DEPARTMENT OF HUMAN SERVICES

Discussion Items

MHCP Enrolled Providers – Pharmacies

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

(December 2025)

Drug	**Zelsuvmi™ (berdazimer) [**LNHC, Inc.**]**
Therapeutic Area	Keratolytics

Approval criteria:

- The patient has a diagnosis of molluscum contagiosum (MC) AND
- The patient's age is within FDA labeling for the requested indication for the requested agent AND
- The prescriber is a specialist in the area of the patient's diagnosis (e.g., dermatologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis AND
- The patient will NOT be using the requested agent in combination with another conventional therapy (e.g., cantharidin, cryotherapy, curettage, podofilox) for the requested indication AND
- The patient does NOT have any FDA labeled contraindications to the requested agent AND
- The patient has ONE of the following:
    - Tried and had an inadequate response to ONE conventional therapy (e.g.,cantharidin, cryotherapy, curettage, podofilox) OR
    - An intolerance or hypersensitivity to ONE conventional therapy OR
    - An FDA labeled contraindication to ALL conventional therapy AND

Quantity limits

- 1 carton per 4 weeks for 12 weeks

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(December 2025)

Drug	**Sephience™ (sepiapterin) [**PTC Therapeutics, Inc.**]**
Therapeutic Area	Phenylketonuria

Initial approval criteria:

- Age ≥ 1 month; **AND**
- Diagnosis of phenylketonuria (PKU); **AND**
- Phenylalanine (Phe) levels cannot be maintained within the recommended maintenance range with dietary intervention (Phe restriction); **AND**
- Phe-restricted diet will continue during treatment with Sephience; **AND**
- Prescriber has obtained blood Phe levels at baseline and will continue to monitor as clinically appropriate; **AND**
- Patient has tried and had an inadequate response to generic sapropterin despite monitored adherence to treatment; **OR**
- Patient has an intolerance or hypersensitivity to generic sapropterin that is not expected to occur with Sephience; **OR**
- Patient has an FDA labeled contraindication to generic sapropterin that is not expected to occur with Sephience; **AND**
- Patient will NOT use Sephience in combination with another targeted agent for PKU (e.g., sapropterin [Kuvan, Javygtor], pegvaliase-pqpz [Palynziq]); **AND**
- The prescriber is a specialist in the area of the patient's diagnosis (e.g., metabolic disorders) or the prescriber has consulted with a specialist in the area of the patient's diagnosis.
- Initial approval:
    - 2 months if initial dose is 7.5 mg/kg/day to < 60 mg/kg/day
    - 1 month if initial dose is 60 mg/kg/day

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient must have disease improvement and/or stabilization (e.g., blood Phe levels within an acceptable range, decrease in blood Phe levels from baseline); AND
- Patient has not experienced any treatment-restricting adverse effects (e.g., active bleeding).
- Renewal approval is for 12 months

Quantity limits

- Max dose 60 mg/kg/day
- Patient's weight (in kg) must be submitted at time of request
- When a combination of the two Sephience strengths must be prescribed, the prescriber must provide:
    - Attestation that two separate prescriptions for two Sephience strengths will be issued AND
    - The requested quantity, number of refill(s), and directions for use for each Sephience strength on the prior authorization request form AND
    - Attestation that when patient becomes stabilized on one Sephience strength, reasonable efforts will be taken to ensure that the other Sephience strength will be used up to minimize waste

Background

Sephience is a phenylalanine hydroxylase (PAH) activator indicated for the treatment of hyperphenylalaninemia (HPA) in adult and pediatric patients 1 month of age and older with sepiapterin-responsive phenylketonuria (PKU). Sephience is to be used in conjunction with a phenylalanine (Phe)- restricted diet.

MHCP Enrolled Providers – Pharmacies

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

(December 2025)

Drug	**Orlynvah™ (sulopenem etzadroxil and probenecid) [**Iterum Therapeutics plc**]**
Therapeutic Area	Cephalosporins and Related Antibiotics

Approval criteria:

- The patient's age is within FDA labeling for the requested indication for the requested agent AND
- Diagnosis of uncomplicated urinary tract infection (uUTI) based on signs and symptoms attributable to uUTI (e.g., urinary frequency, urinary urgency, pain or burning on micturition, suprapubic pain); AND
- Infection is proven or strongly suspected to be caused by at least one of the following organisms: *Escherichia coli, Klebsiella pneumoniae* or *Proteus mirabilis*; AND
- Patient has tried and had an inadequate response or contraindication or intolerance to first-line therapy or alternatives (e.g., nitrofurantoin, trimethoprim/sulfamethoxazole, fosfomycin, amoxicillin/clavulanic acid, ciprofloxacin, levofloxacin); AND
- Orlynvah will NOT be used for complicated urinary tract infections (cUTI) or as step-down treatment after intravenous (IV) antibacterial treatment of cUTI; AND
- Orlynvah will NOT be used for complicated intra-abdominal infections (cIAI) or as step-down treatment after IV antibacterial treatment of cIAI; AND
- Patient does NOT have history of uric acid kidney stones; AND
- Patient does NOT have history of blood dyscrasias; AND
- Patient is NOT on concomitant ketorolac tromethamine therapy and will not receive ketorolac tromethamine while on Orlynvah; AND
- Patient does NOT have a history of hypersensitivity (e.g., angioedema, anaphylaxis, serious skin reactions) to beta-lactams, probenecid or any component of the product; AND
- Prescriber has reviewed Orlynvah Warnings/Precautions and Drug Interactions and will monitor patient status as appropriate.

