DEPARTMENT OF HUMAN SERVICES

Discussion Items:

MHCP Enrolled Providers – Pharmacies

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

(December 2026)

Drug	**Isturisa® (osilodrostat) [**Recordati Rare Diseases, Inc.**]**
Therapeutic Area	Cushing's syndrome

Initial approval criteria:

- The patient has a diagnosis of Cushing's syndrome; AND
- The patient has ONE of the following:
    - The patient had an inadequate response to surgery OR
    - The patient is NOT a candidate for surgery AND
- The patient has ONE of the following:
    - Tried and had an inadequate response to at least ONE of the following conventional agents:
        - Mifepristone OR
        - Signifor/Signifor LAR (pasireotide) OR
        - Recorlev (levoketoconazole) OR
        - Cabergoline OR
        - Metyrapone OR
        - Lysodren (mitotane) OR
    - An intolerance or hypersensitivity to mifepristone,pasireotide, or levoketoconazole OR
    - An FDA labeled contraindication to mifepristone, pasireotide, and levoketoconazole AND
- The patient has ONE of the following:
    - Tried and had an inadequate response to ketoconazole tablets OR
    - An intolerance or hypersensitivity to ketoconazole tablets (medical records required) OR
    - An FDA labeled contraindication to ketoconazole tablets (medical records required) AND
- The patient's age is within the FDA labeling for Isturisa AND
- The prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist), 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 glucocorticoid replacement therapy for the requested indication AND
- The patient does NOT have any FDA labeled contraindications to the requested agent

Renewal criteria:

- The patient continues to meet initial approval criteria; AND
- The patient has had clinical benefit

Quantity limits

- 30 mg twice daily
- When a combination of the two Isturisa strengths must be prescribed for titration, the prescriber must provide attestation that when the patient becomes stabilized on one Isturisa strength, reasonable efforts will be taken to ensure that the other Isturisa strength will be used up to minimize waste

MHCP Enrolled Providers – Pharmacies

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

(December 2026)

Drug	**Filspari® (sparsentan) [**Travere Therapeutics, Inc.**]**
Therapeutic Area	Nephrology

Initial approval criteria:

- The patient's age is within FDA labeling for the requested indication; 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
- The patient will NOT use Filsapri in combination with an ACEi, ARB or endothelin receptor antagonist (e.g., bosentan), or aliskiren; AND
- The patient does NOT have any FDA label contraindications to Filsapri

AND

- The patient has a diagnosis of primary immunoglobulin A nephropathy (IgAN) confirmed by kidney biopsy and ALL of the following:
    - Filsapri will be used to slow kidney function decline in a patient at risk for disease progression AND
    - ONE of the following:
        - The patient has a urine protein-to-creatinine ration (UPCR) greater than or equal to 0.44 g/g OR
        - The patient has proteinuria greater than or equal to 0.5 g/day AND
    - The patient's EGFR is greater than or equal to 30 mL/min/1.73m^2 AND
    - ONE of the following:
        - Tried and had an inadequate response after at least a 3-month duration of therapy with a maximally tolerated angiotensin converting enzyme inhibitor (ACEi) or angiotensin II blocker (ARB), or a combination medication containing an ACEi or ARB; OR
        - An intolerance or hypersensitivity to an ACEi or ARB, or a combination medication containing an ACEi or ARB
        - An FDA labeled contraindication to ALL ACEi or ARB

OR

- The patient has a diagnosis of focal segmental glomerulosclerosis (FSGS) and ALL of the following:
    - Filsapri will be used to reduce proteinuria; AND
    - The patient does not have nephrotic syndrome; AND
    - The patient's diagnosis was confirmed with one of the following:
        - Light microscopy of the kidney biopsy OR
        - Electron microsopy of the kidney biopsy OR
        - Genetic testing

Renewal criteria:

- The patient continues to meet initial approval criteria; AND
- The patient has had clinical benefit with Filsapri

