DEPARTMENT OF HUMAN SERVICES

Discussion Items

MHCP Enrolled Providers – Pharmacies

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

(July 2026)

Drug	**Forzinity™ (elamipretide) [**Stealth BioTherapeutics Inc.**]**
Therapeutic Area	Barth syndrome

Initial approval criteria:

- Adult or pediatric patient with weight ≥ 30 kg; AND
- Diagnosis of Barth syndrome confirmed by a pathogenic variant in the tafazzin (TAZ) gene; AND
- Patient has documented skeletal muscle weakness or functional impairment (e.g., reduced knee extensor muscle strength measured by handheld dynamometry, impaired 6-minute walk test [6MWT] score); AND
- Patient does NOT have a history of hypersensitivity to elamipretide or any of the excipients in Forzinity; AND
- Prescriber has reviewed Forzinity Warnings/Precautions and will monitor patient status as appropriate; AND
- Prescriber is a specialist in the area of diagnosis (e.g., cardiologist, neurologist, endocrinologist, hematologist, geneticist) or prescriber has consulted with a specialist in the area of diagnosis.
- Initial approval is for 6 months

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient must have disease improvement and/or stabilization (e.g., improvement or stabilization in knee extensor muscle strength measured by handheld dynamometry, improvement or maintenance of 6MWT score); AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., serious hypersensitivity reactions, including persistent or severe skin reactions).
- Renewal approval is for 12 months

Quantity limits

- Four vials (280 mg/3.5 mL) every 28 days
- Maximum dosage 40 mg daily

Background

Forzinity is a mitochondrial cardiolipin binder indicated to improve muscle strength in adult and pediatric patients with Barth syndrome weighing at least 30 kg. This indication is approved under accelerated approval based on an improvement in knee extensor muscle strength, an intermediate clinical endpoint. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(July 2026)

Drug	**Itvisma® (onasemnogene abeparvovec-brve) [**Novartis Pharmaceutical Corporation**]**
Therapeutic Area	Spinal Muscular Atrophy

Initial approval criteria:

- Patient must be ≥ 2 years of age; AND
- Patients has a diagnosis of spinal muscular atrophy (SMA); AND
- Patient has a diagnosis of 5q SMA confirmed by either bi-allelic deletion or dysfunctional point mutation of the *survival motor neuron 1 (SMN1)* gene; AND
- Patient must NOT have advanced disease (e.g., complete limb paralysis, permanent ventilation support); AND
    - Patient is treatment-naïve for any SMN-targeting agents for SMA (e.g., nusinersen [Spinraza], risdiplam [Evrysdi]) AND is able to sit independently but has never had the ability to walk independently; OR
    - Patient has received prior SMN-targeting agents for SMA (e.g., Spinraza, Evrysdi) AND has one or more of the following:
        - Able to sit independently, but has never had the ability to walk independently; OR
        - Has 3 or fewer copies of *SMN2* gene; OR
        - Achieved and subsequently lost the ability to walk independently; AND
- Will only be administered intrathecally using a lumbar puncture by healthcare professionals (e.g., interventional radiologist or neurologist) experienced in performing lumbar punctures; AND
- Patient is clinically stable in their overall baseline health status (e.g., hydration and nutritional status, respiratory status) prior to administration; AND
- Patient does NOT have an active infection, including clinically important localized infections; AND
- Patient must have a baseline anti-adeno-associated virus serotype 9 (anti-AAV9) antibody titer of ≤ 1:50 measured by ELISA; AND
- Baseline liver function will be assessed prior to initiating therapy and will continue to be monitored for at least 3 months after therapy and as clinically indicated; AND
- Baseline platelet counts will be assessed prior to initiating therapy and will continue to be monitored on a regular basis (e.g., at least weekly for the first month and as clinically indicated until platelet counts return to baseline); AND
- Patient is up to date with all vaccinations (including seasonal prophylaxis against respiratory syncytial virus [RSV]), in accordance with current vaccination guidelines, prior to initiating therapy; AND
- Used concomitantly with systemic corticosteroids; AND
- Patient will be considered for neurologic or cardiac evaluation based on clinical presentation; AND
- Patient must NOT have previously received treatment with SMA gene therapy (e.g., onasemnogene abeparvovec-xioi [Zolgensma]); AND
- Will NOT be used in combination with other SMN-targeting agents for SMA (e.g., Spinraza, Evrysdi, Zolgensma); AND
- Females of reproductive potential should have a negative pregnancy test prior to receiving Itvisma and should use effective contraception (methods that result in <1% pregnancy rates) and should refrain from egg donation for 6 months following Itvisma administration; AND
- Male patients with female partners of reproductive potential should use a barrier method of contraception and should refrain from sperm donation for 3 months following Itvisma administration.