Quantity limits

- 10 tablets per 5-day course and may not be renewed

Background

Orlynvah, a combination of sulopenem etzadroxil, a penem antibacterial, and probenecid, a renal tubular transport inhibitor, is indicated for the treatment of uncomplicated urinary tract infections (uUTI) caused by the designated microorganisms *Escherichia coli, Klebsiella pneumoniae,* or *Proteus mirabilis* in patients who have limited or no alternative oral antibacterial treatment options.

Orlynvah is NOT indicated for the treatment of:

- Complicated urinary tract infections (cUTI) or as step-down treatment after intravenous antibacterial treatment of cUTI.
- Complicated intra-abdominal infections (cIAI) or as step-down treatment after intravenous antibacterial treatment of cIAI.

To reduce the development of drug-resistant bacteria and maintain the effectiveness of Orlynvah and other antibacterial drugs, Orlynvah should be used only to treat uUTI that are proven or strongly suspected to be caused by susceptible bacteria. Culture and susceptibility information should be utilized in selecting or modifying antibacterial therapy.

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(December 2025)

Drug	**Brinsupri™ (brensocatib) [**Insmed Incorporated**]**
Therapeutic Area	DPP1 inhibitor

Initial approval criteria:

- Age ≥ 12 years; AND
- Patient has a diagnosis of bronchiectasis and ALL of the following:
    - Patient has a clinical history consistent with bronchiectasis (e.g., cough, chronic sputum production, recurrent respiratory infections); AND
    - Patient has had computed tomography (CT) to confirm the diagnosis of bronchiectasis; AND
    - Patient does NOT have cystic fibrosis, primary or secondary immunodeficiency, non-tuberculous mycobacterial (NTM) disease, allergic bronchopulmonary aspergillosis (ABPA) or tuberculosis; AND
    - Patient has had at least two pulmonary exacerbations that required an antibiotic prescription within the last 12 months; AND
- The prescriber is a specialist in the area of the patient's diagnosis (e.g., pulmonologist) 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 treatment (e.g., reduced rate of pulmonary exacerbations); AND
- Patient has NOT experienced any treatment-restricting adverse effects.

Quantity limits

- 30 tablets per 30 days

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(December 2025)

Drug	**Casgevy® (exagamglogene autotemcel) [**Vertex Pharmaceuticals Inc.**]**
Therapeutic Area	Sickle Cell Disease (SCD) and Transfusion-Dependent Beta-Thalassemia (TDT)

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 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

Transfusion-Dependent Beta-Thalassemia (TDT)
Approval criteria:

- Patient is at least twelve (12) years of age; 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 TDT [e.g., Zynteglo® (betibeglogene autotemcel)]; AND
- Patient is a candidate for autologous HSCT and has not had prior HSCT; AND
    - Patient has a confirmed diagnosis of beta-thalassemia (including hemoglobin E beta thalassemia) with confirmatory genetic testing; OR
    - Patient has severe microcytic hypochromic anemia, absence of iron deficiency, anisopoikilocytosis with nucleated red blood cells on peripheral blood smear, and hemoglobin analysis that reveals decreased amounts or complete absence of hemoglobin A (HbA) and increased HbA2 with or without increased amounts of hemoglobin F (HbF);
- Patient has transfusion-dependent beta-thalassemia disease defined as a history of transfusions of ≥ 100 mL/kg/year or ≥10 units/year of packed red blood cells (pRBCs) in the 2 years preceding therapy; AND
- Patient will be transfused prior to achieving a total Hb ≥ 11 g/dL for 60 days prior to myeloablative conditioning; AND
- Patient must NOT have any of the following:
    - Severely elevated iron in the heart (e.g., patients with cardiac T2* < 10 msec by magnetic resonance imaging [MRI] or left ventricular ejection fraction [LVEF] < 45% by echocardiogram); **OR**
    - Advanced liver disease (e.g., aspartate transaminase [AST] or alanine transaminase [ALT] > 3 times the upper limit of normal [ULN], or direct bilirubin value > 2.5 times the ULN, or if a liver biopsy demonstrated bridging fibrosis or cirrhosis).
- Casgevy is prescribed in consultation with a board-certified hematologist with TDT expertise

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:

- Casgevy must be billed as a professional claim

Provider Call Center (844) 575-7887

Consent Agenda Items:

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Antimigraine Agents, Other - DRAFT

(December 2025)

Please refer to the Preferred Drug List for the preferred and non-preferred status of drugs.