Quantity limits

- IgAN: 400 mg once daily
- FSGS: 800 mg once daily. Patient's weight (in kg) must be submitted at time of request

MHCP Enrolled Providers – Pharmacies

Fee-for-Service PA Criteria Sheet – Lynavoy - DRAFT

(December 2026)

Drug	**Lynavoy (linerixibat) [**Intercept Pharmaceuticals, Inc.**]**
Therapeutic Area	Bile therapy

Initial approval criteria:

- Patient is ≥18 years of age; AND
- Patient is using Lynavoy for treatment of cholestatic pruritus in primary biliary cholangitis (PBC); AND
- Patient has ONE of the following:
    - Tried and had an inadequate response to ONE prerequisite agent (cholestyramine, naltrexone, rifampicin, sertraline, ursodiol); OR
    - An intolerance or hypersensitivity to ONE prerequisite agent (see above for list); OR
    - An FDA labeled contraindication to ALL prerequisite agents (see above for list); AND
- Patient does NOT have any of the following:
    - Decompensated cirrhosis;
    - Prior or active hepatic decompensation events (e.g., variceal hemorrhage, ascites, hepatic encephalopathy); AND
- ONE of the following:
    - Patient has NOT had a liver transplant; OR
    - Patient has had a liver transplant and there is support for using Lynavoy post liver-transplant; AND
- Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis; AND
- Patient will NOT be using the Lynavoy in combination with another ileal bile acid transporter (IBAT) inhibitor (e.g., odevixibat [Bylvay], maralixibat [Livmarli]) for cholestatic pruritus in PBC; AND
- Prescriber has reviewed Lynavoy Warnings/Precautions and Drug Interactions and will monitor patient status as appropriate.

Renewal criteria:

- Patient must continue to meet the initial approval criteria; AND
- Patient must have disease improvement and/or stabilization OR improvement in the slope of decline (e.g., improvements in pruritus); AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., persistent liver test elevations, persistent diarrhea, fat-soluble vitamin deficiency that worsens or persists despite adequate supplementation).

Quantity limits

- 60 tablets/30 days (max of 40 mg [1 tablet] twice daily)

Background

Lynavoy is an ileal bile acid transporter (IBAT) inhibitor indicated for the treatment of cholestatic pruritus associated with primary biliary cholangitis (PBC) in adult patients. Avoid use of Lynavoy in patients with decompensated cirrhosis or those with prior or active hepatic decompensation events (e.g. variceal hemorrhage, ascites, hepatic encephalopathy).

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(December 2026)

Drug	**Trutakna™ (atacicept-vymj) [**Vera Therapeutics, Inc.**]**
Therapeutic Area	Nephrology

Initial approval criteria:

- Patient is ≥18 years of age; AND
- Patient has a 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's estimated glomerular filtration rate (eGFR) is ≥30 mL/min/1.73 m^2; AND
- Patient has ONE of the following:
  - Tried and had an inadequate response after at least a 3-month duration of therapy with 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; OR
  - An intolerance or hypersensitivity to an ACEi or ARB, or a combination medication containing an ACEi or ARB; OR
  - An FDA labeled contraindication to ALL ACEi and ARB; AND
- Patient must NOT have hypersensitivity to any component of the product; AND
- 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 Trutakna Warnings/Precautions and Drug Interactions and will monitor patient status as appropriate.

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient has had improvements or stabilization with Trutakna as indicated by ONE of the following:
  - Decrease from baseline (prior to treatment with Trutakna) of UPCR ratio; OR
  - Decrease from baseline (prior to treatment with Trutakna) in proteinuria; AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., serious infections).

Quantity limits

- 4 pens/28 days (max dose of 1 pen [150 mg] per 7 days)

Background

Trutakna is a B-lymphocyte stimulator (BLyS)-specific inhibitor and 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 a reduction of proteinuria. It has not been established whether Trutakna 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.

