MODULATORS section reviewed 6-18-2025

Preferred	Nonpreferred
BENAZEPRIL (ORAL)	ALISKIREN (ORAL)
BENAZEPRIL HCTZ (ORAL)	ALTACE (ORAL)
CAPTOPRIL (ORAL)	ATACAND (ORAL)
CAPTOPRIL HCTZ (ORAL)	ATACAND HCT (ORAL)
ENALAPRIL (ORAL)	AVALIDE (ORAL)
ENALAPRIL HCTZ (ORAL)	AVAPRO (ORAL)
ENTRESTO (ORAL)	BENICAR (ORAL)
FOSINOPRIL (ORAL)	BENICAR HCT (ORAL)
FOSINOPRIL HCTZ (ORAL)	CANDESARTAN (ORAL)
IRBESARTAN (ORAL)	CANDESARTAN HCTZ (ORAL)
IRBESARTAN HCTZ (ORAL)	COZAAR (ORAL)
LISINOPRIL (ORAL)	DIOVAN (ORAL)
LISINOPRIL HCTZ (ORAL)	DIOVAN HCT (ORAL)
LOSARTAN (ORAL)	EDARBI (ORAL)
LOSARTAN HCTZ (ORAL)	EDARBYCLOR (ORAL)
MOEXIPRIL (ORAL)	ENALAPRIL SOLUTION (ORAL)
OLMESARTAN (ORAL)	ENTRESTO SPRINKLE CAP (ORAL)
OLMESARTAN HCTZ (ORAL)	EPANED POWDER (ORAL)
PERINDOPRIL (ORAL)	EPANED SOLUTION (ORAL)
~~QUINAPRIL (ORAL)~~	EPROSARTAN (ORAL)
QUINAPRIL HCTZ (ORAL)	HYZAAR (ORAL)
RAMIPRIL (ORAL)	LOTENSIN (ORAL)
TRANDOLAPRIL (ORAL)	LOTENSIN HCT (ORAL)
VALSARTAN (ORAL)	MICARDIS (ORAL)
VALSARTAN HCTZ (ORAL)	MICARDIS HCT (ORAL)
	QBRELIS SOLUTION (ORAL)
	<u>QUINAPRIL (ORAL)</u>
	TEKTURNA (ORAL)
	TELMISARTAN (ORAL)
	TELMISARTAN HCTZ (ORAL)
	VASERETIC (ORAL)
	VASOTEC (ORAL)
	ZESTORETIC (ORAL)
	ZESTRIL (ORAL)

ANTIBIOTICS, INHALED section reviewed 6-18-2025

Preferred	Nonpreferred
BETHKIS (INHALATION)	<u>ARIKAYCE (INHALATION)</u>
KITABIS PAK (INHALATION)	CAYSTON (INHALATION)
TOBRAMYCIN (TOBI) (INHALATION)	TOBI (INHALATION)
TOBRAMYCIN (TOBI) (AG) (INHALATION)	TOBI PODHALER (INHALATION)
	TOBRAMYCIN (BETHKIS) (AG) (INHALATION)
	TOBRAMYCIN (BETHKIS) (INHALATION)
	TOBRAMYCIN PAK (AG) (INHALATION)

ANTIFUNGALS, ORAL section reviewed 6-18-2025

Preferred	Nonpreferred
FLUCONAZOLE SUSPENSION (ORAL)	ANCOBON (ORAL)
FLUCONAZOLE TABLET (ORAL)	BREXAFEMME (ORAL)
NYSTATIN SUSPENSION (ORAL)	CRESEMBA (ORAL)
TERBINAFINE (ORAL)	DIFLUCAN TABLET (ORAL)
VORICONAZOLE TABLET (ORAL)	DIFLUCAN SUSPENSION (ORAL)
	FLUCYTOSINE (ORAL)
	GRIS-PEG (ORAL)
	GRISEOFULVIN SUSPENSION (ORAL)
	GRISEOFULVIN TABLETS (ORAL)
	GRISEOFULVIN ULTRAMICROSIZE (ORAL)
	ITRACONAZOLE (ORAL)
	KETOCONAZOLE (ORAL)
	NOXAFIL SUSPENSION (ORAL)
	NOXAFIL TABLETS (ORAL)
	NYSTATIN TABLET (ORAL)
	ONMEL (ORAL)
	ORAVIG (BUCCAL)
	POSACONAZOLE TABLET AND SUSPENSION (ORAL)
	SPORANOX CAPSULE (ORAL)
	SPORANOX SOLUTION (ORAL)
	TOLSURA (ORAL)
	VFEND TABLET (ORAL)
	VFEND SUSPENSION (ORAL)
	VIVJOA CAPSULE (ORAL)
	VORICONAZOLE SUSPENSION (ORAL)