- **All agents require prior authorization**
- For Vyepti, coverage may be provided if members meet the prior authorization (PA) criteria for "Vyepti"
- For all other drugs, coverage may be provided if members meet PA criteria below

Initial approval criteria:

Preventive treatment of migraine

Criteria for preferred drugs

- The requested drug is FDA-approved for the preventive treatment of migraine AND
- The requested drug is not used in combination with botulinum toxins unless the combination therapy is FDA-approved
- Patient must meet the age limit indicated in the FDA-approved label of the requested drug AND
- Requested drug is prescribed by, or in consultation with a specialist (including neurologist or pain specialist) AND
- Patient has a diagnosis of migraine with or without aura based on International Classification of Headache Disorders (ICHD-III) diagnostic criteria AND
- Patient has tried and failed a ≥ 1 month trial of any 2 of the following oral medications:
    - Antidepressants (e.g., amitriptyline, venlafaxine)
    - Beta blockers (e.g., propranolol, metoprolol, timolol, atenolol)
    - Anti-epileptics (e.g., valproate, topiramate)
    - Angiotensin converting enzyme inhibitors/angiotensin II receptor blockers (e.g., lisinopril, candesartan)
- Initial approval is for 3 months

Criteria for nonpreferred drugs

- Patient must meet all initial approval criteria for preferred drug AND
- Patient has tried and failed a 3-month trial of the preferred drug, unless contraindicated
- Initial approval is for 3 months

Acute treatment of migraine

Criteria for preferred drugs

- The requested drug is FDA-approve for the acute treatment of migraine AND
- Patient must meet the age limit indicated in the FDA-approved label of the requested drug AND
- Requested drug is prescribed by, or in consultation with a specialist (including neurologist or pain specialist) AND
- Patient has a diagnosis of migraine with or without aura based on International Classification of Headache Disorders (ICHD-III) diagnostic criteria AND
- Patient has tried and failed a ≥ 1 month trial of any 2 triptans
- Initial approval is for 3 months

Criteria for nonpreferred drugs

- Patient must meet all initial approval criteria for preferred drug AND
- Patient has tried and failed a 3-month trial of the preferred drug, unless contraindicated
- Initial approval is for 3 months

Treatment of episodic cluster headache

- The requested drug is FDA-approve for the treatment of episodic cluster headache AND
- Patient must meet the age limit indicated in the FDA-approved label of the requested drug AND
- Requested drug is prescribed by, or in consultation with a specialist (including neurologist or pain specialist) AND
- Patient has a diagnosis of episodic cluster headaches based on International Classification of Headache Disorders (ICHD-III) diagnostic criteria as documented in patient chart notes; AND
- Patient has at least 5 attacks occurring in bouts (cluster periods) that meet the following criteria:

    - Severe or very severe unilateral orbital, supraorbital, and/or temporal pain lasting 15 to 180 minutes when untreated; during part (but less than half) of the active time course of cluster headache, attacks may be less severe and/or of shorter or longer duration AND
    - Either or both of the following:
        - At least one of the following symptoms or signs ipsilateral to the headache
            - Conjunctival injection and/or lacrimation OR
            - Nasal congestion and/or rhinorrhea OR
            - Eyelid edema OR
            - Forehead and facial swelling OR
            - Miosis and/or ptosis OR
        - A sense of restlessness or agitation AND
    - Attacks have a frequency between 1 every other day to 8 every day; during part (but less than half) of the active time-course of cluster headache, attacks may be less frequent; AND
- Patient has experienced at least two cluster periods lasting from 7 days to 365 days, separated by pain-free periods lasting at least 3 months; AND
- Medication overuse has been ruled out by trial and failure of titrating off treatments in the past AND
- Patient has tried and failed a ≥ 1 month trial of the following oral medications:
    - Verapamil (maximum total daily dose of 480mg to 960mg, unless contraindicated or maximum daily dose cannot be reached due to intolerance) AND
    - Topiramate (maximum total daily dose of 100mg, unless contraindicated or maximum daily dose cannot be reached due to intolerance)
- Initial approval is for 3 months

Renewal criteria for all FDA-approved indications:

- Patient demonstrated significant decrease in the number, frequency, and/or intensity of headaches AND
- Patient has an overall improvement in function with therapy AND
- Has not reached the end of the cluster period, if for cluster headaches AND
- Absence of unacceptable toxicity (e.g., intolerable injection site pain)
- Renewal approval is for 12 months

Quantity limits

- Quantity limits pursuant to the FDA-approved label will apply.

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Weight Management Agents - DRAFT

(December 2025)

Please refer to the Preferred Drug List for the preferred and non-preferred status of drugs.

- All drugs require prior authorization
- For drugs with a FDA-approved indication for weight loss that are being requested for weight loss purposes, coverage may be provided if members meet the prior authorization (PA) criteria for "Anti-Obesity Medications"
- For agents with other FDA-approved indications that are not being requested for weight loss purposes, coverage may be provided if members meet PA criteria below

Initial and renewal approval criteria (up to 12 months):

Reduce risk of major adverse cardiovascular events (MACE)

- The requested drug is FDA approved for MACE; **AND**
- Diagnosis of obesity or overweight; **AND**
- Patient must meet the age limit indicated in the FDA-approved label of the requested drug

AND

(one of the following)

  - Documentation of initiation of or ongoing reduced calorie diet; **OR**
  - Documentation of ongoing care of a registered dietitian nutritionist;

AND

- Documentation of initiation of or ongoing regimen of increased physical activity unless medically contraindicated by co-morbidity; **AND**
- No concurrent use of any other GLP-1 receptor agonist; **AND**
- Diagnosis of established cardiovascular (CV) disease; **AND**
- Documentation of management of CV risk factors; **AND**
- Requested agent is prescribed by or in consultation with a cardiologist

Treat noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH)

- The requested drug is FDA approved for MASH; **AND**
- Patient must meet the age limit indicated in the FDA-approved label of the requested drug

AND

(one of the following)

  - Documentation of initiation of or ongoing reduced calorie diet; **OR**
  - Documentation of ongoing care of a registered dietitian nutritionist;