MHCP Enrolled Providers – Pharmacies

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

(December 2026)

Drug	**Besremi® (ropeginterferon alfa-2b-njft) [**PharmaEssentia USA**]**
Therapeutic Area	Immunomodulators, Miscellaneous

Initial approval criteria:

- Patient is at least 18 years of age; **AND**
- Patient of reproductive potential have had a negative pregnancy test prior to the start of therapy, unless otherwise specified; **AND**

Universal Criteria

- The patient does NOT have any FDA labeled contraindications to the requested agent (e.g., existence of, or history of severe psychiatric disorders [particularly severe depression, suicidal ideation, or suicide attempt], hypersensitivity to interferons including interferon alfa-2b or any of the inactive ingredients of Bersami, moderate [Child-Pugh B] or severe [Child-Pugh C] hepatic impairment, history or presence of active serious or untreated autoimmune disease, history of transplantation and receiving immunosuppressant agents); **AND**
- Patient does not have serious or untreated endocrine disorders associated with an autoimmune disease; **AND**
- Patient does not have severe or unstable cardiovascular disease, recent stroke, or recent myocardial infarction; **AND**
- Patient will have ophthalmological examinations prior to the start of and during therapy; **AND**
- Patient does not have severe renal impairment (i.e., eGFR < 30 mL/min); **AND**
- Will not be used in combination with other interferon type products (i.e., alfa-, beta-, gamma-interferon, etc.); **AND**

Polycythemia Vera

- Used as single agent therapy *(Note: excludes use when transitioning from hydroxyurea)*; **AND**
    - Used as cytoreductive treatment; **AND**
        - Patient has high-risk disease; **OR**
        - Patient has symptomatic low-risk disease; **OR**
        - Patient has had an inadequate response, loss of response, or intolerance to at least a 3-month trial of prior cytoreductive therapy; **AND**
            - Patient has not previously received treatment with ropeginterferon alfa-2b-njft; **OR**
- Used as a substitute for peginterferon alfa-2a if it is unavailable

OR

Essential Thrombocythemia

- Used as cytoreductive treatment; **AND**
    - Patient has had an inadequate response or loss of response to prior cytoreductive therapy; OR
- Used as a substitute for peginterferon alfa-2a if it is unavailable

AND

- Initial approval is for 6 months

Renewal criteria:

- Patient continues to meet relevant criteria identified in the initial approval criteria section AND
- Absence of unacceptable toxicity from the drug AND
- Renewal approval is for 6 months

Quantity limits

- 500 mcg every 14 days

MHCP Enrolled Providers – Pharmacies

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

(December 2026)

Drug	**Lumvoa™ (veligrotug-vvze) [**PharmaEssentia USA**]**
Therapeutic Area	Immunomodulators, Miscellaneous

Initial approval criteria:

- Age ≥18 years; AND
- Clinical diagnosis of thyroid eye disease (TED) based on characteristic clinical signs and features in the context of autoimmune thyroid disease; AND
- Lumvoa will be used as a single agent therapy; AND
- Patient has NOT received prior treatment with an insulin-like growth factor-1 receptor inhibitor; AND
- Patient is euthyroid, or thyroid function is being actively managed and is clinically stable on current therapy; AND
- Patient was advised or counseled to refrain from or discontinue tobacco smoking; AND
- Patient does NOT have a history of inflammatory bowel disease (IBD); AND
- Patient does NOT have uncontrolled hyperglycemia or diabetes; AND
- Patient's hearing will be assessed before, during and after treatment; AND
- Lumvoa must be prescribed by, or in consultation with, a specialist in ophthalmology, endocrinology, oculoplastic surgery or neuro-ophthalmology; AND
- Prescriber has reviewed Lumvoa Warnings/Precautions and will monitor patient status as appropriate; AND
- Patients of reproductive potential must have a negative pregnancy test prior to initiation of Lumvoa and must use effective contraception prior to initiation, during treatment and for 6 months after the last dose.