ANTIFUNGALS, TOPICAL section reviewed 6-18-2025

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

ANTIVIRALS, GENERAL section added and reviewed 6-18-2025

Preferred	Nonpreferred
PAXLOVID TAB DOSE PACK (ORAL)	NONE

BETA-BLOCKERS section reviewed 6-18-2025

Preferred	Nonpreferred
ATENOLOL (ORAL)	ACEBUTOLOL (ORAL)
BISOPROLOL (ORAL)	ATENOLOL/CHLORTHALIDONE (ORAL)
BISOPROLOL HCTZ (ORAL)	BETAPACE / AF (ORAL)
CARVEDILOL (ORAL)	BETAXOLOL (ORAL)
COREG CR (ORAL)	~~BISOPROLOL HCTZ (ORAL)~~
LABETALOL (ORAL)	BYSTOLIC (ORAL)
METOPROLOL (ORAL)	CARVEDILOL ER (ORAL)
METOPROLOL XL (ORAL)	COREG (ORAL)
NADOLOL (ORAL)	~~CORGARD (ORAL)~~
NEBIVOLOL (ORAL)	HEMANGEOL (ORAL)
~~PINDOLOL (ORAL)~~	INDERAL LA (ORAL)
PROPRANOLOL ER (ORAL)	INDERAL XL (ORAL)
PROPRANOLOL/HCTZ (ORAL)	INNOPRAN XL (ORAL)
PROPRANOLOL SOLUTION (ORAL)	KAPSPARGO (ORAL)
PROPRANOLOL TABLET (ORAL)	LOPRESSOR (ORAL)
SOTALOL (ORAL)	LOPRESSOR HCT (ORAL)
	METOPROLOL/HCTZ (ORAL)
	PINDOLOL (ORAL)
	~~NEBIVOLOL (ORAL)~~
	SOTYLIZE (ORAL)
	TENORETIC (ORAL)

Preferred	Nonpreferred
	TENORMIN (ORAL) TIMOLOL (ORAL) TOPROL XL (ORAL) ZIAC (ORAL)

BONE RESORPTION SUPPRESSION AND RELATED AGENTS section reviewed 6-18-2025

Preferred	Nonpreferred
ALENDRONATE SOLUTION (ORAL) ALENDRONATE TABLETS (ORAL) CALCITONIN SALMON (NASAL) FORTEO (SUBCUTANEOUS) IBANDRONATE TABLETS (ORAL) MIACALCIN (NASAL) RALOXIFENE (ORAL)	ACTONEL (ORAL) ATELVIA (ORAL) BINOSTO (ORAL) ~~BONIVA (ORAL)~~ ~~ETIDRONATE DISODIUM (ORAL)~~ EVENITY (SUBCUTANEOUS) EVISTA (ORAL) FORTICAL (NASAL) FOSAMAX (ORAL) FOSAMAX PLUS D (ORAL) PROLIA (SUBCUTANE.) RISEDRONATE (ACTONEL) (ORAL) RISEDRONATE (ATELVIA) (ORAL) TERIPARATIDE (SUBCUTANEOUS) TYMLOS (SUBCUTANE.)

BPH TREATMENTS section reviewed 6-18-2025

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

CEPHALOSPORINS AND RELATED ANTIBIOTICS section reviewed 6-18-2025

Preferred	Nonpreferred
AMOXICILLIN/CLAV SUSPENSION (ORAL) AMOXICILLIN/CLAV TABLET (ORAL) CEFACLOR CAPSULE (ORAL) CEFACLOR SUSPENSION (ORAL) CEFADROXIL CAPSULE (ORAL) CEFADROXIL SUSPENSION (ORAL) CEFDINIR CAPSULE (ORAL) CEFDINIR SUSPENSION (ORAL) CEFIXIME CAPSULE (ORAL) CEFPROZIL SUSPENSION (ORAL)	AMOXICILLIN/CLAV CHEW TABLET (ORAL) AMOXICILLIN/CLAV XR (ORAL) AUGMENTIN 125 SUSPENSION (ORAL) AUGMENTIN ES-600 SUSPENSION (ORAL) ~~AUGMENTIN XR (ORAL)~~ CEFACLOR TABLET ER (ORAL) CEFADROXIL TABLET (ORAL) CEFIXIME SUSPENSION (ORAL) CEFPODOXIME SUSPENSION (ORAL) CEFPODOXIME TABLET (ORAL)