AND

- Documentation of initiation of or ongoing regimen of increased physical activity unless medically contraindicated by co-morbidity; **AND**
- No contraindications (disease state or current therapy) should exist unless the prescriber documents that benefits outweigh risks; **AND**
- No concurrent use of any other GLP-1 receptor agonist; **AND**
- Diagnosis of noncirrhotic metabolic dysfunction-associated steatohepatitis (MASH); **AND**
- Moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis); **AND**
- Requested agent is prescribed by on in consultation with a gastroenterologist or hepatologist

Treat moderate to severe obstructive sleep apnea (OSA)

- The requested drug is FDA approved for OSA; **AND**
- Diagnosis of obesity; **AND**
- Patient must meet the age limit indicated in the FDA-approved label of the requested drug; **AND**

AND

(one of the following)

  - Documentation of initiation of or ongoing reduced calorie diet; **OR**
  - Documentation of ongoing care of a registered dietitian nutritionist;

AND

- Documentation of initiation of or ongoing regimen of increased physical activity unless medically contraindicated by co-morbidity; **AND**
- No concurrent use of any other GLP-1 receptor agonist; **AND**
- Diagnosis of moderate to severe obstructive sleep apnea (OSA); **AND**
- Requested agent is prescribed by a sleep specialist, pulmonologist, ENT specialist, or cardiologist

Quantity limits

- Quantity limits pursuant to the FDA-approved label will apply.

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(December 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

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Consent Agenda Items:

ANTICONVULSANTS, OTHER section reviewed 12-17-2025 no change

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

HEMOPHILIA TREATMENTS section reviewed 12-17-2025

Preferred	Nonpreferred
ADVATE (INTRAVEN.)	NONE
ADYNOVATE (INTRAVEN)	
AFSTYLA (INTRAVEN)	
ALPHANATE (INTRAVEN.)	
ALPHANINE SD (INTRAVEN.)	
ALPROLIX (INTRAVEN)	
BENEFIX KIT (INTRAVEN.)	
COAGADEX (INTRAVEN)	
CORIFACT KIT (INTRAVEN)	
ELOCTATE (INTRAVEN)	
ESPEROCT (INTRAVEN)	
FEIBA NF (INTRAVEN)	
HEMOFIL-M (INTRAVEN.)	
HUMATE-P KIT (INTRAVEN.)	
IDELVION (INTRAVEN)	
IXINITY (INTRAVEN)	
JIVI (INTRAVEN)	
KOATE-DVI KIT (INTRAVEN.)	
KOATE-DVI VIAL (INTRAVEN)	
KOGENATE FS (INTRAVEN.)	
KOVALTRY (INTRAVEN.)	
~~MONONINE KIT (INTRAVEN)~~	
NOVOEIGHT (INTRAVEN)	
NOVOSEVEN RT (INTRAVEN)	
NUWIQ (INTRAVEN)	
OBIZUR (INTRAVEN)	
PROFILNINE SD (INTRAVEN)	
REBINYN (INTRAVEN)	
RECOMBINATE (INTRAVEN.)	
RIXUBIS (INTRAVEN)	
SEVENFACT (INTRAVEN)	
TRETTEN (INTRAVEN)	
VONVENDI (INTRAVEN)	
WILATE (INTRAVEN)	
XYNTHA KIT (INTRAVEN)	
XYNTHA SOLOFUSE SYRINGE KIT (INTRAVEN.)	

HEPATITIS B AGENTS section reviewed 12-17-2025

Preferred	Nonpreferred
~~EPIVIR HBV SOLUTION (ORAL)~~	ADEFOVIR DIPIVOXIL (ORAL)
~~EPIVIR HBV TABLET (ORAL)~~	BARACLUDE TABLET (ORAL)

Preferred	Nonpreferred
BARACLUDE SOLUTION (ORAL) ENTECAVIR TABLET (ORAL) LAMIVUDINE HBV TABLET (ORAL) ~~HEPSERA (ORAL)~~	VEMLIDY (ORAL)

HEPATITIS C AGENTS section reviewed 12-17-2025

Preferred	Nonpreferred
MAVYRET PELLET PACK (ORAL) MAVYRET TABLET (ORAL) ~~PEGASYS PROCLICK (SUB-Q)~~ PEGASYS SYRINGE (SUB-Q) PEGASYS VIAL (SUBCUTANE.) RIBAVIRIN CAPSULE (ORAL) RIBAVIRIN TABLET (ORAL)	EPCLUSA PELLET PACK (ORAL) EPCLUSA TABLET (ORAL) HARVONI PELLET PACK (ORAL) HARVONI TABLET (ORAL) LEDIPASVIR/SOFOSBUVIR (AG) (ORAL) RIBAVIRIN DOSE PACK (ORAL) SOFOSBUVIR/VELPATASVIR (AG) (ORAL) SOVALDI PELLET PACK (ORAL) SOVALDI TABLET (ORAL) VOSEVI (ORAL) ZEPATIER (ORAL)

OTIC ANTIBIOTICS section reviewed 12-17-2025 no change

Preferred	Nonpreferred
CIPRO HC (OTIC) CIPROFLOXACIN/DEXAMETHASONE (OTIC) CIPROFLOXACIN/DEXAMETHASONE (AG) (OTIC) OFLOXACIN (OTIC) NEOMYCIN/POLYMYXIN/HC SOLN/SUSP (OTIC)	CIPROFLOXACIN (OTIC) CIPROFLOXACIN/FLUOCINOLONE (AG) (OTIC) CORTISPORIN-TC (OTIC)

