Formulary Updates

Published March 2026

Following is the update to the Highmark Drug Formularies and pharmaceutical management procedures for January 2026. The formularies and pharmaceutical management procedures are updated after each Pharmacy and Therapeutics Committee meeting, and the following changes reflect the decisions made in January by our Pharmacy and Therapeutics Committee. These updates are effective on the dates noted throughout this document.

Please reference the guide below to navigate this communication:

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As an added convenience, you can also search our drug formularies and view utilization management policies on the Provider Resource Center (PRC), which accessible via Availity Essentials® or our website. Once on the PRC, go to **Policies and Programs** > **Formulary** and then scroll down to find the formulary you're looking for.

Important Drug Safety Updates

FDA Requests Removal of Suicidal Behavior and Ideation Warning from Glucagon-Like Peptide-1 Receptor Agonist (GLP-1 RA) Medications

On Jan. 31, 2026, the FDA released a drug safety communication requesting that drug application holders remove information regarding the risk of suicidal ideation and behavior (SI/B) from the labeling of glucagon-like peptide-1 receptor agonist (GLP-1 RA) medications that currently include such language. Similar information about SI/B is also included in the labeling of other types of weight loss medicines and is based on reports of such events observed with a variety of older medicines used or studied for weight loss. The GLP-1 RA medications affected are Saxenda (liraglutide), Wegovy (semaglutide), and Zepbound (tirzepatide). This action follows a comprehensive FDA review that found no increased risk of SI/B associated with the use of GLP-1 RA medications. Labeling for GLP-1 RA medications that are approved to improve glycemic (blood sugar) control or other complications in patients with type 2 diabetes mellitus does not currently include information on the risk of SI/B. This new FDA action will ensure consistent messaging across the labeling for all FDA-approved GLP-1 RA medications. To help FDA track safety issues with medicines, report side effects involving GLP-1 RA medications to the FDA MedWatch program.

Highmark Formulary Update – January 2026

SECTION I. Highmark Commercial and Healthcare Reform Formularies

A. Changes to the Highmark Comprehensive Formulary and the Highmark Healthcare Reform Comprehensive Formulary

The Highmark Pharmacy and Therapeutics Committee has reviewed the medications listed in the tables below. Please Note all medications added to the Comprehensive Closed/Incentive Formulary are also added to the Comprehensive Open Formulary. For your convenience, you can search the following formularies online:

- Highmark Comprehensive Formulary
- Highmark Healthcare Reform Comprehensive Formulary

Highmark is happy to inform you that Table 1 includes products that have been added to the formulary. Adding products to the formulary may mean lower copays or coinsurance rates for members. By doing so, Highmark hopes to promote adherence to medication protocols and improve the overall health of our members.

Table 1. Products Added

All products added to the formulary.

Brand Name	Generic Name	Comments
Pazopanib 400 mg	pazopanib	treatment of adults with advanced renal cell carcinoma (RCC) or advanced soft tissue sarcoma (STS) who have received prior chemotherapy.

Coverage may be contingent upon plan benefits.

Table 2. Products Not Added**

Brand Name	Generic Name	Preferred Alternatives
Aqvesme	mitapivat	prescriber discretion
Armlupeg	pegfilgrastim-unne	Fulphila, Ziextenzo, Neulasta syringe
Boncresa	denosumab-mobz	alendronate sodium tablet, risedronate sodium tablet 5 mg, risedronate sodium tablet 150 mg
Bynfezia Pen	octreotide acetate	octreotide acetate vial, octreotide acetate ampule, octreotide acetate syringe
Cardamyst	etripamil	prescriber discretion
Daybue Stix	trofinetide	prescriber discretion
desloratadine oral solution	desloratadine	cetirizine Hcl oral solution
Hyrnuo	sevabertinib	prescriber discretion
Javadin	clonidine hydrochloride	clonidine tablets

Brand Name	Generic Name	Preferred Alternatives
Jaythari oral suspension	deflazacort	prednisone tablet, prednisone oral solution
Jubereq	denosumab-desu	prescriber discretion
Komzifti	ziftomenib	prescriber discretion
Kygevvi	doxecitine and doxribtimine	prescriber discretion
Kymbee	deflazacort	prednisone tablet, prednisone oral solution
Lerochol	lerodalcibep-liga	Repatha
Lynkuet	elinzanetant	estradiol tablet oral, estradiol-norethindrone acetate tablet
Myqorzo	aficamten	prescriber discretion
Nuzolvence	zoliflodacin	prescriber discretion
orforglipron	orforglipron	prescriber discretion
Orladeyo oral pellets	berotralstat	prescriber discretion
Osvyrti	denosumab-desu	alendronate sodium tablet, risedronate sodium tablet 5 mg, risedronate sodium tablet 150 mg
Oziltus	denosumab-mobz	prescriber discretion
potassium chloride 40 mEq packet	Potassium chloride	potassium chloride 20 mEq tablet, extended release, potassium chloride capsules, extended release
Redemplo	plozasiran	prescriber discretion
Voyxact	sibeprenlimab-szsi	irbesartan oral tablet, losartan oral tablet, valsartan oral tablet
Vybrique	sildenafil	prescriber discretion

Coverage may be contingent upon plan benefits.
Physicians may request coverage of these products using the Prescription Drug Medication Request Form. To access this form for your region, go to the Provider Resource Center and choose your region from the top right. Select **Resources & Education > Forms > Pharmacy Prior Authorization Forms and then scroll down to the **Prescription Drug Medication Request Form**.

Table 3. Additions to the Specialty Tier Copay Option

Note: The specialty tier does not apply to Highmark Delaware Healthcare Reform members; see Highmark Delaware's online Provider Resource Center and access the Pharmacy Program/Formularies link for details on the formularies and formulary options that apply to Highmark Delaware Healthcare Reform members. Once on the page, click on Heathcare Reform, which is under the **Line of Business** header.

Brand Name	Generic Name
Aqvesme	mitapivat
Armlupeg	pegfilgrastim-unne
Boncresa	denosumab-mobz
Bynfezia Pen	octreotide acetate

Cardamyst	etripamil
Daybue Stix	trofinetide
desloratadine oral solution	desloratadine
Hyrnuo	sevabertinib
Javadin	clonidine hydrochloride
Jaythari oral suspension	deflazacort
Jubereq	denosumab-desu
Komzifti	ziftomenib
Kygevvi	doxecitine and doxribtimine
Kymbee	deflazacort
Myqorzo	aficamten
orforglipron	orforglipron
Orladeyo oral pellets	berotralstat
Osvyrti	denosumab-desu
Oziltus	denosumab-mobz
pazopanib 400 mg	pazopanib
potassium chloride 40 mEq packet	potassium chloride
Redemplo	plozasiran
Voyxact	sibeprenlimab-szsi

B. Changes to the Highmark Healthcare Reform Essential Formulary

The Essential Formulary is a closed formulary for select Healthcare Reform (HCR) Individual plans. A list of drugs included on the Essential Formulary, listed by therapeutic class, is available here.

Table 1. Formulary Updates

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
Items listed below were added to the formulary			
pazopanib 400 mg	pazopanib	4	treatment of adults with advanced renal cell carcinoma (RCC) or advanced soft tissue sarcoma (STS) who have received prior chemotherapy.
Items listed below were not added to the formulary			
Aqvesme	mitapivat	NF	prescriber discretion
Armlupeg	pegfilgrastim-unne	NF	Nivestym, Zarxio
Boncresa	denosumab-mobz	NF	Prolia
Bynfezia Pen	octreotide acetate	NF	octreotide acetate vial, octreotide acetate ampule
Cardamyst	etripamil	NF	prescriber discretion
Daybue Stix	trofinetide	NF	prescriber discretion
desloratadine oral solution	desloratadine	NF	desloratadine tablet, levocetirizine dihydrochloride tablet
Hyrnuo	sevabertinib	NF	prescriber discretion

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
Javadin	clonidine hydrochloride	NF	clonidine tablets
Jaythari oral suspension	deflazacort	NF	prednisone tablet, prednisone oral solution
Jubereq	denosumab-desu	NF	prescriber discretion
Komzifti	ziftomenib	NF	prescriber discretion
Kygevvi	doxecitine and doxribtimine	NF	prescriber discretion
Kymbee	deflazacort	NF	prednisone tablet, prednisone oral solution
Lerochol	lerodalcibep-liga	NF	Repatha
Lynkuet	elinzanetant	NF	estradiol tablet oral, estradiol-norethindrone acetate tablet
Myqorzo	aficamten	NF	prescriber discretion
Nuzolvence	zoliflodacin	NF	prescriber discretion
orforglipron	orforglipron	NF	prescriber discretion
Orladeyo oral pellets	berotralstat	NF	Takhzyro
Osvyrti	denosumab-desu	NF	Prolia
Oziltus	denosumab-mobz	NF	prescriber discretion
potassium chloride 40 mEq packet	potassium chloride	NF	potassium chloride 20 mEq tablet, extended release, potassium chloride capsules, extended release
Redemplo	plozasiran	NF	prescriber discretion
Voyxact	sibeprenlimab-szsi	NF	irbesartan oral tablet, losartan oral tablet, valsartan oral tablet
Vybrique	sildenafil	NF	sildenafil citrate (generic Viagra), tadalafil (generic Cialis)

Formulary options: **Tier 1:** Generic drugs; **Tier 2:** Generic and Brand drugs; **Tier 3:** Generic and Brand drugs; **Tier 4:** Generic and Brand drugs; **Non-formulary (NF)**.
*Effective date to be determined.

