DEPARTMENT OF HUMAN SERVICES

# Discussion Items:

## MHCP Enrolled Providers – Pharmacies

### Fee-for-Service Medical Assistance - Covered OTC Fat-Soluble Vitamins - DRAFT

**(September 2025)**

| Name |
|---|
| MVW Chewable Bubblegum Flavored Tablets |
| MVW Chewables D3000 Bubblegum Flavored Tablets |
| MVW Chewables D3000 Orange Flavored Tablets |
| MVW Chewables D5000 Flavored Tablets |
| MVW Chewables Grape Flavored Tablets |
| MVW Chewables Orange Flavored Tablets |
| MVW Hi-D Drops W/extra Vit D Liquid |
| MVW Modulator Formulation Caps |
| MVW Modulator Formulation Mini Caps |
| MVW Pediatric Flavored Drops |
| MVW Softgels Capsules |
| MVW Softgels D3000 Capsules |
| MVW Softgels D5000 Capsules |
| MVW Softgels Minis Capsules |
| DEKAS Essential Caps |
| DEKAS Essential Liquid |
| DEKAS Plus Caps |
| DEKAS Plus Chew |
| DEKAS Plus Liquid |

**Provider Call Center** (844) 575-7887

# MHCP Enrolled Providers – Pharmacies

## Fee-for-Service PA Criteria Sheet – Niktimvo™ - DRAFT

**(September 2025)**

| | |
|---|---|
| **Drug** | **Niktimvo™ (axatilimab-csfr) [**Incyte Corporation**]** |
| Therapeutic Area | Chronic graft versus host disease (cGVHD) |

**Initial approval criteria:**

- Patient is at least 6 years of age; AND

*Universal Criteria*

- Patient weighs at least 40 kg; AND

*Chronic Graft versus Host Disease (cGVHD)*

- Patient has recurrent or refractory disease; AND
- Used as a single agent or in conjunction with systemic steroids, calcineurin inhibitors (e.g., cyclosporin, etc.) or mTOR inhibitors (e.g., sirolimus, everolimus, etc.); AND
- Patient is post-allogeneic stem cell transplant (generally 3 or more months); AND
- Patient has failed two or more previous lines of systemic therapy for the treatment of cGVHD; AND
- Patient has had an inadequate response to an adequate trial of, or contraindication or intolerance to belumosudil ; AND
- Niktimvo is prescribed by or in consultation with a specialist in the area of the patient's diagnosis
- Initial approval is for 6 months

**Renewal criteria:**

- Patient continues to meet the universal and other indication-specific relevant criteria identified in the initial approval; AND
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include severe infusion related reactions, etc.; AND
- Response to therapy with an improvement in one or more of the following:
    - Clinician assessments (e.g., NIH Skin Score, Upper GI Response Score, NIH Lung Symptom Score, etc.) OR
    - Patient-reported symptoms (e.g., Lee Symptom Scale, etc.)
- Renewal approval is for 6 months

**Quantity limits:**

- For patients weighing at least 40 kg, administer Niktimvo 0.3 mg/kg, up to a maximum dose of 35 mg, as an intravenous infusion over 30 minutes every 2 weeks until progression or unacceptable toxicity.
- Patient's weight (in kg) must be provided at time of request

**Billing for Niktimvo:**

Niktimvo must be billed as a professional claim

**Provider Call Center** (844) 575-7887

# MHCP Enrolled Providers – Pharmacies

## Fee-for-Service PA Criteria Sheet – Ctexli™ - DRAFT

**(September 2025)**

| | |
|---|---|
| **Drug** | **Ctexli™ (chenodiol) [**Mirum Pharmaceuticals, Inc.**]** |
| Therapeutic Area | Bile Salts |

**Initial approval criteria:**

- The patient has a diagnosis of cerebrotendinous xanthomatosis (CTX) as confirmed by ONE of the following:
    - Genetic testing confirming variants in the CYP27A1 gene OR
    - ALL of the following:
        - Elevated plasma cholestanol greater than or equalto 5 to 10 times ULN (upper limit of normal) AND
        - Urine positive for bile alcohols AND
        - Clinical findings consistent for CTX [e.g., xanthomas (present in lungs, tendons, bone or central nervous system), infantile-onset diarrhea, childhood-onset cataract(s), adult-onset progressive neurologic dysfunction (dementia, psychiatric disturbances, pyramidal and/or cerebellar signs, dystonia, atypical parkinsonism, peripheral neuropathy, and seizures]

AND

- The patient's age is within FDA labeling for the requested indication AND
- The patient has had a baseline liver transaminase (alanine aminotransferase [ALT] and aspartate aminotransferase [AST]) and total bilirubin level prior to initiating the requested agent AND
- Ctexli is prescribed by or in consultation with a specialist in the area of the patient's diagnosis AND
- The patient does NOT have any FDA labeled contraindications to the requested agent

**Renewal criteria:**

- The patient has had clinical benefit with the requested agent AND
- The patient is monitored for changes in liver transaminase (alanine aminotransferase [ALT] and aspartate aminotransferase [AST]) and total bilirubin level AND BOTH of the following:
    - The patient has liver transaminase levels less than 3 times the upper limit of normal (ULN) AND
    - The patient has a total bilirubin level less than 2 times the ULN AND
- Ctexli is prescribed by or in consultation with a specialist in the area of the patient's diagnosis AND
- The patient does NOT have any FDA labeled contraindications to the requested agent

**Quantity limits**

- 102 tablets per 34 days

**Provider Call Center** (844) 575-7887

# MHCP Enrolled Providers – Pharmacies

## Fee-for-Service PA Criteria Sheet – Qfitlia™ - DRAFT

**(September 2025)**

| | |
|---|---|
| **Drug** | **Qfitlia™ (fitusiran) [**Genzyme Corporation**]** |
| Therapeutic Area | Hemophilia treatments |