Quantity limits

- 10 mg/kg every 3 weeks for a total of 5 infusions and cannot be renewed
- Patient's weight (in kg) must be submitted at time of request

Billing for Lumvoa

- Lumvoa must be billed on a professional claim

Provider Call Center (844) 575-7887

Discussion Items:

ANDROGENIC AGENTS section reviewed 12-16-2026

Preferred	Nonpreferred
TESTOSTERONE GEL PACKET (AG) (VOGELXO) (TRANSDERM) TESTOSTERONE GEL PUMP (ANDROGEL) (TRANSDERM) TESTIM (TRANSDERM.)	ANDROGEL GEL PUMP (TRANSDERM) TESTOSTERONE GEL (FORTESTA) (TRANSDERM) TESTOSTERONE GEL (TESTIM) (TRANSDERM) TESTOSTERONE GEL PACKET (ANDROGEL) (TRANSDERM) TESTOSTERONE GEL (VOGELXO) (TRANSDERM) TESTOSTERONE GEL (AG) (VOGELXO) (TRANSDERM) TESTOSTERONE GEL PUMP (VOGELXO) (TRANSDERM) TESTOSTERONE GEL PUMP (AG) (VOGELXO) (TRANSDERM) TESTOSTERONE PUMP (AXIRON) (TRANSDERM) VOGELXO GEL (TRANSDERM) VOGELXO GEL PACKET (TRANSDERM) VOGELXO GEL PUMP (TRANSDERM)

ANTIHISTAMINES, MINIMALLY SEDATING section reviewed 12-16-2026

Preferred	Nonpreferred
CETIRIZINE SOLUTION (ORAL) CETIRIZINE SOLUTION OTC (ORAL) CETIRIZINE TABLETS OTC (ORAL) CETIRIZINE-D OTC (ORAL) FEXOFENADINE 60 MG, 180 MG OTC (ORAL) FEXOFENADINE SUSPENSION OTC (ORAL) LEVOCETIRIZINE SOLUTION (ORAL) LEVOCETIRIZINE TABLETS (ORAL) LORATADINE ODT OTC (ORAL) LORATADINE SOLUTION OTC (ORAL) LORATADINE TABLETS OTC (ORAL) LORATADINE-D OTC (ORAL) * Not all OTC products are covered. Please consult the NDC lookup website for specific NDC coverage information	CETIRIZINE CHEWABLE OTC (ORAL) CLARINEX TABLET (ORAL) CLARINEX-D 12 HOUR (ORAL) DESLORATADINE (ORAL) DESLORATADINE ODT (ORAL) DESLORATADINE SOLUTION (ORAL)

ANTIPARASITICS, TOPICAL section section reviewed 12-16-2026

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

ERYTHROPOIESIS STIMULATING PROTEINS section reviewed 12-16-2026

Preferred	Nonpreferred
ARANESP DISP SYRIN (INJECTION) ARANESP VIAL (INJECTION)	MIRCERA (INJECTION) PROCRIT (INJECTION)

Preferred	Nonpreferred
EPOGEN (INJECTION) RETACRIT (INJECTION)	REBLOZYL (SUBCUTANEOUS) RETACRIT (VIFOR) (INJECTION) VAFSEO TABLET (ORAL)

GLUCAGON AGENTS section reviewed 12-16-2026

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

HISTAMINE II RECEPTOR BLOCKER section added and reviewed 12-16-2026

Preferred	Nonpreferred
FAMOTIDINE TABLET (ORAL) FAMOTIDINE SUSPENSION (ORAL)	CIMETIDINE TABLET (ORAL) CIMETIDINE SUSPENSION (ORAL) NIZATIDINE CAPSULE (ORAL) RANITIDINE SYRUP (ORAL) RANITIDINE TABLET (ORAL)