C. Changes to the Highmark Core Formulary

The Core Formulary is a closed formulary for select Commercial Individual plans. A list of drugs included on the Core Formulary, listed by therapeutic class, is available here.

Table 1. Formulary Updates

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
Items listed below were added to the formulary			
pazopanib 400 mg	pazopanib	4	treatment of adults with advanced renal cell carcinoma (RCC) or advanced soft tissue sarcoma (STS) who have received prior chemotherapy.
Items listed below were not added to the formulary			

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
Aqvesme	mitapivat	NF	prescriber discretion
Armlupeg	pegfilgrastim-unne	NF	Nivestym
Boncresa	denosumab-mobz	NF	Prolia
Bynfezia Pen	octreotide acetate	NF	octreotide acetate vial, octreotide acetate ampule
Cardamyst	etripamil	NF	prescriber discretion
Daybue Stix	trofinetide	NF	prescriber discretion
desloratadine oral solution	desloratadine	NF	Desloratadine tablet, cetirizine hcl oral solution, levocetirizine dihydrochloride tablet
Hyrnuo	sevabertinib	NF	prescriber discretion
Javadin	clonidine hydrochloride	NF	clonidine tablets
Jaythari oral suspension	deflazacort	NF	prednisone tablet
Jubereq	denosumab-desu	NF	prescriber discretion
Komzifti	ziftomenib	NF	prescriber discretion
Kygevvi	doxecitine and doxribtimine	NF	prescriber discretion
Kymbee	deflazacort	NF	prednisone tablet
Lerochol	lerodalcibep-liga	NF	Repatha
Lynkuet	elinzanetant	NF	estradiol tablet oral, estradiol-norethindrone acetate tablet
Myqorzo	aficamten	NF	prescriber discretion
Nuzolvence	zoliflodacin	NF	prescriber discretion
orforglipron		NF	prescriber discretion
Orladeyo oral pellets	berotralstat	NF	Takhzyro
Osvyrti	denosumab-desu	NF	Prolia
Oziltus	denosumab-mobz	NF	prescriber discretion
potassium chloride 40 mEq packet	potassium chloride	NF	potassium chloride 20 mEq tablet, extended release, potassium chloride capsules, extended release
Redemplo	plozasiran	NF	prescriber discretion
Voyxact	sibeprenlimab-szsi	NF	irbesartan oral tablet, losartan oral tablet, valsartan oral tablet
Vybrique	sildenafil	NF	sildenafil citrate (generic Viagra)

Formulary options: **Tier 1:** Generic drugs; **Tier 2:** Generic and Brand drugs; **Tier 3:** Generic and Brand drugs; **Tier 4:** Generic and Brand drugs; **Non-formulary (NF)**.

D. Changes to the Highmark National Select Formulary

The National Select Formulary is an incentive formulary with a non-formulary drug list to manage products in therapeutic categories for which preferred alternatives are available. The National Select Formulary is available for select Commercial self-funded (ASO) plans. A list of drugs included on the National Select Formulary, listed by therapeutic class, is available here.

Table 1. Formulary Updates

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
Items listed below were added to the formulary (Preferred)			
Kymbee	deflazacort	1	treatment of Duchenne muscular dystrophy (DMD) in patients 5 years of age and older
Jaythari oral suspension	deflazacort	1	Treatment of Duchenne muscular dystrophy (DMD) in patients 5 years of age and older
pazopanib 400 mg	pazopanib	2	treatment of adults with advanced renal cell carcinoma (RCC) or advanced soft tissue sarcoma (STS) who have received prior chemotherapy.
Komzifti	ziftomenib	2	Treatment of adults with relapsed or refractory acute myeloid leukemia (AML) with a susceptible nucleophosmin 1 (NPM1) mutation.
Items listed below were added to the formulary (Non-Preferred)			
Armlupeg	pegfilgrastim-unne	3*	Fulphila, Ziextenzo
Boncresa	denosumab-mobz	3*	alendronate sodium tablet, risedronate sodium tablet 5 mg, risedronate sodium tablet 150 mg
Cardamyst	etripamil	3*	prescriber discretion
Hyrnuo	sevabertinib	3*	prescriber discretion
Jubereq	denosumab-desu	3*	prescriber discretion
Kygevvi	doxecitine and doxribtimine	3*	prescriber discretion
Lerochol	lerodalcibep-liga	3*	Repatha
Lynkuet	elinzanetant	3	estradiol tablet oral, estradiol-norethindrone acetate tablet
Myqorzo	aficamten	3*	prescriber discretion
Nuzolvence	zoliflodacin	3*	prescriber discretion
orforglipron	orforglipron	3*	prescriber discretion
Osvyrti	denosumab-desu	3*	alendronate sodium tablet, risedronate sodium tablet 5 mg, risedronate sodium tablet 150 mg
Oziltus	denosumab-mobz	3*	prescriber discretion
Redemplo	plozasiran	3*	Prescriber discretion
Voyxact	sibeprenlimab-szsi	3*	irbesartan oral tablet, losartan oral tablet, valsartan oral tablet
Vybrique	sildenafil	3*	sildenafil citrate (generic Viagra)
Aqvesme	mitapivat	3	prescriber discretion
Orladeyo oral pellets	berotralstat	3*	prescriber discretion
Items listed below were not added to the formulary			
Bynfezia Pen	octreotide acetate	NF	octreotide acetate vial, octreotide acetate ampule, octreotide acetate syringe
Daybue Stix	trofinetide	NF	prescriber discretion

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
desloratadine oral solution	desloratadine	NF	cetirizine HCl oral solution
potassium chloride 40 mEq packet	potassium chloride	NF	potassium chloride 20 mEq tablet, extended release, potassium chloride capsules, extended release
Javadin	clonidine hydrochloride	NF	clonidine tablets

Formulary options: **Tier 1:** Generic drugs; **Tier 2:** Preferred Brand drugs; **Tier 3:** Non-Preferred Brand drugs; **Non-formulary (NF)**.
*Effective date and final formulary position to be determined.

Table 2. Additions to the Specialty Tier Copay Option

Brand Name	Generic Name
Aqvesme	mitapivat
Armlupeg	pegfilgrastim-unne
Boncresa	denosumab-mobz
Bynfezia Pen	octreotide acetate
Cardamyst	etripamil
Daybue Stix	trofinetide
desloratadine oral solution	desloratadine
Hyrnuo	sevabertinib
Javadin	clonidine hydrochloride
Jaythari oral suspension	deflazacort
Jubereq	denosumab-desu
Komzifti	ziftomenib
Kygevvi	doxecitine and doxribtimine
Kymbee	deflazacort
Myqorzo	aficamten
orforglipron	orforglipron
Orladeyo oral pellets	berotralstat
Osvyrti	denosumab-desu
Oziltus	denosumab-mobz
pazopanib 400 mg	pazopanib
potassium chloride 40 mEq packet	potassium chloride
Redemplo	plozasiran
Voyxact	sibeprenlimab-szsi

E. Updates to the Pharmacy Utilization Management Programs

1. Prior Authorization Program

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Accrufer (ferric maltol) – Commercial and Healthcare Reform	02/13/2026	Policy revised for Accrufer (ferric maltol) to add age is 10 years or older and if pediatric female or male 10 to 14 years of age, hemoglobin level less than 12 g/dL. For pediatrics 15-17 years, hemoglobin less than 12 g/dL if female or 13 g/dL if male.
Addyi (flibanserin) – Commercial and Healthcare Reform	02/13/2026	Policy revised for Addyi (flibanserin) to add post-menopausal adult females under the age of 65 to initial and reauthorization.
Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors – Commercial and Healthcare Reform	02/13/2026	Policy revised to include Nexletol (bempedoic acid) and Nexlizet (bempedoic acid/ezetimibe) new broadened indication. Removed policy criteria requiring LDL-C and non-HDL-C levels related to new broadened indication. For reauthorization, the prescriber attests that the member requires continued therapy.
Anti-EGFR and HER2 Kinase Inhibitors – Commercial and Healthcare Reform	02/13/2026	Policy revised to add Hyrnuo (sevabertinib) as a target requiring FDA-approved age and indication. Reauthorization requiring disease improvement or delayed disease progression.
Antifibrotic Pulmonary Medications – Commercial and Healthcare Reform	02/13/2026	Policy revised to include new indication of Jascayd (nerandomilast). The member must have a diagnosis of progressive pulmonary fibrosis (PPF), documentation of a chest computed tomography scan demonstrating ≥ 10% pulmonary fibrosis, the member has a baseline forced vital capacity (FVC) of at least 45%, and the member has a percent predicted diffusing capacity of the lungs of carbon monoxide of at least 25%. The member also must present with clinical signs of progression defined as one of the following: FVC decline ≥ 10%, FVC decline ≥ 5% and < 10% with worsening of respiratory symptoms or imaging or worsening of respiratory symptoms and worsening imaging all in the 24 months prior to screening. The member is a non-smoker or the member is currently engaged in smoking cessation. The member has been stable on therapy with Ofev (nintedanib) with no dose change for at least 12 weeks and will continue Ofev concomitantly with Jascayd, the member