Quantity limits

- One treatment course and may not be renewed

Billing for Itvisma

Itvisma must be billed as a professional claim

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(July 2026)

Drug	**Redemplo® (plozasiran) [**Arrowhead Pharmaceuticals, Inc.**]**
Therapeutic Area	Lipotropics, Other

Initial approval criteria:

- Age ≥ 18 years; AND
- Patient has a diagnosis of familial chylomicronemia syndrome (FCS) as confirmed by ONE of the following:
    - Genetic confirmation of biallelic pathogenic variants in affected genes (e.g., *lipoprotein lipase [LPL], apolipoprotein [APO]A5, APOC2, lipase maturation factor 1 [LMF1], glycosylphosphatidylinositol-anchored high-density lipoprotein-binding protein 1 [GPIHBP1], glycerol-3-phosphate dehydrogenase 1 [G3PDH1]*); OR
    - ALL of the following:
        - Fasting triglyceride (TG) levels ≥ 880 mg/dL for three consecutive measurements; AND
        - Secondary causes of hypertriglyceridemia have been ruled out (e.g., alcohol use, chronic kidney disease, hypothyroidism, uncontrolled diabetes, medications [e.g., atypical antipsychotics, beta-blockers, corticosteroids, oral estrogens]); AND
        - History of pancreatitis or unexplained recurrent abdominal pain; AND
        - No response (TG decrease < 20%) to conventional lipid lowering therapies (e.g., fibrates, omega-3 fatty acids, statins, niacin, ezetimibe, proprotein convertase subtilisin/kexin type 9 [PCSK9] inhibitors); AND
- The prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist, endocrinologist, geneticist, lipidologist), 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 must have disease improvement since starting Redemplo (e.g., improvement in TG levels, absence of acute pancreatitis); AND
- Patient has NOT experienced any treatment-restricting adverse effects.
- Renewal approval is for 12 months

Quantity limits

- 1 single-dose prefilled syringe (25 mg/0.5 mL) per 84 days
- Maximum dose: 25 mg every 3 months

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(July 2026)

Drug	**Voyxact® (sibeprenlimab) [**Otsuka America Pharmaceutical, Inc.**]**
Therapeutic Area	Primary immunoglobulin A nephropathy (IgAN)

Initial approval criteria:

- Age ≥ 18 years; AND
- Diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy; AND
- ONE of the following:
    - Patient has a urine protein-to-creatinine ratio (UPCR) ≥ 0.44 g/g; OR
    - Patient has proteinuria ≥ 0.5 g/day; AND
- Patient has an estimated glomerular filtration rate (eGFR) ≥ 30 mL/min/1.73 m^2; AND
- Patient does NOT have history of a hypersensitivity reaction to sibeprenlimab-szsi or any component of Voyxact; AND
- ONE of the following:
    - Patient is taking a maximally tolerated angiotensin-converting enzyme inhibitor (ACEI) (e.g., benazepril, lisinopril) or angiotensin II receptor blocker (ARB) (e.g., losartan) or a combination medication containing an ACEI or ARB for at least a 90-day duration of therapy AND patient will continue maximally tolerated ACEI or ARB, or combination medication containing an ACEI or ARB, in combination with Voyxact; OR
    - Patient has intolerance, hypersensitivity or FDA-labeled contraindication to all ACEIs or ARBs, or combination medications containing an ACEI or ARB; AND
- The prescriber is a specialist in the area of the patient's diagnosis (e.g., nephrologist) or the prescriber has consulted with a specialist in the area of the patient's diagnosis; AND
- Prescriber has reviewed Voyxact Warnings/Precautions and will monitor patient status as appropriate.
- Initial approval is for 9 months