**Initial approval criteria:**

- Patient is ≥ 12 years of age; AND
- Patient has a diagnosis of severe hemophilia A (congenital factor VIII deficiency) or hemophilia B (congenital factor IX deficiency; also known as Christmas Disease) as confirmed by blood coagulation testing *(Note: severity defined as a factor VIII level < 1% or factor IX level ≤ 2%)*; AND
- Must be used for routine prophylaxis to prevent or reduce the frequency of bleeding episodes; AND
- Used as treatment in one of the following:
    - Primary prophylaxis in patients with severe factor deficiency; OR
    - Secondary prophylaxis in patients with at least TWO documented episodes of spontaneous bleeding into joints; AND
- Will NOT be used for the treatment of breakthrough bleeds (Note: on-demand clotting factor concentrates [CFC] or bypassing agents [BPA] may be administered, with a reduced dose and frequency when occurring > 7 days after initiation of Qfitlia, on an as-needed basis for the treatment of breakthrough bleeds in patients being treated with Qfitlia); AND
- Patient has an antithrombin (AT) activity level of ≥ 60% prior to start of therapy and AT activity will be monitored periodically, as outlined in the prescribing information, throughout therapy; AND
- Patient does NOT have a co-existing thrombophilic disorder or a history of, or risk factors predisposing to, thrombosis; AND
- Provider will consider alternative treatments in patients with a history of symptomatic gallbladder disease, or interruption/discontinuation of therapy in patients with acute/recurrent gallbladder disease; AND
- Patient does NOT have hepatic impairment (Child-Pugh Class A, B and C); AND
- Will NOT be used in combination with any of the following (Note: patient may continue their prior CFC or BPA prophylaxis for the first 7 days of Qfitlia treatment; discontinue CFC or BPA prophylaxis no later than 7 days after the initial dose of Qfitlia):
    - Hemophilia BPA prophylaxis (e.g., factor VIIa, anti-inhibitor coagulant complex); OR
    - Immune tolerance induction with clotting factor products (e.g., factor VIII or factor IX concentrates) as prophylactic therapy; OR
    - Emicizumab-kxwh (Hemlibra) for hemophilia A with inhibitors.
- 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., the frequency of bleeding episodes has decreased from pre-treatment baseline); AND
- Patient's latest AT activity result is categorized as one of the following*:
    - Less than 15%; AND
        - Reduction in dose according to package labeling (Note: patient is already receiving 10 mg every 2 months must discontinue therapy); OR
    - 15% to 35%; AND
        - Continue at the current dosage; OR
- Patient has NOT achieved satisfactory bleed control compared to baseline or the patient's latest AT activity result is categorized as > 35% after ≥ 6 months*; AND
    - Escalation in dose and frequency according to package labeling; AND
- Absence of unacceptable toxicity from the drug (e.g., severe hepatotoxicity, thromboembolic events, severe gallbladder disease).
- Renewal approval is for 12 months

* Note: Patient AT activity should be monitored at prescribed times following the initiation of therapy and after any dose modifications using an FDA-cleared test

**Quantity limits:**

- 50 mg every month

**Provider Call Center** (844) 575-7887

# MHCP Enrolled Providers – Pharmacies

## Fee-for-Service PA Criteria Sheet – Vykat™ XR - DRAFT

**(September 2025)**

| | |
|---|---|
| **Drug** | **Vykat™ XR (diazoxide choline) [**Soleno Therapeutics, Inc.**]** |
| Therapeutic Area | Prader-Willi syndrome (PWS) |

**Initial approval criteria:**

- Age ≥ 4 years; AND
- Diagnosis of Prader-Willi syndrome and BOTH of the following:
    - Presence of hyperphagia; AND
    - Diagnosis has been confirmed by genetic testing indicating mutation on chromosome 15 (medical records required); AND
- Patient does NOT have known hypersensitivity to diazoxide, other components of Vykat XR or thiazides; AND
- Vykat XR is prescribed by or in consultation with a specialist in the area of the patient's diagnosis; AND
- Prescriber has reviewed Vykat XR Warnings/Precautions and Drug Interactions and will monitor patient status as appropriate.
- Initial approval is for 4 months

**Renewal criteria:**

- Patient must continue to meet the above criteria; AND
- Patient must have clinical benefit with the use of Vykat XR (e.g., reduction in hyperphagic and/or food-related behaviors); AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., severe hyperglycemia).
- Renewal approval is for 12 months

**Quantity limits**

- 5.8 mg/kg/day or 525 mg/day
- Patient's weight (in kg) must be submitted at time of request.
- When a combination of two Vykat XR strength is needed, provide the requested quantity, number of refill(s) and directions for use for each of the Vykat XR strength on the prior authorization request form.

**Provider Call Center** (844) 575-7887

# MHCP Enrolled Providers – Pharmacies

## Fee-for-Service PA Criteria Sheet – Imaavy™ - DRAFT

**(September 2025)**

| | |
|---|---|
| **Drug** | **Imaavy™ (nipocalimab-aahu) [**Janssen Biotech, Inc.**]** |
| Therapeutic Area | Immunomodulators, Miscellaneous |

**Initial approval criteria:**

- Age ≥ 12 years; AND
- Diagnosis of generalized myasthenia gravis (gMG) with Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of Class II to IV disease; AND
- Positive serologic test for anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibodies; AND
- Patient has had a thymectomy (*note: applicable only to patients with AChR-positive disease and with thymomas OR non-thymomatous patients who are ≤ 50 years of age*); AND
- Provider has assessed objective signs of neurological weakness and fatiguability on a baseline neurological examination (e.g., Quantitative Myasthenia Gravis [QMG] score); AND
- Patient has a baseline Myasthenia Gravis-Activities of Daily Living (MG-ADL) total score of ≥ 3; AND
    - Patient had an inadequate response to initial therapy based on their antibodies:
        - AChR+ disease: minimum one-year trial of concurrent use with an oral corticosteroid plus another immunosuppressive therapy (e.g., azathioprine, cyclosporine, mycophenolate); OR
        - MuSK+ disease: minimum one-year trial with immunosuppressive therapy (e.g., corticosteroids, azathioprine, mycophenolate) and rituximab; OR
    - Patient required at least one acute or chronic treatment with plasmapheresis or plasma exchange or intravenous immunoglobulin (IVIG) in addition to immunosuppressant therapy; AND
- Patient does NOT have a history of serious hypersensitivity reaction to nipocalimab or any of the excipients in Imaavy; AND
- Patient does NOT have an active infection, including clinically important localized infections; AND
- Imaavy will NOT be used in combination with other immunomodulatory biologic therapies (e.g., rituximab, eculizumab, ravulizumab, rozanolixizumab-noli, pegcetacoplan, satralizumab, inebilizumab, efgartigimod); AND
- Patient will avoid or use caution with medications known to worsen or exacerbate symptoms of gMG (e.g., certain antibiotics, beta-blockers, botulinum toxins, hydroxychloroquine); AND
- Imaavy will NOT be administered with live-attenuated or live vaccines during treatment; AND
- Patient is up to date with all vaccinations in accordance with current vaccination guidelines prior to initiation of therapy.
- Initial approval is for 6 months

**Renewal criteria:**

- Patient must continue to meet the above criteria; AND
- Patient must have an improvement of ≥ 1-point from baseline in the MG-ADL total score (*note: can be substituted for an improvement of ≥ 1-point from baseline in the QMG total score, if available*); AND
- Patient must demonstrate improvement in muscle strength testing with fatigue maneuvers as evidenced on neurologic examination when compared to baseline; AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., serious infection, severe hypersensitivity reactions [e.g., anaphylaxis, angioedema], severe infusion-related reactions).
- Renewal approval is for 12 months

**Quantity limits**

- Initial dose: 30 mg/kg
- Maintenance dose: Tw15mg/kg every two weeks after the initial dose
- Patient's weight (in kg) must be submitted at time of request

**Billing for Imaavy:**

Imaavy must be billed as a professional claim.