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		is treatment naive to antifibrotic treatment, or the member previously discontinued Ofev for at least 8 weeks and does not plan to start or re-start background PPF treatment.
Anti-Obesity (Enhanced) – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised to add orforglipron as a target mirroring initial and maintenance criteria for Wegovy (semaglutide) oral tablet when FDA-approved age and indication is shared. Maintenance criteria requires FDA-approved maintenance dosing or attestation of titration to maintenance dosing.
Anti-Obesity (Standard) – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised to add orforglipron as a target mirroring initial, maintenance, and continuation criteria for Zepbound (tirzepatide) when FDA-approved age and indication is shared. Maintenance and continuation criteria requires FDA-approved maintenance dosing or attestation of titration to maintenance dosing.
Anti-Obesity (Standard) – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised to add orforglipron as a target mirroring initial, maintenance, and continuation criteria for Zepbound (tirzepatide) when FDA-approved age and indication is shared. Maintenance and continuation criteria requires FDA-approved maintenance dosing or attestation of titration to maintenance dosing. For initiation, continuation, and maintenance, trial/failure/contraindication to Zepbound (tirzepatide).
BRAF Mutation-Targeting & MEK Kinase Inhibitors – Commercial and Healthcare Reform	02/13/2026	Policy revised for Koselugo (selumetinib) for expanded indication to allow for age of 1 year or older.
BTK Inhibitors – Commercial and Healthcare Reform	02/13/2026	Policy revised for Jaypirca (pirtobrutinib) to require criteria based on updated indication for relapsed or refractory chronic lymphocytic leukemia or small lymphocytic lymphoma.
Bynfezia (octreotide acetate) – Commercial and Healthcare Reform	02/13/2026	Policy reactivated due to Bynfezia (octreotide acetate) being back on the market. Initial criteria is based on FDA-approved indications and therapeutic failure or intolerance to plan-preferred generic octreotide acetate. Reauthorization criteria for acromegaly requires one of the following, decreased IGF-1 from baseline or normalized IGF-1 from

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		baseline. Reauthorization criteria for carcinoid tumors and VIPomas requires positive clinical response to therapy.
Cablivi (caplacizumab-yhdp) – Commercial and Healthcare Reform	02/13/2026	Policy revised for Cablivi (caplacizumab-yhdp) to update age to 12 years and older.
Cardamyst (etripamil) – Commercial and Healthcare Reform	02/17/2026	Policy created for Cardamyst (etripamil). Policy criteria for initial authorization includes age, the medication is prescribed by or in consultation with a cardiologist, diagnosis of paroxysmal supraventricular tachycardia (PSVT) supported by a documented physical electrographic heart test, and the member has a history of symptomatic episodes of PSVT (typically lasting approximately 20 minutes or longer). For reauthorization criteria, the prescriber attests that the member has used Cardamyst for a previous episode of PSVT, had a positive clinical result and the medication is prescribed by or in consultation with a cardiologist. Authorization duration of 6 months.
Cardiac Myosin Inhibitors – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised to add new product Myqorzo (aficamten) requiring age, FDA-approved diagnosis confirmed by guideline-recommended imaging or cardiovascular magnetic resonance (CMR), prescribed by or in consultation with a specialist, NYHA functional class II or III, and trial/failure to a non-vasodilating beta-blocker or a non-dihydropyridine calcium channel blocker. Authorization duration of 12 months. Policy revised for Camzyos (mavacamten) to require FDA-approved diagnosis confirmed by guideline-recommended imaging or CMR. Removed requirement that the member is not going to be treated with disopyramide, ranolazine, or combination of beta blockers and calcium channel blockers. Reauthorization for Camzyos and Myqorzo updated to require a reduction/maintenance in NYHA symptom class, improvement/stabilization in LVOT peak gradient, or stabilization in pVO2.

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Chronic Inflammatory Diseases – Commercial and Healthcare Reform	12/01/2025	Policy revised for Rinvoq (upadacitinib) to update for ulcerative colitis or Crohn's disease when TNF blockers are not advisable, the member has experienced therapeutic failure or intolerance to at least one systemic therapy.
Chronic Inflammatory Diseases – Commercial and Healthcare Reform	01/01/2026	Policy revised for Rinvoq (upadacitinib) to update for ulcerative colitis or Crohn's disease when TNF blockers are not advisable, the member has experienced therapeutic failure or intolerance to at least one systemic therapy.
Chronic Inflammatory Diseases – Commercial and Healthcare Reform	01/15/2026	Policy revised to allow approval exception for adalimumab-adaz 10mg for polyarticular juvenile idiopathic arthritis or pediatric uveitis in patients weighing 10 kg to less than 15 kg. Background updated to include information about adverse drug reactions to a biosimilar must be classified as definite or certain by a causality tool and reported to FDA MedWatch or FDA's Adverse Events Reporting system (FAERS).
Chronic Inflammatory Diseases – Commercial and Healthcare Reform	02/13/2026	Policy revised for Omvoh (mirikizumab-mrkz) SC to include new maintenance dosage for ulcerative colitis of one 200 mg/2 ml pen/syringe every 4 weeks and to include unbranded adalimumab-bwwd as a non-preferred adalimumab biosimilar.
Chronic Inflammatory Diseases – Commercial National Select Formulary	12/01/2025	Policy revised for Rinvoq (upadacitinib) to update for ulcerative colitis or Crohn's disease when TNF blockers are not advisable, the member has experienced therapeutic failure or intolerance to at least one systemic therapy.
Chronic Inflammatory Diseases – Commercial National Select Formulary	01/01/2026	Policy revised for Rinvoq (upadacitinib) to update for ulcerative colitis or Crohn's disease when TNF blockers are not advisable, the member has experienced therapeutic failure or intolerance to at least one systemic therapy.
Chronic Inflammatory Diseases – Commercial National Select Formulary	01/15/2026	Policy revised to allow approval exception for adalimumab-adaz 10mg for polyarticular juvenile idiopathic arthritis or pediatric uveitis in patients weighing 10 kg to less than 15 kg. Background updated to include information

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		about adverse drug reactions to a biosimilar must be classified as definite or certain by a causality tool and reported to FDA MedWatch or FDA's Adverse Events Reporting system (FAERS).
Chronic Inflammatory Diseases – Commercial National Select Formulary	02/13/2026	Policy revised for Omvoh (mirikizumab-mrkz) SC to include new maintenance dosage for ulcerative colitis of one 200 mg/2 ml pen/syringe every 4 weeks and to include unbranded adalimumab-bwwd as a non-preferred adalimumab biosimilar.
Cystic Fibrosis Inhaled Medications – Commercial and Healthcare Reform	02/13/2026	Policy updated to require members to experience therapeutic failure, contraindication, intolerance, or resistance to generic inhaled tobramycin to be approved for Cayston (aztreonam inhaled solution).
Daybue (trofinetide) and Daybue Stix (trofinetide) – Commercial and Healthcare Reform	02/13/2026	Policy revised to add Daybue Stix (trofinetide) to require the member is 2 years of age or older, diagnosis of Rett syndrome (RTT) confirmed by pathogenic mutation in the MECP2 gene and meeting all of the diagnostic criteria for typical RTT, and the medication is being prescribed by or in consultation with a specialist experienced in the treatment of RTT. Reauthorization criteria requires stabilization or improvement in clinical features of RTT.
Deflazacort – Commercial and Healthcare Reform	02/13/2026	Policy revised to include Kymbee (deflazacort) and Jaythari (deflazacort) oral suspension requiring age of 5 years or older, confirmed diagnosis of Duchenne muscular dystrophy (DMD) with documented mutation of the dystrophin gene, prescribed by or in consultation with a physician who specializes in treating neuromuscular disorders, onset of weakness or history of disease prior to age 5 years, and intolerable adverse events or severe behavioral adverse event from plan preferred prednisone. Reauthorization requiring positive clinical response to therapy. For Jaythari (deflazacort) oral suspension, the member has experienced therapeutic failure or intolerance to Jaythari (deflazacort) tablets, Kymbee (deflazacort) , or generic deflazacort tablets for initial and reauthorization.