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient must have disease improvement and/or stabilization as indicated by ONE of the following:
    - Decrease from baseline (prior to treatment with Voyxact) of UPCR ratio; OR
    - Decrease from baseline (prior to treatment with Voyxact) in proteinuria; AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., serious infections).
- Renewal approval is for 12 months

Quantity limits

- One 400 mg/2 mL prefilled syringe/28 days
- Max dose 400 mg every 4 weeks

Background

Voyxact is an A Proliferation Inducing Ligand (APRIL) blocker, indicated to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk for disease progression. This indication is approved under accelerated approval based on reduction of proteinuria. It has not been established whether Voyxact slows kidney function decline over the long-term in patients with IgAN. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory clinical trial.

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(July 2026)

Drug	**Aqvesme™ (mitapivat) [**Agios Pharmaceuticals, Inc.**]**
Therapeutic Area	Anemia with alpha- or beta-thalassemia

Initial approval criteria:

- Patient is ≥ 18 years of age; AND
- The patient has ONE of the following:
    - A diagnosis of anemia with alpha-thalassemia with genetic testing confirming alpha-thalassemia; OR
    - A diagnosis of anemia with beta-thalassemia and ONE of the following:
        - Hemoglobin analysis showing beta-thalassemia; OR
        - Genetic testing confirming beta-thalassemia; AND
- The patient has ONE of the following:
    - Transfusion-dependent thalassemia (6 or more red blood cell [RBC] units transfused per 24 weeks); OR
    - BOTH of the following:
        - Non-transfusion-dependent thalassemia (no more than 5 RBC units per 24 weeks); AND
        - Hemoglobin ≤ 10 g/dL; AND
- Iron deficiency anemia has been ruled out; AND
- Patient does NOT have cirrhosis (Child-Pugh Class A, B, or C); AND
- Prescriber has evaluated liver laboratory tests (alanine transaminase [ALT], aspartate transferase [AST], alkaline phosphatase and total bilirubin with fractionation) at baseline and will assess every 4 weeks for 24 weeks and then as clinically indicated; AND
- Prescriber attestation that Aqvesme will be discontinued if hepatocellular injury is suspected; AND
- Prescriber has reviewed Aqvesme Drug Interactions and will monitor patient status as appropriate; AND
- The prescriber is a specialist in the area of the patient's diagnosis (e.g., hematologist), 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 must have improvement in hemolytic anemia and/or stabilization OR improvement in the slope of decline based on the totality of laboratory results and clinical status of the patient, unless there is another explanation for response failure (e.g., bleeding, surgery, other concomitant illnesses); AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., hepatocellular injury).

Quantity limits

- One 28-day pack per 28 days
- Maximum dose:100 mg twice daily

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(July 2026)

Drug	**Myqorzo™ (aficamten) [**Cytokinetics, Inc.**]**
Therapeutic Area	Cardiovascular, Other

Initial approval criteria:

- Age ≥ 18 years; AND
- Diagnosis of symptomatic obstructive hypertrophic cardiomyopathy (oHCM) AND ALL of the following:
    - Left ventricular ejection fraction (LVEF) ≥ 55%; AND
    - No known infiltrative or storage disorder causing cardiac hypertrophy that mimics oHCM (e.g., Fabry disease, amyloidosis, Noonan syndrome with left ventricular hypertrophy); AND
- ONE of the following:
    - The patient has ONE of the following:
        - Tried and had an inadequate response to ONE beta blocker; OR
        - An intolerance or hypersensitivity to ONE beta blocker; OR
        - An FDA labeled contraindication to ALL beta blockers; OR
    - The patient has ONE of the following:
        - Tried and had an inadequate response to ONE calcium channel blocker (CCB); OR
        - An intolerance or hypersensitivity to ONE CCB; OR
        - An FDA labeled contraindication to ALL CCBs; AND
- Echocardiogram assessments will be performed before initiation and during treatment with Myqorzo (e.g., two to eight weeks after initiation of treatment, dose adjustment or initiation/discontinuation of moderate/strong cytochrome P450 [CYP] 3A inducers/inhibitors, every three months [LVEF ≥ 50% to < 55%] to six months [LVEF ≥ 55%] after maintenance dose is established) to monitor for systolic dysfunction; AND
- Patient is NOT on concomitant treatment with rifampin; AND
- Prescriber has reviewed Myqorzo Warnings/Precautions and Drug Interactions will monitor patient status as appropriate; AND
- Prescriber is a specialist in the area of the patient's diagnosis (e.g., cardiologist) 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 Myqorzo; AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., LVEF < 40%, heart failure symptoms or worsening clinical status due to systolic dysfunction).

Quantity limits

- 34 tablets per 34 days
- Maximum dosage: 20 mg once daily

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(July 2026)

Drug	**Veopoz® (pozelimab-bbfg) [**Regeneron Pharmaceuticals, Inc..**]**
Therapeutic Area	CHAPLE disease

Initial approval criteria:
Patient is at least 1 year of age; AND

Universal Criteria

- Patients must be administered a meningococcal vaccine (for serogroups A, C, W and Y, and serogroup B) according to current ACIP recommendations at least two weeks prior to initiation of therapy and will continue to be revaccinated in accordance with ACIP recommendations (If urgent Veopoz therapy is indicated in a patient who is not up-to-date with meningococcal vaccines according to ACIP recommendations, administer meningococcal vaccine(s) as soon as possible and provide patients with antibacterial drug prophylaxis); AND
- Patient must be administered vaccinations for the prevention of Streptococcus pneumoniae and Haemophilus influenzae type b (Hib) infections according to ACIP guidelines; AND
- Will not be used in combination with other complement therapies; AND
- Patient does not have an unresolved Neisseria meningitidis infection; AND
- Patient will avoid concomitant therapy with intravenous immunoglobulin, if therapy is unavoidable, the patient will be monitored closely for adverse reactions and/or worsening of disease symptoms; AND

Complement Hyperactivation, Angiopathic thrombosis, and Protein-Losing Enteropathy Disease (CHAPLE)

- Patient has a confirmed clinical diagnosis of CD55-deficient protein-losing enteropathy (PLE) evidenced by biallelic CD55 loss-of-function mutation detected by genotype analysis; AND
- Patient has active disease as defined as hypoalbuminemia (serum albumin concentration of ≤3.2 g/dL) with one or more of the following signs or symptoms attributed to CD55-deficient PLE within the last six months:
    - Abdominal pain
    - Diarrhea
    - Peripheral edema
    - Facial edema

Renewal criteria:
- Patient continues to meet the universal and other indication-specific relevant criteria identified in section III; AND
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include: serious meningococcal infections (septicemia and/or meningitis), other serious bacterial infections, serious hypersensitivity reactions, etc.; AND
- Patient exhibits disease response compared to pretreatment baseline in ALL of the following: Normalization/improvement in serum proteins (e.g., albumin, or immunoglobulin G, etc.); AND
- Stabilization/improvement in signs and symptoms of disease; AND
- Reduction in albumin transfusion requirements, exogenous immunoglobulin, and/or hospitalization (as applicable)