PANCREATIC ENZYMES section reviewed 12-17-2025

Preferred	Nonpreferred
CREON (ORAL) ZENPEP (ORAL)	~~PANCREAZE (ORAL)~~ PERTZYE (ORAL) VIOKACE (ORAL)

PHOSPHATE BINDERS section reviewed 12-17-2025

Preferred	Nonpreferred
CALCIUM ACETATE CAPSULE (ORAL) CALCIUM ACETATE TABLET (ORAL) ~~RENVELA TABLET (ORAL)~~ SEVELAMER CARBONATE POWDER PACK (ORAL) SEVELAMER CARBONATE TABLET (ORAL)	AURYXIA (ORAL) FOSRENOL CHEWABLE TABLET (ORAL) FOSRENOL POWDER PACK (ORAL) LANTHANUM CARBONATE CHEWABLE TABLET (ORAL) RENVELA POWDER PACK (ORAL) RENVELA TABLET (ORAL) SEVELAMER HCL TABLET (ORAL) VELPHORO (ORAL) XPHOZAH TABLET (ORAL)

PLATELET AGGREGATION INHIBITORS section reviewed 12-17-2025

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

Preferred	Nonpreferred
PRASUGREL (ORAL) TICAGRELOR (ORAL)	PLAVIX (ORAL)

PROGESTINS FOR CACHEXIA section reviewed 12-17-2025 no change

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

PROTON PUMP INHIBITORS section reviewed 12-17-2025

Preferred	Nonpreferred
ESOMEPRAZOLE CAPSULES (ORAL) LANSOPRAZOLE CAPSULES (ORAL) NEXIUM SUSPENSION (ORAL) OMEPRAZOLE (ORAL) PANTOPRAZOLE (ORAL) * Prilosec OTC, Prevacid OTC, Zegerid OTC (omeprazole sodium bicarb) excluded from coverage	~~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) PREVACID SOLUTAB (ORAL) PRILOSEC SUSPENSION (ORAL) PROTONIX (ORAL) PROTONIX SUSPENSION (ORAL) RABEPRAZOLE TABLETS (ORAL) ~~ZEGERID (ORAL)~~

ULCERATIVE COLITIS AGENTS section reviewed 12-17-2025

Preferred	Nonpreferred
~~APRISO (ORAL)~~ BALSALAZIDE (ORAL) MESALAMINE (CANASA) (RECTAL) MESALAMINE (LIALDA) (ORAL) PENTASA (ORAL) ROWASA (RECTAL) SFROWASA (RECTAL) SULFASALAZINE (ORAL) SULFASALAZINE DR (ORAL)	AZULFIDINE TABLET (ORAL) AZULFIDINE TABLET DR (ORAL) BUDESONIDE (RECTAL) BUDESONIDE DR (ORAL) CANASA (RECTAL) ~~COLAZAL (ORAL)~~ DIPENTUM (ORAL) LIALDA (ORAL) MESALAMINE (ASACOL HD) (ORAL) MESALAMINE (DELZICOL) (ORAL) MESALAMINE (ROWASA) (RECTAL) MESALAMINE (SFROWASA) (RECTAL) MESALAMINE ER (APRISO) (ORAL) MESALAMINE ER (PENTASA) (ORAL) ~~UCERIS (ORAL)~~ ~~UCERIS (RECTAL)~~