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Denosumab Products for Bone Disease and Evenity (romosozumab-aqqg) – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised to add Osvyrti (denosumab-desu) and Boncresa (denosumab-mobz) as targets mirroring criteria for all other Prolia (denosumab) biosimilars.
Familial Chylomicronemia Syndrome (FCS) Medications – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised to add Redemplo (plozasiran) as a target. Criteria requires requiring diagnosis of familial chylomicronemia syndrome (FCS), determined by one of the following: genetic test demonstrating biallelic pathogenic variants in at least one gene causing FCS or genetic test results are inconclusive, and meets one of the following: the member has a FCS score ≥ 10, NAFCS score ≥ 45, the member has a history of pancreatitis, the member has a history of eruptive xanthomas, the member has a history of lipemia retinalis, and the member has a fasting triglyceride level ≥ 880 mg/dL, the member will use Redemplo in combination with diet, and if the request is for Tryngolza (olezarsen) the member has experienced therapeutic failure or intolerance to Redemplo. Reauthorization requiring the member has experienced improvement in triglycerides from baseline and if the request is for Tryngolza the member has experienced therapeutic failure or intolerance to Redemplo. Initial authorization duration of 6 months. Reauthorization duration of 12 months.
Fingolimod – Commercial and Healthcare Reform	02/13/2026	Policy revised for Gilenya (fingolimod) and Tascenso (fingolimod) 0.5 mg to remove weight requirement from adults.
Gabarone (gabapentin) – Commercial and Healthcare Reform	02/13/2026	Policy for Gabarone (gabapentin) for postherpetic neuralgia requiring that the member has experienced therapeutic failure or intolerance to plan-preferred generic gabapentin immediate-release at a dose of at least 1,800 mg per day for initial and reauthorization.
Hereditary Angioedema – Commercial and Healthcare Reform	02/13/2026	Policy revised for Orladeyo (berotralstat) to update age to 2 years and older.

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Horizant (gabapentin enacarbil) – Commercial and Healthcare Reform	02/13/2026	Policy revised for Horizant (gabapentin enacarbil) to require that the member has experienced therapeutic failure or intolerance to plan preferred generic gabapentin immediate-release at a dose of at least 1,800 mg per day in initial and reauthorization.
Immunoglobulin A Nephropathy (IgAN) Therapies – Commercial and Healthcare Reform	02/13/2026	Policy revised to add Voyxact (sibeprenlimab-szsi) as a target requiring, age, diagnosis of primary immunoglobulin A nephropathy, proteinuria ≥ 0.5 g/day, and concurrent use of or intolerance/contraindication to a maximum tolerated dose angiotensin converting enzyme (ACE) inhibitor, maximum tolerated dose angiotensin receptor blocker (ARB) or sodium-glucose cotransporter-2 inhibitors (SGLT2i). For reauthorization, the member must experience a decrease in proteinuria from baseline and be concurrently using, or have intolerance/contraindication to, an ACE, ARB, or SGLT2i.
Kygevvi (doxecitine and doxribtimine) – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	New policy for Kygevvi (doxecitine and doxribtimine) requiring diagnosis of thymidine kinase 2 deficiency genetically confirmed by a pathogenic variant of TK2 and symptom onset on or before the age of 12 years. Reauthorization requiring slowed disease progression, regaining a motor milestone, decreased ventilatory support, or decreased need for feeding support.
Mavenclad (cladribine) – Commercial and Healthcare Reform	02/13/2026	Policy revised to add generic cladribine as a target.
Mavenclad (cladribine) – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised to require step through generic cladribine for brand Mavenclad (cladribine).
Menin Inhibitors – Commercial and Healthcare Reform	02/13/2026	Policy revised for Revuforj (revumenib) to require age and criteria based on expanded FDA-approved indication for acute myeloid leukemia with a susceptible NPM1 mutation and updated indication for acute leukemia with KMT2A translocation. Policy revised to add Komzifti (ziftomenib) to require age and criteria based on FDA-approved indication for

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		AML with a susceptible NPM1 mutation in those with no satisfactory alternative treatment options.
Menopause Agents – Commercial and Healthcare Reform	02/13/2026	Policy revised to add Lynkuet (elinzanetant) requiring age, FDA-approved diagnosis, and trial/failure/contraindication to a generic hormone therapy or hormone therapy is not clinically appropriate. Reauthorization of positive clinical response and authorization duration of 12 months.
Mitapivat Products – Commercial and Healthcare Reform	02/13/2026	Policy revised to add Aqvesme (mitapivat) requiring age, FDA-approved diagnosis confirmed by DNA-analysis or hemoglobin-analysis, and hemoglobin ≤ 10 g/dL or member requires regular red blood cell (RBC) transfusions (6 or more RBC transfusions per 24 weeks with no transfusion-free period greater than 8 weeks during that period). Reauthorization of increase of hemoglobin ≥ 1.0 g/dL from baseline or decrease in transfusion burden from baseline. Aqvesme in patients with cirrhosis should be avoided. Initial authorization duration of 24 weeks and reauthorization duration of 12 months.
Non-preferred Oral Potassium Chloride Products – Commercial and Healthcare Reform	02/13/2026	Policy revised to add potassium chloride 40 mEq packets for oral solution as a target requiring diagnosis based on FDA-approved indication, an inability to swallow solid oral dosage forms, and if the member is 18 years of age or older, trial/failure of potassium chloride oral capsules and tablets. Reauthorization requiring need for continued therapy and continued inability to swallow oral dosage forms.
Novel Loop Diuretics (furosemide, bumetanide) – Commercial and Healthcare Reform	02/13/2026	Policy revised, requiring criteria based on FDA-approved expanded indication in pediatric patients weighing 43 kg and above.
Oral Isotretinoin Therapy – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised to add generic isotretinoin capsules (Aurobindo manufacturer) requiring age, diagnosis, trial/failure of a topical retinoid, topical antibiotic, oral antibiotic (acne), and one preferred isotretinoin product. Reauthorization requiring not receiving

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		isotretinoin for at least 8 weeks after completion of the initial course and persistent/recurring severe acne. Authorization duration of 5 months.
Oral Isotretinoin Therapy – Commercial and Healthcare Reform	02/13/2026	Policy revised to remove Myorisan (isotretinoin) as step therapy option since no longer available on the market.
PARP Inhibitors – Commercial and Healthcare Reform	02/13/2026	Policy revised for Akeega (niraparib and abiraterone acetate) to require age and criteria based on expanded FDA-approved indication for BRCA2-mutated castration-sensitive prostate cancer. Policy revised for Rubraca (rucaparib) to remove requirement that member has been treated with taxane-based chemotherapy based on updated FDA-approved indication for prostate cancer.
PCSK9 Inhibitors – Commercial and Healthcare Reform	12/19/2026	Policy was revised to include Praluent's (alirocumab) expanded indication. For the indication risk of cardiovascular events, Praluent was added as a target and the criteria was updated requiring if the request is for Praluent, the member has experienced therapeutic failure or intolerance to plan-preferred Repatha for initial and maintenance criteria. Maintenance criteria was also updated for the indication risk of cardiovascular events to now read, prior to the start of Praluent or Repatha therapy, the member met one (1) of the following; the member had a current LDL-C ≥ 90 mg/dL, the member had a current non-HDL-C ≥ 120 mg/dL, the member had a current apolipoprotein B ≥ 80 mg/dL.
PCSK9 Inhibitors – Commercial and Healthcare Reform	Effective upon completion of internal review and implementation.	Policy revised to add Lerochol (lerodalcibep-liga) as a target mirroring authorization criteria for Praluent (alirocumab) when there is a shared FDA-approved age and indication.
Pulmonary Hypertension – Commercial and Healthcare Reform	02/13/2026	Policy revised for Winrevair (sotatercept-csrk) to allow approval in patients with NYHA or WHO functional class IV symptoms at baseline.
Testosterone (Androgens) –	02/13/2026	Policy revised for Xyosted (testosterone enanthate) to require trial/failure of generic testosterone injectable product.

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Commercial and Healthcare Reform		
Voquezna (vonoprazan) Products – Commercial and Healthcare Reform	02/13/2026	Voquezna (vonoprazan) for *Helicobacter pylori* requires allergy, intolerance, or contraindication to any component of bismuth quadruple therapy.

*For Commercial and Healthcare Reform policies, an exception to some or all the criteria above may be granted for select members and/or circumstances based on state and/or federal regulations.
**All effective dates are tentative and subject to delay pending internal review or approval.

2. Managed Prescription Drug Coverage (MRxC) Program

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
Atypical Antipsychotics – Commercial	02/13/2026	Policy revised for Caplyta (lumateperone) to include criteria for a new FDA-approved indication: adjunctive therapy with antidepressants for the treatment of major depressive disorder (MDD) in adults. Member must be 18 years of age or older, have a diagnosis of MDD, Caplyta is prescribed as an adjunct to a currently used antidepressant in the treatment of MDD, the member has experienced therapeutic failure, contraindication, or intolerance to one (1) other generic antidepressant in addition to the antidepressant currently being used for the treatment of MDD, and the member has experienced therapeutic failure, contraindication or intolerance to one of the plan-preferred generic products, quetiapine ER or aripiprazole tablets. In addition, criteria for Vraylar (cariprazine) has been revised to include FDA-approved changes in age for schizophrenia and bipolar mania or mixed episodes. For schizophrenia, the age has been lowered to 13 years of age, and for bipolar mania, the age has been lowered to 10 years of age.
Atypical Antipsychotics – Healthcare Reform	02/13/2026	Policy revised for Caplyta (lumateperone) to include criteria for a new FDA-approved indication: adjunctive therapy with antidepressants for the treatment of major depressive disorder (MDD) in adults. Member must be 18 years of age or older, have a diagnosis of MDD, Caplyta is prescribed as an adjunct to a currently used antidepressant in the treatment of MDD, the member has experienced therapeutic failure, contraindication, or intolerance