**Provider Call Center** (844) 575-7887

# MHCP Enrolled Providers – Pharmacies

## Fee-for-Service PA Criteria Sheet – Ryzneuta® - DRAFT

**(September 2025)**

| | |
|---|---|
| **Drug** | **Ryzneuta® (efbemalenograstim alfa-vuxw) [**Acrotech Biopharma, Inc.**]** |
| Therapeutic Area | Colony stimulating factors |

**Initial approval criteria:**

- Patient is at least 18 years of age; AND
- Will not be used for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation; AND
- Patient does not have a history of serious allergic reactions to granulocyte stimulating factor products (e.g., pegfilgrastim, filgrastim, etc.); AND

*Prophylactic use in patients with non-myeloid malignancy*

- Patient is undergoing myelosuppressive chemotherapy with an expected incidence of febrile neutropenia* of greater than 20% OR
- Patient is undergoing myelosuppressive chemotherapy with an expected incidence of febrile neutropenia* of 10% to 20% AND one or more of the following co-morbidities:
    - Age >65 years receiving full dose intensity chemotherapy
    - Prior exposure to chemotherapy or radiation therapy
    - Persistent neutropenia (ANC ≤ 1000/$mm^3$)
    - Bone marrow involvement by tumor
    - Patient has a condition that can potentially increase the risk of serious infection (i.e., HIV/AIDS with low CD4 counts)
    - Recent surgery and/or open wounds
    - Poor performance status
    - Renal dysfunction (creatinine clearance <50 mL/min)
    - Liver dysfunction (elevated bilirubin >2.0 mg/dL)
    - Chronic immunosuppression in the post-transplant setting, including organ transplant

      Note: Dose-dense therapy, in general, requires growth factor support to maintain dose intensity and schedule. In the palliative setting, consideration should be given to dose reduction or change in regimen.

*****Febrile neutropenia is defined as:
− Temperature: a single temperature ≥38.3 °C orally or ≥38.0 °C over 1 hour; AND
− Neutropenia: <500 neutrophils/mcL or <1,000 neutrophils/mcL and a predicted decline to ≤500 neutrophils/mcL over the next 48 hours

**Renewal criteria:**

- Patient continues to meet indication-specific relevant criteria such as concomitant therapy requirements (not including prerequisite therapy), performance status, etc. identified in the initial approval criteria; AND
- Absence of unacceptable toxicity from the drug. Examples of unacceptable toxicity include splenic rupture, acute respiratory distress syndrome (ARDS), serious allergic reactions/anaphylaxis, sickle cell crisis, glomerulonephritis, leukocytosis, thrombocytopenia, capillary leak syndrome, potential for tumor growth stimulation of malignant cells, aortitis, myelodysplastic syndrome and acute myeloid leukemia in patients with breast and lung cancer, etc.

**Quantity limits**

- 20 mg administered subcutaneously once per chemotherapy cycle

**Billing for Ryzneuta:**
Ryzneuta must be billed as a professional claim.

**Background**
Ryzneuta is a leukocyte growth factor indicated to decrease the incidence of infection, as manifested by febrile neutropenia, in adult patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia. Ryzneuta is not indicated for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation.

**Provider Call Center** (844) 575-7887

# MHCP Enrolled Providers – Pharmacies

## Fee-for-Service PA Criteria Sheet – Vanrafia™ - DRAFT

**(September 2025)**

| | |
|---|---|
| **Drug** | **Vanrafia™ (atrasentan) [**Novartis Pharmaceuticals Corporation**]** |
| Therapeutic Area | Primary immunoglobulin A nephropathy (IgAN) |

**Initial approval criteria:**

- Age ≥ 18 years; AND
- Diagnosis of primary immunoglobin 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 atrasentan or any component of Vanrafia; AND
- ONE of the following:
  - Patient is taking a maximally tolerated angiotensin-converting enzyme inhibitor (ACEI) (e.g., benazepril, lisinopril) or angiotensin II 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 Vanrafia; OR
  - Patient has intolerance, hypersensitivity, or FDA-labeled contraindication to all ACEIs or ARBs, or combination medications containing an ACEI or ARB; AND
- Vanrafia is prescribed by or in consultation with a specialist in the area of the patient's diagnosis; AND
- Negative pregnancy status must be confirmed in patients of reproductive potential prior to initiation of Vanrafia; AND
- Patients of reproductive potential should use effective contraception prior to initiation of Vanrafia, during treatment and for 2 weeks after discontinuation; AND
- Prescriber has reviewed Vanrafia Warnings/Precautions and Drug Interactions and will monitor patient status as appropriate.
- Initial approval is for 9 months

**Renewal criteria:**

- Patient must continue to meet the initial approval criteria; AND
- Patient must have disease improvement and/or stabilization as indicated by ONE of the following:
  - Decrease from baseline (prior to treatment with Vanrafia) of UPCR ratio; OR
  - Decrease from baseline (prior to treatment with Vanrafia) in proteinuria; AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., clinically relevant aminotransferase elevations or aminotransferase elevations accompanied by bilirubin increase > 2 times upper limit of normal [ULN] or by clinical symptoms of hepatotoxicity).
- Renewal approval is for 12 months

**Quantity limits**

- 30 tablets per 30 days

**Background**

Vanrafia is an endothelin receptor antagonist indicated to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g. This indication is approved under accelerated approval based on a reduction of proteinuria. It has not been established whether Vanrafia slows kidney function decline 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

# Consent Agenda Items:

September 2025 DRAFT
**Drug** – **Synagis** [palivizumab]
2025-2026 RSV Season

# Prior authorization is required for all patients

Providers must fax the completed Synagis Prior Authorization Form to the MHCP Prescription Drug Prior Authorization Agent.

# FDA-approved indications and usage

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

# Dosing allowance policy

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

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

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

# How Supplied

50 mg vial or 100 mg vial

# Criteria

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

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

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

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

- Interstitial Lung Disease
- Neuromuscular disease
- Congenital airway abnormality

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

**Infant with congenital heart disease (CHD) (see also addendum A)**
Any infant younger than 12 months of age, at the time of request, who has a diagnosis of hemodynamically significant congenital heart disease (CHD) and meets any of the following criteria:

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

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

**Infants with a history of premature birth**
Any infant up to 12 months of age, born at less than 29 weeks, 0 days' gestation.