IMMUNOMODULATORS, ATOPIC DERMATITIS section reviewed 12-6-2026

Preferred	Nonpreferred
DUPIXENT (SUBCUTANE.) ~~EUCRISA (TOPICAL)~~ TACROLIMUS (TOPICAL) PIMECROLIMUS (TOPICAL)	ADBRY (SUBCUTANEOUS) ANZUPGO CREAM (TOPICAL) EBGLYSS (SUBCUTANEOUS) EUCRISA (TOPICAL) NEMLUVIO PEN (SUBCUTANEOUS) OPZELURA (TOPICAL) VTAMA (TOPICAL) ZORYVE 0.15% CREAM (TOPICAL) ZORYVE 0.05% CREAM (TOPICAL)

LIPOTROPICS, OTHER section reviewed 12-16-2026

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

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

MACROLIDES/KETOLIDES section reviewed 12-16-2026

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

NEUROPATHIC PAIN AND SELECT AGENTS section renamed and reviewed 12-16-2026

Preferred	Nonpreferred
DULOXETINE (CYMBALTA GEN.) (ORAL) GABAPENTIN CAPSULE (ORAL) GABAPENTIN SOLUTION (ORAL) GABAPENTIN TABLET (ORAL) PREGABALIN CAPSULE (ORAL)	CYMBALTA (ORAL) DRIZALMA SPRINKLE (ORAL) DULOXETINE (IRENKA) (ORAL) DULOXETINE (NO BRAND) (ALMATICA) (ORAL) GABAPENTIN ER TABLET (GRALISE) (ORAL)

Preferred	Nonpreferred
SAVELLA (ORAL) SAVELLA DOSE PACK (ORAL)	GABARONE TABLET (ORAL) GRALISE (ORAL) HORIZANT (ORAL) LIDOCAINE (TOPICAL) LYRICA CAPSULE (ORAL) LYRICA CR (ORAL) LYRICA SOLUTION (ORAL) MILNACIPRAL TABLET (ORAL) NEURONTIN CAPSULE (ORAL) NEURONTIN SOLUTION (ORAL) NEURONTIN TABLET (ORAL) PREGABALIN ER (ORAL) PREGABALIN SOLUTION (ORAL) QUTENZA KIT (TOPICAL) TONMYA (SUBLINGUAL) ZTLIDO (TOPICAL)

OPHTHALMICS, ANTI-INFLAMMATORIES section reviewed 12-16-2026

Preferred	Nonpreferred
DICLOFENAC (OPHTHALMIC) FLUOROMETHOLONE (OPHTHALMIC) KETOROLAC (OPHTHALMIC) ~~KETOROLAC LS (OPHTHALMIC)~~ PREDNISOLONE ACETATE (OPHTHALMIC) TRIESENCE (INTRAOCULR)	ACULAR (OPHTHALMIC) ACULAR LS (OPHTHALMIC) ACUVAIL (OPHTHALMIC) BROMFENAC (BROMSITE) (OPHTHALMIC) BROMFENAC (PROLENSA) (OPHTHALMIC) BROMSITE (OPHTHALMIC) BYQLOVI (OPHTHALMIC) DEXAMETHASONE (OPHTHALMIC) DEXTENZA (INTRAOCULAR) DIFLUPREDNATE (OPHTHALMIC) DIFLUPREDNATE (AG) (OPHTHALMIC) DUREZOL (OPHTHALMIC) FLURBIPROFEN (OPHTHALMIC) ILEVRO (OPHTHALMIC) ILUVIEN (INTRAOCULAR) INVELTYS (OPHTHALMIC) KETOROLAC LS (OPHTHALMIC) LOTEMAX DROPS (OPHTHALMIC) LOTEMAX GEL (OPHTHALMIC) LOTEMAX OINTMENT (OPHTHALMIC) LOTEPREDNOL GEL (AG) (OPHTHALMIC) LOTEPREDNOL GEL (OPHTHALMIC) LOTEPREDNOL DROPS (AG) (OPHTHALMIC) LOTEPREDNOL DROPS (OPHTHALMIC) NEVANAC (OPHTHALMIC) OZURDEX (INTRAOCULR) PREDNISOLONE SOD PHOSPHATE (OPHTHALMIC) PROLENSA (OPHTHALMIC) RETISERT (INTRAOCULR) XIPERE (SUPRACHOROIDAL INJECTION) ~~YUTIQ (INTRAOCULR)~~

