Formulary Updates

Published February 2026

Following is the update to the Highmark Drug Formularies and pharmaceutical management procedures for November 2025. The formularies and pharmaceutical management procedures are updated after each Pharmacy and Therapeutics Committee meeting, and the following changes reflect the decisions made in November 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:

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

Important Drug Safety Updates

Otsuka ICU Medical LLC Issues Voluntary Nationwide Recall of 20 mEq Potassium Chloride Injection Due To Overwrap Mislabeled As 10 mEq Potassium Chloride Injection

On Oct. 31, 2025, Otsuka ICU Medical LLC issued a voluntary recall to the user level, for a mislabeled lot of Potassium Chloride Injection 20 mEq, NDC 0990-7077-14. The overwrap label of lot 1030613, Expiration Date: 09-30-2026 may incorrectly identify the product as Potassium Chloride Injection 10 mEq with NDC 0990-7074-26. Otsuka ICU Medical LLC has identified this discrepancy due to a manufacturing issue. The dosage is correctly printed on the labeling affixed to the product bag which is not visible when the 10 mEq overwrap is in place.

If the incorrect dosage on the 10 mEq overwrap is used instead of the correct 20mEq dosage printed on the product, an overdose of potassium chloride is possible. Overdose of potassium chloride can lead to hyperkalemia. Hazards of severe hyperkalemia after large intravenous overdoses causes neuromuscular dysfunction including muscle weakness, ascending paralysis, listlessness, vertigo, mental confusion, hypotension, cardiac dysrhythmias, or death from cardiac arrest. Premature infants, patients on chronic parenteral nutrition, patients who have a history of cardiac arrythmias, patients with chronic renal insufficiency, patients who have acute renal failure, patients on potassium-sparing diuretics — all are at risk for adverse and potentially fatal outcomes. Otsuka ICU Medical LLC has not received reports of adverse events associated with this issue to date.

Fresenius Kabi Issues Voluntary Nationwide Recall of Three Lots of Famotidine Injection, USP, 20 mg per 2 mL (10 mg per mL), 2 mL Fill in a 2 mL Vial Due to Out-of-Specification Endotoxin Results in Certain Reserve Samples

On Nov. 06, 2025, Fresenius Kabi, part of the global healthcare company Fresenius, and a leading provider of essential medicines and medical technologies is voluntarily recalling three lots (numbers 6133156, 6133194, 6133388) of Famotidine Injection, USP, 20 mg per 2 mL (10 mg per mL), 2 mL Fill in a 2 mL vial. This recall is being performed to the user level in the United States.

The product is being recalled due to out-of-specification (OOS) endotoxin results of certain reserve samples from a single lot. Based upon the investigation, two additional lots were also included in the recall as a precautionary measure.

Elevated endotoxin levels can precipitate severe systemic reactions such as sepsis and septic shock. Severe responses may include inflammatory and life-threatening immune responses and death. Non-serious adverse event reports potentially associated with the OOS have been received for one lot. These non-serious adverse events included chills, change in mental status, change in respiratory status, fever, increase in body temperature, shivering and shaking. To date, no adverse event reports have been received for the second and third lots.

Early Alert: Glucose Monitor Sensor Issue from Abbott Diabetes Care

On Dec. 2, 2025, the Food and Drug Administration (FDA) issued an early alert of a potentially high-risk issue. Abbott Diabetes Care has issued a letter to distributors, health care providers, and affected customers recommending certain FreeStyle Libre 3 Sensors and FreeStyle Libre 3 Sensors Plus be removed from where they are used or sold. Certain FreeStyle Libre 3 and FreeStyle Libre 3 Plus sensors provide incorrect low glucose readings.

If undetected, incorrect low glucose readings over an extended period may lead to wrong treatment decisions for people living with diabetes, such as excessive carbohydrate intake or skipping or delaying insulin doses. These decisions may pose serious health risks, including potential injury or death, or other less serious complications. FreeStyle Libre 3 readers and mobile apps are not impacted. Additionally, no other Libre products (FreeStyle Libre 14 day, FreeStyle Libre 2, FreeStyle Libre 2 Plus, or Libre Pro sensors) or Abbott biowearables are impacted.

Patients should verify if their sensors are impacted and immediately discontinue use and dispose of the affected sensor(s). To determine if a sensor is impacted, locate the sensor serial number and visit www.freestylecheck.com.

Customers in the U.S. with adverse reactions, quality problems, or questions about this recall should contact Abbott Diabetes Care at 833-815-4273. Health care professionals and consumers may report adverse reactions or quality problems they experienced using these devices to MedWatch: The FDA Safety Information and Adverse Event Reporting Program.

Highmark Formulary Update – November 2025

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 adding products to the formulary, 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
Eliquis 0.15 mg, 0.5 mg, 1.5 mg, 2 mg	apixaban	To reduce the risk of stroke and systemic embolism in adult patients with nonvalvular atrial fibrillation; For the prophylaxis of deep vein thrombosis (DVT), which may lead to pulmonary embolism (PE), in adult patients who have undergone hip or knee replacement surgery; for the treatment of DVT and PE, and for the reduction in the risk of recurrent DVT and PE in adult patients following initial therapy; treatment of venous thromboembolism (VTE) and reduction in the risk of recurrent VTE in pediatric patients from birth and older after at least 5 days of initial anticoagulant treatment.
Otezla XR	apremilast	Adult patients with: • Active psoriatic arthritis • Plaque psoriasis who are candidates for phototherapy or systemic therapy • Oral ulcers associated with Behçet's Disease

		Pediatric patients 6 years of age and older with: • Active psoriatic arthritis weighing at least 50 kg. • Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy weighing at least 50 kg.

Coverage may be contingent upon plan benefits.

Table 2. Products Not Added**

Brand Name	Generic Name	Preferred Alternatives
Aukelso	denosumab-kyqq	Prescriber Discretion
Bildyos	denosumab-nxxp	alendronate sodium tablet risedronate sodium tablet 5 mg risedronate sodium tablet 150 mg
Bilprevda	denosumab-nxxp	Prescriber Discretion
Bondlido	lidocaine 10% topical system	Prescriber Discretion
Bosaya	denosumab-kyqq	alendronate sodium tablet risedronate sodium tablet 5 mg risedronate sodium tablet 150 mg
Clotic	clotrimazole	Prescriber Discretion
Dawnzera	donidalorsen	Prescriber Discretion
Enbumyst	bumetanide	furosemide tablet bumetanide tablet torsemide tablet
Enoby	denosumab-qbde	alendronate sodium tablet risedronate sodium tablet 5 mg risedronate sodium tablet 150 mg
Escitalopram 15 mg capsule	escitalopram	escitalopram tablets
Inluriyo	imlunestrant	anastrozole tablet
Jascayd	nerandomilast	Prescriber Discretion
Koselugo sprinkle capsules	selumetinib	Prescriber Discretion
Lasix Onyu	furosemide injection	furosemide tablet, bumetanide tablet, torsemide tablet
Palsonify	paltusotine	octreotide vial, octreotide ampule
Rhapsido	remibrutinib	Xolair syringe, Xolair auto-injector, Dupixent
Subvenite suspension	lamotrigine	lamotrigine tablet, divalproex sodium tablet, levetiracetam tablet
Vyjuvek	beremagene geperpavec-svdt	Prescriber Discretion
Wayrilz	rilzabrutinib	eltrombopag olamine, Doptelet
Wegovy oral tablet	semaglutide	Prescriber Discretion

Brand Name	Generic Name	Preferred Alternatives
Xtrenbo	denosumab-qbde	Prescriber Discretion
Zanaflex 8 mg capsule	tizanidine	tizanidine tablets
Zolymbus	bimatoprost ophthalmic gel	latanoprost 0.005% eye drops, timolol maleate drops
Zoryve 0.05% cream	roflumilast	tacrolimus ointment (gram)

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 Healthcare Reform, which is under the "Line of Business" header.

Brand Name	Generic Name
Aukelso	denosumab-kyqq
Bildyos	denosumab-nxxp
Bilprevda	denosumab-nxxp
Bosaya	denosumab-kyqq
Dawnzera	donidalorsen
Enoby	denosumab-qbde
Inluriyo	imlunestrant
Jascayd	nerandomilast
Koselugo	selumetinib
Lasix Onyu	furosemide injection
Otezla XR	apremilast
Palsonify	paltusotine
Rhapsido	remibrutinib
Subvenite	lamotrigine
Vyjuvek	beremagene geperpavec-svdt
Wayrilz	rilzabrutinib
Xtrenbo	denosumab-qbde
Zanaflex 8 mg capsule	tizanidine
Zoryve 0.05% cream	roflumilast

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			
Eliquis 0.15 mg, 0.5 mg, 1.5 mg, 2 mg	apixaban	3	To reduce the risk of stroke and systemic embolism in adult patients with nonvalvular atrial fibrillation; For the prophylaxis of deep vein thrombosis (DVT), which may lead to pulmonary embolism (PE), in adult patients who have undergone hip or knee replacement surgery; for the treatment of DVT and PE, and for the reduction in the risk of recurrent DVT and PE in adult patients following initial therapy; treatment of venous thromboembolism (VTE) and reduction in the risk of recurrent VTE in pediatric patients from birth and older after at least 5 days of initial anticoagulant treatment.
Otezla XR	apremilast	4	Adult patients with: • Active psoriatic arthritis • Plaque psoriasis who are candidates for phototherapy or systemic therapy • Oral ulcers associated with Behçet's Disease Pediatric patients 6 years of age and older with: • Active psoriatic arthritis weighing at least 50 kg. • Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy weighing at least 50 kg.
Items listed below were not added to the formulary			
Aukelso	denosumab-kyqq	NF	Prescriber Discretion
Bildyos	denosumab-nxxp	NF	Prolia
Bilprevda	denosumab-nxxp	NF	Prescriber Discretion
Bondlido	lidocaine 10% topical system	NF	Prescriber Discretion
Bosaya	denosumab-kyqq	NF	Prolia

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
Clotic	clotrimazole	NF	Prescriber Discretion
Dawnzera	donidalorsen	NF	Takhzyro
Enbumyst	bumetanide	NF	furosemide tablet, bumetanide tablet, torsemide tablet
Enoby	denosumab-qbde	NF	Prolia
Escitalopram 15 mg capsule	escitalopram	NF	escitalopram tablets
Inluriyo	imlunestrant	NF	exemestane, anastrozole tablet
Jascayd	nerandomilast	NF	Prescriber Discretion
Koselugo sprinkle capsules	selumetinib	NF	Prescriber Discretion
Lasix Onyu	furosemide injection	NF	furosemide tablet, bumetanide tablet, torsemide tablet
Palsonify	paltusotine	NF	octreotide vial, octreotide ampule
Rhapsido	remibrutinib	NF	Xolair Syringe, Xolair Auto-Injector, Dupixent
Subvenite suspension	lamotrigine	NF	lamotrigine tablet, divalproex sodium tablet, levetiracetam tablet
Vyjuvek	beremagene geperpavec-svdt	NF	Prescriber Discretion
Wayrilz	rilzabrutinib	NF	eltrombopag olamine
Wegovy oral tablet	semaglutide	NF	Prescriber Discretion
Xtrenbo	denosumab-qbde	NF	Prescriber Discretion
Zanaflex 8 mg capsule	tizanidine	NF	tizanidine tablets
Zolymbus	bimatoprost ophthalmic gel	NF	latanoprost 0.005% eye drops, timolol maleate drops
Zoryve 0.05% cream	roflumilast	NF	tacrolimus ointment (gram), pimecrolimus

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			

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
Eliquis 0.15 mg, 0.5 mg, 1.5 mg, 2 mg	apixaban	3	To reduce the risk of stroke and systemic embolism in adult patients with nonvalvular atrial fibrillation; For the prophylaxis of deep vein thrombosis (DVT), which may lead to pulmonary embolism (PE), in adult patients who have undergone hip or knee replacement surgery; for the treatment of DVT and PE, and for the reduction in the risk of recurrent DVT and PE in adult patients following initial therapy; treatment of venous thromboembolism (VTE) and reduction in the risk of recurrent VTE in pediatric patients from birth and older after at least 5 days of initial anticoagulant treatment.
Otezla XR	apremilast	4	Adult patients with: • Active psoriatic arthritis • Plaque psoriasis who are candidates for phototherapy or systemic therapy • Oral ulcers associated with Behçet's Disease Pediatric patients 6 years of age and older with: • Active psoriatic arthritis weighing at least 50 kg. • Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy weighing at least 50 kg.
Items listed below were not added to the formulary			
Aukelso	denosumab-kyqq	NF	Prescriber Discretion
Bildyos	denosumab-nxxp	NF	Prolia
Bilprevda	denosumab-nxxp	NF	Prescriber Discretion
Bondlido	lidocaine 10% topical system	NF	Prescriber Discretion
Bosaya	denosumab-kyqq	NF	Prolia
Clotic	clotrimazole	NF	Prescriber Discretion
Dawnzera	donidalorsen	NF	Takhzyro
Enbumyst	bumetanide	NF	furosemide tablet, bumetanide tablet, torsemide tablet
Enoby	denosumab-qbde	NF	Prolia
Escitalopram 15 mg capsule	escitalopram	NF	escitalopram tablets
Inluriyo	imlunestrant	NF	exemestane, anastrozole tablet
Jascayd	nerandomilast	NF	Prescriber Discretion