Quantity limits
- Loading dose: 30 mg/kg by intravenous infusion
- Maintenance dose:10 mg/kg by subcutaneous injection once weekly starting on Day 8
- Patient’s weight (in kg) must be submitted at time of request

Billing for Veopoz
Veopoz must be billed as a professional claim

Provider Call Center (844) 575-7887

Discussion Items

ANTIDEPRESSANTS, OTHER section reviewed 7-15-2026

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

ANTIDEPRESSANTS, SSRIs section reviewed 7-15-2026

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

ANTIMIGRAINE AGENTS, OTHER section reviewed 7-15-2026

Preferred	Nonpreferred
AIMOVIG (SUBCUTANE.)	BREKIYA AUTOINJECTOR (SUBCUTANE.)
AJOVY (SUBCUTANE.)	ELYXYB SOLUTION (ORAL)

Preferred	Nonpreferred
AJOVY AUTOINJECTOR (SUBCUTANE.)	NURTEC ODT (ORAL)
AJOVY AUTOINJECTOR 3-PK (SUBCUTANE.)	~~QULIPTA (ORAL)~~
EMGALITY 120 MG/ML (PEN) (SUBCUTANE.)	REYVOW (ORAL)
EMGALITY 120 MG/ML (SYRINGE) (SUBCUTANE.)	VYEPTI (INTRAVENOUS)
QULIPTA (ORAL)	ZAVZPRET (NASAL)
UBRELVY (ORAL)	

ANTIMIGRAINE AGENTS, TRIPTANS section reviewed 7-15-2026

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

ANTIPSYCHOTICS section reviewed 7-15-2026

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)	BYSANTI (ORAL)
INVEGA SUSTENNA (INTRAMUSC)	CAPLYTA (ORAL)
INVEGA TRINZA (INTRAMUSC)	CLOZARIL (ORAL)
LURASIDONE	COBENFY (ORAL)
OLANZAPINE (INTRAMUSC)	ERZOFRI (INTRAMUSC.)
OLANZAPINE TABLET (ORAL)	FANAPT TABLET (ORAL)
PALIPERIDONE (ORAL)	FANAPT TITRATION PACK (ORAL)
QUETIAPINE ER (ORAL)	GEODON (INTRAMUSC)
QUETIAPINE TABLETS (ORAL)	GEODON (ORAL)

Preferred	Nonpreferred
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)
ZIPRASIDONE (INTRAMUSC)	OLANZAPINE/FLUOXETINE (ORAL)
	OPIPZA FILM (ORAL)
	REXULTI (ORAL)
	RISPERDAL SOLUTION (ORAL)
	RISPERDAL TABLET (ORAL)
	RISPERIDONE (INTRAMUSC.)
	RYKINDO (INTRAMUSC.)
	SAPHRIS (SUBLINGUAL)
	SECUADO (TRANSDERMAL)
	SEROQUEL (ORAL)
	SEROQUEL XR (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 7-15-2026

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

Preferred	Nonpreferred
~~YESINTEK VIAL (SUBCUTANE.)~~	CIMZIA SYRINGE KIT (INJECTION) COSENTYX PEN INJECTER (SUBCUTANE.) COSENTYX SYRINGE (SUBCUTANE.) COSENTYX VIAL (INTRAVENOUS) 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.) ICODYTE (ORAL) IDACIO SYRINGE (SUBCUTANE.) IDACIO PEN (SUBCUTANE.) ILARIS (SUBCUTANE.) 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) PYZCHIVA VIAL (SUBCUTANE.) PYZCHIVA SYRINGE (SUBCUTANEOUS) PYZCHIVA 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.)