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

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

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

# Addendum A

Patients with CHD who are NOT candidates for Synagis include:

- Hemodynamically insignificant heart disease
- Secundum ASD
- Small VSD
- Pulmonic stenosis
- Uncomplicated aortic stenosis
- Mild coarctation of the aorta
- Patent ductus arteriosus (PDA)
- Infants with corrected surgical lesions unless they continue to require medication for CHF
- Infants with mild cardiomyopathy who are not receiving medical therapy

# Addendum B

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

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

# Addendum C

During the 2025-2026 RSV season, prior authorization request may be approved if the patient meets applicable clinical criteria AND one of the following:

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

# Questions?

**Provider Call Center** (844) 575-7887

# MHCP Enrolled Providers – Pharmacies

## Fee-for-Service PA Criteria Sheet – Botulinum Toxins - DRAFT

**(September 2025)**

| | |
|---|---|
| **Drugs:** | **Botox (onabotulinumtoxin A)**<br>**Dysport (abobotulinumtoxin A)**<br>**Xeomin (incobotulinumtoxin A)**<br>**Myobloc (rimabotulinumtoxin B)**<br>**Daxxify (daxibotulinumtoxin A-lanm)** |
| Therapeutic Area | Botulinum toxins |

**Initial approval criteria:**

- The requested drug will not be prescribed for an excluded indication (e.g. cosmetic) AND
- The requested drug is prescribed for ONE of the following:
    - A medically accepted indication as defined in Section 1927 of the Social Security Act; OR
    - Continuation of therapy:
        - Continuation of therapy is defined as the patient has received treatment with the requested drug for at least 90 days preceding the prior authorization request for a medically accepted indication as defined in Section 1927 of the Social Security Act
        - The use of free goods or pharmaceutical samples will not be considered as meeting this criterion
- Must be age-appropriate according to a medically accepted indication as defined in Section 1927 of the Social Security Act AND
- The patient does NOT have any FDA labeled contraindications to the requested drug; AND
- Initial approval is for 12 months

**Renewal criteria:**

- Patient continues to meet the initial approval criteria AND
- Documentation showing a positive response to the requested drug AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., severe hypersensitivity reactions).
- Renewal approval is for 12 months

**Quantity limits:**

- The requested drug is being prescribed within recommended dosing guidelines

**Billing for botulinum toxin:**

- The requested drug must be billed as a professional claim

**Definition:**

**Free goods or pharmaceutical samples**: medication samples, medications obtained from any patient assistance programs or any discount programs, medications obtained through free trial programs, manufacturer vouchers, coupons, or debit cards while the member is on Medical Assistance.

**Provider Call Center** (844) 575-7887

# Consent Agenda Items:

## ANTIMIGRAINE AGENTS, OTHER section reviewed 9-17-2025 no change

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

## ANTIVIRALS, ORAL section reviewed 9-17-2025 no change

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

## ANTIVIRALS, TOPICAL section reviewed 9-17-2025 no change

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

## DIABETES METERS, CONTINUOUS section reviewed 9-17-2025 no change

| Preferred | Nonpreferred |
|---|---|
| DEXCOM G6 CGM | DEXCOM RECEIVER KIT |
| DEXCOM G7 CGM | DEXCOM G5 RECEIVER KIT |
| FREESTYLE LIBRE 14 DAY READER | |
| FREESTYLE LIBRE 2 READER | |
| FREESTYLE LIBRE 3 READER CGM | |
| See Transmitter and Sensors section for Preferred and Nonpreferred Transmitters and Sensors | |

## TRANSMITTERS AND SENSORS section reviewed 9-17-2025

| Preferred | Nonpreferred |
|---|---|
| DEXCOM G6 SENSOR<br>DEXCOM G6 TRANSMITTER<br>DEXCOM G7 SENSOR<br>FREESTYLE LIBRE 14 DAY SENSOR<br>FREESTYLE LIBRE 2 SENSOR<br>FREESTYLE LIBRE 3 SENSOR<br>FREESTYLE LIBRE 3 PLUS SENSOR KIT<br>FREESTYLE LIBRE 2 PLUS SENSOR KIT<br><br>See Diabetes Meters, Continuous section for Preferred and Nonpreferred Readers and Receivers | DEXCOM G5-G4 SENSOR KIT<br>DEXCOM G5 TRANSMITTER KIT |

## HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS section reviewed 9-17-2025 no change

| Preferred | Nonpreferred |
|---|---|
| ACARBOSE (ORAL) | MIGLITOL (ORAL)<br>PRECOSE (ORAL) |

## IMMUNOMODULATORS, ASTHMA section reviewed 9-17-2025 no change

| Preferred | Nonpreferred |
|---|---|
| XOLAIR SYRINGE/AUTOINJ (SUB-Q)<br>XOLAIR VIAL (SUB-Q) | CINQAIR (INTRAVEN)<br>FASENRA PEN (SUBCUTANEOUS)<br>FASENRA SYRINGE (SUBCUTANEOUS)<br>NUCALA AUTO-INJECTOR (SUBCUTANEOUS)<br>NUCALA SYRINGE (SUBCUTANEOUS)<br>NUCALA VIAL (SUBCUTANEOUS)<br>TEZSPIRE PEN (SUBCUTANEOUS)<br>TEZSPIRE SYRINGE (SUBCUTANEOUS) |

## LIPOTROPICS, STATINS section reviewed 9-17-2025 no change

| Preferred | Nonpreferred |
|---|---|
| ATORVASTATIN (ORAL)<br>LOVASTATIN (ORAL)<br>PRAVASTATIN (ORAL)<br>SIMVASTATIN (ORAL)<br>ROSUVASTATIN (ORAL) | ALTOPREV (ORAL)<br>AMLODIPINE-ATORVASTATIN (ORAL)<br>ATORVALIQ (ORAL)<br>CADUET (ORAL)<br>EZALLOR SPRINKLE (ORAL)<br>EZETIMIBE-SIMVASTATIN (ORAL)<br>FLOLIPID SUSPENSION (ORAL)<br>FLUVASTATIN (ORAL)<br>FLUVASTATIN ER (ORAL)<br>LESCOL XL (ORAL)<br>LIPITOR (ORAL)<br>LIVALO (ORAL)<br>PITAVASTATIN CALCIUM (ORAL)<br>VYTORIN (ORAL)<br>ZOCOR (ORAL)<br>ZYPITAMAG (ORAL) |

## OPHTHALMIC ANTIBIOTICS section reviewed 9-17-2025 no change

| Preferred | Nonpreferred |
|---|---|
| CIPROFLOXACIN SOLUTION (OPHTHALMIC)<br>MOXIFLOXACIN (VIGAMOX) (OPHTHALMIC) | AZASITE (OPHTHALMIC)<br>BACITRACIN (OPHTHALMIC) |

| Preferred | Nonpreferred |
|---|---|
| OFLOXACIN (OPHTHALMIC) | BESIVANCE (OPHTHALMIC)<br>CILOXAN OINTMENT (OPHTHALMIC)<br>GATIFLOXACIN (OPHTHALMIC)<br>MOXIFLOXACIN (MOXEZA) (OPHTHALMIC)<br>NATACYN (OPHTHALMIC)<br>OCUFLOX (OPHTHALMIC)<br>SULFACETAMIDE OINTMENT(OPHTHALMIC)<br>VIGAMOX (OPHTHALMIC) |