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
Koselugo sprinkle capsules	selumetinib	NF	Prescriber Discretion
Lasix Onyu	furosemide injection	NF	furosemide tablet, bumetanide tablet, torsemide tablet
Palsonify	paltusotine	NF	octreotide vial, octreotide ampule
Rhapsido	remibrutinib	NF	Xolair Syringe, Xolair Auto-Injector, Dupixent
Subvenite suspension	lamotrigine	NF	lamotrigine tablet, divalproex sodium tablet, levetiracetam tablet
Vyjuvek	beremagene geperpavec-svdt	NF	Prescriber Discretion
Wayrilz	rilzabrutinib	NF	eltrombopag olamine, Doptelet
Wegovy oral tablet	semaglutide	NF	Prescriber Discretion
Xtrenbo	denosumab-qbde	NF	Prescriber Discretion
Zanaflex 8 mg capsule	tizanidine	NF	tizanidine tablets
Zolymbus	bimatoprost ophthalmic gel	NF	latanoprost 0.005% eye drops, timolol maleate drops
Zoryve 0.05% cream	roflumilast	NF	tacrolimus ointment (gram), pimecrolimus

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)			
Eliquis 0.15 mg, 0.5 mg, 1.5 mg, 2 mg	apixaban	2	To reduce the risk of stroke and systemic embolism in adult patients with nonvalvular atrial fibrillation; For the prophylaxis of deep vein thrombosis (DVT), which may lead to pulmonary embolism (PE), in adult patients who have undergone hip or knee replacement surgery; for the treatment of DVT and PE, and for the reduction in the risk of recurrent DVT and PE in adult patients following initial therapy; treatment of venous thromboembolism (VTE) and

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
			reduction in the risk of recurrent VTE in pediatric patients from birth and older after at least 5 days of initial anticoagulant treatment.
Bildyos	denosumab-nxxp	2	Osteoporosis
Bilprevda	denosumab-nxxp	2	Skeletal-related events, hypercalcemia
Otezla XR	apremilast	2	Adult patients with: • Active psoriatic arthritis • Plaque psoriasis who are candidates for phototherapy or systemic therapy • Oral ulcers associated with Behçet's Disease Pediatric patients 6 years of age and older with: • Active psoriatic arthritis weighing at least 50 kg. • Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy weighing at least 50 kg.
Rhapsido	remibrutinib	2	Treatment of chronic spontaneous urticaria in adults who remain symptomatic despite H2 antihistamine treatment
Items listed below were added to the formulary (Non-Preferred)			
Aukelso	denosumab-kyqq	3*	Prescriber Discretion
Bondlido	lidocaine 10% topical system	3*	Prescriber Discretion
Bosaya	denosumab-kyqq	3*	alendronate sodium tablet, risedronate sodium tablet 5 mg, risedronate sodium tablet 150 mg
Clotic	clotrimazole	3*	Prescriber Discretion
Enbumyst	bumetanide	3*	furosemide tablet, bumetanide tablet, torsemide tablet
Enoby	denosumab-qbde	3*	alendronate sodium tablet, risedronate sodium tablet 5 mg, risedronate sodium tablet 150 mg
Inluriyo	imlunestrant	3*	anastrozole tablet
Jascayd	nerandomilast	3*	Prescriber Discretion
Palsonify	paltusotine	3*	octreotide vial, octreotide ampule
Vyjuvek	beremagene geperpavec-svdt	3	Prescriber Discretion
Wegovy oral tablet	semaglutide	3*	Prescriber Discretion
Xtrenbo	denosumab-qbde	3*	Prescriber Discretion
Zolymbus	bimatoprost ophthalmic gel	3*	latanoprost 0.005% eye drops, timolol maleate drops

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
Zoryve 0.05% cream	roflumilast	3	tacrolimus ointment (gram)
Koselugo sprinkle capsules	selumetinib	3	Prescriber Discretion
Lasix Onyu	furosemide injection	3*	furosemide tablet, bumetanide tablet, torsemide tablet
Subvenite suspension	lamotrigine	3*	lamotrigine tablet, divalproex sodium tablet, levetiracetam tablet
Items listed below were not added to the formulary			
Dawnzera	donidalorsen	NF	Andembry, Haegarda, Takhzyro
Escitalopram 15 mg capsule	escitalopram	NF	escitalopram tablets
Wayrilz	rilzabrutinib	NF	eltrombopag olamine, Doptelet
Zanaflex 8 mg capsule	tizanidine	NF	tizanidine 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
Aukelso	denosumab-kyqq
Bildyos	denosumab-nxxp
Bilprevda	denosumab-nxxp
Bosaya	denosumab-kyqq
Dawnzera	donidalorsen
Enoby	denosumab-qbde
Inluriyo	imlunestrant
Jascayd	nerandomilast
Koselugo	selumetinib
Lasix Onyu	furosemide injection
Otezla XR	apremilast
Palsonify	paltusotine
Rhapsido	remibrutinib
Subvenite suspension	lamotrigine
Vyjuvek	beremagene geperpavec-svdt
Wayrilz	rilzabrutinib
Xtrenbo	denosumab-qbde
Zanaflex 8 mg capsule	tizanidine
Zoryve 0.05% cream	roflumilast

E. Updates to the Pharmacy Utilization Management Programs

1. Prior Authorization Program

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Acromegaly – Commercial and Healthcare Reform	12/19/2025	Policy revised to add Somavert (pegvisomant) as a target, requiring previously approved criteria for initial and reauthorization. Policy revised to add Palsonify (paltusotine hydrochloride) as a target requiring FDA-approved age and indication, high pre-treatment insulin-like growth factor (IGF-1), previous response to octreotide or lanreotide, and trial/failure to Mycapssa (octreotide). Reauthorization requiring decrease or normalization of IGF-1 from baseline.
Antifibrotic Pulmonary Medications – Commercial and Healthcare Reform	12/19/2025	Policy revised to include Jascayd (nerandomilast). The member must have a diagnosis of IPF, the member's baseline forced vital capacity (FVC) must be at least 50%, the member's percent predicted diffusing capacity of the lungs of carbon monoxide (DLco) of at least 30%, the member is a non-smoker or the member is currently engaged in smoking cessation, the member must meet one of the following: member is receiving Jascayd concomitantly with plan-preferred Esbriet (pirfenidone) or plan-preferred Ofev AND has been receiving this medication at a stable dose for at least 12 weeks. If the member has been receiving Esbriet (pirfenidone) and will remain on this drug with Jascayd, the Jascayd dose must be 18 mg twice daily OR the member will be using Jascayd as monotherapy and meets one of the following criteria: the member has received Esbriet (pirfenidone) and Ofev and is unable to

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		tolerate these medications or the member has contraindications to both Esbriet (pirfenidone) and Ofev. For reauthorization the prescriber attests that the member has experienced a therapeutic response, the member is a non-smoker or engaged in smoking cessation.
Anti-Obesity (Enhanced) – Commercial and Healthcare Reform	12/19/2025	Policy revised for Zepbound (tirzepatide) to adults who initiated Saxenda (liraglutide) or Wegovy (semaglutide) as adolescents. Maintenance criteria was updated to include the member has experienced and maintained at least a 5% BMI reduction from baseline and the member meets one of the following; the requested dose is 5 mg, 7.5 mg, 10 mg, 12.5 mg, or 15 mg once weekly or the prescriber attests the member is titrating to a dose of 5 mg once weekly.
Anti-Obesity (Enhanced) – Commercial and Healthcare Reform	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add Wegovy (semaglutide) oral tablet as a target mirroring initial and maintenance criteria for Wegovy single-dose pen injector when FDA-approved age and indication is shared between the dosage forms. Maintenance criteria requires FDA-approved maintenance dosing or attestation of titration to maintenance dosing.
Anti-Obesity (Enhanced) – Commercial and Healthcare Reform	10/08/2025	Policy revised for Wegovy (semaglutide) to include metabolic associated steatohepatitis with moderate to advanced liver fibrosis as an allowable comorbidity. Policy criteria added for Zepbound (tirzepatide) for reauthorization that if baseline apnea/hypopnea index (AHI) or respiratory disturbance index (RDI) with positive airway pressure (PAP) or oral appliance use prior to the initiation of the requested therapy was 0, then the AHI/RDI remained at 0, as documented by a PAP device report or sleep study.

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Anti-Obesity (Enhanced) – Commercial and Healthcare Reform	10/28/2025	Policy revised for Wegovy (semaglutide), Zepbound (tirzepatide), and Saxenda (liraglutide) to allow approval for patients with one of the following comorbidities: coronary artery disease, myocardial infarction, stroke, peripheral arterial disease, peripheral vascular disease, moderate to severe obstructive sleep apnea, or metabolic dysfunction-associated steatohepatitis with moderate to advanced (F2 to F3) liver fibrosis.
Anti-Obesity (Standard) – Commercial and Healthcare Reform	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add Wegovy (semaglutide) oral tablet as a target mirroring initial, maintenance, and continuation criteria for Wegovy single-dose pen injector when FDA-approved age and indication is shared between the dosage forms. Maintenance and continuation criteria requires FDA-approved maintenance dosing or attestation of titration to maintenance dosing.
Benlysta (belimumab) – Commercial and Healthcare Reform	12/19/2025	Policy revised for Benlysta (belimumab) to allow approval for patients 5 years of age and older with active lupus nephritis receiving standard therapy. Quantity limits revised to reflect FDA-approved induction and maintenance dosing in this population.
BRAF Mutation-Targeting & MEK Kinase Inhibitors – Commercial and Healthcare Reform	12/19/2025	Policy revised for Koselugo (selumetinib) for expanded age of 1 to 17 years of age. For Koselugo (selumetinib) granules, the member has a body surface area <0.55 m2 or has an inability to swallow capsules.
Chronic Inflammatory Diseases – Commercial and Healthcare Reform	11/20/2025	Policy revised to add Otezla XR (apremilast) into existing Otezla criteria for Behcet's disease, plaque psoriasis (PsA) and psoriatic arthritis (PsO) with the addition of requiring weight greater than or equal to 50 kg for pediatric patients with PsA and PsO. Policy revised for Tremfya (guselkumab) to add expanded indication for PsA and PsO in pediatric patients 6 years of age or older and weighing at least 40 kg into existing

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		criteria and for ulcerative colitis the member has received or currently undergoing IV induction therapy or using Tremfya SC for induction dosing. Policy revised for Rinvoq (upadacitinib) to include exception for the expanded indication in ulcerative colitis or Crohn's disease that if TNF blockers are not advisable, the member steps through one non-TNF inhibitor step 1 agent. Policy revised for Xeljanz (tofacitinib) tablet and oral solution to add expanded indication for PsA in pediatric patients 2 years of age or older into existing criteria. Policy revised to include Avtozma (tocilizumab-anoh) as a non-preferred tocilizumab product. Cimzia (certolizumab) criteria for CD and Simponi (golimumab) criteria for UC updated to allow step through any step 1 preferred product. Policy revised for Simponi (golimumab) to add expanded indication of ulcerative colitis in pediatric patients weighing at least 15 kg into existing criteria with pediatrics greater than 5 years of age stepping through adalimumab.
Chronic Inflammatory Diseases – Commercial and Healthcare Reform	01/01/2026	Policy revised to make Simlandi (adalimumab-ryvk) the single preferred adalimumab product and Yesintek (ustekinumab-kfce) the single preferred ustekinumab product.
Chronic Inflammatory Diseases – Commercial National Select Formulary	11/20/2025	Policy revised to add Otezla XR (apremilast) into existing Otezla criteria for Behcet's disease, plaque psoriasis (PsA) and psoriatic arthritis (PsO) with the addition of requiring weight greater than or equal to 50 kg for pediatric patients with PsA and PsO. Policy revised for Tremfya (guselkumab) to add expanded indication for PsA and PsO in pediatric patients 6 years of age or older and weighing at least 40 kg into existing criteria and for ulcerative colitis the member has received or currently undergoing IV induction therapy or using

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		Tremfya SC for induction dosing. Policy revised for Rinvoq (upadacitinib) to include exception for the expanded indication in ulcerative colitis or Crohn's disease that if TNF blockers are not advisable, the member steps through one non-TNF inhibitor step 1 agent. Policy revised for Xeljanz (tofacitinib) tablet and oral solution to add expanded indication for PsA in pediatric patients 2 years of age or older into existing criteria. Policy revised to include Avtozma (tocilizumab-anoh) as a non-preferred tocilizumab product. Cimzia (certolizumab) criteria for CD and Simponi (golimumab) criteria for UC updated to allow step through any step 1 preferred product. Policy revised for Simponi (golimumab) to add expanded indication of ulcerative colitis in pediatric patients weighing at least 15 kg into existing criteria with pediatrics greater than 5 years of age stepping through adalimumab.
Chronic Inflammatory Diseases – Commercial National Select Formulary	01/01/2026	Policy revised to make Simlandi (adalimumab-ryvk) the single preferred adalimumab product and Yesintek (ustekinumab-kfce) the single preferred ustekinumab product.
Denosumab Products for Bone Disease and Evenity (romosozumab-aqqg) – Commercial and Healthcare Reform	12/19/2025	Policy revised to add Bildyos (denosumab-nxxp) as a target mirroring criteria for all other Prolia (denosumab) biosimilars.
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 Bosaya (denosumab-kyqq) and Enoby (denosumab-qbde) as targets mirroring criteria for all other Prolia (denosumab) biosimilars.
Drugs for Chagas Disease – Commercial and Healthcare Reform	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Termination of policy.