OPHTHALMICS, GLAUCOMA AGENTS AND RELATED AGENTS section renamed and reviewed 12-16-2026

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

PHOSPHATE BINDERS section reviewed 12-16-2026

Preferred	Nonpreferred
CALCIUM ACETATE CAPSULE (ORAL)	AURYXIA (ORAL)

Preferred	Nonpreferred
CALCIUM ACETATE TABLET (ORAL) SEVELAMER CARBONATE POWDER PACK (ORAL) SEVELAMER CARBONATE TABLET (ORAL)	FERRIC CITRATE (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)

SEDATIVE HYPNOTICS section reviewed 12-16-2026

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

Consent Agenda Items:

ANTIBIOTICS, INHALED section reviewed 12-16-2026 no change

Preferred	Nonpreferred
BETHKIS (INHALATION)	ARIKAYCE (INHALATION)
KITABIS PAK (INHALATION)	CAYSTON (INHALATION)
TOBRAMYCIN (TOBI) (INHALATION)	TOBI (INHALATION)
TOBRAMYCIN (TOBI) (AG) (INHALATION)	TOBI PODHALER (INHALATION)
	TOBRAMYCIN (BETHKIS) (AG) (INHALATION)
	TOBRAMYCIN (BETHKIS) (INHALATION)
	TOBRAMYCIN PAK (AG) (INHALATION)

ANTIBIOTICS, TOPICAL section reviewed 12-16-2026

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

BLADDER RELAXANT PREPARATIONS section reviewed 12-16-2026

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

HEMOPHILIA TREATMENTS section reviewed 12-16-2026 no change

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.)	

Preferred	Nonpreferred
IDELVION (INTRAVEN) IXINITY (INTRAVEN) JIVI (INTRAVEN) KOATE-DVI KIT (INTRAVEN.) KOATE-DVI VIAL (INTRAVEN) KOGENATE FS (INTRAVEN.) KOVALTRY (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.)	

HYPOGLYCEMICS, ALPHA-GLUCOSIDASE INHIBITORS section reviewed 12-16-2026

Preferred	Nonpreferred
ACARBOSE (ORAL)	MIGLITOL (ORAL) ~~PRECOSE (ORAL)~~

HYPOGLYCEMICS, TZD section reviewed 12-16-2026

Preferred	Nonpreferred
PIOGLITAZONE (ORAL)	ACTOPLUS MET (ORAL) ACTOS (ORAL) DUETACT (ORAL) PIOGLITAZONE/GLIMEPIRIDE (ORAL) PIOGLITAZONE/METFORMIN (ORAL)

INTRANASAL RHINITIS AGENTS section reviewed 12-16-2026

Preferred	Nonpreferred
AZELASTINE (ASTELIN) (NASAL) AZELASTINE (ASTEPRO) (NASAL) FLUTICASONE (NASAL) IPRATROPIUM (NASAL) MOMETASONE (NASAL)	AZELASTINE/FLUTICASONE (NASAL) AZELASTINE/FLUTICASONE (AG) (NASAL) DYMISTA (NASAL) FLUNISOLIDE (NASAL) OLOPATADINE (NASAL) OMNARIS (NASAL) QNASL 40 (NASAL) QNASL 80 (NASAL) RYALTRIS (NASAL) SINUVA (SINUS IMPLANT) ~~TICANASE (NASAL)~~ XHANCE (NASAL)

LEUKOTRIENE MODIFIERS section reviewed 12-16-2026

Preferred	Nonpreferred
MONTELUKAST CHEWABLE TABLET (ORAL) MONTELUKAST TABLET (ORAL)	~~ACCOLATE (ORAL)~~ MONTELUKAST GRANULES (ORAL) SINGULAIR CHEWABLE TABLET (ORAL) ~~SINGULAIR GRANULES (ORAL)~~ SINGULAIR TABLET (ORAL) ZAFIRLUKAST (ORAL) ZILEUTON ER (ORAL) ZYFLO (ORAL)