## WEIGHT MANAGEMENT AGENTS section reviewed 9-17-2025 no change

| Preferred | Nonpreferred |
|---|---|
| SAXENDA (SUBCUTANEOUS)<br>WEGOVY (SUBCUTANEOUS) | ORLISTAT (ORAL)<br>XENICAL (ORAL)<br>ZEPBOUND (SUBCUTANEOUS) |

# Discussion Items

## ANDROGENIC AGENTS section reviewed 9-17-2025

| Preferred | Nonpreferred |
|---|---|
| TESTOSTERONE GEL (AG) (VOGELXO) (TRANSDERM)<br>TESTOSTERONE GEL PACKET (AG) (VOGELXO) (TRANSDERM)<br>TESTOSTERONE GEL PUMP (ANDROGEL) (TRANSDERM)<br>TESTIM (TRANSDERM.) | ANDROGEL GEL PUMP (TRANSDERM)<br>TESTOSTERONE GEL (FORTESTA) (TRANSDERM)<br>TESTOSTERONE GEL (TESTIM) (TRANSDERM)<br>~~TESTOSTERONE GEL (VOGELXO) (TRANSDERM)~~<br>TESTOSTERONE GEL PACKET (ANDROGEL) (TRANSDERM)<br>TESTOSTERONE GEL PUMP (AXIRON) (TRANSDERM)<br>VOGELXO GEL (TRANSDERM)<br>VOGELXO GEL PACKET (TRANSDERM)<br>VOGELXO GEL PUMP (TRANSDERM) |

## GI MOTILITY, CHRONIC section added 9-17-2025

| Preferred | Nonpreferred |
|---|---|
| LINZESS (ORAL)<br>LUBIPROSTONE (AG) (ORAL)<br>LUBIPROSTONE (ORAL) | AMITIZA (ORAL)<br>ALOSETRON (AG) (ORAL)<br>ALOSETRON (ORAL)<br>IBSRELA (ORAL)<br>LOTRONEX (ORAL)<br>MOTEGRITY (ORAL)<br>MOVANTIK (ORAL)<br>RELISTOR (ORAL)<br>RELISTOR SYRINGE (SUBCUTANE.)<br>RELISTOR VIAL (SUBCUTANE.)<br>SYMPROIC (ORAL)<br>TRULANCE (ORAL)<br>VIBERZI (ORAL) |

## GLUCAGON AGENTS section reviewed 9-17-2025

| Preferred | Nonpreferred |
|---|---|
| BAQSIMI (NASAL)<br>~~GLUCAGON (INJECTION)~~<br>GLUCAGON EMERGENCY KIT (AMPHASTAR) (INJECTION)<br>PROGLYCEM SUSPENSION (ORAL)<br>ZEGALOGUE SYRINGE (SUBCUTANEOUS)<br>ZEGALOGUE AUTOINJECTOR (SUBCUTANEOUS) | DIAZOXIDE SUSPENSION (ORAL)<br>GLUCAGON EMERGENCY KIT (FRESENIUS) (INJECTION)<br>GLUCAGON EMERGENCY KIT (LUPIN) (INJECTION)<br>GVOKE VIAL (SUBCUTANEOUS)<br>GVOKE SYRINGE (SUBCUTANEOUS)<br>GVOKE PEN (SUBCUTANEOUS)<br>~~ZEGALOGUE SYRINGE (SUBCUTANEOUS)~~<br>~~ZEGALOGUE AUTOINJECTOR (SUBCUTANEOUS)~~ |

## GLUCOCORTICOIDS, INHALED section reviewed 9-17-2025

| Preferred | Nonpreferred |
|---|---|
| ADVAIR DISKUS (INHALATION)<br>ADVAIR HFA (INHALATION)<br>ARNUITY ELLIPTA (INHALATION)<br>ASMANEX (INHALATION)<br>ASMANEX HFA (INHALATION)<br>BUDESONIDE 0.25, 0.5 MG RESPULES (INHALATION)<br>BUDESONIDE 1 MG RESPULES (INHALATION)<br>DULERA (INHALATION)<br>FLUTICASONE HFA (AG) (INHALATION)<br>PULMICORT FLEXHALER (INHALATION)<br>QVAR REDIHALER (INHALATION)<br>SYMBICORT (INHALATION) | AIRDUO RESPICLICK (INHALATION)<br>AIRSUPRA (INHALATION)<br>ALVESCO (INHALATION)<br>BREO ELLIPTA (INHALATION)<br>BREYNA (INHALATION)<br>BREZTRI AEROSPHERE (INHALATION)<br>BUDESONIDE/FORMOTEROL (SYMBICORT) (AG) (INHALATION)<br>FLUTICASONE FUROATE (ELLIPTA) (AG) (INHALATION)<br>FLUTICASONE (FLOVENT DISKUS) (AG) (INHALATION)<br>FLUTICASONE/SALMETEROL (ADVAIR DISKUS) (INHALATION)<br>FLUTICASONE/SALMETEROL (ADVAIR HFA) (INHALATION) |

| Preferred | Nonpreferred |
|---|---|
| | FLUTICASONE/SALMETEROL (AIRDUO) (AG) (INHALATION)<br>FLUTICASONE/VILANTEROL (BREO) (INHALATION)<br>PULMICORT 0.25, 0.5 MG RESPULES (INHALATION)<br>PULMICORT 1 MG RESPULES (INHALATION)<br>TRELEGY ELLIPTA (INHALATION) |

## GROWTH HORMONE section reviewed 9-17-2025

| Preferred | Nonpreferred |
|---|---|
| ~~GENOTROPIN CARTRIDGE (INJECTION)~~<br>~~GENOTROPIN DISP SYRIN (INJECTION)~~<br>NORDITROPIN PEN (INJECTION)<br>~~NUTROPIN AQ PEN (INJECTION)~~<br>ZOMACTON VIAL (INJECTION) | GENOTROPIN CARTRIDGE (INJECTION)<br>GENOTROPIN DISP SYRIN (INJECTION)<br>HUMATROPE CARTRIDGE (INJECTION)<br>HUMATROPE VIAL (INJECTION)<br>NGENLA (INJECTION)<br>OMNITROPE CARTRIDGE (INJECTION)<br>OMNITROPE VIAL (INJECTION)<br>SAIZEN CARTRIDGE (INJECTION)<br>SAIZEN VIAL (INJECTION)<br>SEROSTIM VIAL (INJECTION)<br>SKYTROFA CARTRIDGE (SUBCUTANEOUS)<br>SOGROYA (SUBCUTANEOUS)<br>~~ZOMACTON VIAL (INJECTION)~~<br>ZORBTIVE VIAL (INJECTION) |