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Dry Eye Disease Products – Commercial and Healthcare Reform	01/01/2026	Policy revised for reauthorization of Cequa (cyclosporine), Miebo (perfluorohexyloctane), Tryptyr (acoltremon), Tyrvaya (varenicline), or Vevye (cyclosporine) to require therapeutic failure, contraindication, or intolerance to plan preferred products generic cyclosporine and Xiidra (lifitegrast), verified by pharmacy claims or documented chart notes.
Dupixent (dupilumab) – Commercial and Healthcare Reform	10/13/2025	Policy revised for Dupixent (dupilumab) for chronic rhinosinusitis with nasal polyps to remove systemic corticosteroid step.
Dupixent (dupilumab) – Commercial and Healthcare Reform	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised for Dupixent (dupilumab) for chronic spontaneous urticaria (CSU) to add that it must be prescribed by or in consultation with a dermatologist, immunologist, or allergist; member must have been experiencing symptoms for at least 6 weeks; the prescriber has ruled out other potential causes of urticaria; the member has tried two second generation antihistamines at up to fourfold the FDA maximum recommended dose; and the member will not be receiving Dupixent in combination with Rhapsido (remibrutinib) or Xolair (omalizumab). Reauthorization requires reduction in itch severity or reduction in number or severity of hives or swelling episodes.
Emflaza (deflazacort) – Commercial and Healthcare Reform	10/29/2025	Policy revised to add generic Jaythari (deflazacort) and Pyquvi (deflazacort) to require FDA-approved age and indication, and has experienced intolerable adverse events from trial of plan-preferred prednisone. Pyquvi also requires inability to swallow tablets or trial and failure of plan-preferred Jaythari or deflazacort tablets.
Enspryng (satralizumab-mwge) – Commercial and Healthcare Reform	12/19/2025	Policy revised for Enspryng (satralizumab-mwge) to remove requirement of step through immunosuppressant.

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Entresto (sacubitril/valsartan) – Commercial and Healthcare Reform	01/01/2026	Policy criteria for Entresto Sprinkle (sacubitril/valsartan) was updated to require therapeutic failure or intolerance to generic sacubitril/valsartan tablets instead of brand Entresto (sacubitril/valsartan) tablets for initial authorization and reauthorization. Criteria was also added to the policy targeting brand Entresto (sacubitril/valsartan) tablets. Initial authorization criteria requires diagnosis of heart failure and therapeutic failure or intolerance to generic sacubitril/valsartan. Reauthorization criterion requiring prescriber attestation that the member has had a positive clinical response to therapy and therapeutic failure or intolerance to generic sacubitril/valsartan
Experimental and Investigational Products – Commercial and Healthcare Reform	01/06/2026	Policy revised to add Forzinity (elamipretide). No exception will be made for experimental and investigational products.
Fertility – Commercial and Healthcare Reform – New York	12/19/2025	Policy revised to add new generic to Endometrin (progesterone) mirroring current brand Endometrin criteria, and new generic of Milophene (clomiphene citrate) mirroring current clomiphene citrate criteria. If the request is for brand Endometrin or Crinone 8% (progesterone), the member has tried/failed generic progesterone, micronized insert.
Fertility – Commercial and Select Healthcare Reform Plans	12/19/2025	Policy revised to add new generic to Endometrin (progesterone) mirroring current brand Endometrin criteria, and new generic of Milophene (clomiphene citrate) mirroring current clomiphene citrate criteria. If the request is for brand Endometrin or Crinone 8% (progesterone), the member has tried/failed generic progesterone, micronized insert.
Fertility – Pennsylvania Healthcare Reform Individual Plans	12/19/2025	Policy revised to add new generic to Endometrin (progesterone) mirroring current brand Endometrin criteria, and

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		new generic of Milophene (clomiphene citrate) mirroring current clomiphene citrate criteria. If the request is for brand Endometrin or Crinone 8% (progesterone), the member has tried/failed generic progesterone, micronized insert.
Forzinity (elamipretide) – Commercial and Healthcare Reform – Delaware	01/06/2026	New policy for Forzinity (elamipretide) requiring male sex, age of 12 years or older, diagnosis of Barth syndrome genetically confirmed by a pathogenic mutation in the TAFAZZIN gene, weight of ≥ 30 kg, using to improve muscle strength. Reauthorization requiring improvement in muscle strength.
Glatiramer Acetate – Commercial	01/01/2026	Policy revised to exclude Healthcare Reform.
Glatiramer Acetate – Healthcare Reform	12/19/2025	New policy for Healthcare Reform formularies for Copaxone (glatiramer acetate) and Glatopa (glatiramer acetate) requiring age of 18 years or older, FDA-approved diagnosis, and for requests for brand Copaxone (glatiramer acetate), therapeutic failure or intolerance to glatiramer acetate or Glatopa (glatiramer acetate). Reauthorization requiring disease improvement, stability, or delayed disease progression and for requests for brand Copaxone (glatiramer acetate), therapeutic failure or intolerance to glatiramer acetate or Glatopa (glatiramer acetate).
Hereditary Angioedema – Commercial and Healthcare Reform	10/29/2025	Policy revised to add Dawnzera (donidalorsen) to require age, diagnosis of hereditary angioedema (HAE) type 1, 2, or 3 supported by laboratory values and genetic testing (type 3 only), prescribed by or in consultation with a specialist, history of 1 symptom of moderate or severe angioedema attack, avoiding medications that cause angioedema, and not using two prophylactic medications simultaneously. Reauthorization of decrease in HAE attacks or improvement in duration or

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		severity of attacks from baseline, and dose de-escalation has been assessed.
Human Growth Hormone – Commercial and Healthcare Reform	12/19/2025	Policy revised for Commercial Comprehensive and Healthcare Reform Comprehensive for Skytrofa (lonapegsomatropin-tcgd) to require only a single step through a plan-preferred/preferred product. For these formularies, Sogroya (somapacitan-beco) and Nglena (somatrogon-ghla) require step through all plan-preferred/preferred products and Skytrofa.
Human Growth Hormone – Commercial and Healthcare Reform – Delaware	12/19/2025	Policy revised for Commercial Comprehensive and Healthcare Reform Comprehensive for Skytrofa (lonapegsomatropin-tcgd) to require only a single step through a plan-preferred/preferred product. For these formularies, Sogroya (somapacitan-beco) and Nglena (somatrogon-ghla) require step through all plan-preferred/preferred products and Skytrofa.
Market Watch Programs – Delaware	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add tizanidine 8 mg capsules for the member to step through tizanidine 2 mg and 4 mg tablets and tizanidine 2 mg, 4 mg, or 6 mg capsules. Also added Tonyma 2.5 mg sublingual requiring the member step through cyclobenzaprine 5 mg or 10 mg oral tablets.
Market Watch Programs – New York, Pennsylvania, and West Virginia	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add tizanidine 8 mg capsules for the member to step through tizanidine 2 mg and 4 mg tablets and tizanidine 2 mg, 4 mg, or 6 mg capsules. Also added Tonyma 2.5 mg sublingual requiring the member step through cyclobenzaprine 5 mg or 10 mg oral tablets.
Market Watch Programs – Delaware	01/01/2026	Policy revised to include additional High Cost Low Value (HCLV) drug targets and their alternatives. Policy also revised to include additional criteria prior to approval of Market Watch Program drugs. For HCLV, trial and failure of

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		alternatives must be verified by pharmacy claims or documented chart notes, and for combination medications the member must try and fail the alternatives available separately and taken together. No exceptions will be made for HCLV combination drugs for the sole purpose of increasing patient adherence or convenience. For Rx with OTC equivalent targets for which the same chemical and strength can be achieved OTC, the member has experienced contraindication or intolerance to the OTC product that would not be expected with the Rx Product.
Market Watch Programs – New York, Pennsylvania, and West Virginia	01/01/2026	Policy revised to include additional High Cost Low Value (HCLV) drug targets and their alternatives. Policy also revised to include additional criteria prior to approval of Market Watch Program drugs. For HCLV, trial and failure of alternatives must be verified by pharmacy claims or documented chart notes, and for combination medications the member must try and fail the alternatives available separately and taken together. No exceptions will be made for HCLV combination drugs for the sole purpose of increasing patient adherence or convenience. For Rx with OTC equivalent targets for which the same chemical and strength can be achieved OTC, the member has experienced contraindication or intolerance to the OTC product that would not be expected with the Rx Product.
Metabolic Dysfunction – Associated Steatohepatitis (MASH) – Commercial and Healthcare Reform	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add Wegovy (semaglutide) oral tablet mirroring criteria for Wegovy single-dose pen injector when FDA-approved age and indication is shared between the dosage forms.
Metabolic Dysfunction – Associated	10/08/2025	Policy revised for all targets to allow metabolic specialist prescribing when in

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Steatohepatitis (MASH) – Commercial and Healthcare Reform		consultation with a gastroenterologist or hepatologist.
Metabolic Dysfunction–Associated Steatohepatitis (MASH) – Commercial and Healthcare Reform	10/08/2025	Policy revised for all targets to allow endocrinologist prescribing when in consultation with a gastroenterologist or hepatologist.
Miscellaneous Immunomodulators – Commercial and Healthcare Reform	02/01/2026	Policy revised for brand Revlimid (lenalidomide) to require therapeutic failure or intolerance to generic lenalidomide for initial authorization and reauthorization.
Nascobal (cyanocobalamin) – Commercial and Healthcare Reform	12/19/2025	Policy revised for Nascobal (cyanocobalamin) to update laboratory B12 criteria to 350 pg/mL and if the request is for brand Nascobal a step through generic cyanocobalamin nasal spray is required.
Non-Preferred Riluzole Products – Commercial and Healthcare Reform	12/19/2025	Policy was updated to remove Exservan (riluzole) as a target due to discontinuation.
Novel Loop Diuretics (furosemide, bumetanide) – Commercial and Healthcare Reform	12/19/2025	Policy revised to add Enbumyst (bumetanide) to require that the following criteria be met for coverage: age and diagnosis based on FDA-approved indication. Enbumyst is prescribed by or in consultation with a cardiologist/nephrologist/hepatologist or gastroenterologist, the prescriber attests that the member has experienced a previous episode of congestion due to fluid overload and has been treated with a parenteral loop diuretic; the member has been receiving an oral loop diuretic as part of their medication regimen; and treatment with the oral diuretic will be discontinued until patient is transitioned back to oral diuretic maintenance therapy. Reauthorization requires attestation that the member has used Enbumyst for a previous episode of congestion due to chronic heart failure/chronic kidney disease, nephrotic syndrome, or edema associated with hepatic disease, had positive clinical

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		results and avoided hospitalization; the Enbumyst must be prescribed by or in consultation with a cardiologist/nephrologist/hepatologist or gastroenterologist; the member continues to have a FDA-approved diagnosis; the member has been receiving an oral loop diuretic as part of their chronic heart failure medication regimen; and treatment with the oral diuretic will be discontinued until patient is transitioned back to oral diuretic maintenance therapy. Authorization duration is 6 months.
Novel Loop Diuretics (furosemide, bumetanide) – Commercial and Healthcare Reform	01/06/2026	Policy revised to add Lasix ONYU (furosemide) to require that the following criteria be met for coverage: age and diagnosis based on FDA-approved indication, Lasix ONYU is prescribed by or in consultation with a cardiologist, the prescriber attests that the member has experienced a previous episode of congestion due to fluid overload and has been treated with a parenteral loop diuretic; the member has been receiving an oral loop diuretic as part of their chronic heart failure medication regimen; and treatment with the oral diuretic will be discontinued until patient is transitioned back to oral diuretic maintenance therapy. Reauthorization requires attestation that the member has used Lasix ONYU for a previous episode of congestion due to chronic heart failure, had positive clinical results and avoided hospitalization; the Lasix ONYU must be prescribed by or in consultation with a cardiologist; the member continues to have a diagnosis of heart failure; the member has been receiving an oral loop diuretic as part of their chronic heart failure medication regimen; and treatment with the oral diuretic will be discontinued until patient is transitioned back to oral diuretic