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
		to one (1) other generic antidepressant in addition to the antidepressant currently being used for the treatment of MDD, and the member has experienced therapeutic failure, contraindication or intolerance to one of the plan-preferred generic products, quetiapine ER or aripiprazole tablets. In addition, criteria for Vraylar (cariprazine) has been revised to include FDA-approved changes in age for schizophrenia and bipolar mania or mixed episodes. For schizophrenia, the age has been lowered to 13 years of age, and for bipolar mania, the age has been lowered to 10 years of age.
Banzel (rufinamide) – Commercial and Healthcare Reform	Effective upon completion of internal review and implement ation.	New policy for brand Banzel (rufinamide) to require age and diagnosis based on FDA-approved indication, therapeutic failure, intolerance or contraindication to valproic acid/divalproex sodium, lamotrigine, topiramate or clobazam and step through generic rufinamide. Reauthorization requires reduction on seizure frequency.
Carafate (sucralfate) – Commercial and Healthcare Reform	Effective upon completion of internal review and implement ation.	Policy revised for Carafate (sucralfate) to remove automatic approval criteria.
Carbidopa/Levodopa – Commercial and Healthcare Reform	Effective upon completion of internal review and implement ation.	Policy revised for Crexont (carbidopa/levodopa ER), Dhivy (carbidopa/levodopa), and Rytary (carbidopa/levodopa ER) to require trial of generic carbidopa-levodopa immediate release tablets and extended release tablets.
Desloratadine Oral Solution – Commercial and Healthcare Reform	Effective upon completion of internal review and implement ation.	Policy created for desloratadine oral solution to require FDA-approved diagnosis and age, step through generic desloratadine tablets/orally disintegrating tablets, therapeutic failure, contraindication or intolerance to two other generic antihistamine products, and inability to swallow solid oral dosage forms. Reauthorization requires positive clinical response to therapy and continued inability to swallow solid oral dosage forms.
Erectile Dysfunction Limits – Commercial,	Effective upon completion	Policy revised to add Vybrique (sildenafil) with quantity limit for Commercial and Healthcare Reform of 6 films per retail and 18 films per mail,

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
Healthcare Reform, and Medicare	of internal review and implement ation.	and quantity limit for Medicare of 18 films per 90 days.
Gralise (gabapentin extended-release) – Commercial and Healthcare Reform	02/13/2026	Policy revised for Gralise (gabapentin extended-release) to require that the member has experienced therapeutic failure or intolerance to the plan-preferred product, generic immediate-release gabapentin at a dose of at least 1,800 mg per day for initial and reauthorization.
Intraocular Pressure Reducing Agents – Commercial and Healthcare Reform	01/13/2026	Policy revised to add Omlonti (omidenepag isopropyl) requiring age, diagnosis based on FDA-approved indication, therapeutic failure or intolerance to latanoprost and an additional generic ophthalmic alternative. Reauthorization requiring attestation of positive clinical response to therapy.
Intraocular Pressure Reducing Agents – Commercial and Healthcare Reform	Effective upon completion of internal review and implement ation.	Policy revised to add Betimol (timolol) and timolol maleate gel forming solution to require diagnosis based on FDA-approved indication and therapeutic failure or intolerance to generic timolol maleate ophthalmic solution (non-dropperette). Automatic approval criteria updated to add Betimol (timolol) and timolol maleate gel forming solution as targets.
Liquid Formulations of Anti-Hypertensive Medications – Commercial and Healthcare Reform	Effective upon completion of internal review and implement ation.	Policy revised to add Javadin (clonidine) oral solution as a target requiring FDA-approved age, diagnosis, inability to swallow tablets whole, and trial/failure of a plan-preferred alternative tablet with the same active ingredient. Reauthorization requiring positive clinical response to therapy and inability to swallow tablets or capsules.
Non-Preferred Erectile Dysfunction Therapy – Commercial and Healthcare Reform	Effective upon completion of internal review and implement ation.	Policy revised to add Vybrique (sildenafil) requiring 18 years of age or older, diagnosis of erectile dysfunction, and therapeutic failure or intolerance generic tadalafil and generic sildenafil citrate tablets.
Non-Preferred Liquid Dosage Form Drugs – Commercial and Healthcare Reform	02/13/2026	Policy revised to include Subvenite (lamotrigine) Oral Suspension as a target. The medication must be used for an FDA-approved indication, and the member must have an inability to swallow solid oral dosage forms.
Non-Preferred Ranolazine Products –	02/13/2026	Policy revised to remove brand Ranexa (ranolazine) from auto-authorization criteria due discontinuation.

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
Commercial and Healthcare Reform		
Prednisone Delayed-Release Tablet – Commercial and Healthcare Reform	02/13/2026	Policy revised to update to generic prednisone delayed-release tablet as the target requiring FDA-approved indication, documentation of step through generic immediate release oral prednisone and documentation of step through generic prednisolone, methylprednisolone, or hydrocortisone.
Premarin (conjugated estrogens) Tablets – Commercial and Healthcare Reform	Effective upon completion of internal review and implement ation.	New policy created for brand Premarin (conjugated estrogens) tablets requiring FDA-approved diagnosis and contraindication/intolerance to generic conjugated estrogen tablets that would not be expected with the brand product documented by pharmacy claims or chart notes.
Temozolomide – Commercial and Healthcare Reform	2/12/2026	New policy for temozolomide requiring age and criteria based on FDA-approved indications. Authorization duration of 12 months. Automatic approval criteria to allow for automatic adjudication if the member has at least one paid claim for temozolomide or Temodar (temozolomide) within the previous 720 days.

*For Commercial and Healthcare Reform policies, an exception to some or all the criteria above may be granted for select members and/or circumstances based on state and/or federal regulations.

**All effective dates are tentative and subject to delay pending internal review or approval. Standard prior authorization criteria will apply for members who do not meet the automatic approval criteria.

3. Formulary Program

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
General Non-Formulary Request Criteria – Delaware – Commercial	12/23/2025	Policy revised to better align with Delaware Step Therapy Program exception language.
Market Watch Programs – Delaware	01/01/2026	Policy revised to better align with Delaware Step Therapy Program exception language.
Market Watch Programs – Delaware	Effective upon completion of internal review and	Policy revised for New to Market drugs to require alternatives be in the same therapeutic class/category as the requested medication when available. Policy revised to add potassium chloride 40 mEq packets and Pokonza (potassium chloride) 15 mEq packets requiring step through potassium

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
	implement ation.	chloride capsule, potassium chloride tablet, and potassium chloride 20 mEq packet. Adding cefixime 400 mg tablet to step through cefixime 400 mg capsules. Added Javadin (clonidine) oral solution to step through clonidine oral tablets 0.1 mg, 0.2 mg, 0.3 mg.
Market Watch Programs – New York, Pennsylvania and West Virginia	Effective upon completion of internal review and implement ation.	Policy revised to add potassium chloride 40 mEq packets and Pokonza (potassium chloride) 15 mEQ packets requiring step through potassium chloride capsule, potassium chloride tablet, and potassium chloride 20 mEq packet. Adding cefixime 400 mg tablet to step through cefixime 400 mg capsules. Added Javadin (clonidine) oral solution to step through clonidine oral tablets 0.1 mg, 0.2 mg, 0.3 mg.

4. Quantity Level Limit (QLL) Programs*

Table 1. Quantity Level Limits – Quantity per Duration for Commercial and Healthcare Reform Plans

Drug Name	Retail Edit Limit	Mail Edit Limit
Bynfezia Pen (octreotide acetate)	7 pens per 30 days	21 pens per 90 days
Hyrnuo (sevabertinib)	120 tablets per 30 days	360 tablets per 90 days
Javadin (Clonidine hydrochloride)	1000 mL (4 bottles) per 30 days	3000 mL (12 bottles) per 90 days
Lerochol (lerodalcibep-liga)	1 prefilled syringe (300 mg/1.2 mL) per 30 days	3 prefilled syringes (300 mg/1.2 mL) per 90 days
Omvoh (mirikizumab-mrkz) 200 mg/2 mL	1 injection (2 mL) per 28 days	3 injections (6 mL)

Drug Name	Retail Edit Limit	Mail Edit Limit
		per 84 days
Omvoh (mirikizumab-mrkz) all strengths	2 injections per 28 days	6 injections per 84 days
Redemplo (plozasiran)	1 syringe (0.5 mL) per 90 days	1 syringe (0.5 mL) per 90 days
Voyxact (sibeprenlimab-szsi)	1 pre-filled syringe (400 mg/2 mL) per 28 days	3 pre-filled syringe (400 mg/2 mL) per 84 days
Vybrique (sildenafil)	18 films per 90 days	18 films per 90 days
Xpovio 80 mg/week	8 tablets per 28 days	24 tablets per 84 days

Table 2. Quantity Level Limits – Quantity per Dispensing Event – Commercial and Healthcare Reform Plans

Drug Name	Retail Edit Limit	Mail Edit Limit
Cardamyst (etripamil)	1 carton per dispensing event	1 carton per dispensing event
Nuzolvence (zoliflodacin)	1 kit per dispensing event	1 kit per dispensing event
Vybrique (sildenafil)	6 films per dispensing event	18 films per dispensing event

Quantity per dispensing event limits the quantity of medication that can be dispensed per each fill. If the submitted day supply on a claim is 34 days or less, the retail limit will apply. If the submitted day supply on a claim is greater than 34 days, the mail limit will apply.