Discussion Items

ACNE AGENTS, TOPICAL section reviewed 12-17-2025

Preferred	Nonpreferred
ADAPALENE GEL (TOPICAL)	ACANYA W/PUMP (TOPICAL)
ADAPALENE GEL OTC (TOPICAL)	ADAPALENE / BENZOYL PEROXIDE (EPIDUO) (TOPICAL)
BENZOYL PEROXIDE 10% WASH OTC (TOPICAL)	ADAPALENE CREAM (TOPICAL)
BENZOYL PEROXIDE 3% CLEANSER OTC (TOPICAL)	ADAPALENE GEL PUMP (TOPICAL)
BENZOYL PEROXIDE 5% WASH OTC (TOPICAL)	AKLIEF (TOPICAL)
BENZOYL PEROXIDE 6% CLEANSER OTC (TOPICAL)	ALTRENO (TOPICAL)
BENZOYL PEROXIDE 9% CLEANSER OTC (TOPICAL)	AMZEEQ (TOPICAL)
BENZOYL PEROXIDE GEL (TOPICAL)	ARAZLO (TOPICAL)
BENZOYL PEROXIDE LOTION OTC (TOPICAL)	ATRALIN (TOPICAL)
CLINDAMYCIN / BENZOYL PEROXIDE (BENZACLIN) (TOPICAL)	AVAR CLEANSER (TOPICAL)
	AVITA CREAM (TOPICAL)
CLINDAMYCIN / BENZOYL PEROXIDE (DUAC) (TOPICAL)	AVITA GEL (TOPICAL)
CLINDAMYCIN PHOSPHATE GEL (TOPICAL)	BENZOYL PEROXIDE CLEANSER OTC (TOPICAL)
CLINDAMYCIN PHOSPHATE LOTION (TOPICAL)	BENZOYL PEROXIDE FOAM OTC (TOPICAL)
CLINDAMYCIN PHOSPHATE MED. SWAB (TOPICAL)	BENZOYL PEROXIDE TOWELETTE OTC (TOPICAL)
CLINDAMYCIN PHOSPHATE SOLUTION (TOPICAL)	~~BP 10-1 (TOPICAL)~~
ERYTHROMYCIN GEL (TOPICAL)	CABTREO (TOPICAL)
ERYTHROMYCIN MED. SWAB (TOPICAL)	CLEOCIN T GEL (TOPICAL)
ERYTHROMYCIN SOLUTION (TOPICAL)	CLEOCIN LOTION (TOPICAL)
ERYTHROMYCIN-BENZOYL PEROXIDE (TOPICAL)	CLINDACIN PAC KIT
~~RETIN-A CREAM (TOPICAL)~~	CLINDAMYCIN / BENZOYL PEROXIDE (ACANYA) W/PUMP (TOPICAL)
~~RETIN-A GEL (TOPICAL)~~	
SULFACETAMIDE/SULFUR CLEANSER (TOPICAL)	CLINDAMYCIN / BENZOYL PEROXIDE (BENZACLIN) W/PUMP (TOPICAL)
SULFACETAMIDE SODIUM/SULFUR (TOPICAL)	
SULFACETAMIDE SUSPENSION (TOPICAL)	CLINDAMYCIN / BENZOYL PEROXIDE (ONEXTON) W/PUMP (TOPICAL)
TRETINOIN CREAM (TOPICAL)	
TRETINOIN GEL (AVITA, RETIN-A) (TOPICAL)	CLINDAMYCIN / TRETINOIN (TOPICAL)
	CLINDAMYCIN PHOSPHATE FOAM (TOPICAL)
	CLINDAMYCIN PHOSPHATE GEL (CLINDAGEL) (TOPICAL)
	DAPSONE GEL
	FABIOR (TOPICAL)
	NEUAC (TOPICAL)
	NEUAC KIT (TOPICAL)
	ONEXTON GEL (TOPICAL)
	ONEXTON W/PUMP (TOPICAL)
	~~OVACE PLUS CREAM ER (TOPICAL)~~
	~~OVACE PLUS SHAMPOO (TOPICAL)~~
	RETIN-A MICRO 0.04%, 0.1% (TOPICAL)
	RETIN-A MICRO 0.04%, 0.1% PUMP (TOPICAL)
	RETIN-A MICRO 0.06% PUMP (TOPICAL)
	RETIN-A MICRO 0.08% PUMP (TOPICAL)
	SULFACETAMIDE/SULFUR SUSPENSION (TOPICAL)
	TAZAROTENE CREAM (TOPICAL)
	TAZAROTENE FOAM (TOPICAL)
	TAZAROTENE GEL (TOPICAL)
	~~TRETINOIN CREAM (TOPICAL)~~
	~~TRETINOIN GEL (AVITA, RETIN-A) (TOPICAL)~~
	TRETINOIN GEL (ATRALIN) (TOPICAL)
	TRETINOIN MICROSPHERES GEL 0.04%, 0.1% (TOPICAL)

Preferred	Nonpreferred
	TRETINOIN MICROSPHERES GEL 0.04%, 0.08%, 0.1% PUMP (TOPICAL) WINLEVI (TOPICAL) ZIANA (TOPICAL)

ANTICONVULSANTS section reviewed 12-17-2025

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

Preferred	Nonpreferred
	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) 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)

BONE RESORPTION SUPPRESSION AND RELATED AGENTS section reviewed 12-17-2025

Preferred	Nonpreferred
ALENDRONATE SOLUTION (ORAL) ALENDRONATE TABLETS (ORAL) CALCITONIN SALMON (NASAL) FORTEO (SUBCUTANEOUS) IBANDRONATE TABLETS (ORAL) MIACALCIN (NASAL) RALOXIFENE (ORAL)	ACTONEL (ORAL) ATELVIA (ORAL) BILDYOS (SUBCUTANE.) BILPREVDA (SUBCUTANE.) BOMYNTRA (SUBCUTANE.) BINOSTO (ORAL) BONSITY (SUBCUTANE.) CONEXXENCE (SUBCUTANE.) EVENITY (SUBCUTANEOUS) EVISTA (ORAL) ~~FORTICAL (NASAL)~~ FOSAMAX (ORAL) FOSAMAX PLUS D (ORAL) JUBBONTI (SUBCUTANE.) OSENVELT (SUBCUTANE.) PROLIA (SUBCUTANE.) RISEDRONATE (ACTONEL) (ORAL) RISEDRONATE (ATELVIA) (ORAL) STOBOCLO (SUBCUTANE.) TERIPARATIDE (SUBCUTANEOUS) TYMLOS (SUBCUTANE.)

Preferred	Nonpreferred
	WYOST (SUBCUTANE.) XGEVA (SUBCUTANE.)