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		maintenance therapy. Authorization duration is 6 months.
Ofev (nintedanib) and Esbriet (pirfenidone) – Commercial and Healthcare Reform	11/10/2025	Policy updated for systemic sclerosis-associated interstitial lung disease and chronic fibrosing interstitial lung disease (ILD) with progressive phenotype to require a computed tomography scan demonstrating ≥ 10% pulmonary fibrosis.
Opzelura (ruxolitinib) – Commercial and Healthcare Reform	12/19/2025	Policy revised for Opzelura (ruxolitinib) to update atopic dermatitis age restriction to 2 years of age and older
PCSK9 Inhibitors – Commercial and Healthcare Reform	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy was revised based on Repatha (evolocumab) expanded indication. For Repatha (evolocumab) initial authorization criteria was added to the policy requiring that the member is 18 years of age or older. The member to be at risk for a major cardiovascular event substantiated by all of the following criteria: atherosclerotic cerebrovascular disease, coronary artery disease, peripheral arterial disease, high-risk diabetes mellitus. Prescriber attests that the requested agent is being used for primary prevention of cardiovascular events, demonstrated by both of the following: the member does not have a history of myocardial infarction, the member does not have a history of stroke. The member meets one of the following; the member has a current LDL-C ≥ 90 mg/dL, the member has a current non-HDL-C ≥ 120 mg/dL, member has a current apolipoprotein B ≥ 80 mg/dL. The member has experienced one of the following: member has experienced a maximally tolerated statin or member is statin intolerant. If member is statin intolerant member must show rhabdomyolysis or skeletal-related muscle symptoms while receiving at least two (2) separate trials of different statins which resolved upon discontinuation of the statins or one (1) of the following: creatinine kinase increase to 10 times upper limit of

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		normal, liver function tests increase to 3 times upper limit of normal, or hospitalization due to severe statin-related adverse event. The member will continue to receive concurrent lipid-lowering therapies for the treatment of major adverse cardiovascular event risk reduction. Maintenance criteria mirrors initial criteria excluding statin intolerance criteria. For the indication Primary Hyperlipidemia, not associated with ASCVD, HeFH, or HoFH; the following maintenance criteria was removed, the member met one of the following: the member had a coronary artery calcium or calcification (CAC) score ≥ 1,000 Agatston units, or the member had a baseline untreated LDL ≥ 190 mg/dL.
Phenylalanine Hydroxylase Activator Products – Commercial and Healthcare Reform	10/29/2025	Policy revised to add Zelvysia to require diagnosis based on FDA-approved indication supported by baseline phenylalanine (Phe) levels greater than 6 mg/dL, and documentation supporting compliance to a Phe-restrictive diet; documentation of member's current weight; the dose does not exceed 20 mg/kg/day. Reauthorization to require either 30% or greater decrease in blood Phe levels from baseline or Phe levels within targeted Phe levels; the member is on a Phe-restrictive diet; clinical documentation of the member's current weight; and the dose does not exceed 20 mg/kg/day. Initial authorization duration 3 months; reauthorization duration 12 months. Policy revised to remove step through generic sapropterin dihydrochloride for Javygtor.
Presbyopia Products – Commercial and Healthcare Reform	12/19/2025	Policy revised for brand Vuity (pilocarpine hydrochloride), Vizz (aceclidine), and Qlosi (pilocarpine hydrochloride), to require therapeutic failure, intolerance, or contraindication to

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		plan-preferred pilocarpine 1.25% ophthalmic solution.
Pulmonary Hypertension – Commercial and Healthcare Reform	12/19/2025	Policy revised to add bosentan tablets for oral suspension as a target mirroring criteria for Tracleer (bosentan) tablets for oral suspension). For initial authorization and reauthorization of brand and generic Tracleer tablets for oral suspension, requiring age less than or equal to 12 years and if the request is for brand Tracleer tablets for oral suspensions, trial/failure of generic bosentan tablets for oral suspension. Criteria requiring step through oral tablets for oral tablets for suspension removed.
Rhapsido (remibrutinib) – Commercial and Healthcare Reform	12/19/2025	New policy for Rhapsido (remibrutinib) requiring FDA-approved age and diagnosis; prescribed by or in consultation with a dermatologist, immunologist, or allergist; has been experiencing symptoms for at least 6 weeks; has ruled out other potential causes of urticaria; has tried two second-generation, non-sedating, H1 antihistamines at up to fourfold the maximum FDA recommended dose; has tried Xolair (omalizumab) and Dupixent (dupilumab); and will not be receiving in combination with Xolair (omalizumab) and Dupixent (dupilumab). Reauthorization requiring one of the following: reduction in itch severity, reduction in number or severity of hives, reduction in number or severity of swelling episodes.
Selective Estrogen Receptor Degraders – Commercial and Healthcare Reform	12/19/2025	Policy revised to add Inluriyo (imlunestrant) requiring age and diagnosis per FDA-approved indication, a tumor status of ER-positive, HER2-negative, with an ESR1 gene mutation detected by FDA-approved test, and to have experienced disease progression on or after an endocrine-based therapy.
Somavert (pegvisomant) – Commercial and Healthcare Reform	TERMED ON 12/18/2025	Policy terminated (combined with J-0286)

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Step Therapy Exceptions – Commercial and Healthcare Reform	01/01/2026	Policy revised for New York to include requirements from 2024-2025 legislative session passed Senate Bill S1267A and Assembly Bill A443. If the member is required to try and fail more than two (2) plan-preferred mediations, the member tried and failed two (2) plan-preferred medications.
Tarpeyo (budesonide) – Commercial and Healthcare Reform	12/19/2025	Policy criteria for Tarpeyo (budesonide) was updated to include sodium-glucose cotransporter 2 inhibitors (SGLT2i) as a qualifier.
Tezspire (tezepelumab-ekko) – Commercial and Healthcare Reform	12/19/2025	Policy updated to include coverage of Tezspire (tezepelumab-ekko) if the member has an FDA-approved indication, the prescriber submits documentation of both the patient's baseline bilateral nasal polyp score and baseline nasal congestion score, and the member has experienced therapeutic failure, contraindication, or intolerance to one (1) generic intra-nasal corticosteroid. For reauthorization, the prescriber attests the member has a decrease in their nasal polyp score or the member has a reduction in their nasal congestion/obstruction severity score.
Thrombopoiesis Stimulating Agents – Commercial and Healthcare Reform	12/19/2025	Policy revised to update FDA-approved indications for Promacta (eltrombopag olamine) and Alvaiz (eltrombopag choline) to include persistent immune thrombocytopenia.
Ultomiris (ravulizumab-cwvz) Subcutaneous – Commercial and Healthcare Reform	TERMED ON 10/27/2025	Policy termination due to manufacturer discontinuing plans for subcutaneous formulation of Ultomiris (ravulizumab)
Urea Cycle Disorder Medications – Commercial and Healthcare Reform	12/19/2025	Policy revised to update Olpruva (sodium phenylbutyrate) to one year of age or older and weight of at least 7 kg per expanded indication. Generic of Ravicti (glycerol phenylbutyrate) added as target. Requests for brand Ravicti (glycerol phenylbutyrate) require trial or failure of generic glycerol phenylbutyrate.

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Voquezna (vonoprazan) Products – Commercial and Healthcare Reform	12/19/2025	Policy revised for Voquezna (vonoprazan) in erosive esophagitis to clarify that total treatment duration should not exceed 8 months in the past 365 days.
Vtama (tapinarof) and Zoryve (roflumilast) – Commercial and Healthcare Reform	12/19/2025	Policy revised to add new strength of Zoryve (roflumilast) 0.05% requiring the member is 2 to 5 years of age, FDA-approved diagnosis, and trial/failure/contraindication to topical tacrolimus or pimecrolimus.
Vyjuvek (beremagene geperpavec-svdt) – Commercial and Healthcare Reform	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	New policy for Vyjuvek (beremagene geperpavec-svdt) requiring dystrophic epidermolysis bullosa with mutation(s) in the collagen type VII alpha 1 chain (COL7A1) gene, specialist restriction, administered in the home setting by the patient or caregiver after receiving training, one or more open wounds, continuation of standard wound care, not exceeding maximum dose per age, target wounds have adequate granulation and vascularization, member does not meet any exclusion criteria and Vyjuvek will not be used on healed wounds. Reauthorization requires new or reopened recurrent wounds or if target wounds remain open the target wounds have decreased in size, increased in granulation tissue or experienced at least 75% of wound healing, administered in the home setting by the patient or caregiver, continuation of standard wound care, not exceeding maximum dose per age, target wounds have adequate granulation and vascularization, member does not meet any exclusion criteria and Vyjuvek will not be used on healed wounds
Wayrilz (rilzabrutinib) – Commercial and Healthcare Reform	10/29/2025	New policy for Wayrilz (rilzabrutinib) to require diagnosis of FDA-approved indication, insufficient response to corticosteroid therapy or IVIG OR splenectomy, AND platelet count > 30 x 10^9/L and significant mucous membrane

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		bleeding or 1 risk factor for bleeding OR platelet count ≤ 30 x 10^9/L. Reauthorization to require prescriber attestation of positive clinical response to therapy.
Xiidra (Lifitegrast Ophthalmic Solution) – Healthcare Reform	12/19/2025	Policy revised for Xiidra (lifitegrast) to require verification of use of generic ophthalmic cyclosporine with pharmacy claims or documented chart notes.
Xolair (omalizumab) Syringe and Autoinjector – Commercial and Healthcare Reform	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised for Xolair (omalizumab) for chronic spontaneous urticaria (CSU) to add that it must be prescribed by or in consultation with a dermatologist, immunologist, or allergist; member must have been experiencing symptoms for at least 6 weeks; the prescriber has ruled out other potential causes of urticaria; the member has tried two second generation antihistamines at up to fourfold the FDA maximum recommended dose; and the member will not be receiving Xolair in combination with Rhapsido (remibrutinib) or Dupixent (dupilumab) Reauthorization requires reduction in itch severity or reduction in number or severity of hives or swelling episodes.
Zurzuvae (zuranolone) – Commercial and Healthcare Reform	12/19/2025	Policy revised to remove criteria requiring documentation of a diagnosis of moderate to severe postpartum depression. Criteria will now require documentation of diagnosis of postpartum depression and prescriber attestation that the symptom onset began during the third trimester of pregnancy or up to 4 weeks post-delivery and the member is ≤ 12 months postpartum

*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
Acute Migraine Therapies – Commercial and Healthcare Reform	10/24/2025	Policy revised for Reyvow (lasmiditan) to change step through two triptans to one triptan.
Benzodiazepines for Emergency Use – Commercial and Healthcare Reform	12/19/2025	Policy revised to remove reauthorization criteria.
Bevespi (glycopyrrolate / formoterol) – Commercial	TERMED ON 12/18/2025	Terming policy to combine with other Long-Acting Muscarinic Antagonist - Long-Acting Beta Agonist Combination Inhalers-Commercial and Healthcare Reform Policy, J-0233.
Branded Antiandrogen Therapy – Commercial and Healthcare Reform	12/19/2025	Policy revised to change authorization duration from 2 years to 12 months.
Branded Aromatase Inhibitors – Commercial and Healthcare Reform	12/19/2025	Policy revised to change authorization duration from 2 years to 12 months.
Carbidopa/Levodopa – Commercial and Healthcare Reform	12/19/2025	Policy revised to add authorized generic of Rytary (carbidopa-levodopa extended release) as a target.
Carbinoxamine Products – Commercial and Healthcare Reform	01/01/2026	Policy revised for non-preferred carbinoxamine product reauthorization to require trial/failure of generic carbinoxamine 4 mg tablets; or if the request is for a liquid formulation, the member is unable to swallow tablets.
CGRP Inhibitors – Commercial and Healthcare Reform	11/06/2025	Policy revised to change Zavzpret (zavegepant) back to a double step through triptans.
CGRP Inhibitors – Commercial and Healthcare Reform	10/24/2025	Policy revised for Nurtec ODT (rimegepant), Ubrelvy (ubrogepant), and Zavzpret (zavegepant) when used for acute treatment of migraine to change step through two triptans to one triptan.
Cyclobenzaprine, Metaxalone, Methocarbamol, and Tizanidine Products – Commercial and Healthcare Reform	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to include Zanaflex (tizanidine) 8 mg capsules to require the member has a diagnosis of spasticity, the member has experienced therapeutic failure or intolerance to both tizanidine 2 mg and 4 mg tablets and the member has experienced therapeutic failure or intolerance to one of the following agents: tizanidine 2 mg, 4 mg, or 6 mg capsules.