Table 3. Maximum Daily Quantity Limits – Commercial and Healthcare Reform Plans

Drug Name	Daily Limit
Aqvesme (mitapivat)	2 tablets per day
Daybue Stix (trofinetide) 5,000 mg and 6,000 mg	4 packets per day
Daybue Stix (trofinetide) 8,000 mg	2 packets per day

Drug Name	Daily Limit
desloratadine oral solution	10 mL per day
Komzifti (ziftomenib)	3 capsules per day
Kygevvi (doxecitine and doxribtimine)	16 packets per day
Lynkuet (elinzanetant)	2 tablets per day
Myqorzo (aficamten)	1 tablet per day
Orforglipron	Maintenance dose per FDA label
Orladeyo (berotralstat) oral pellets	1 packet per day
pazopanib 400 mg	2 tablets per day
Potassium chloride 40 mEq packet	5 packets per day

*Quantity per Duration (QD) rule also applies to this medication (refer to Table 1).
Members can receive up to the maximum day supply according to their benefits, but the daily limit must not be exceeded for each individual day.

Requests for coverage of select medications exceeding the defined quantity level limits may be submitted for clinical review. Maximum-day supply on certain medications may vary depending on member's benefit design.

SECTION II. Highmark Medicare Part D Formularies

A. Changes to the Highmark Medicare Part D 5-Tier Open Formularies

The Highmark Pharmacy and Therapeutics Committee has reviewed the medications listed in the tables below. For your convenience, you can search the Highmark Medicare Part D Formularies online at:

- **Incentive Formulary**
- **Compass Formulary**

Table 1. Preferred Products
Effective immediately pending Centers for Medicare and Medicaid Services (CMS) approval and upon completion of internal review and implementation.

No changes at this time.

Table 2. Non-Preferred Products
Effective immediately pending CMS approval and upon completion of internal review and implementation.

Brand Name	Generic Name	Preferred Alternatives
Boncresa	denosumab-mobz	Prolia
Lerochol	lerodalcibep-liga	Repatha (evolocumab)
Lynkuet	elinzanetant	estradiol oral tablet*, estradiol-norethindrone acetate tablet
Nuzolvence	zoliflodacin	prescriber discretion
Osvyrti	denosumab-desu	Prolia

***This only pertains to Incentive Formulary**

B. Changes to the Highmark Medicare Part D 5-Tier Closed Formulary

The Highmark Pharmacy and Therapeutics Committee has reviewed the medications listed in the tables below. For your convenience, you can search the Highmark Medicare Part D Formularies online at:

- **Performance Formulary**
- **Venture Formulary**
- **Fundamental Formulary**

Table 1. Preferred Products
Effective immediately pending CMS approval and upon completion of internal review and implementation.

No changes at this time.

Table 2. Non-Preferred Products
Effective immediately pending CMS approval and upon completion of internal review and implementation.

Brand Name	Generic Name	Preferred Alternatives
Nuzolvence	zoliflodacin	Prescriber discretion

Table 3. Products Not Added*
Effective immediately pending CMS approval and upon completion of internal review and implementation.

Brand Name	Generic Name	Preferred Alternatives
Armlupeg	pegfilgrastim-unne	Nivestym, Zarxio
Boncresa	denosumab-mobz	Prolia
Bynfezia Pen	octreotide acetate	octreotide acetate
Cardamyst	etripamil	prescriber discretion
Daybue Stix	trofinetide	prescriber discretion
desloratadine oral solution	desloratadine	desloratadine tablet, levocetirizine oral solution
Javadin	clonidine hydrochloride	clonidine tablets
Jaythari oral suspension	deflazacort	prednisone
Kymbee	deflazacort	prednisone
Lerochol	lerodalcibep-liga	Repatha (evolocumab)
Lynkuet	elinzanetant	estradiol oral tablet, estradiol-norethindrone acetate tablet
Myqorzo	aficamten	prescriber discretion
Orladeyo oral pellets	berotralstat	Takhzyro 150 mg/mL syringe**, Cinryze ***
Osvyrti	denosumab-desu	Prolia
Redemplo	plozasiran	prescriber discretion
Voyxact	sibeprenlimab-szsi	irbesartan oral tablet, losartan oral tablet, valsartan oral tablet

*Physicians may request coverage of these products using the Prescription Drug Medication Request Form.
**Only pertains to Venture and Peformance formularies
***Only pertains to Fundamental formulary

C. Additions to the Specialty Tier
Effective immediately pending CMS approval and upon completion of internal review and implementation.

Brand Name	Generic Name
Aqvesme	mitapivat

Armlupeg*	pegfilgrastim-unne
Bynfezia Pen*	octreotide acetate
Cardamyst*	etripamil
Contepo	fosfomycin
Daybue Stix*	trofinetide
desloratadine oral solution*	desloratadine
Exdensur	depemokimab-ulaa
Hyrnuo	sevabertinib
Javadin*	clonidine hydrochloride
Jaythari oral suspension*	deflazacort
Jubereq	denosumab-desu
Komzifti	ziftomenib
Kygevvi	doxecitine and doxribtimine
Kymbee*	deflazacort
Lunsumio Velo	mosunetuzumab-axgb
Myqorzo*	aficamten
Nufymco	ranibizumab-leyk
Orladeyo oral pellets*	berotralstat
Oziltus	denosumab-mobz
pazopanib 400 mg	pazopanib
Poherdy	pertuzumab-dpzb
potassium chloride 40 mEq packet	potassium chloride
Redemplo*	plozasiran
Rybrevant Faspro	amivantamab and hyaluronidase-lpuj
Voyxact*	sibeprenlimab-szsi

*Pertains only to Incentive and Compass Formularies

D. Updates to the Pharmacy Utilization Management Programs

1. Prior Authorization Program

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Adenosine Triphosphate-Citrate Lyase (ACL) Inhibitors – Medicare	Effective upon completion of internal review and implementation.	Policy revised to include Nexletol (bempedoic acid) and Nexlizet (bempedoic acid/ezetimibe) new broadened indication. Removed policy criteria requiring LDL-C and non-HDL-C levels related to new broadened indication. For reauthorization, the prescriber attests that the member requires continued therapy.
Anti-EGFR and HER2 Kinase Inhibitors – Medicare	02/13/2026	Policy revised to add Hyrnuo (sevabertinib) as a target requiring FDA-approved indication.
Antifibrotic Pulmonary Medications – Medicare	Effective upon completion of internal	Policy revised to include new indication of Jascayd (nerandomilast). The member must have a diagnosis of

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
	review and implementation.	progressive pulmonary fibrosis (PPF), documentation of a chest computed tomography scan demonstrating ≥ 10% pulmonary fibrosis, the member has a baseline forced vital capacity (FVC) of at least 45%, and the member has a percent predicted diffusing capacity of the lungs of carbon monoxide of at least 25%. The member also must present with clinical signs of progression defined as one of the following: FVC decline ≥ 10%, FVC decline ≥ 5% and < 10% with worsening of respiratory symptoms or imaging or worsening of respiratory symptoms and worsening imaging all in the 24 months prior to screening. The member has been stable on therapy with Ofev (nintedanib) and will continue Ofev concomitantly with Jascayd, the member is treatment naive to antifibrotic treatment, or the member previously discontinued Ofev and does not plan to start or re-start background PPF treatment. Policy also updated to remove the timeframe of 12 weeks for Jascayd for the member to be receiving Esbriet (pirfenidone) or Ofev concomitantly for treatment of idiopathic pulmonary fibrosis.
Atypical Antipsychotics – Medicare	Effective upon completion of internal review and implementation.	Policy revised for Caplyta (lumateperone) to include criteria for a new FDA-approved indication: adjunctive therapy with antidepressants for the treatment of major depressive disorder (MDD) in adults. Member must have a diagnosis of MDD, Caplyta is prescribed as an adjunct to a currently used antidepressant in the treatment of MDD, the member has experienced therapeutic failure, contraindication, or intolerance to one (1) other generic antidepressant in addition to the antidepressant currently being used for the treatment of MDD. Also,

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		information added to background concerning changes to Vraylar (cariprazine) prescribing information, however, no changes to criteria needed.
BRAF Mutation-Targeting & MEK Kinase Inhibitors – Medicare	02/13/2026	Policy revised for Koselugo (selumetinib) to remove age restriction.
BTK Inhibitors – Medicare	02/13/2026	Policy revised for Jaypirca (pirtobrutinib) to require criteria based on updated indication for relapsed or refractory chronic lymphocytic leukemia or small lymphocytic lymphoma.
Cardamyst (etripamil) – Medicare	02/13/2026	Policy created for Cardamyst (etripamil). Policy criteria for initial authorization includes diagnosis of paroxysmal supraventricular tachycardia (PSVT) and the member has a history of symptomatic episodes of PSVT. Authorization duration of 6 months.
Cardiac Myosin Inhibitors – Medicare	Effective upon completion of internal review and implementation.	Policy revised to add new product Myqorzo (aficamten) requiring FDA-approved diagnosis confirmed by imaging, NYHA functional class II or III, and trial/failure to a non-vasodilating beta-blocker or a non-dihydropyridine calcium channel blocker. Authorization duration of 12 months. For Camzyos (mavacamten), removed requirement that the member is not going to be treated with disopyramide, ranolazine, or combination of beta blockers and calcium channel blockers. Reauthorization for Camzyos and Myqorzo updated to require a reduction/maintenance in NYHA symptom class, improvement/stabilization in LVOT peak gradient, or stabilization in pVO2.
Cardiac Myosin Inhibitors – Medicare	Effective upon completion of internal review and implementation.	Policy revised for Camzyos (mavacamten) and Myqorzo (aficamten) to require FDA-approved diagnosis confirmed by guideline-recommended imaging or CMR for