Preferred	Nonpreferred
CEFPROZIL TABLET (ORAL) CEFUROXIME TABLET (ORAL) CEPHALEXIN CAPSULE (ORAL) CEPHALEXIN SUSPENSION (ORAL)	CEPHALEXIN TABLET (ORAL) ~~KEFLEX (ORAL)~~ SUPRAX SUSPENSION (ORAL) SUPRAX TAB CHEW (ORAL)

COPD AGENTS section reviewed 6-18-2025

Preferred	Nonpreferred
ANORO ELLIPTA (INHALATION) ATROVENT HFA (INHALATION) COMBIVENT RESPIMAT (INHALATION) IPRATROPIUM / ALBUTEROL (INHALATION) IPRATROPIUM NEBULIZER (INHALATION) ROFLUMILAST (ORAL) SPIRIVA (INHALATION) SPIRIVA RESPIMAT (INHALATION) STIOLTO RESPIMAT (INHALATION) ~~TUDORZA PRESSAIR (INHALATION)~~	BEVESPI AEROSPHERE (INHALATION) DALIRESP (ORAL) DUAKLIR PRESSAIR (INHALATION) INCRUSE ELLIPTA (INHALATION) OHTUVAYRE (INHALATION) TIOTROPIUM (SPIRIVA) (INHALATION) TUDORZA PRESSAIR (INHALATION) UMECLIDINIUM-VILANTEROL ELLIPTA (INHALATION) YUPELRI (INHALATION)

EPINEPHRINE, SELF-INJECTED section reviewed 6-18-2025

Preferred	Nonpreferred
EPIPEN (INTRAMUSC) EPIPEN JR (INTRAMUSC) EPINEPHRINE AUTOINJECTOR (INTRAMUSC), AUTHORIZED GENERIC OF EPIPEN & EPIPEN JR ~~SYMJEPI~~	AUVI-Q (INTRAMUSC) EPINEPHRINE AUTOINJECTOR (INTRAMUSC), AUTHORIZED GENERIC OF ADRENACLICK EPINEPHRINE AUTOINJECTOR, TEVA PHARMACEUTICALS NEFFY SPRAY (NASAL)

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS section reviewed 6-18-2025

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

IMMUNOMODULATORS, ATOPIC DERMATITIS section reviewed 6-18-2025

Preferred	Nonpreferred
DUPIXENT (SUBCUTANE.)	ADBRY (SUBCUTANEOUS)
EUCRISA (TOPICAL)	EBGLYSS (SUBCUTANEOUS)
	~~EUCRISA (TOPICAL)~~
	NEMLUVIO PEN (SUBCUTANEOUS)
	OPZELURA (TOPICAL)
	ZORYVE 0.15% CREAM (TOPICAL)
	ZORYVE FOAM (TOPICAL)

LIPOTROPICS, OTHER section updated 6-18-2025

Preferred	Nonpreferred
CHOLESTYRAMINE/ASPARTAME (ORAL)	ANTARA (ORAL)
CHOLESTYRAMINE/SUCROSE (ORAL)	COLESEVELAM (ORAL)
COLESTIPOL GRANULES (ORAL)	COLESEVELAM POWDER PACK (ORAL)
COLESTIPOL TABLET (ORAL)	COLESTID TABLET (ORAL)
EZETIMIBE (ORAL)	EVKEEZA (INTRAVENOUS)
FENOFIBRATE CAPSULE (LOFIBRA) (ORAL)	FENOFIBRATE (ANTARA) (ORAL)
FENOFIBRATE TABLET (LOFIBRA) (ORAL)	FENOFIBRATE (FENOGLIDE) (ORAL)
FENOFIBRATE TABLET (TRICOR) (ORAL)	FENOFIBRATE (TRIGLIDE) (ORAL)
GEMFIBROZIL (ORAL)	FENOFIBRATE CAPSULE (LIPOFEN) (ORAL)
NIACIN TABLET OTC (ORAL)	FENOFIBRIC ACID (FIBRICOR) (ORAL)
NIACIN CAPSULE ER OTC (ORAL)	FENOFIBRIC ACID (TRILIPIX) (ORAL)
NIACIN ER (ORAL)	FENOGLIDE (ORAL)
NIACIN TABLET ER OTC (ORAL)	FIBRICOR (ORAL)
OMEGA-3 ACID ETHYL ESTERS (LOVAZA) (ORAL)	ICOSAPENT ETHYL (ORAL)
	LEQVIO (SUBCUTANEOUS)
	LOPID
	LIPOFEN (ORAL)
	~~LOVAZA (ORAL)~~
	NEXLETOL (ORAL)
	NEXLIZET (ORAL)
	PRALUENT PEN (SUBCUTANEOUS)
	QUESTRAN (ORAL)
	QUESTRAN LIGHT (ORAL)
	REPATHA PUSHTRONEX (SUBCUTANEOUS)
	REPATHA SURECLICK (SUBCUTANEOUS)
	REPATHA SYRINGE (SUBCUTANEOUS)
	TRICOR (ORAL)
	TRILIPIX (ORAL)
	TRYNGOLZA (SUBCUTANEOUS)
	WELCHOL POWDER PACK (ORAL)
	WELCHOL TABLET (ORAL)
	ZETIA (ORAL)