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
Doxycycline Products – Commercial and Healthcare Reform	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy updated to add doxycycline hyclate delayed-release 50 mg, 100 mg, 150 mg, and 200 mg tablets, doxycycline hyclate 50 mg and 150 mg tablets, doxycycline monohydrate 75 mg and 150 mg capsules, doxycycline monohydrate 150 mg tablet, and Mondoxyne NL 75 mg capsules as targets requiring the member to have an infection due to microorganism of susceptible strains and the member has experienced therapeutic failure or intolerance to plan-preferred generic immediate-release doxycycline. For acne, the member is 8 years of age or older, weighs at least 45 kg, has a diagnosis of severe acne vulgaris, has experienced therapeutic failure, contraindication, or intolerance to at least one (1) topical agent indicated for the treatment of acne, and has therapeutic failure, contraindication, or intolerance to both generic doxycycline and another plan-preferred oral antibiotic indicated for the treatment of acne.
Fibrates – Commercial and Healthcare Reform	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to move fenofibrate 130 mg to a target. Policy criteria also revised to require therapeutic failure or intolerance to two (2) plan-preferred fibrate medications.
Gralise (gabapentin) – Commercial and Healthcare Reform	12/19/2025	Policy updated to include if the request is for brand Gralise, the member has experienced therapeutic failure or intolerance to generic gabapentin extended-release tablets for both the initial authorization and reauthorization.
Ibuprofen/famotidine – Commercial and Healthcare Reform	12/19/2025	Policy was updated to remove brand Duexis (ibuprofen/famotidine) as a target due to discontinuation. Policy criteria was updated to remove criteria applied to brand Duexis (ibuprofen/famotidine).
Inhaled Corticosteroid and Inhaled Corticosteroid-Long-Acting Beta Agonist Inhalers – Commercial	12/19/2025	Policy updated to remove the authorized generic of umeclidinium/vilanterol and move to policy J-0233. Policy also updated to include fluticasone furoate (the authorized generic only) to require the member has a diagnosis of asthma and

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
and Select Healthcare Reform		the member has experienced therapeutic failure or intolerance to brand Arnuity Ellipta (fluticasone furoate) that would not be expected with the authorized generic product. Use must be verified by pharmacy claims or documented chart notes. For both fluticasone furoate/vilanterol and fluticasone propionate/salmeterol HFA, the member has experienced therapeutic failure or intolerance to the brand product that would not be expected with the authorized generic product. Use must be verified by pharmacy claims or documented chart notes.
Intraocular Pressure Reducing Agents – Commercial and Healthcare Reform	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add Zolymbus (bimatoprost ophthalmic gel) requiring diagnosis based on FDA-approved indications and trial and failure to latanoprost and one other plan-preferred, generic, ophthalmic alternative.
Lidocaine Patches and Topical System – Commercial and Healthcare Reform	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add Bondlido (lidocaine 10%) topical system as a targeted medication. Criteria for post-herpetic neuralgia (PHN) to require diagnosis and the member has experienced therapeutic failure, contraindication or intolerance to one plan-preferred agents (tricyclic antidepressant, gabapentin, or pregabalin). Criteria for neuropathic pain associated with cancer to require diagnosis and that the member meets one of the following: the member is using the product as adjuvant therapy with an antidepressant, the member is using the product as adjuvant with an anticonvulsant, the member is using the product as adjuvant with an opioid, or the member is using the product as adjuvant therapy in patients who are unable to swallow. Reauthorization to require that the prescriber attests that the member has experienced a positive clinical response to therapy.
Long-Acting Muscarinic Antagonists (LAMAs) –	01/01/2026	New policy for Spiriva Handihaler (tiotropium bromide) to require age,

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
Commercial and Healthcare Reform		diagnosis based on FDA-approved indication, and trial/failure/contraindication to tiotropium bromide or Spiriva Respimat (tiotropium bromide) and Incruse Ellipta (umeclidinium). Reauthorization to require attestation of reduction in symptoms of chronic obstructive pulmonary disease (COPD), improvement in exercise tolerance, delayed disease progression, or reduction in number of COPD exacerbations. Policy combined with other long-acting muscarinic antagonists: Tudorza Pressair (aclidinium bromide) and Yuperli (revefenacin). For Tudorza, the criteria was updated for a member to have experienced therapeutic failure, contraindication, or intolerance to either generic tiotropium bromide inhalation powder or Spiriva Respimat. For Yuperli, the criteria was updated for a member to have experienced therapeutic failure, contraindication, or intolerance to either generic tiotropium bromide inhalation powder or Spiriva Respimat. The member has also experienced therapeutic failure, contraindication, or intolerance to both of the following plan-preferred agents: Incruse Ellipta and Tudorza Pressair.
Long-Acting Muscarinic Antagonist – Long-Acting Beta Agonist Combination Inhalers – Commercial and Healthcare Reform	12/19/2025	Policy updated to include Bevespi (glycopyrrolate/formoterol) from J-1330 to require the member to have an FDA-approved diagnosis, 18 years of age and older, and to have therapeutic failure or intolerance to both Anoro Ellipta (umeclidinium/vilanterol) and Stiolto Respimat (tiotropium/olodaterol). Umeclidinium/vilanterol was included from J-0268 to require an FDA-approved diagnosis, 18 years of age and older, and if the request is for umeclidinium/vilanterol, the member has experienced contraindication or intolerance to brand Anoro Ellipta that would not be expected with the authorized generic product. Use must be verified by pharmacy claims or documented chart notes. For reauthorization for both

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
		Bevespi and umeclidinium/vilanterol, the member meets one of the following: The prescriber attests that the member has experienced a reduction in symptoms of COPD, the prescriber attests that the member has experienced an improvement in exercise tolerance, the prescriber attests that the member has experienced delayed disease progression, or the prescriber attests that the member has experienced a reduction in the number of exacerbations.
Motegrity (prucalopride) – Commercial and Healthcare Reform	01/01/2026	Policy revised for Motegrity (prucalopride) to add an additional step through Trulance (plecanatide).
Non-Preferred Dipeptidyl Peptidase IV Inhibitors (DPP-IV) and Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors – Commercial and Healthcare Reform	12/19/2025	Policy revised to remove Qtern (dapagliflozin/saxagliptin) as a target.
Non-Preferred Liquid Dosage Form Drugs – Commercial and Healthcare Reform	12/19/2025	Policy revised to include Jylamvo (methotrexate) as a target medication.
Non-Preferred Selective Serotonin Reuptake Inhibitors (SSRIs) – Commercial and Healthcare Reform	12/19/2025	Policy revised to include Escitalopram 15 mg capsules. Member must have an FDA-approved diagnosis and be 12-64 years of age for a major depressive disorder diagnosis (MDD) or 18-64 years of age for a generalized anxiety disorder (GAD) diagnosis. In addition, the member has initiated therapy with escitalopram 10 mg or the member has been receiving escitalopram 20 mg and has been experiencing unfavorable tolerability to the 20 mg dose. Also, the member has experienced therapeutic failure or intolerance to plan-preferred generic escitalopram tablets as well as therapeutic failure, contraindication, or intolerance to two (2) other plan-preferred generic antidepressants (e.g., SSRI, TCA, MAOI). For reauthorization, the prescriber attests that the member has experienced positive

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
		clinical response to therapy and the member continues to be unable to tolerate plan-preferred generic escitalopram.
Non-Preferred Topical Antifungals – Commercial and Healthcare Reform	12/19/2025	Policy updated to include econazole nitrate foam to require a member to have a diagnosis of tinea pedis and the member to experience therapeutic failure or intolerance to both econazole 1% cream and ketoconazole 2% cream.
Rayos (prednisone) – Commercial and Healthcare Reform	TERMED ON 12/18/2025	Policy terminated.
Topical Acne Products – Commercial and Healthcare Reform	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add generic clindamycin/tretinoin as a target requiring age, diagnosis, and trial/failure to two preferred, generic, acne therapeutic categories (topical retinoid + topical antibiotic). Reauthorization of positive clinical response and acne requires additional courses of treatment. Authorization duration of 12 months.
Topical Acne Products – Commercial and Healthcare Reform	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add Azelex (azelaic acid) and generic clindamycin/tretinoin as a target requiring age, diagnosis, and trial/failure to two preferred, generic, acne therapeutic categories (topical retinoid + topical antibiotic). Reauthorization of positive clinical response and acne requires additional courses of treatment. Authorization duration of 12 months.
Topical Antifungals – Commercial and Healthcare Reform	12/19/2025	Policy revised to remove brand Kerydin (tavaborole) as product is no longer available on the market. Policy also revised to add if the request is for Jublia, the member has experienced therapeutic failure, contraindication, or intolerance to plan-preferred tavaborole.
Topical Corticosteroids – Commercial and Healthcare Reform	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to move hydrocortisone butyrate 0.1% cream, ointment or solution, hydrocortisone valerate 0.2% ointment and fluocinonide-E 0.05% cream to targets requiring diagnosis and therapeutic failure or intolerance to 2 plan-preferred topical corticosteroids.

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
Topical Vitamin D Analogues – Commercial and Healthcare Reform	12/19/2025	Policy revised to remove brand Taclonex (calcipotriene/betamethasone dipropionate) ointment and brand Dovonex (calcipotriene) cream as products are no longer available on the market.
Trulance (plecanatide) – Commercial and Healthcare Reform	TERMED ON 01/01/2026	Policy terminated.
Tudorza Pressair (aclidinium bromide) – Commercial and Healthcare Reform	TERMED ON 01/01/2026	Termination of Policy. Combining LAMAs into one policy
Yupelri (revefenacin) – Commercial and Healthcare Reform	TERMED ON 01/01/2026	Termination of Policy. Combining LAMAs into one policy
Zelnorm (tegaserod) – Commercial and Healthcare Reform	01/01/2026	Policy revised for Zelnorm (tegaserod) to add an additional step through Trulance (plecanatide).

*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

No changes at this time.

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
Dawnzera (donidalorsen)	1 injection (0.8 mL) per 28 days	3 injections (2.4 mL) per 84 days
Eliquis (apixaban) 0.15 mg capsule	70 capsules per 28 days	210 capsules per 84 days
Eliquis (apixaban) 0.5 mg tablet	112 packets (112 tablets) per 28 days	336 packets (336 tablets) per 84 days
Eliquis (apixaban) 1.5 mg tablet	112 packets (336 tablets) per 28 days	336 packets (1,008 tablets) per 84 days
Eliquis (apixaban) 2 mg tablet	140 packets (560 tablets) per 28 days	420 packets (1,680 tablets) per 84 days

Drug Name	Retail Edit Limit	Mail Edit Limit
Forzinity (elamipretide)	4 vials (14 mL) per 28 days	12 vials (42 mL) per 84 days
Lasix Onyu (furosemide injection) Starter Kit	1 kit per 365 days	1 kit per 365 days
Modd1 Patient Welcome Kit	1 kit per 90 days	1 kit per 90 days
Modd1 Supply Kit Combo. Pkg	1 (10 cartridges) kit per 30 days	3 (30 cartridges) kits per 90 days
Otezla XR (apremilast) starter pack	1 starter pack per 365 days	1 starter pack per 365 days
Otezla/Otezla XR (apremilast) starter packs	1 starter pack per 365 days	1 starter pack per 365 days
Vyjuvek (beremagene geperpavec-svdt)	4 vials (10 mL) per 28 days	12 vials (30 mL) 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
Blujepa (gepotidacin)	20 tablets per dispensing event	20 tablets per dispensing event
Clotic (clotrimazole)	56 single-use droppers per dispensing event	56 single-use droppers per dispensing event
Enbumyst (bumetanide)	12 nasal sprays per dispensing event	12 nasal sprays per dispensing event
Lasix Onyu (furosemide injection) Kit	2 kits per dispensing event	2 kits per dispensing event
Zoryve (roflumilast) 0.05% cream	1 tube (60 grams) per dispensing event	3 tubes (180 grams) 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
Benznidazole 100 mg	4 tablets per day
Benznidazole 12.5 mg	6 tablets per day
Bondlido (lidocaine 10% topical system)	2 patches per day
escitalopram 10 mg tablet	1.5 tablets per day
Escitalopram 15 mg capsule	1 capsule per day
Firdapse (amifampridine phosphate)	10 tablets per day
Inluriyo (imlunestrant)	2 tablets per day
Jascayd (nerandomilast)	2 tablets per day
Koselugo (selumetinib) oral granules 5 mg	20 granules per day
Koselugo (selumetinib) oral granules 7.5 mg	12 granules per day

Drug Name	Daily Limit
Lampit (nifurtimox) 120 mg	8 tablets per day
Lampit (nifurtimox) 30 mg	12 tablets per day
Olpruva 0.5 g, 1 g (sodium phenylbutyrate)	20 g per day
Otezla XR (apremilast) 75 mg tablet	1 tablet per day
Palsonify (paltusotine)	2 tablets per day
Rhapsido (Remibrutinib)	2 tablets per day
Subvenite (lamotrigine) suspension	70 mL per day
Wayrilz (rilzabrutinib)	2 tablets per day
Wegovy (semaglutide) oral tablet	1 tablet per day
Zanaflex 8 mg capsule	4 capsules per day
Zolymbus (bimatoprost ophthalmic gel)	One single-use dropper 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.