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		maximum left ventricular wall thickness.
CGRP Inhibitors and Reyvow – Medicare	01/01/2026	Policy revised for Ajovy (fremanezumab-vfrm) to add back in step through one agent from two different prophylactic classes or all are contraindicated.
CGRP Inhibitors and Reyvow – Medicare	01/16/2026	Policy revised to remove prophylactic step from Aimovig (erenumab-aooe), Ajovy (fremanezumab-vfrm), Emgality (galcanezumab-gnlm), Qulipta (atogepant), Nurtec ODT (rimegepant), and Vyepti (eptinezumab-jjmr).
Chronic Inflammatory Diseases – Medicare	02/09/2026	Policy revised for Omvoh (mirikizumab-mrkz) SC to include new maintenance dosage for ulcerative colitis of one 200 mg/2 ml pen/syringe every 4 weeks and to include unbranded adalimumab-bwwd as a non-preferred adalimumab biosimilar.
Cystic Fibrosis Inhaled Medications – Medicare	Effective upon completion of internal review and implementation.	Policy updated to require members to experience therapeutic failure, contraindication, intolerance, or resistance to generic inhaled tobramycin to be approved for Cayston (aztreonam inhaled solution).
Darzalex (daratumumab) and Darzalex Faspro (daratumumab and hyaluronidase-fihj) – Medicare	02/13/2026	Policy revised for Darzalex Faspro (daratumumab and hyaluronidase) to require criteria based on expanded FDA-approved indication for high-risk smoldering multiple myeloma.
Daybue (trofinetide) and Daybue Stix (trofinetide) – Medicare	02/13/2026	Policy revised to add Daybue Stix (trofinetide) to require diagnosis of Rett syndrome (RTT) confirmed by meeting all of the diagnostic criteria for typical RTT.
Deflazacort – Medicare	Effective upon completion of internal review and implementation.	Policy revised to include Kymbee (deflazacort) and Jaythari (deflazacort) oral suspension requiring confirmed diagnosis of Duchenne muscular dystrophy (DMD) with documented mutation of the dystrophin gene, onset of weakness or history of disease prior to age 5 years, and trial of prednisone or intolerable adverse events or severe behavioral adverse event from plan

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		preferred prednisone. For Jaythari (deflazacort) oral suspension, the member has experienced therapeutic failure or intolerance to Jaythari (deflazacort) tablets, Kymbee (deflazacort) , or generic deflazacort tablets or the member has an inability to swallow tablets.
Denosumab Products for Bone Disease – Medicare	Effective upon completion of internal review and implementation.	Policy revised to add Osvyrti (denosumab-desu) and Boncresa (denosumab-mobz) as targets mirroring criteria for all other Prolia (denosumab) biosimilars.
Denosumab Products for Oncology – Medicare	Effective upon completion of internal review and implementation.	Policy revised to add Jubereq (denosumab-desu) and Oziltus (denosumab-mobz) as targets mirroring criteria for all other Xgeva (denosumab) biosimilars.
Desloratadine Oral Solution – Medicare	02/13/2026	Policy created for desloratadine oral solution to require FDA-approved diagnosis, intolerance to desloratadine tablets/orally disintegrating tablets, and therapeutic failure, contraindication or intolerance to one other generic antihistamine product.
Elevidys (delandistrogene moxeparvovec-rokl) – Medicare	Effective upon completion of internal review and implementation.	Policy revised for Elevidys (delandistrogene moxeparvovec-rokl) to add criteria requiring that member is ambulatory.
Epkinly (epcoritamab-bysp) – Medicare	02/13/2026	Policy revised for Epkinly (epcoritamab-bysp) to require criteria based on expanded and updated FDA-approved indications for use in follicular lymphoma.
Evrysdi (risdiplam) – Medicare	01/01/2026	Policy revised for Evrysdi (risdiplam) to remove criteria requiring that the member has not previously received gene therapy for treatment of SMA or experienced a decline in clinical status since receipt of gene therapy. Reauthorization criteria revised to attestation of slowed disease progression or stabilization of SMA-associated symptoms.
Familial Chylomicronemia	02/13/2026	Policy revised to add Redemplo (plozasiran) as a target. Criteria

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Syndrome (FCS) Medications – Medicare		requires diagnosis of familial chylomicronemia syndrome (FCS), determined by one of the following: genetic test demonstrating biallelic pathogenic variants in at least one gene causing FCS or genetic test results are inconclusive, and meets one of the following: the member has a FCS score ≥ 10, NAFCS score ≥ 45, the member has a history of pancreatitis, the member has a history of eruptive xanthomas, the member has a history of lipemia retinalis, and the member has a fasting triglyceride level ≥ 750 mg/dL which does not respond to standard lipid-lowering therapy, and the member will use Redemplo in combination with diet. Reauthorization requiring the member has experienced improvement in triglycerides from baseline. Initial authorization duration of 6 months. Reauthorization duration of 12 months.
Familial Chylomicronemia Syndrome (FCS) Medications – Medicare	Effective upon completion of internal review and implementation.	Policy revised to require if the request is for Tryngolza (olezarsen) the member has experienced therapeutic failure or intolerance to Redemplo (plozasiran) in initial and reauthorization criteria .
Gleostine (lomustine) – Medicare	Effective upon completion of internal review and implementation.	Policy revised to target generic lomustine and to require intolerance to generic lomustine for brand Gleostine (lomustine).
Glucagon-Like Peptide-1 Receptor Agonists (GLP-1 RAs) – Medicare	01/01/2026	Policy revised for liraglutide to remove requirement for step through preferred agent.
Human Growth Hormone – Medicare	12/12/2025	Policy revised for all targets to remove reauthorization requirement of growth velocity < 2 cm/year where previously present. For treatment of growth hormone deficiency in adults, macimorelin serum growth hormone concentration requirement revised to ≤ 2.8 ng/mL.

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Immunoglobulin A Nephropathy (IgAN) Therapies – Medicare	02/13/2026	Policy revised to add Voyxact (sibeprenlimab-szsi) as a target requiring diagnosis of primary immunoglobulin A nephropathy, proteinuria ≥ 0.5 g/day, and concurrent use of or intolerance/contraindication to a maximum tolerated dose angiotensin converting enzyme (ACE) inhibitor, maximum tolerated dose angiotensin receptor blocker (ARB) or plan-preferred sodium-glucose cotransporter-2 inhibitors (SGLT2i). For reauthorization, the member must experience a decrease in proteinuria from baseline and be concurrently using, or have intolerance/contraindication to, an ACE, ARB, or plan-preferred SGLT2i.
Increlex (mecasermin) – Medicare	01/22/2026	Policy revised to remove reauthorization criteria; indication (for example, growth charts) of a growth velocity of at least 2 cm/year.
Injectable Somatostatin Receptor Ligands – Medicare	02/13/2026	Policy revised to include Bynfezia (octreotide acetate) as a target, requiring criteria based on FDA-approved indications excluding age.
Interleukin (IL)-5 Antagonists – Medicare	Effective upon completion of internal review and implementation.	Policy revised to include Exdensur (depemokimab-ulaa) to require FDA-approved diagnosis, the member has a history of ≥ 2 asthma exacerbations requiring oral or injectable corticosteroid treatment in the previous 12 months or the member has a history of ≥ asthma exacerbation requiring hospitalization in the previous 12 months, the member has a baseline eosinophil level of ≥ 150 cells/microliter within the past 6 weeks or ≥ 300 cells/microliter within the past 12 months, the member has inadequate symptom control despite regular treatment with medium- or high-dose inhaled corticosteroids (ICS) and at least one (1) additional asthma controller, with or without oral corticosteroids (OCS), unless intolerant

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		of, or has contraindications to all of these agents, and the member will continue treatment with medium- or high-dose ICS and at least one (1) additional asthma controller, with or without OCS, while using Exdensur. For reauthorization, the member has decreased rescue medication or OCS use, the member has had a decrease in frequency of severe asthma exacerbations, the member has experienced an increase in pulmonary function from baseline, or the member has experienced a reduction in reported asthma-related symptoms.
Korlym (mifepristone) – Medicare	01/12/2026	Policy revised to remove the member has experienced therapeutic failure to one (1) previous pharmacologic therapy for type 2 diabetes, or the member is taking Korlym (mifepristone) in addition to pharmacologic therapy for type 2 diabetes.
Kygevvi (doxecitine and doxribtimine) – Medicare	Effective upon completion of internal review and implementation.	New policy for Kygevvi (doxecitine and doxribtimine) requiring diagnosis of thymidine kinase 2 deficiency genetically confirmed by a pathogenic variant of TK2 and symptom onset on or before the age of 12 years.
Lunsumio (mosunetuzumab-axgb) and Lunsumio Velo (mosunetuzumab-axgb) – Medicare	Effective upon completion of internal review and implementation.	Policy revised to add Lunsumio Velo (mosunetuzumab-axgb) as a target, requiring criteria based on FDA-approved indication.
Mavenclad (cladribine) – Medicare	02/13/2026	Policy revised to add generic cladribine as a target.
Mavenclad (cladribine) – Medicare	Effective upon completion of internal review and implementation.	Policy revised to require step through generic cladribine for brand Mavenclad (cladribine).
Menin Inhibitors – Medicare	Effective upon completion of internal review and implementation.	Policy revised to add Komzifti (ziftomenib) to require criteria based on FDA-approved indication for AML with a susceptible *NPM1* mutation in those with no satisfactory alternative treatment options.