Consent Agenda Items:

ALZHEIMER'S AGENTS section reviewed 6-18-2025

Preferred	Nonpreferred
DONEPEZIL ODT (ORAL)	ADLARITY (TRANSDERM)
DONEPEZIL TABLET (ORAL)	ARICEPT (ORAL)
EXELON (TRANSDERM.)	ARICEPT 23 MG (ORAL)
MEMANTINE TABLET (ORAL)	ARICEPT ODT (ORAL)
	DONEPEZIL 23 MG (ORAL)
	~~EXELON (TRANSDERM.)~~
	~~EXELON CAPSULES (ORAL)~~
	GALANTAMINE ER (ORAL)
	GALANTAMINE SOLUTION (ORAL)
	GALANTAMINE TABLET (ORAL)
	MEMANTINE ER (ORAL)
	MEMANTINE SOLUTION (ORAL)
	MEMANTINE TABLET DOSE PACK (AG) (ORAL)
	NAMENDA TABLET (ORAL)
	NAMENDA TABLET DOSE PACK (ORAL)
	~~NAMENDA XR (ORAL)~~
	NAMZARIC (ORAL)
	NAMZARIC DOSE PACK (ORAL)
	RIVASTIGMINE (AG) (TRANSDERM.)
	RIVASTIGMINE (TRANSDERM.)
	RIVASTIGMINE CAPSULES (ORAL)

ANTIBIOTICS, TOPICAL section reviewed 6-18-2025 no change

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

ANTICOAGULANTS section reviewed 6-18-2025

Preferred	Nonpreferred
ELIQUIS (ORAL)	ARIXTRA (SUBCUTANE.)
ELIQUIS DOSE PACK (ORAL)	~~COUMADIN (ORAL)~~
ENOXAPARIN SODIUM VIAL (SUBCUTANEOUS)	DABIGATRAN (ORAL)
ENOXAPARIN SYRINGE (SUBCUTANEOUS)	FONDAPARINUX (SUBCUTANE.)
FRAGMIN VIAL (SUBCUTANEOUS)	FRAGMIN DISP SYRIN (SUBCUTANE.)
JANTOVEN (ORAL)	LOVENOX SYRINGE (SUBCUTANE.)
PRADAXA (ORAL)	LOVENOX VIAL (SUBCUTANE.)
WARFARIN (ORAL)	PRADAXA PELLET PACK (ORAL)
XARELTO (ORAL)	SAVAYSA (ORAL)
XARELTO DOSE PACK (ORAL)	XARELTO SOLUTION (ORAL)

BLADDER RELAXANT PREPARATIONS section reviewed 6-18-2025

Preferred	Nonpreferred
FESOTERODINE ER (ORAL)	DARIFENACIN ER (ORAL)
MYRBETRIQ (ORAL)	DETROL (ORAL)
OXYBUTYNIN ER (ORAL)	DETROL LA (ORAL)

Preferred	Nonpreferred
OXYBUTYNIN ER (AG) (ORAL) OXYBUTYNIN SYRUP (ORAL) OXYBUTYNIN TABLET (ORAL) OXYTROL (TRANSDERM.) SOLIFENACIN (ORAL) TOLTERODINE (ORAL) TOLTERODINE ER (ORAL) ~~TOVIAZ (ORAL)~~	~~DITROPAN XL (ORAL)~~ ~~ENABLEX (ORAL)~~ ~~FESOTERODINE ER (ORAL)~~ FLAVOXATE (ORAL) GELNIQUE GEL PUMP (TRANSDERMAL) GEMTESA (ORAL) MIRABEGRON ER (ORAL) ~~MYRBETRIQ (ORAL)~~ MYRBETRIQ GRANULES (ORAL) TOVIAZ (ORAL) TROSPIUM (ORAL) TROSPIUM ER (ORAL) VESICARE (ORAL) VESICARE LS (ORAL)