Preferred	Nonpreferred
	SOTYKTU (ORAL) SPEVIGO (INTRAVEN.) SPEVIGO SYRINGE (SUBCUTANE.) STELARA SYRINGE (INJECTION) STELARA VIAL (INJECTION) STARJEMZA VIAL (INTRAVENOUS) STEQEYMA SYRINGE (SUBCUTANE.) STEQEYMA VIAL (INTRAVENOUS) 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-AAUZ SYRINGE (SUBCUTANE.) USTEKINUMAB -AEKN SYRINGE (SUBCUTANE.) USTEKINUMAB -TTWE VIAL (QUALLENT) (INTRAVENOUS) USTEKINUMAB -TTWE SYRINGE (QUALLENT) (SUBCUTANE.) VELSIPITY (ORAL) WEZLANA SYRINGE (SUBCUTANE.) WEZLANA VIAL (INTRAVENOUS) WEZLANA VIAL (SUBCUTANE.) XELJANZ SOLUTION (ORAL) XELJANZ (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 7-15-2026

Preferred	Nonpreferred
JANUMET (ORAL)	ALOGLIPTIN (AG) (ORAL)
~~JANUMET XR (ORAL)~~	ALOGLIPTIN/METFORMIN (ORAL)
JANUVIA (ORAL)	ALOGLIPTIN/PIOGLITAZONE (ORAL)
JENTADUETO (ORAL)	BRYNOVIN (ORAL)
JENTADUETO XR (ORAL)	DAPAGLIFLOZIN/SAXAGLIPTIN (ORAL)
MOUNJARO (SUBCUTANE.)	EXENATIDE PEN (SUBCUTANE.)
OZEMPIC (SUBCUTANE.)	GLYXAMBI (ORAL)
OZEMPIC TABLET (ORAL)	JANUMET XR (ORAL)
SYMLIN PENS (SUBCUTANE.)	LINAGLIPTIN/METFORMIN (ORAL)
TRADJENTA (ORAL)	LIRAGLUTIDE (SUBCUTANE.)
VICTOZA (SUBCUTANE.)	~~MOUNJARO (SUBCUTANE.)~~
TRULICITY (SUBCUTANE.)	QTERN (ORAL)
	RYBELSUS (ORAL)
	SAXAGLIPTIN (ORAL)
	SAXAGLIPTIN/METFORMIN ER (ORAL)
	SITAGLIPTIN (ORAL) (ZITUVIO)
	SITAGLIPTIN/METFORMIN (ORAL) (ZITUVIMET)
	SITAGLIPTIN/METFORMIN ER (ORAL) (ZITUVIMET XR)
	SITAGLIPTIN PHOSPHATE (ORAL)
	SITAGLIPTIN PHOS/METFORMIN (ORAL)
	SOLIQUA (SUBCUTANE.)
	STEGLUJAN (ORAL)
	TRIJARDY XR (ORAL)
	XULTOPHY (SUBCUTANE.)
	ZITUVIMET (ORAL)
	ZITUVIMET XR (ORAL)
	ZITUVIO (ORAL)

IMMUNOMODULATORS, ASTHMA section reviewed 7-15-2026

Preferred	Nonpreferred
NUCALA AUTO-INJECTOR (SUBCUTANEOUS)	CINQAIR (INTRAVEN)
NUCALA SYRINGE (SUBCUTANEOUS)	EXDENSUR SYRINGE (SUBCUTANEOUS)
NUCALA VIAL (SUBCUTANEOUS)	FASENRA PEN (SUBCUTANEOUS)
XOLAIR SYRINGE/AUTOINJ (SUB-Q)	FASENRA SYRINGE (SUBCUTANEOUS)
XOLAIR VIAL (SUB-Q)	~~NUCALA AUTO-INJECTOR (SUBCUTANEOUS)~~
	~~NUCALA SYRINGE (SUBCUTANEOUS)~~
	~~NUCALA VIAL (SUBCUTANEOUS)~~
	TEZSPIRE PEN (SUBCUTANEOUS)
	TEZSPIRE SYRINGE (SUBCUTANEOUS)