Brand Name	Generic Name	Comments
Eliquis 0.15 mg, 0.5 mg, 1.5 mg, 2 mg	apixaban	To reduce the risk of stroke and systemic embolism in adult patients with nonvalvular atrial fibrillation; For the prophylaxis of deep vein thrombosis (DVT), which may lead to pulmonary embolism (PE), in adult patients who have undergone hip or knee replacement surgery; for the

		treatment of DVT and PE, and for the reduction in the risk of recurrent DVT and PE in adult patients following initial therapy; treatment of venous thromboembolism (VTE) and reduction in the risk of recurrent VTE in pediatric patients from birth and older after at least 5 days of initial anticoagulant treatment.

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

Brand Name	Generic Name	Preferred Alternatives
Bildyos	denosumab-nxxp	Prolia
Bondlido	lidocaine 10% topical system	Lidocaine 5% patch
Bosaya	denosumab-kyqq	Prolia
Clotic	clotrimazole	Prescriber Discretion
Enoby	denosumab-qbde	Prolia
Escitalopram 15 mg capsule	escitalopram	escitalopram tablets
Modd1		Prescriber Discretion
Subvenite suspension	lamotrigine	lamotrigine tablet, divalproex tablet, levetiracetam tablet
Zolymbus	bimatoprost ophthalmic gel	latanoprost 0.005% eye drops, timolol maleate 0.25% eye drops
Zoryve 0.05% cream	roflumilast	hydrocortisone ointment, betamethasone valerate cream, fluticasone propionate cream 0.05%

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

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

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

Brand Name	Generic Name	Comments
Eliquis 0.15 mg, 0.5 mg, 1.5 mg, 2 mg	apixaban	To reduce the risk of stroke and systemic embolism in adult patients with nonvalvular atrial fibrillation; For the prophylaxis of deep vein thrombosis (DVT), which may lead to pulmonary embolism (PE), in adult patients who have undergone hip or knee replacement surgery; for the treatment of DVT and PE, and for the reduction in the risk of recurrent DVT and PE in adult patients following initial therapy; treatment of venous thromboembolism (VTE) and reduction in the risk of recurrent VTE in pediatric patients from birth and older after at least 5 days of initial anticoagulant treatment.

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

Brand Name	Generic Name	Preferred Alternatives
Clotic	clotrimazole	Prescriber Discretion
Escitalopram 15 mg capsule	escitalopram	escitalopram tablets
Zoryve 0.05% cream	roflumilast	hydrocortisone ointment, betamethasone valerate cream, fluticasone propionate cream 0.05%

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

Brand Name	Generic Name	Preferred Alternatives
Beizray	docetaxel	Prescriber Discretion
Bildyos	denosumab-nxxp	Prolia
Bondlido	lidocaine 10% topical system	Lidocaine 5% patch
Bosaya	denosumab-kyqq	Prolia
Dawnzera	donidalorsen	Cinryze,
Enbumyst	bumetanide	furosemide tablet, bumetanide tablet, torsemide tablet
Enoby	denosumab-qbde	Prolia
Eydenzelt	aflibercept-boav	Avastin, Eylea
Modd1		V-Go

Palsonify	paltusotine	octreotide
Qivigy	immune globulin intravenous, human-kthm	Gammagard, Privigen
Rhapsido	remibrutinib	levocetirizine tablet, cetirizine, desloratadine
Subvenite suspension	lamotrigine	lamotrigine tablet, divalproex tablet, levetiracetam tablet
Wayrilz	rilzabrutinib	Eltrombopag olamine, Doptelet
Wegovy oral tablet	semaglutide	Prescriber Discretion
Zanaflex 8 mg capsule	tizanidine	tizanidine tablets
Zolymbus	bimatoprost ophthalmic gel	latanoprost 0.005% eye drops, timolol maleate 0.25% eye drops

*Physicians may request coverage of these products using the Prescription Drug Medication Request Form.

C. Additions to the Specialty Tier

Effective immediately pending CMS approval and upon completion of internal review and implementation.

Brand Name	Generic Name
Aukelso	denosumab-kyqq
Beizray*	docetaxel
Bilprevda	denosumab-nxxp
Blenrep	belantamab mafodotin-blmf
Dawnzera*	donidalorsen
Enbumyst*	bumetanide
Eydenzelt*	aflibercept-boav
Forzinity	elamipretide
Inluriyo	imlunestrant
Jascayd	nerandomilast
Keytruda Qlex	pembrolizumab and berahyaluronidase alfa-pmph
Koselugo	selumetinib
Lasix Onyu	furosemide injection
Otezla XR	apremilast
Palsonify*	paltusotine
Qivigy*	immune globulin intravenous, human-kthm
Rhapsido*	remibrutinib
Wayrilz*	rilzabrutinib
Wegovy oral tablet*	semaglutide
Xtrenbo	denosumab-qbde
Zanaflex 8 mg capsule*	tizanidine

*Only pertains 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
7-Day Supply Limit for Opioid Naïve Patients – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy created to allow a member to get coverage for more than a 7-day fill of opioid analgesics when all of the following criteria are met: the member has a diagnosis of pain and meets one of the following criteria: diagnosis of active cancer, diagnosis of sickle cell anemia, receiving hospice care, palliative care, or end-of-life care, member is a cancer survivor being treated for chronic pain and meets one of the following: completed cancer treatment, in clinical remission, under cancer surveillance only. The member is currently using opioid therapy on a consistent basis for chronic pain (defined as prescribed use for 74 out of the past 90 days). And the drug is being used for severe pain and all these criteria are met: attestation that non-opiate therapies have been explored, attestation that the member's history of controlled substance prescriptions have been checked using the state prescription monitoring program (PDMP) and counseling has been provided on the potential adverse effects of opioid analgesics, including the risk of misuse, abuse, and addiction. Also, the prescriber states based on the member's clinical circumstances that the amount of opioid prescribed is warranted in order to adequately manage the member's pain. A 12-month authorization will be given.
Adakveo (crizanlizumab-tmca) – Medicare	12/19/2025	Policy revised for Adakveo (crizanlizumab-tmca) to remove age restriction.

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Administrative Prior Authorizations for Medicare Part D Plans – Medicare	01/01/2026	Removed from Infusion Pump section: Aggrastat, Baclofen (Gablofen & Lioresal), Cyramza, Cytovene, Elzonris, Lamzede, Loqtorzi, Marqibo, Nulibry, Olinvyk, Onpattro, Pemrydi, Roctavian, Uplizna, Vectibix. Add to Infusion Section: Adriamycin, Desferal, Mitigo, Vincasar. Removed from Provider Section: Amiodarone, Cidofovir, Cytogam, Empliciti, Nitroglycerin vial and D5W, Nitroprusside. Added to Provider Section: Aurlumyn, Lamzede, Loqtorzi, Nulibry, Onpattro, Uplizna. Added to BvD IG Section: Yimmugo. Added to Section H. Injectable Osteoporosis Agents: Ospomyv
Adstiladrin (nadofaragene firadenovec-vncg) and Inlexzo (gemcitabine) – Medicare	12/19/2025	Policy revised to add Inlexzo (gemcitabine) to require diagnosis based on FDA-approved indication. Approval for Inlexzo requires a diagnosis of BCG-unresponsive NMIBC, the patient has carcinoma *in situ* (CIS), and the disease occurs with or without papillary tumors.
Ampyra (dalfampridine) – Medicare	01/01/2026	Policy revised to update authorization duration to 12 months.
Anabolic Steroids – Medicare	12/19/2025	Policy revised to remove Android (methyltestosterone) and Testred (methyltestosterone) as targets.
Antifibrotic Pulmonary Medication – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to include Jascayd (nerandomilast). The member must have a diagnosis of IPF, the member's baseline forced vital capacity (FVC) must be at least 50%, the member's percent predicted diffusing capacity of the lungs of carbon monoxide (DLco) of at least 30%, the member must meet one of the following: member is receiving Jascayd concomitantly with Esbriet (pirfenidone) or Ofev

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		AND has been receiving this medication at a stable dose for at least 12 weeks. If the member has been receiving Esbriet (pirfenidone) and will remain on this drug with Jascayd, the Jascayd dose must be 18 mg twice daily OR the member will be using Jascayd as monotherapy and meets one of the following criteria: the member has received Esbriet (pirfenidone) and Ofev and is unable to tolerate these medications or the member has contraindications to both Esbriet (pirfenidone) and Ofev.
Atypical Antipsychotics – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised for Latuda (lurasidone), for both diagnoses of Bipolar I Depression and Schizophrenia: if the request is for brand Latuda, the member has experienced intolerance to generic lurasidone; therapeutic failure has been removed. For Saphris (asenapine), for both diagnoses of Schizophrenia and Bipolar Disorder, if the request is for brand Saphris, the member has experienced intolerance to generic asenapine sublingual tablets; therapeutic failure has been removed.
Benlysta (belimumab) – Medicare	12/03/2025	Quantity limits with policy revised for Benlysta (belimumab) to reflect FDA-approved induction and maintenance dosing for patients 5 years of age and older with active lupus nephritis receiving standard therapy.
Blenrep (belantamab mafodotin-blmf) – Medicare	12/19/2025	New policy for Blenrep (belantamab mafodotin-blmf) to require criteria based on FDA-approved diagnosis and to require combination use with dexamethasone and bortezomib for the first eight cycles of

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		treatment, followed by Blenrep as a single agent.
Bondlido and ZTLido (lidocaine topical systems) – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy updated to include Bondlido (lidocaine 10%) topical system. Member must have a diagnosis of post-herpetic neuralgia (PNH) and the member must meet one (1) of the following criteria: 1. therapeutic failure or intolerance to one (1) other agent used to treat PHN, 2. the member is unable to swallow oral medications, 3. the member is unable to take an oral medication due to potential adverse events. In addition, the member must have experienced therapeutic failure, contraindication, or intolerance to generic lidocaine patch 5%.
BRAF Mutation-Targeting & MEK Kinase Inhibitors – Medicare	12/19/2025	Policy revised for Koselugo (selumetinib) for expanded age of 1 to 17 years of age. For Koselugo (selumetinib) granules, the member has a body surface area <0.55 m2 or has an inability to swallow capsules.
Carac (fluorouracil) cream – Medicare	12/19/2025	Policy revised for Carac (fluorouracil) cream to add protected class drug language. Administrative changes only to remove therapeutic failure language.
CGRP Inhibitors and Reyvow – Medicare	01/01/2026	Policy revised for Nurtec ODT (rimegepant) and Qulipta (atogepant) for acute migraine to add exemption from triptan step if all triptans are contraindicated.
CGRP Inhibitors and Reyvow – Medicare	11/26/2025	Policy revised for Ajovy (fremanezumab-vfrm) to remove step through 2 prophylactic migraine classes.
Chronic Inflammatory Diseases – Medicare	01/01/2026	Policy revised to move Enbrel (etanercept) to non-preferred requiring failure on one preferred adalimumab product, Humira (adalimumab) [00074] labeler and Cyltezo (adalimumab-adbm)

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		moved to non-preferred adalimumab products. Stelara (ustekinumab) moved to non-preferred ustekinumab products, and non-preferred ustekinumab products updated to require failure on two preferred ustekinumab products. Authorization duration updated to end of plan year for all indications except Zeposia (ozanimod) for multiple sclerosis.
Chronic Inflammatory Diseases – Medicare	01/01/2026	Policy revised to move tocilizumab products to non-preferred with step through 2 preferred biologics for rheumatoid arthritis and polyarticular juvenile idiopathic arthritis.
Chronic Inflammatory Diseases – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add Otezla XR (apremilast) into existing Otezla criteria for Behcet's disease, plaque psoriasis (PsA) and psoriatic arthritis (PsO) with the addition of requiring weight greater than or equal to 50 kg for pediatric patients with PsA and PsO. Policy revised for Tremfya (guselkumab) to add expanded indication for PsO and PsA in pediatric patients 6 years of age or older and weighing at least 40 kg into existing criteria and for ulcerative colitis the member has received or currently undergoing IV induction therapy or using Tremfya SC for induction dosing. Policy revised for Rinvoq (upadacitinib) to include exception for the expanded indication in ulcerative colitis or Crohn's disease that if TNF blockers are not advisable, the member steps through one systemic therapy. Policy revised for Xeljanz (tofacitinib) tablet and oral solution to add expanded indication for PsA in pediatric patients 2 years of age or older into existing criteria.