CYTOKINE AND CAM ANTAGONISTS section reviewed 12-17-2025

Preferred	Nonpreferred
ADALIMUMAB-ADBM SYRINGE (SUBCUTANE.) ADALIMUMAB ADBM PEN (SUBCUTANE.) CYLTEZO SYRINGE (SUBCUTANE.) CYLTEZO PEN (SUBCUTANE.) ENBREL KIT (INJECTION) ENBREL MINI CARTRIDGE (SUBCUTANE.) ENBREL PEN (INJECTION) ENBREL SYRINGE (INJECTION) ENBREL VIAL (SUBCUTANE.) ~~HUMIRA KIT (INJECTION)~~ ~~HUMIRA PEN KIT (INJECTION)~~ INFLIXIMAB (INJECTION) OTEZLA (ORAL) PYZCHIVA VIAL (SUBCUTANE.) PYZCHIVA SYRINGE (SUBCUTANEOUS) PYZCHIVA VIAL (INTRAVENOUS) STEQEYMA SYRINGE (SUBCUTANE.) STEQEYMA VIAL (INTRAVENOUS) XELJANZ (ORAL) YESINTEK SYRINGE (SUBCUTANE.) YESINTEK VIAL (SUBCUTANE.)	ABRILADA SYRINGE (SUBCUTANE.) ABRILADA PEN (SUBCUTANE.) ACTEMRA PEN (SUBCUTANE.) ACTEMRA SYRINGE (SUBCUTANE.) ACTEMRA VIAL (INJECTION) ADALIMUMAB-AACF PEN (SUBCUTANE.) ADALIMUMAB-AACF SYRINGE (SUBCUTANE.) ADALIMUMAB-AATY PEN (SUBCUTANE.) ADALIMUMAB-AATY SYRINGE (SUBCUTANE.) ADALIMUMAB-ADAZ SYRINGE (SUBCUTANE.) ADALIMUMAB-ADAZ PEN (SUBCUTANE.) ~~ADALIMUMAB-ADBM SYRINGE (SUBCUTANE.)~~ ~~ADALIMUMAB ADBM PEN (SUBCUTANE.)~~ ADALIMUMAB-ADBM SYRINGE (QUALLENT)(SUBCUTANE.) ADALIMUMAB ADBM PEN (QUALLENT)(SUBCUTANE.) ADALIMUMAB-FKJP SYRINGE (SUBCUTANE.) ADALIMUMAB-FKJP PEN (SUBCUTANE.) ADALIMUMAB-RYVK AUTOINJECT (SUBCUTANE.) AMJEVITA SYRINGE (SUBCUTANE.) AMJEVITA AUTOINJECTOR (SUBCUTANE.) ARCALYST (SUBCUTANE.) AVSOLA (INJECTION) AVTOZMA (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.) HUMIRA KIT (INJECTION) HUMIRA PEN KIT (INJECTION) HYRIMOZ SYRINGE(SUBCUTANE.) HYRIMOZ PEN (SUBCUTANE.) IDACIO SYRINGE (SUBCUTANE.) IDACIO PEN (SUBCUTANE.) ILARIS (SUBCUTANE.)

Preferred	Nonpreferred
	ILUMYA SYRINGE (SUBCUTANE.) IMULDOSA SYRINGE (SUBCUTANE.) IMULDOSA VIAL (INTRAVENOUS) INFLECTRA VIAL (INTRAVEN.) KEVZARA (SUBCUTANE.) KINERET (INJECTION) OLUMIANT (ORAL) OMVOH PEN (SUBCUTANE.) OMVOH SYRINGE (SUBCUTANE.) OMVOH VIAL (INJECTION) ORENCIA CLICKJECT (SUBCUTANE.) ORENCIA SYRINGE (SUBCUTANE.) ORENCIA VIAL (INJECTION) OTEZLA XR (ORAL) OTULFI SYRINGE (SUBCUTANEOUS) OTULFI VIAL (INTRAVENOUS) REMICADE (INJECTION) RENFLEXIS (INTRAVEN.) RINVOQ ER (ORAL) RINVOQ LQ SOLUTION (ORAL) SELARSDI SYRINGE (SUBCUTANE.) SELARSDI VIAL (INTRAVENOUS) 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.) USTEKINUMAB SYRINGE (SUBCUTANE) USTEKINUMAB VIAL (INTRAVENOUS) USTEKINUMAB VIAL (SUBCUTANE) USTEKINUMAB-AEKN SYRINGE (SUBCUTANE.) USTEKINUMAB-TTWE VIAL (QUALLENT) (INTRAVENOUS) USTEKINUMAB-TTWE SYRINGE (QUALLENT) (SUBCUTANE.) VELSIPITY (ORAL)

Preferred	Nonpreferred
	WEZLANA SYRINGE (SUBCUTANE.) WEZLANA VIAL (INTRAVENOUS) WEZLANA VIAL (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.)

HAE TREATMENTS section reviewed 12-17-2025

Preferred	Nonpreferred
BERINERT (INTRAVEN) CINRYZE (INTRAVEN) ICATIBANT (SUB-Q)	ANDEMBRY (SUB-Q) DAWNZERA (SUB-Q) EKTERLY (ORAL) FIRAZYR (SUB-Q) HAEGARDA (SUB-Q) KALBITOR (SUB-Q) ORLADEYO (ORAL) RUCONEST (INTRAVEN) TAKHZYRO (SUB-Q)

HYPOGLYCEMICS, INCRETIN MIMETICS/ENHANCERS section reviewed 12-17-2025

Preferred	Nonpreferred
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) BRYNONIN (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) XULTOPHY (SUBCUTANE.) ZITUVIMET (ORAL) ZITUVIMET XR (ORAL) ZITUVIO (ORAL)

PAH AGENTS, ORAL AND INHALED section reviewed 12-17-2025

Preferred	Nonpreferred
AMBRISENTAN (ORAL)	ADCIRCA (ORAL)