## HYPOGLYCEMICS, INSULIN AND RELATED AGENTS section reviewed 9-17-2025

| Preferred | Nonpreferred |
|---|---|
| HUMALOG CARTRIDGE (SUBCUTANE.)<br>HUMALOG JUNIOR KWIKPEN (SUBCUTANE.)<br>HUMALOG MIX PEN (SUBCUTANE.)<br>HUMALOG PEN (SUBCUTANE.)<br>HUMALOG VIAL (SUBCUTANE.)<br>HUMALOG MIX VIAL (SUBCUTANE.)<br>HUMULIN 500 U/M PEN (SUBCUTANE.)<br>HUMULIN 500 U/M VIAL (SUBCUTANE.)<br>HUMULIN 70/30 PEN OTC (SUBCUTANE.)<br>HUMULIN 70/30 VIAL OTC (SUBCUTANE.)<br>HUMULIN VIAL OTC (SUBCUTANE.)<br>INSULIN ASPART VIAL<br>INSULIN ASPART FLEXPEN<br>INSULIN ASPART PENFILL<br>INSULIN ASPART/INSULIN ASPART PROTAMINE VIAL (AG) (SUBCUTANEOUS)<br>INSULIN ASPART/INSULIN ASPART PROTAMINE<br>INSULIN PEN (AG) (SUBCUTANEOUS)<br>INSULIN LISPRO JUNIOR KWIKPEN<br>INSULIN LISPRO PEN (SUBCUTANE.)<br>INSULIN LISPRO VIAL (SUBCUTANE.)<br>LANTUS SOLOSTAR PEN (SUBCUTANE.)<br>LANTUS VIAL (SUBCUTANE.)<br>NOVOLIN VIAL OTC (SUBCUTANE.)<br>NOVOLOG CARTRIDGE (SUBCUTANE.)<br>NOVOLOG MIX PEN (SUBCUTANE.)<br>NOVOLOG MIX VIAL (SUBCUTANE.)<br>NOVOLOG PEN (SUBCUTANE.)<br>NOVOLOG VIAL (SUBCUTANE.) | ADMELOG SOLOSTAR PEN (SUBCUTANE.)<br>ADMELOG VIAL (SUBCUTANE.)<br>AFREZZA CARTRIDGE (INHALATION)<br>APIDRA SOLOSTAR PEN (SUBCUTANE.)<br>APIDRA VIAL (SUBCUTANE.)<br>BASAGLAR KWIKPEN (SUBCUTANE.)<br>BASAGLAR TEMPO PEN (SUBCUTANE.)<br>FIASP FLEXTOUCH PEN (SUBCUTANE.)<br>FIASP PENFILL (SUBCUTANE.)<br>FIASP PUMPCART (SUBCUTANE.)<br>FIASP VIAL (SUBCUTANE.)<br>HUMALOG 200 U/ML PEN (SUBCUTANE.)<br>HUMALOG TEMPO PEN (SUBCUTANE.)<br>HUMULIN PEN OTC (SUBCUTANE.)<br>INSULIN DEGLUDEC VIAL (SUBCUTANE.)<br>INSULIN DEGLUDEC PEN (U-100) (SUBCUTANE.)<br>INSULIN DEGLUDEC PEN (U-200) (SUBCUTANE.)<br>INSULIN GLARGINE VIAL (WINTHROP) (SUBCUTANE.)<br>INSULINE GLARGINE SOLOSTAR PEN (SUBCUTANE.)<br>INSULIN GLARGINE MAX SOLOSTAR PEN (SUBCUTANE.)<br>INSULIN GLARGINE-YFGN VIAL (SUBCUTANE.)<br>INSULIN GLARGINE-YFGN PEN (SUBCUTANE.)<br>INSULIN LISPRO PROTAMINE MIX KWIKPEN (AG) (SUBCUTANEOUS)<br>LYUMJEV VIAL<br>LYUMJEV KWIKPEN U-100<br>LYUMJEV KWIKPEN U-200<br>LYUMJEV TEMPO PEN U-100<br>MERILOG VIAL (SUBCUTANE.)<br>MERILOG SOLOSTAR PEN (SUBCUTANE)<br>NOVOLIN 70/30 PEN OTC (SUBCUTANE.)<br>NOVOLIN 70/30 VIAL OTC (SUBCUTANE.)<br>NOVOLIN PEN OTC (SUBCUTANE.)<br>REZVOGLAR KWIKPEN (SUBCUTANE.) |

| Preferred | Nonpreferred |
|---|---|
| | SEMGLEE (YFGN) PEN (SUBCUTANE.)<br>SEMGLEE (YFGN) VIAL (SUBCUTANE.)<br>TOUJEO MAX SOLOSTAR PEN (SUBCUTANE.)<br>TOUJEO SOLOSTAR PEN (SUBCUTANE.)<br>TRESIBA FLEXTOUCH 100 U/ML PEN (SUBCUTANE.)<br>TRESIBA FLEXTOUCH 200 U/ML PEN (SUBCUTANE.)<br>TRESIBA VIAL |

## HYPOGLYCEMICS, SGLT2 section reviewed 9-17-2025

| Preferred | Nonpreferred |
|---|---|
| FARXIGA (ORAL)<br>~~INVOKANA (ORAL)~~<br>JARDIANCE (ORAL)<br>SYNJARDY (ORAL)<br>SYNJARDY XR (ORAL)<br>XIGDUO XR (ORAL) | DAPAGLIFLOZIN (ORAL)<br>DAPAGLIFLOZIN/MEFORMIN ER (ORAL)<br>INPEFA (ORAL)<br>INVOKAMET (ORAL)<br>INVOKAMET XR (ORAL)<br>INVOKANA (ORAL)<br>SEGLUROMET (ORAL)<br>STEGLATRO (ORAL) |

## HYPOGLYCEMICS, TZD section reviewed 9-17-2025

| Preferred | Nonpreferred |
|---|---|
| PIOGLITAZONE (ORAL) | ACTOPLUS MET (ORAL)<br>DUETACT (ORAL)<br>PIOGLITAZONE/GLIMEPIRIDE (ORAL)<br>PIOGLITAZONE/METFORMIN (ORAL) |