BRONCHODILATORS, BETA AGONIST section reviewed 6-18-2025

Preferred	Nonpreferred
ALBUTEROL HFA (PROAIR HFA) (INHALATION) ALBUTEROL HFA (PROAIR HFA) (AG) (INHALATION) ALBUTEROL HFA (PROVENTIL HFA) (INHALATION) ALBUTEROL NEB SOLN 0.63, 1.25 MG (INHALATION) ALBUTEROL NEB SOLN 100 MG/20 ML (INHALATION) ALBUTEROL NEB SOLN 2.5 MG/0.5 ML (INHALATION) ALBUTEROL NEB SOLN 2.5 MG/3 ML (INHALATION) ALBUTEROL SYRUP (ORAL) METAPROTERENOL SYRUP (ORAL) SEREVENT (INHALATION) VENTOLIN HFA (INHALATION) XOPENEX HFA (INHALATION)	ALBUTEROL ER (ORAL) ~~ALBUTEROL HFA (PROAIR HFA) (INHALATION)~~ ~~ALBUTEROL HFA (PROAIR HFA) (AG) (INHALATION)~~ ~~ALBUTEROL HFA (PROVENTIL HFA) (INHALATION)~~ ALBUTEROL HFA (PROVENTIL HFA) (AG) (INHALATION) ALBUTEROL HFA (VENTOLIN) (AG) (INHALATION) ALBUTEROL TABLET (ORAL) ARFORMOTEROL (INHALATION) BROVANA (INHALATION) FORMOTEROL (INHALATION) LEVALBUTEROL HFA (INHALATION) LEVALBUTEROL NEB SOLN (INHALATION) LEVALBUTEROL NEB SOLN CONC (INHALATION) METAPROTERENOL TABLET (ORAL) PERFOROMIST (INHALATION) PROAIR DIGIHALER (INHALATION) PROAIR RESPICLICK (INHALATION) STRIVERDI RESPIMAT (INHALATION)

CALCIUM CHANNEL BLOCKERS section reviewed 6-18-2025

Preferred	Nonpreferred
AMLODIPINE (ORAL) DILTIAZEM CAPSULE ER (ORAL) DILTIAZEM TABLET (ORAL) FELODIPINE ER (ORAL) NIFEDIPINE ER (ORAL) NIFEDIPINE IR (ORAL) VERAPAMIL CAPSULE ER (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)

Preferred	Nonpreferred
	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 PM (ORAL)

ERYTHROPOIESIS STIMULATING PROTEINS section reviewed 6-18-2025

Preferred	Nonpreferred
ARANESP DISP SYRIN (INJECTION) ARANESP VIAL (INJECTION) EPOGEN (INJECTION) RETACRIT (INJECTION)	~~JESDUVROQ (ORAL)~~ MIRCERA (INJECTION) PROCRIT (INJECTION) REBLOZYL (SUBCUTANEOUS) RETACRIT (VIFOR) (INJECTION)

FLUOROQUINOLONES, ORAL section reviewed 6-18-2025

Preferred	Nonpreferred
CIPROFLOXACIN TABLET (ORAL) LEVOFLOXACIN SOLUTION (ORAL) LEVOFLOXACIN TABLET (ORAL)	BAXDELA (ORAL) CIPRO SUSPENSION (ORAL) CIPRO TABLET (ORAL) ~~CIPROFLOXACIN ER (ORAL)~~ CIPROFLOXACIN SUSPENSION (ORAL) MOXIFLOXACIN (ORAL) OFLOXACIN (ORAL)

NEUROPATHIC PAIN AND SELECT AGENTS section reviewed 6-18-2025 no change

Preferred	Nonpreferred
DULOXETINE (CYMBALTA GEN.) (ORAL) GABAPENTIN CAPSULE (ORAL) GABAPENTIN SOLUTION (ORAL) GABAPENTIN TABLET (ORAL) PREGABALIN CAPSULE (ORAL) SAVELLA (ORAL) SAVELLA DOSE PACK (ORAL)	CYMBALTA (ORAL) DRIZALMA SPRINKLE (ORAL) DULOXETINE (IRENKA) (ORAL) GRALISE (ORAL) HORIZANT (ORAL) LIDOCAINE (TOPICAL) LYRICA CAPSULE (ORAL) LYRICA CR (ORAL) LYRICA SOLUTION (ORAL) NEURONTIN CAPSULE (ORAL) NEURONTIN SOLUTION (ORAL) NEURONTIN TABLET (ORAL) PREGABALIN ER (ORAL) PREGABALIN SOLUTION (ORAL) QUTENZA KIT (TOPICAL) ZTLIDO (TOPICAL)