NSAIDS section reviewed 7-15-2026

Preferred	Nonpreferred
CELECOXIB (ORAL)	ARTHROTEC (ORAL)
DICLOFENAC GEL OTC (TOPICAL)	CELEBREX (ORAL)
DICLOFENAC POTASSIUM TABLET (ORAL)	COXANTO (ORAL)
DICLOFENAC SODIUM (ORAL)	DICLOFENAC PATCH (AG) (TRANSDERMAL)
DICLOFENAC SR (ORAL)	~~DICLOFENAC POTASSIUM TABLET (ORAL)~~
ETODOLAC (ORAL)	DICLOFENAC POTASSIUM CAPSULE (ORAL)
FLURIBIPROFEN (ORAL)	DICLOFENAC SODIUM/MISOPROSTOL (ORAL)
IBUPROFEN 400 MG, 600 MG, 800 MG (ORAL)	DICLOFENAC SODIUM PUMP (TOPICAL)
INDOMETHACIN CAPSULE (ORAL)	DICLOFENAC SOLUTION (TOPICAL)

Preferred	Nonpreferred
INDOMETHACIN CAPSULE ER (ORAL) KETOROLAC (ORAL) MELOXICAM TABLET (ORAL) NABUMETONE (ORAL) NAPROXEN EC (ORAL) NAPROXEN SODIUM (ORAL) NAPROXEN TABLET (ORAL) PIROXICAM (ORAL) SULINDAC (ORAL)	DIFLUNISAL (ORAL) DOLOBID (ORAL) ETODOLAC TAB SR (ORAL) FENOPROFEN (ORAL) FLECTOR (TOPICAL) IBUPROFEN 300 MG TABLET (ORAL) IBUPROFEN/FAMOTIDINE TABLET (ORAL) INDOMETHACIN ORAL SUSP (ORAL) INDOMETHACIN (RECTAL) KETOPROFEN (ORAL) KETOPROFEN ER (ORAL) KETOROLAC (SPRIX) (NASAL) LICART PATCH (TRANSDERMAL) LOFENA (ORAL) MEFENAMIC ACID (ORAL) MELOXICAM CAPSULE (ORAL) MECLOFENAMATE (ORAL) NALFON (ORAL) NAPRELAN (ORAL) NAPROXEN CR (ORAL) NAPROXEN SUSPENSION (ORAL) NAPROXEN/ESOMEPRAZOLE (ORAL) ORUDIS (ORAL) OXAPROZIN (ORAL) RELAFEN DS (ORAL) TOLMETIN SODIUM CAPSULE (ORAL) TOLMETIN SODIUM TABLET (ORAL) VYSCOXA SUSPENSION (ORAL) ZYBIC ORAL SUSP (ORAL)

STIMULANTS AND RELATED AGENTS section reviewed 7-15-2026

Preferred	Nonpreferred
AMPHETAMINE SALT COMBO (ORAL) AMPHETAMINE SALT COMBO ER (ORAL) ATOMOXETINE (ORAL) CLONIDINE ER (ORAL) DEXMETHYLPHENIDATE (ORAL) DEXMETHYLPHENIDATE XR (ORAL) DEXTROAMPHETAMINE CAPSULE ER (ORAL) DEXTROAMPHETAMINE TABLET (ORAL) GUANFACINE ER (ORAL) LISDEXAMFETAMINE CAPSULE (ORAL) METHYLIN SOLUTION (ORAL) METHYLPHENIDATE (ORAL) METHYLPHENIDATE SOLUTION (ORAL) METHYLPHENIDATE ER (CONCERTA) (ORAL) METHYLPHENIDATE ER (METADATE ER) (ORAL) METHYLPHENIDATE ER (RITALIN LA) (ORAL) ~~VYVANSE CAPSULE (ORAL)~~	ADDERALL XR (ORAL) ADZENYS XR-ODT (ORAL) AMPHETAMINE ER ODT (ORAL) AMPHETAMINE SALT COMBO ER (MYDAYIS) (ORAL) AMPHETAMINE SULFATE (ORAL) AMPHETAMINE SUSPENSION ER (ORAL) APTENSIO XR (ORAL) ARYNTA SOLUTION (ORAL) AZSTARYS (ORAL) CONCERTA (ORAL) COTEMPLA XR ODT (ORAL) DAYTRANA (TRANSDERMAL) DEXTROAMPHETAMINE SOLUTION (ORAL) DYANAVEL XR (ORAL) EVEKEO (ORAL) EVEKEO ODT (ORAL) FOCALIN (ORAL) FOCALIN XR (ORAL) INTUNIV (ORAL)