## IMMUNOSUPPRESSIVES, ORAL section reviewed 9-17-2025

| Preferred | Nonpreferred |
|---|---|
| AZATHIOPRINE (ORAL)<br>CELLCEPT SUSPENSION (ORAL)<br>CYCLOSPORINE CAPSULE (ORAL)<br>CYCLOSPORINE SOFTGEL (ORAL)<br>CYCLOSPORINE, MODIFIED CAPSULE (ORAL)<br>CYCLOSPORINE, MODIFIED SOLUTION (ORAL)<br>MYCOPHENOLATE MOFETIL CAPSULE (ORAL)<br>MYCOPHENOLATE MOFETIL TABLET (ORAL)<br>SIROLIMUS (ORAL)<br>TACROLIMUS (ORAL) | ASTAGRAF XL (ORAL)<br>AZASAN (ORAL)<br>CELLCEPT CAPSULE (ORAL)<br>CELLCEPT TABLET (ORAL)<br>ENVARSUS XR (ORAL)<br>EVEROLIMUS TABLET (ZORTRESS) (ORAL)<br>IMURAN (ORAL)<br>MYCOPHENOLATE MOFETIL SUSPENSION (ORAL)<br>MYCOPHENOLIC ACID (ORAL)<br>MYFORTIC (ORAL)<br>MYHIBBIN SUSPENSION (ORAL)<br>NEORAL CAPSULE (ORAL)<br>NEORAL SOLUTION (ORAL)<br>PROGRAF (ORAL)<br>REZUROCK (ORAL)<br>SANDIMMUNE CAPSULE (ORAL)<br>SANDIMMUNE SOLUTION (ORAL)<br>TAVNEOS (ORAL)<br>ZORTRESS (ORAL) |

## INTRANASAL RHINITIS AGENTS section reviewed 9-17-2025

| Preferred | Nonpreferred |
|---|---|
| AZELASTINE (ASTELIN) (NASAL)<br>AZELASTINE (ASTEPRO) (NASAL)<br>FLUTICASONE (NASAL)<br>IPRATROPIUM (NASAL)<br>MOMETASONE (NASAL) | AZELASTINE/FLUTICASONE (NASAL)<br>AZELASTINE/FLUTICASONE (AG) (NASAL)<br>DYMISTA (NASAL)<br>FLUNISOLIDE (NASAL)<br>~~NASONEX (NASAL)~~<br>OLOPATADINE (NASAL)<br>OMNARIS (NASAL)<br>QNASL 40 (NASAL)<br>QNASL 80 (NASAL) |

| Preferred | Nonpreferred |
|---|---|
| | RYALTRIS (NASAL)<br>SINUVA (SINUS IMPLANT)<br>TICANASE (NASAL)<br>~~VERAMYST (NASAL)~~<br>XHANCE (NASAL)<br>~~ZETONNA (NASAL)~~ |

## LEUKOTRIENE MODIFIERS section reviewed 9-17-2025

| Preferred | Nonpreferred |
|---|---|
| MONTELUKAST CHEWABLE TABLET (ORAL)<br>MONTELUKAST TABLET (ORAL)<br>~~ZAFIRLUKAST (ORAL)~~ | ACCOLATE (ORAL)<br>MONTELUKAST GRANULES (ORAL)<br>SINGULAIR CHEWABLE TABLET (ORAL)<br>SINGULAIR GRANULES (ORAL)<br>SINGULAIR TABLET (ORAL)<br>ZAFIRLUKAST (ORAL)<br>ZILEUTON ER (ORAL)<br>ZYFLO (ORAL) |

## MACROLIDES/KETOLIDES section reviewed 9-17-2025

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

## NSAIDS section reviewed 9-17-2025

| Preferred | Nonpreferred |
|---|---|
| CELECOXIB (ORAL)<br>~~DICLOFENAC GEL (TOPICAL)~~<br>DICLOFENAC GEL OTC (TOPICAL)<br>DICLOFENAC SODIUM (ORAL)<br>DICLOFENAC SR (ORAL)<br>ETODOLAC (ORAL)<br>FLURIBIPROFEN (ORAL)<br>IBUPROFEN 400 MG, 600 MG, 800 MG (ORAL)<br>INDOMETHACIN CAPSULE (ORAL)<br>INDOMETHACIN CAPSULE ER (ORAL)<br>~~KETOPROFEN (ORAL)~~<br>KETOROLAC (ORAL)<br>MELOXICAM TABLET (ORAL)<br>NABUMETONE (ORAL)<br>NAPROXEN SODIUM (ORAL) | ARTHROTEC (ORAL)<br>CELEBREX (ORAL)<br>DICLOFENAC PATCH (AG) (TRANSDERMAL)<br>DICLOFENAC POTASSIUM TABLET (ORAL)<br>DICLOFENAC POTASSIUM CAPSULE (ORAL)<br>DICLOFENAC SODIUM/MISOPROSTOL (ORAL)<br>DICLOFENAC SODIUM PUMP (TOPICAL)<br>DICLOFENAC SOLUTION (TOPICAL)<br>DIFLUNISAL (ORAL)<br>ETODOLAC TAB SR (ORAL)<br>FENOPROFEN (ORAL)<br>FLECTOR (TOPICAL)<br>IBUPROFEN 300 MG TABLET (ORAL)<br>IBUPROFEN/FAMOTIDINE TABLET (ORAL)<br>INDOMETHACIN ORAL SUSP (ORAL) |

| Preferred | Nonpreferred |
|---|---|
| NAPROXEN TABLET (ORAL)<br>NAPROXEN EC (ORAL)<br>PIROXICAM (ORAL)<br>SULINDAC (ORAL) | INDOMETHADIN (RECTAL)<br>KETOPROFEN (ORAL)<br>KETOPROFEN ER (ORAL)<br>KETOROLAC (SPRIX) (NASAL)<br>LICART PATCH (TRANSDERMAL)<br>LOFENA (ORAL)<br>~~MOBIC TABLET (ORAL)~~<br>MEFENAMIC ACID (ORAL)<br>MELOXICAM CAPSULE (ORAL)<br>MECLOFENAMATE (ORAL)<br>NALFON (ORAL)<br>NAPRELAN (ORAL)<br>NAPROXEN CR (ORAL)<br>NAPROXEN SUSPENSION (ORAL)<br>NAPROXEN/ESOMEPRAZOLE (ORAL)<br>OXAPROZIN (ORAL)<br>RELAFEN DS (ORAL)<br>TOLMETIN SODIUM CAPSULE (ORAL)<br>TOLMETIN SODIUM TABLET (ORAL)<br>~~ZIPSOR (ORAL)~~<br>~~ZORVOLEX (ORAL)~~ |

## OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS section reviewed 9-17-2025

| Preferred | Nonpreferred |
|---|---|
| ALREX (OPHTHALMIC)<br>AZELASTINE (OPHTHALMIC)<br>BEPREVE (OPHTHALMIC)<br>CROMOLYN SODIUM (OPHTHALMIC)<br>KETOTIFEN OTC (OPHTHALMIC)<br>OLOPATADINE (PATANOL) (OPHTHALMIC)<br>OLOPATADINE DROPS (PATADAY) (OPHTHALMIC)<br>OLOPATADINE 0.1% OTC (OPHTHALMIC)<br>OLOPATADINE 0.2% OTC (OPHTHALMIC) | ~~ALOMIDE (OPHTHALMIC)~~<br>~~AZELASTINE (OPHTHALMIC)~~<br>BEPOTASTINE (OPHTHALMIC)<br>EPINASTINE (OPHTHALMIC)<br>LOTEPREDNOL (OPHTHALMIC)<br>ZADITOR OTC (OPHTHALMIC)<br>ZERVIATE (OPHTHALMIC) |