LIPOTROPICS, STATINS section reviewed 12-16-2026

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

OPHTHALMICS FOR ALLERGIC CONJUNCTIVITIS section reviewed 12-16-2026

Preferred	Nonpreferred
ALREX (OPHTHALMIC) AZELASTINE (OPHTHALMIC) BEPREVE (OPHTHALMIC) CROMOLYN SODIUM (OPHTHALMIC) KETOTIFEN OTC (OPHTHALMIC) OLOPATADINE (PATANOL) (OPHTHALMIC) OLOPATADINE DROPS (PATADAY) (OPHTHALMIC) OLOPATADINE 0.1% OTC (OPHTHALMIC) OLOPATADINE 0.2% OTC (OPHTHALMIC)	BEPOTASTINE (OPHTHALMIC) EPINASTINE (OPHTHALMIC) LOTEPREDNOL (OPHTHALMIC) PATADAY ONCE DAILY OTC (OPHTHALMIC) PATADAY TWICE A DAY OTC (OPHTHALMIC) ZADITOR OTC (OPHTHALMIC) ZERVIATE (OPHTHALMIC)

OPHTHALMICS, DRY EYE AGENTS section reviewed 12-16-2026

Preferred	Nonpreferred
RESTASIS (OPHTHALMIC) ~~RESTASIS MULTIDOSE (OPHTHALMIC)~~ XIIDRA (OPHTHALMIC)	CEQUA (OPHTHALMIC) CYCLOSPORINE (OPHTHALMIC) EYSUVIS (OPHTHALMIC) MIEBO (OPHTHALMIC) RESTASIS MULTIDOSE (OPHTHALMIC) TRYPTYR (OPHTHALMIC)

Preferred	Nonpreferred
	TYRVAYA SPRAY (NASAL) VERKAZIA (OPHTHALMIC) VEVYE (OPHTHALMIC)

PAH AGENTS, ORAL AND INHALED section reviewed 12-16-2026

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

PANCREATIC ENZYMES section reviewed 12-16-2026 no change

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

PLATELET AGGREGATION INHIBITORS section reviewed 12-16-2026 no change

Preferred	Nonpreferred
CLOPIDOGREL (ORAL) DIPYRIDAMOLE (ORAL) PRASUGREL (ORAL) TICAGRELOR (ORAL)	ASPIRIN/DIPYRIDAMOLE (ORAL) BRILINTA (ORAL) EFFIENT (ORAL) PLAVIX (ORAL)

PROGESTINS FOR CACHEXIA section reviewed 12-16-2026 no change

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

PROTON PUMP INHIBITORS section reviewed 12-16-2026

Preferred	Nonpreferred
ESOMEPRAZOLE CAPSULES (ORAL)	DEXILANT (ORAL)

Preferred	Nonpreferred
ESOMEPRAZOLE SUSPENSION (ORAL) LANSOPRAZOLE CAPSULES (ORAL) ~~NEXIUM SUSPENSION (ORAL)~~ OMEPRAZOLE (ORAL) PANTOPRAZOLE (ORAL) * Prilosec OTC, Prevacid OTC, Zegerid OTC (omeprazole sodium bicarb) excluded from coverage	DEXLANSOPRAZOLE CAPSULE (ORAL) ~~ESOMEPRAZOLE SUSPENSION (ORAL)~~ KONVOMEP (ORAL) LANSOPRAZOLE SOLUTAB (ORAL) NEXIUM (ORAL) NEXIUM SUSPENSION (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)

SICKLE CELL ANEMIA TREATMENTS section reviewed 12-16-2026

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

ULCERATIVE COLITIS AGENTS section reviewed 12-16-2026

Preferred	Nonpreferred
BALSALAZIDE (ORAL) MESALAMINE (CANASA) (RECTAL) MESALAMINE (LIALDA) (ORAL) MESALAMINE ER (APRISO) (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) 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)