Preferred	Nonpreferred
	JORNAY PM (ORAL) LISDEXAMFETAMINE CHEWABLE TABLET (ORAL) METHYLPHENIDATE CD (ORAL) METHYLPHENIDATE CHEWABLE TABLETS (ORAL) METHYLPHENIDATE ER (APTENSIO XR) (AG) (ORAL) METHYLPHENIDATE ER (RELEXXII) (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 CAPSULE (ORAL) VYVANSE CHEWABLE TABLET (ORAL) XELSTRYM (TRANSDERMAL) ZENZEDI (ORAL)

Consent Agenda Items

ANALGESICS, NARCOTICS LONG section reviewed 7-15-2026 no change

Preferred	Nonpreferred
BELBUCA (BUCCAL)	BUPRENORPHINE (BUCCAL)
BUPRENORPHINE (TRANSDERM)	CONZIP (ORAL)
MORPHINE ER TABLET (ORAL)	FENTANYL (12, 37.5, 62.5, 87.5 MG, 75, 100MCG) (TRANSDERM)
FENTANYL (25, 50MCG) 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)
	OPANA ER (ORAL)
	OXYCONTIN (ORAL)
	OXYCODONE ER (ORAL)
	OXYMORPHONE ER (ORAL)
	TRAMADOL ER (CONZIP) (ORAL)
	TRAMADOL ER (RYZOLT) (ORAL)
	TRAMADOL ER (ULTRAM ER) (ORAL)
	ZOHYDRO ER (ORAL)

BETA-BLOCKERS section reviewed 7-15-2026

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

BRONCHODILATORS, BETA AGONIST section reviewed 7-15-2026

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

CEPHALOSPORINS AND RELATED ANTIBIOTICS section reviewed 7-15-2026

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

EPINEPHRINE, SELF-INJECTED section reviewed 7-15-2026 no change

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

GI MOTILITY, CHRONIC section reviewed 7-15-2026

Preferred	Nonpreferred
LINZESS (ORAL)	AMITIZA (ORAL)
LUBIPROSTONE (AG) (ORAL)	ALOSETRON (AG) (ORAL)
LUBIPROSTONE (ORAL)	ALOSETRON (ORAL)
PRUCALOPRIDE TABLET (ORAL)	IBSRELA (ORAL)
	LOTRONEX (ORAL)

Preferred	Nonpreferred
	MOTEGRITY (ORAL) MOVANTIK (ORAL) SYMPROIC (ORAL) TRULANCE (ORAL) VIBERZI (ORAL)

WEIGHT MANAGEMENT AGENTS section reviewed 7-15-2026

Preferred	Nonpreferred
~~SAXENDA (SUBCUTANEOUS)~~ FOUNDAYO TABLET (ORAL) WEGOVY (SUBCUTANEOUS) WEGOVY HD (SUBCUTANEOUS) WEGOVY TABLET (ORAL) ZEPBOUND PEN (SUBCUTANEOUS)	LIRAGLUTIDE (SUBCUTANEOUS) ORLISTAT (ORAL) SAXENDA (SUBCUTANEOUS) XENICAL (ORAL) ZEPBOUND KWIKPEN (SUBCUTANEOUS)