## OPHTHALMICS, ANTI-INFLAMMATORIES section reviewed 9-17-2025

| Preferred | Nonpreferred |
|---|---|
| DICLOFENAC (OPHTHALMIC)<br>FLUOROMETHOLONE (OPHTHALMIC)<br>KETOROLAC (OPHTHALMIC)<br>KETOROLAC LS (OPHTHALMIC)<br>PREDNISOLONE ACETATE (OPHTHALMIC)<br>TRIESENCE (INTRAOCULR) | ACULAR (OPHTHALMIC)<br>ACULAR LS (OPHTHALMIC)<br>ACUVAIL (OPHTHALMIC)<br>BROMFENAC (BROMSITE) (OPHTHALMIC)<br>BROMFENAC (PROLENSA) (OPHTHALMIC)<br>BROMSITE (OPHTHALMIC)<br>DEXTENZA (INTRAOCULAR)<br>~~DEXYCU (INTRAOCULAR)~~<br>DIFLUPREDNATE (OPHTHALMIC)<br>DIFLUPREDNATE (AG) (OPHTHALMIC)<br>DUREZOL (OPHTHALMIC)<br>FLURBIPROFEN (OPHTHALMIC)<br>ILEVRO (OPHTHALMIC)<br>ILUVIEN (INTRAOCULAR)<br>INVELTYS (OPHTHALMIC)<br>LOTEMAX DROPS (OPHTHALMIC)<br>LOTEMAX GEL (OPHTHALMIC)<br>LOTEMAX OINTMENT (OPHTHALMIC)<br>LOTEPREDNOL GEL (AG) (OPHTHALMIC)<br>LOTEPREDNOL GEL (OPHTHALMIC)<br>LOTEPREDNOL DROPS (AG) (OPHTHALMIC)<br>LOTEPREDNOL DROPS (OPHTHALMIC)<br>NEVANAC (OPHTHALMIC)<br>OZURDEX (INTRAOCULR) |

| Preferred | Nonpreferred |
|---|---|
| | PREDNISOLONE SOD PHOSPHATE (OPHTHALMIC)<br>PROLENSA (OPHTHALMIC)<br>RETISERT (INTRAOCULR)<br>XIPERE (SUPRACHOROIDAL INJECTION)<br>YUTIQ (INTRAOCULR) |

**OPHTHALMICS, ~~ANTI-INFLAMMATORY/IMMUNOMODULATOR~~DRY EYE AGENTS section renamed and reviewed 9-17-2025**

| Preferred | Nonpreferred |
|---|---|
| RESTASIS (OPHTHALMIC)<br>RESTASIS MULTIDOSE (OPHTHALMIC)<br>XIIDRA (OPHTHALMIC) | CEQUA (OPHTHALMIC)<br>CYCLOSPORINE (OPHTHALMIC)<br>EYSUVIS (OPHTHALMIC)<br>MIEBO (OPHTHALMIC)<br>TRYPTYR (OPHTHALMIC)<br>TYRVAYA SPRAY (NASAL)<br>VERKAZIA (OPHTHALMIC)<br>VEVYE (OPHTHALMIC) |

**OPHTHALMICS, GLAUCOMA AGENTS section reviewed 9-17-2025**

| Preferred | Nonpreferred |
|---|---|
| ALPHAGAN P 0.1% (OPHTHALMIC)<br>ALPHAGAN P 0.15% (OPHTHALMIC)<br>BRIMONIDINE (OPHTHALMIC)<br>COMBIGAN (OPHTHALMIC)<br>DORZOLAMIDE (OPHTHALMIC)<br>DORZOLAMIDE / TIMOLOL (OPHTHALMIC)<br>LATANOPROST 2.5 ML (OPHTHALMIC)<br>TIMOLOL (OPHTHALMIC)<br>TRAVATAN Z 2.5 ML (OPHTHALMIC)<br>TRAVATAN Z 5 ML (OPHTHALMIC) | APRACLONIDINE (OPHTHALMIC)<br>AZOPT (OPHTHALMIC)<br>BETAGAN (OPHTHALMIC)<br>BETAXOLOL (OPHTHALMIC)<br>BETIMOL (OPHTHALMIC)<br>BETOPTIC S (OPHTHALMIC)<br>BIMATOPROST 2.5ML (OPHTHALMIC)<br>BIMATOPROST 5ML (OPHTHALMIC)<br>BIMATOPROST 7.5ML (OPHTHALMIC)<br>BRIMONIDINE P 0.15% (OPHTHALMIC)<br>BRIMONIDINE TARTRATE/TIMOLOL DROPS (OPHTHALMIC)<br>BRINZOLAMIDE (OPHTHALMIC)<br>CARTEOLOL (OPHTHALMIC)<br>COSOPT (OPHTHALMIC)<br>COSOPT PF (OPHTHALMIC)<br>DORZOLAMIDE / TIMOLOL/PF DROPS (OPHTHALMIC)<br>DURYSTA IMPLANT (INTRACAMERAL)<br>IDOSE TR IMPLANT (INTRACAMERAL)<br>IOPIDINE (OPHTHALMIC)<br>ISTALOL (OPHTHALMIC)<br>IYUZEH (OPHTHALMIC)<br>LEVOBUNOLOL (OPHTHALMIC)<br>LUMIGAN 2.5ML (OPHTHALMIC)<br>LUMIGAN 5ML (OPHTHALMIC)<br>LUMIGAN 7.5ML (OPHTHALMIC)<br>PILOCARPINE (OPHTHALMIC)<br>PILOCARPINE (VUITY) (OPHTHALMIC)<br>RHOPRESSA (OPHTHALMIC)<br>ROCKLATAN (OPHTHALMIC)<br>SIMBRINZA (OPHTHALMIC)<br>TAFLUPROST (OPHTHALMIC)<br>TIMOLOL (ISTALOL) (OPHTHALMIC)<br>TIMOLOL (TIMOPTIC OCCUDOSE) (OPHTHALMIC)<br>TIMOPTIC (OPHTHALMIC)<br>TIMOPTIC OCUDOSE (OPHTHALMIC)<br>TIMOPTIC-XE (OPHTHALMIC)<br>TRAVOPROST 2.5 ML (OPHTHALMIC)<br>TRAVOPROST 5 ML (OPHTHALMIC)<br>~~TRUSOPT (OPHTHALMIC)~~<br>VUITY (OPHTHALMIC) |

| Preferred | Nonpreferred |
| --- | --- |
| | VYZULTA (OPHTHALMIC)<br>XALATAN 2.5 ML (OPHTHALMIC)<br>XELPROS (OPHTHALMIC)<br>ZIOPTAN (OPHTHALMIC) |