Preferred	Nonpreferred
SILDENAFIL (ORAL) SILDENAFIL SUSPENSION (ORAL) SILDENAFIL SUSPENSION (AG) (ORAL) TRACLEER TABLET (ORAL)	ADEMPAS (ORAL) BOSENTAN (ORAL) LETAIRIS (ORAL) ~~LIQREV SUSPENSION (ORAL)~~ OPSUMIT (ORAL) OPSYNVI TABLET (ORAL) ORENITRAM ER (ORAL) ORENITRAM TITRATION KIT (ORAL) REVATIO SUSPENSION (ORAL) REVATIO TABLET (ORAL) TADLIQ SUSPENSION (ORAL) TADALAFIL (ADCIRCA) (ORAL) TRACLEER SUSPENSION (ORAL) TYVASO (INHALATION) TYVASO DPI (INHALATION) UPTRAVI (ORAL) UPTRAVI TABLET DOSE PACK (ORAL) YUTREPIA (INHALATION)

SEDATIVE HYPNOTICS section reviewed 12-17-2025

Preferred	Nonpreferred
BELSOMRA (ORAL) ESZOPICLONE (ORAL) ~~ROZEREM (ORAL)~~ RAMELTEON (ORAL) ZALEPLON (ORAL) ZOLPIDEM TABLET (ORAL)	AMBIEN (ORAL) AMBIEN CR (ORAL) ~~BELSOMRA (ORAL)~~ DAYVIGO (ORAL) DOXEPIN TABLET (ORAL) EDLUAR (SUBLINGUAL) HETLIOZ (ORAL) HETLIOZ LQ (ORAL) LUNESTA (ORAL) QUVIVIQ (ORAL) ~~RAMELTEON (ORAL)~~ ROZEREM (ORAL) TASIMELTEON (ORAL) ZOLPIDEM (SUBLINGUAL) ZOLPIDEM CAPSULE (ORAL) ZOLPIDEM ER (ORAL)

SICKLE CELL ANEMIA TREATMENTS section reviewed 12-17-2025

Preferred	Nonpreferred
ADAKVEO (INTRAVENOUS) DROXIA (ORAL) ENDARI (ORAL) ~~OXBRYTA (ORAL)~~	L-GLUTAMINE (ORAL) SIKLOS (ORAL) XROMI SOLUTION (ORAL)

STIMULANTS AND RELATED AGENTS section reviewed 12-17-2025

Preferred	Nonpreferred
AMPHETAMINE SALT COMBO (ORAL) AMPHETAMINE SALT COMBO ER (ORAL) ATOMOXETINE (ORAL) CLONIDINE ER (ORAL) DEXMETHYLPHENIDATE (ORAL)	ADDERALL XR (ORAL) ~~ADHANSIA XR (ORAL)~~ ADZENYS XR-ODT (ORAL) AMPHETAMINE ER ODT (ORAL) AMPHETAMINE SALT COMBO ER (MYDAYIS) (ORAL)

Preferred	Nonpreferred
DEXMETHYLPHENIDATE XR (ORAL)	AMPHETAMINE SULFATE (ORAL)
DEXTROAMPHETAMINE CAPSULE ER (ORAL)	AMPHETAMINE SUSPENSION ER (ORAL)
DEXTROAMPHETAMINE TABLET (ORAL)	APTENSIO XR (ORAL)
GUANFACINE ER (ORAL)	AZSTARYS (ORAL)
LISDEXAMFETAMINE CAPSULE (ORAL)	CONCERTA (ORAL)
METHYLIN SOLUTION (ORAL)	COTEMPLA XR ODT (ORAL)
METHYLPHENIDATE (ORAL)	DAYTRANA (TRANSDERMAL)
METHYLPHENIDATE SOLUTION (ORAL)	DEXTROAMPHETAMINE SOLUTION (ORAL)
METHYLPHENIDATE ER (CONCERTA) (ORAL)	DYANAVEL XR (ORAL)
METHYLPHENIDATE ER (METADATE ER) (ORAL)	EVEKEO (ORAL)
METHYLPHENIDATE ER (RITALIN LA) (ORAL)	EVEKEO ODT (ORAL)
~~RITALIN LA (ORAL)~~	FOCALIN (ORAL)
VYVANSE CAPSULE (ORAL)	FOCALIN XR (ORAL)
	INTUNIV (ORAL)
	JORNAY PM (ORAL)
	METHYLPHENIDATE CD (ORAL)
	METHYLPHENIDATE CHEWABLE TABLETS (ORAL)
	METHYLPHENIDATE ER (APTENSIO XR) (AG) (ORAL)
	METHYLPHENIDATE ER (RELEXXII) (ORAL)
	~~METHYLPHENIDATE ER (RITALIN LA) (ORAL)~~
	METHYLPHENIDATE ER 72 MG TABLETS (ORAL)
	METHYLPHENIDATE PATCH (DAYTRANA) (TRANSDERMAL)
	METHYLPHENIDATE SOLUTION (AG) (ORAL)
	MYDAYIS ER (ORAL)
	ONYDA XR SUSPENSION (ORAL)
	PROCENTRA (ORAL)
	QELBREE (ORAL)
	QUILLICHEW ER (ORAL)
	QUILLIVANT XR (ORAL)
	RELEXXII (ORAL)
	RITALIN (ORAL)
	STRATTERA (ORAL)
	VYVANSE CHEWABLE TABLET (ORAL)
	XELSTRYM (TRANSDERMAL)
	ZENZEDI (ORAL)