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		Policy revised for Simponi (golimumab) to add expanded indication of ulcerative colitis in pediatric patients weighing at least 15 kg into existing criteria with pediatrics greater than 5 years of age stepping through adalimumab.
Denosumab Products for Bone Disease – Medicare	12/19/2025	Policy revised to add Bildyos (denosumab-nxxp) as a target mirroring criteria for all other Prolia (denosumab) biosimilars.
Denosumab Products for Bone Disease – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add Bosaya (denosumab-kyqq) and Enoby (denosumab-qbde) 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 Aukelso (denosumab-kyqq) and Xtrenbo (denosumab-qbde) as targets requiring FDA-approved indication and therapeutic failure or intolerance to Xgeva (denosumab).
Denosumab Products for Oncology – Medicare	12/19/2025	Policy revised to add Bilprevda (denosumab-nxxp) requiring FDA-approved indication and therapeutic failure or intolerance to Xgeva (denosumab).
Doptelet (avatrombopag) and Mulpleta (lusutrombopag) – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised for Mulpleta (lusutrombopag) criteria for chronic liver disease to require platelet count of < 50 x 10^9/L. Added reauthorization criteria for immune thrombocytopenia indication that member has experienced increase in platelet count in response to Doptelet (avatrombopag) therapy and if the request is for Doptelet Sprinkle, the member is less than 6 years old.
Drugs for Chagas Disease – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Termination of policy.
Dupixent (dupilumab) – Medicare	10/13/2025	Policy revised for Dupixent (dupilumab) for chronic rhinosinusitis with nasal polyps to

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		remove systemic corticosteroid step.
Dupixent (dupilumab) – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised for Dupixent (dupilumab) for chronic spontaneous urticaria (CSU) to require that the member has been experiencing symptoms for at least 6 weeks; the prescriber has ruled out other potential causes of urticaria, and the member will no be receiving Dupixent in combination with Rhapsido (remibrutinib) or Xolair (omalizumab). Reauthorization requiring a reduction in itch severity or reduction in number or severity of hives or swelling episodes.
Endari (L-glutamine) – Medicare	01/01/2026	Administrative changes only to remove therapeutic failure language.
Entresto (sacubitril/valsartan) – Medicare	01/01/2026	Policy criteria for Entresto Sprinkle (sacubitril/valsartan) was updated to require therapeutic failure or intolerance to brand Entresto (sacubitril/valsartan) tablets or generic sacubitril/valsartan tablets for initial authorization and reauthorization. Criteria was also added to the policy targeting brand Entresto tablets. Policy criteria requires diagnosis of heart failure and therapeutic failure or intolerance to generic sacubitril/valsartan.
Evrysdi (risdiplam) – Medicare	01/01/2026	Policy revised to remove "clinically significant" verbiage from reauthorization criteria.
Forzinity (elamipretide) – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	New policy for Forzinity (elamipretide) requiring diagnosis of Barth syndrome genetically confirmed by a pathogenic mutation in the TAFAZZIN gene, weight of ≥ 30 kg, using to improve muscle strength. Reauthorization

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		requiring improvement in muscle strength.
Gabapentin – Medicare	01/01/2026	Policy revised to remove generic gabapentin as a target.
Gazyva (obinutuzumab) – Medicare	01/01/2026	New policy created for Gazyva (obinutuzumab) requiring FDA-approved diagnosis. For lupus nephritis (LN), diagnosis confirmed by renal biopsy or laboratory findings specific to LN. The member will continue to receive concomitant standard of care with corticosteroid and mycophenolic acid analog (MPAA). Authorization duration of 12 months.
Givlaari (givosiran) – Medicare	01/01/2026	Policy revised for Givlaari (givosiran) to add requirement of history of 4 or more acute AHP attacks per year and reauthorization added to require stabilization or decrease in frequency of attacks or decrease in severity of attacks.
Glucagon-Like Peptide-1 Receptor Agonists (GLP-1 RAs) – Medicare	01/01/2026	Policy revised for Victoza (liraglutide) requiring intolerance to liraglutide.
Gralise (gabapentin) – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy updated to include if the request is for brand Gralise, the member has experienced intolerance to generic gabapentin extended-release tablets.
Hereditary Angioedema – Medicare	10/29/2025	Policy revised to add Dawnzera (donidalorsen) to require diagnosis of hereditary angioedema (HAE) type 1, 2, or 3 supported by laboratory values and genetic testing (type 3 only), history of 1 symptom of moderate or severe angioedema attack, avoiding medications that cause angioedema, and not using two prophylactic medications simultaneously.

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Hetlioz and Hetlioz LQ (tasimelteon) – Medicare	01/01/2026	Policy revised for Hetlioz (tasimelteon) and Hetlioz LQ (tasimelteon) to update initial and reauthorization to 12 months.
Horizant (gabapentin enacarbil) – Medicare	01/01/2026	Policy revised to remove step through ropinirole and pramipexole for restless leg syndrome and change to step through generic pregabalin and generic immediate release gabapentin.
Ibuprofen/famotidine – Medicare	12/19/2025	Policy was updated to remove brand Duexis (ibuprofen/famotidine) as a target due to discontinuation. Policy criteria was updated to remove criteria applied to brand Duexis (ibuprofen/famotidine).
Immune Globulin – Medicare	01/01/2026	Policy revised to require for requests of non-preferred intravenous immune globulin the member has therapeutic failure, contraindication, or intolerance to both preferred intravenous Privigen (immune globulin [human]) and Gammagard (immune globulin [human]) products for applicable indications.
Immune Globulin – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add Qivigy (immune globulin, human-kthm) as a non-preferred IVIG target requiring same criteria as existing targets and therapeutic failure, contraindication, or intolerance to both Privigen and a Gammagard product.
Kerendia (finerenone) – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to under limitations of coverage to the member's eGFR being less than 25 mL/min/1.73 m^2 instead of less than or equal to
Lidocaine Patches – Medicare	12/19/2025	Policy was updated to remove Tridacaine (lidocaine patch 5%) and Lidoderm (lidocaine patch 5%) as a targets due to discontinuation. Criteria was also revised to remove step through Lidoderm.

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Mycapssa (octreotide) & Palsonify (paltusotine) – Medicare	12/19/2025	Policy revised to add Palsonify (paltusotine hydrochloride) as a target requiring FDA-approved indication, high pre-treatment insulin-like growth factor (IGF-1), previous response to octreotide or lanreotide, and trial/failure to Mycapssa (octreotide). Reauthorization requiring decrease or normalization of IGF-1 from baseline.
Neimann-Pick Disease Type C – Medicare	12/19/2025	Policy revised to remove age restriction on Miplyffa (arimoclomol).
Nemluvio (nemolizumab-ilto) – Medicare	12/19/2025	Policy revised for Nemluvio (nemolizumab-ilto) in atopic dermatitis to update initial authorization duration to 12 months.
Non-Preferred Dipeptidyl Peptidase IV (DPP-IV) Inhibitors – Medicare	01/01/2026	Policy revised to remove Janumet (sitagliptin/metformin), Janumet XR (sitagliptin/metformin) extended-release as a target. Revised policy criteria to include sitagliptin products (Janumet or Janumet XR) as a qualifier
Non-Preferred Pen needles – Medicare	01/01/2026	Policy created for non-preferred safety and non-safety pen needles requiring therapeutic failure, intolerance, or contraindication to preferred Embecta pen needles with NDC starting with 83017.
Non-Preferred Riluzole Products – Medicare	12/19/2025	Policy was updated to remove Exservan (riluzole) as a target due to discontinuation
Non-Preferred Selective Serotonin Reuptake Inhibitors (SSRIs) and Serotonin and Norepinephrine Reuptake Inhibitors (SNRIs) – Medicare	01/01/2026	Policy revised to include Escitalopram 15 mg capsules. Coverage of Escitalopram 15 mg capsules requires that the member meets all of the following criteria: Diagnosis of major depressive disorder or generalized anxiety, the member has initiated therapy with escitalopram 10 mg OR the member has been receiving escitalopram 20 mg and has been

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		experiencing unfavorable tolerability to the 20 mg dose, and the member has experienced intolerance to generic escitalopram tablets as well as the member has experienced therapeutic failure, contraindication, or intolerance to one (1) other antidepressant.
Novel Loop Diuretics (furosemide, bumetanide) – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add Lasix ONYU (furosemide) to require that the following criteria be met for coverage: Diagnosis of heart failure; member has been receiving an oral loop diuretic (bumetanide, torsemide) as part of their heart failure medication regimen; the prescriber attests that treatment with oral diuretics will replace the use of Lasix ONYU as soon as practical. Authorization duration of 6 months.
Novel Loop Diuretics (furosemide, bumetanide) – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add Enbumyst (bumetanide) to require that the following criteria be met for coverage: diagnosis of heart failure or chronic kidney disease and/or nephrotic syndrome or edema caused by hepatic disease; the member has been receiving an oral loop diuretic (furosemide, bumetanide, torsemide) as part of their medication regimen, and the prescriber attests that treatment with oral diuretics will replace the use of Enbumyst as soon as practical. Authorization duration of 6 months.
Ofev (nintedanib) and Esbriet (pirfenidone) – Medicare	09/23/2025	Policy updated for systemic sclerosis-associated interstitial lung disease and chronic fibrosing interstitial lung disease (ILD) with progressive phenotype to require a computed tomography scan demonstrating ≥ 10% pulmonary fibrosis.

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Opzelura (ruxolitinib) – Medicare	12/19/2025	Administrative changes only.
PCSK9 Therapies – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy criteria was updated based on Repatha (evolocumab) and Praluent (alirocumab) expanded indication. Removed criteria requiring the member to continue to receive concurrent lipid-lowering therapies for the treatment of Homozygous Familial Hypercholesterolemia (HoFH), and Heterozygous Familial Hypercholesterolemia (HeFH). Initial authorization criteria was added to the policy requiring the prescriber attests that the member is at risk for a major cardiovascular event. Reauthorization criteria was updated to require if the member is at risk for a major cardiovascular event, the prescriber attests that the member requires continued therapy. Initial authorization criteria for HoFH was revised to the member meets one of the following LDL-C > 560 mg/dL or LDL-C > 400 mg/dL and meets one of the following: aortic valve disease or xanthomata at < 20 years of age, one or both parents having clinically diagnosed HoFH, positive genetic testing for a known LDL-C–raising (LDLR, Apo[b], PCSK9) gene defect, or autosomal-recessive HeFH.
PI3K Inhibitors – Medicare	12/19/2025	Policy revised for Copiktra (duvelisib) and Piqray (alpelisib) to remove age criteria.
Programmed Death Receptor Therapies – Medicare	12/19/2025	Policy revised to add Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) to require criteria based on FDA-approved indications. Keytruda (pembrolizumab) revised to require criteria based on FDA-approved indications for microsatellite

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		instability-high or mismatch repair deficient colorectal cancer; hepatocellular carcinoma; and triple-negative breast cancer. Policy revised for Tecentriq (atezolizumab) and Tecentriq Hybreza (atezolizumab and hyaluronidase-tqjs) to require criteria based on expanded FDA-approved indication for extensive-stage small cell lung cancer. Limitations of coverage removed.
Pulmonary Hypertension – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add bosentan oral tablets for solution as a target mirroring criteria for Tracleer (bosentan) tablets for oral suspension. For brand Tracleer tablets for oral suspension, requiring intolerance to generic bosentan tablets for oral suspension.
Pulmonary Hypertension – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised for Tracleer (bosentan) requiring member age of 12 years or younger.
Rhapsido (remibrutinib) – Medicare	12/19/2025	New policy for Rhapsido (remibrutinib) requiring FDA-approved diagnosis; has been experiencing symptoms for at least 6 weeks; has ruled out other potential causes of urticaria; has tried one second-generation, non-sedating, H1 antihistamine at the maximum recommended dose; has tried Xolair (omalizumab) and Dupixent (dupilumab); and will not be receiving in combination with Xolair (omalizumab) and Dupixent (dupilumab). Reauthorization requiring one of the following: reduction in itch severity, reduction in number or severity of hives, reduction in number or severity of swelling episodes.