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Menopause Agents – Medicare	02/13/2026	Policy revised to add Lynkuet (elinzanetant) requiring FDA-approved diagnosis and trial/failure/contraindication to a generic hormone therapy or hormone therapy is not clinically appropriate. Authorization duration of 12 months.
Mesalamine Ulcerative Colitis Treatments – Medicare	01/01/2026	Policy revised for Pentasa (mesalamine) to update initial authorization duration to 6 months.
Mitapivat Products – Medicare	02/13/2026	Policy revised to add Aqvesme (mitapivat) requiring FDA-approved diagnosis confirmed by DNA-analysis or hemoglobin-analysis. Reauthorization of increase of hemoglobin or decrease in transfusion burden from baseline. Initial authorization duration of 24 weeks and reauthorization duration of 12 months.
Non-preferred Oral Potassium Chloride Products – Medicare	Effective upon completion of internal review and implementation.	Policy revised to add potassium chloride 40 mEq packets for oral solution as a target requiring diagnosis based on FDA-approved indication, an inability to swallow solid oral dosage forms, and if the member is 18 years of age or older, trial/failure of potassium chloride oral capsules and tablets.
PARP Inhibitors – Medicare	02/13/2026	Policy revised for Akeega (niraparib and abiraterone acetate) to require criteria based on expanded FDA-approved indication for BRCA2-mutated castration-sensitive prostate cancer. Policy revised for Rubraca (rucaparib) to remove requirement that member has been treated with taxane-based chemotherapy based on updated FDA-approved indication for prostate cancer.
PCSK9 Therapies – Medicare	Effective upon completion of internal review and implementation.	Policy revised to add Lerochol (lerodalcibep-liga) as a target mirroring initial and reauthorization criteria for Leqvio (inclisiran).
Pertuzumab Products – Medicare	Effective upon completion of internal review and implementation.	New policy for Perjeta (pertuzumab) and Poherdy (pertuzumab-dpzb) requiring an FDA-approved indication, the disease overexpresses HER2

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		based on an FDA-approved companion diagnostic test for pertuzumab, and if the request is for Perjeta (pertuzumab), the member has experienced intolerance to Poherdy (pertuzumab-dpzb)
Programmed Death Receptor Therapies – Medicare	02/13/2026	Policy revised for Opdivo Qvantig (nivolumab and hyaluronidase-nvhy) to require criteria based on expanded indication for microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer (CRC) following treatment with intravenous nivolumab and ipilimumab and updated indication for MSI-H or dMMR CRC that has progressed following fluoropyrimidine, oxaliplatin, and irinotecan. Policy revised for Keytruda (pembrolizumab) and Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) to require criteria based on expanded FDA-approved indication for muscle invasive bladder cancer. Policy revised for Imfinzi (durvalumab) to require criteria based on expanded FDA-approved indication for gastric or gastroesophageal junction adenocarcinoma.
Revuforj (revumenib) – Medicare	02/13/2026	Policy revised for Revuforj (revumenib) to require criteria based on expanded FDA-approved indication for acute myeloid leukemia (AML) with a susceptible NPM1 mutation and updated indication for acute leukemia with KMT2A translocation.
Rybrevant (amivantamab-vmjw) and Rybrevant Faspro (amivantamab and hyaluronidase-lpuj) – Medicare	02/13/2026	Policy revised to add Rybrevant Faspro (amivantamab and hyaluronidase-lpuj) as a target, requiring criteria based on FDA-approved indications.
Testosterone (Androgens) – Medicare	Effective upon completion of internal review and implementation.	Policy revised for testosterone enanthate for use in metastatic breast cancer to remove requirement for palliative treatment.

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Uplizna (inebilizumab-cdon) – Medicare	02/13/2026	Policy revised to add criteria for a new FDA-approved indication: generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) or anti-muscle specific tyrosine kinase (MuSK) antibody positive. The member must have a diagnosis of gMG, the member's gMG must be one of the following subtypes: anti-AChR Ab+ or anti-MuSK Ab+ and the member has experienced therapeutic failure, contraindication, or intolerance to generic pyridostigmine.
Voquezna (vonoprazan) Products – Medicare	Effective upon completion of internal review and implementation.	Policy revised for Voquezna (vonoprazan), Voquezna Triple Pak (vonoprazan/amoxicillin/clarithromycin), and Voquezna Dual Pak (vonoprazan/amoxicillin) to require Helicobacter pylori be confirmed by invasive techniques or non-invasive techniques and Voquezna for Helicobacter pylori requires allergy, intolerance, or contraindication to any component of bismuth quadruple therapy.
Xermelo (telotristat ethyl) – Medicare	02/13/2026	Policy revised for Xermelo (telotristat ethyl) to remove the age restriction.

*All effective dates are tentative and subject to delay pending internal review or approval.

2. Updates to Step Therapy

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Colony-Stimulating Factors – Medicare	Effective upon completion of internal review and implementation.	Policy revised to add Armlupeg (pegfilgrastim-unne) as a target requiring criteria based on FDA-approved indications and trial/failure to Nivestym (filgrastim-aafi) and/or Zarxio (filgrastim-sndz) as applicable per FDA-approved indication.
Intravitreal Injections – Medicare	02/13/2026	Policy revised for Eylea HD (aflibercept) to include expanded indication of Macular Edema Following Retinal Vein Occlusion.

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Intravitreal Injections – Medicare	Effective upon completion of internal review and implementation.	Policy revised to add Nufymco (ranibizumab-leyk) as a target to require diagnoses based on FDA-approved indications and the member has experienced therapeutic failure after an adequate trial, contraindication, or intolerance to Avastin (bevacizumab) if the member has a diagnosis of neovascular age-related macular degeneration.
Ophthalmic Prostaglandins and Rho Kinase Inhibitors – Medicare	Effective upon completion of internal review and implementation.	Policy revised to add Omlonti (omidenepag isopropyl) requiring diagnosis based on FDA-approved indication, therapeutic failure or intolerance to brand Lumigan (bimatoprost) and an additional generic ophthalmic alternative.
Premarin (conjugated estrogens) Tablets – Medicare	Effective upon completion of internal review and implementation	New policy created for brand Premarin (conjugated estrogens) tablets requiring FDA-approved diagnosis and contraindication/intolerance to generic conjugated estrogen tablets.

3. Quantity Level Limit (QLL) Program

Effective date pending CMS approval, completion of internal review and implementation, unless otherwise noted.

Drug Name	Retail Quantity Limit (31 days)
Aqvesme (mitapivat)	2 tablets per day
Boncresa (denosumab-mobz)	1 syringe/vial (60 mg/1 mL) per 180 days
Bynfezia Pen (octreotide acetate)	7 pens per 30 days (Each pen is 2.8 mL)
Cardamyst (etripamil)	6 cartons (2 devices per carton) per 180 days
Daybue Stix (trofinetide) 5,000 mg and 6,000 mg	4 packets per day
Daybue Stix (trofinetide) 8,000 mg	2 packets per day
desloratadine oral solution	10 mL per day
Exdensur (depemokimab-ulaa)	1 prefilled pen (100 mg/mL) per 180 days
Hyrnuo (sevabertinib)	4 tablets per day
Javadin (Clonidine hydrochloride)	1000 mL (4 of the 250 mL bottles) per 30 days
Komzifti (ziftomenib)	3 capsules per day
Kygevvi (doxecitine and doxribtimine)	16 packets per day

Drug Name	Retail Quantity Limit (31 days)
Lerochol (lerodalcibep-liga)	1 prefilled syringe (300 mg/1.2 mL) per 30 days
Lynkuet (elinzanetant)	2 tablets per day
Myqorzo (aficamten)	1 tablet per day
Nuzolvence (zoliflodacin)	1 kit per day
Omvoh (mirikizumab-mrkz) 200 mg/2 mL	1 injection (2 mL) per 28 days
Orforglipron	Maintenance dose per FDA label
Orladeyo (berotralstat) oral pellets	1 packet per day
Osvyrti (denosumab-desu)	1 syringe/vial (60 mg/1 mL) per 180 days
pazopanib 400 mg	2 tablets per day
Potassium chloride 40 mEq packet	5 packets per day
Redemplo (plozasiran)	1 syringe (0.5 mL) per 90 days
Voyxact (sibeprenlimab-szsi)	1 pre-filled syringe (400 mg/2 mL) per 28 days
Vybrique (sildenafil)	18 films per 90 days
Xpovio 80 mg/week	4 tablets per 28 days