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Selective Estrogen Receptor Degraders – Medicare	01/01/2026	Policy revised to add Inluriyo (imlunestrant) requiring diagnosis per FDA-approved indication, a tumor status of ER-positive, HER2-negative, with an ESR1 gene mutation detected by FDA-approved test, and to have experienced disease progression on or after an endocrine-based therapy.
Somatostatin Receptor Ligands – Medicare	12/19/2025	Policy revised to add lanreotide and Somatuline (lanreotide) Depot as targets, requiring previously approved criteria for initial and reauthorization.
Somatuline (lanreotide) Depot – Medicare	TERMED ON 12/19/2025	Policy terminated (combined with J-1018)
Spleen Tyrosine Kinase Inhibitors – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised for Tavalisse (fostamatinib) to add reauthorization criterion to require attestation that member has experienced an increase in platelet count.
Synarel (nafarelin acetate) – Medicare	12/19/2025	Policy revised for Synarel (nafarelin acetate) for central precocious puberty requiring onset of secondary sexual characteristics before 8 years of age if female and 9 years of age if male.
Tarpeyo (budesonide) – Medicare	12/19/2025	Policy criteria for Tarpeyo (budesonide) was updated to include sodium-glucose cotransporter 2 inhibitors (SGLT2i) as a qualifier.
Tezspire (tezepelumab-ekko) – Medicare	12/19/2025	Policy updated to include coverage of Tezspire (tezepelumab-ekko) if the member has a diagnosis of chronic rhinosinusitis with nasal polyposis and the member has experienced therapeutic failure, contraindication, or intolerance to one (1) generic intra-nasal corticosteroid, and the member has experienced therapeutic failure, intolerance, or

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		contraindication to one (1) of the following: Dupixent (dupilumab), Nucala (mepolizumab), or Xolair (omalizumab). For reauthorization, the member has a decrease in their nasal polyp score or the member has a reduction in their nasal congestion/obstruction severity score.
Thrombopoiesis Stimulating Agents – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to remove therapeutic failure language for Alvaiz (eltrombopag choline) and updated to require member has experienced intolerance to generic eltrombopag olamine. Reauthorization added to require attestation that member has experienced an increase in platelet count, if request is for Alvaiz or brand Promacta, member must have experienced intolerance to generic eltrombopag olamine.
Tocilizumab Biosimilars – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to move tocilizumab products to non-preferred with step through 2 preferred biologics for rheumatoid arthritis and polyarticular juvenile idiopathic arthritis.
Topical Acne Products – Medicare	01/01/2026	Policy revised for retinoid products to update example of topical non-retinoid acne medications from monotherapy antibiotics to clindamycin + benzoyl peroxide.
Urea Cycle Disorder Medications – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add generic of Ravicti (glycerol phenylbutyrate) as target. For brand Ravicti (glycerol phenylbutyrate), intolerance to generic glycerol phenylbutyrate is required.
Voydeya (danicopan) – Medicare	01/01/2026	Policy revised for Voydeya (danicopan) to remove timeframe requirement of 6 months for history of receiving ravulizumab or eculizumab

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Vtama (tapinarof) and Zoryve (roflumilast) – Medicare	12/19/2025	Policy revised to add new strength of Zoryve (roflumilast) 0.05% requiring the member is 2 to 5 years of age, FDA-approved diagnosis, and trial/failure/contraindication to one generic formulary topical corticosteroid, and trial/failure/contraindication to topical tacrolimus or pimecrolimus.
Vuity (pilocarpine hydrochloride) – Medicare	12/19/2025	Policy revised to add generic Vuity (pilocarpine hydrochloride) to policy. For requests for brand Vuity, intolerance to generic pilocarpine hydrochloride 1.25% ophthalmic solution is required.
Vyjuvek (beremagene geperpavec-svdt – Medicare	01/01/2026	Policy revised for Vyjuvek (beremagene geperpavec-svdt) to add requirements of the patient or caregiver receive training when applying in a home setting, continuation of standard wound care, not exceeding maximum dose per age, and Vyjuvek will not be used on healed wounds. Reauthorization revised to require new or reopened recurrent wounds or if target wounds remain open the target wounds have decreased in size, increased in granulation tissue or experienced wound healing, continuation of standard wound care, not exceeding maximum dose per age, and Vyjuvek will not be used on healed wounds.
Wakix (pitolisant) – Medicare	01/01/2026	Policy revised to require step through generic modafinil and stimulant only for members 18 years of age or older.
Wayrilz (rilzabrutinib) – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	New policy for Wayrilz (rilzabrutinib) to require diagnosis of FDA-approved indication, insufficient response to corticosteroid therapy or IVIG or splenectomy, AND platelet count >

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		30 x 10^9/L and significant mucous membrane bleeding or 1 risk factor for bleeding OR platelet count ≤ 30 x 10^9/L. Reauthorization to require prescriber attestation of positive clinical response to therapy.
Wayrilz (rilzabrutinib) – Medicare	01/01/2026	Policy revised for Wayrilz (rilzabrutinib) to update reauthorization criterion to require attestation that member has experienced an increase in platelet count.
Wegovy (semaglutide) and Zepbound (tirzepatide) – Medicare	10/08/2025	Policy revised for Wegovy (semaglutide) for metabolic dysfunction — associated steatohepatitis requiring one cardiometabolic risk factor (BMI ≥ 25 kg/m2 or ethnicity adjusted, or for females, ≥ 80 cm ethnicity adjusted; fasting serum glucose ≥ 100 mg/dL; 2-hour post-prandial serum glucose ≥ 140 mg/dL; HbA1c ≥ 5.7%; diagnosis of type 2 diabetes or is on treatment for type 2 diabetes; plasma triglycerides ≥ 150 mg/dL or is on lipid lowering treatment; plasma HDL ≤ 40 mg/dL (males) or ≤ 50 mg/dL (female) or is on lipid lowering treatment; or blood pressure ≥ 130/85 mmHg or is on treatment for hypertension). Reauthorization requiring attestation of improvement or stabilization demonstrated by NIT, and member does not have cirrhosis, hepatic decompensation, or hepatocellular carcinoma. Policy revised for Wegovy (semaglutide) for all indications to removed maintenance dosing requirements. Policy criteria added for Zepbound (tirzepatide) for reauthorization that if baseline apnea/hypopnea index (AHI) or respiratory disturbance index (RDI) was 0, then the AHI/RDI remained at 0..

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Wegovy (semaglutide) and Zepbound (tirzepatide) – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add Wegovy (semaglutide) oral tablet as a target mirroring criteria for Wegovy single-dose pen injector when FDA-approved age and indication is shared between the dosage forms.
Wegovy (semaglutide) and Zepbound (tirzepatide) – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised for Wegovy (semaglutide) for initial and reauthorization for treatment of metabolic dysfunction-associated steatohepatitis to require attestation that the member does excessively use alcohol. For reauthorization of Wegovy for this indication, requiring attestation of maintenance dosing or titration to maintenance dosing. For Wegovy reauthorization for cardiovascular risk reduction, requiring attestation of maintenance dosing, attestation of titration to maintenance dosing, or attestation of inability to tolerate maintenance dose. For reauthorization of Zepbound (tirzepatide), adding 5 mg weekly as a maintenance dose.
Xolair (omalizumab) – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised for Xolair (omalizumab) for chronic spontaneous urticaria (CSU) to require that the member had symptoms for at least 6 weeks; the prescriber has ruled out other potential causes of urticaria; the member will not be receiving in combination with Rhapsido (remibrutinib) or Dupixent (dupilumab). Reauthorization requiring reduction in itch severity, reduction in number or severity of hives or swelling episodes.
Zanaflex – Medicare	12/19/2025	New policy created to include Zanaflex (tizanidine) 8 mg capsules to require the member has a diagnosis of spasticity, the member has experienced

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		intolerance to either tizanidine 2 mg and 4 mg tablets and the member has experienced intolerance to one of the following agents: tizanidine 2 mg, 4 mg, or 6 mg capsules.
Ztalmy (ganaxolone) – Medicare	01/01/2026	Policy revised to remove step through two previous antiepileptic therapies.
Zurzuvae (zuranolone) – Medicare	01/01/2026	Policy revised to remove criteria requiring documentation of a diagnosis of moderate to severe postpartum depression. Criteria will now require documentation of diagnosis of postpartum depression and prescriber attestation that the symptom onset began during the third trimester of pregnancy or up to 4 weeks post-delivery and the member is ≤ 12 months postpartum

*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
Carbidopa/Levodopa – Medicare	12/19/2025	Policy revised to add authorized generic of Rytary (carbidopa-levodopa extended release) as a target.
Gonadotropin-releasing Hormone (GnRH) Agonists – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy was revised to require the member experienced an onset of secondary sexual characteristics before 8 years of age if female or the member experienced an onset of secondary sexual characteristics before 9 years of age if male.
Gonadotropin-releasing Hormone (GnRH) Agonists – Medicare	01/01/2026	Policy was revised to require the member experienced an onset of secondary sexual characteristics before 8 years of age if female or the member experienced an onset of secondary sexual

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		characteristics before 9 years of age if male.
Gonadotropin-releasing Hormone (GnRH) Agonists – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy was revised to require the member experienced an onset of secondary sexual characteristics before 8 years of age if female or the member experienced an onset of secondary sexual characteristics before 9 years of age if male.
Gonadotropin-releasing Hormone (GnRH) Agonists – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised for Vabrinty (leuprolide acetate) to require therapeutic failure, contraindication, or intolerance to Eligard (leuprolide acetate) and leuprolide acetate depot 22.5 mg.
Intravitreal Injections – Medicare	EFFECTIVE UPON COMPLETION OF INTERNAL REVIEW AND IMPLEMENTATION	Policy revised to add Eydenzelt (aflibercept-boav) requiring FDA-approved diagnosis, intolerance to Eylea (aflibercept), and for a diagnosis of Neovascular (Wet) Age-Related Macular Degeneration (nAMD), trial/failure/contraindication to Avastin (bevacizumab).
Non-Preferred Basal Insulins – Medicare	TERMED ON 12/18/2025	Policy terminated.
Non-Preferred Dipeptidyl Peptidase IV (DPP-IV) Inhibitors – Medicare	01/01/2026	Policy revised to remove Januvia (sitagliptin) as a target
Non-Preferred Rapid-Acting Insulins – Medicare Compass	TERMED ON 1/1/2026	Policy to be terminated on 1/1/2026. Policy is merging with J-1411
Non-Preferred Rapid-Acting Insulins – Medicare	01/01/2026	Policy updated to include Medicare Compass formulary restriction
Non-Preferred Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors – Medicare	01/01/2026	Policy revised to change dapagliflozin from target to qualifier.
Non-Preferred Topical Antifungals – Medicare	12/19/2025	Policy updated to include econazole nitrate foam to require a member to have a diagnosis of tinea pedis and the member to experience therapeutic failure or intolerance to both econazole 1% cream and ketoconazole 2% cream.
Ophthalmic Prostaglandins and Rho	EFFECTIVE UPON COMPLETION OF	Policy updated to add Zolymbus (bimatoprost ophthalmic gel) to require

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Kinase Inhibitors – Medicare	INTERNAL REVIEW AND IMPLEMENTATION	the member to have a diagnosis of either open-angle glaucoma, or ocular hypertension, trial/failure to Lumigan (bimatoprost), and trial/failure to one other generic glaucoma drug.
Topical Vitamin D Analogues – Medicare	12/19/2025	Policy revised to remove brand Taclonex (calcipotriene/betamethasone dipropionate) ointment and brand Dovonex (calcipotriene) cream as products are no longer available on the market.

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)
Benznidazole 100 mg	120 tablets per 30 days
Benznidazole 12.5 mg	180 tablets per 30 days
Bildyos (denosumab-nxxp)	1 syringe/vial (60 mg/1 mL) per 180 days
Blujepa (gepotidacin)	20 tablets per 5 days
Bondlido (lidocaine 10% topical system)	2 patches per day
Bosaya (denosumab-kyqq)	1 syringe (60 mg/1 mL) per 180 days
Clotic (clotrimazole)	56 single-use drop dispensers per 14 days
Dawnzera (donidalorsen)	1 injection (0.8 mL) per 28 days
Eliquis (apixaban) 0.15 mg capsule	70 capsules per 28 days
Eliquis (apixaban) 0.5 mg tablet	112 packets (112 tablets) per 28 days
Eliquis (apixaban) 1.5 mg tablet	112 packets (336 tablets) per 28 days
Eliquis (apixaban) 2 mg tablet	140 packets (560 tablets) per 28 days
Enbumyst (bumetanide)	24 nasal sprays per 30 days
Enoby (denosumab-qbde)	1 syringe (60 mg/1 mL) per 180 days
Escitalopram 15 mg capsule	1 capsule per day
Firdapse (amifampridine phosphate)	10 tablets per day
Forzinity (elamipretide)	4 vials (14 mL) per 28 days
Inluriyo (imlunestrant)	2 tablets per day
Jascayd (nerandomilast)	two tablets per day
Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) 395 mg/4,800 units per 2.4 mL	1 vial (2.4 mL) per 21 days
Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) 790 mg/9,600 units per 4.8 mL	1 vial (4.8 mL) per 42 days
Koselugo (selumetinib) oral granules 5 mg	20 granules per day
Koselugo (selumetinib) oral granules 7.5 mg	12 granules per day

Drug Name	Retail Quantity Limit (31 days)
Lampit (nifurtimox) 120 mg	240 tablets per 30 days
Lampit (nifurtimox) 30 mg	360 tablets per 30 days
Lasix Onyu (furosemide injection) Kit	8 kits per 22 days
Lasix Onyu (furosemide injection) Starter Kit	1 kit per 180 days
Modd1 Patient Welcome Kit	1 kit per 90 days
Modd1 Supply Kit Combo. Pkg	1 (10 cartridges) kit per 30 days
Olpruva 0.5 g, 1 g (sodium phenylbutyrate)	6 units (envelopes) per day
Otezla XR (apremilast) 75 mg tablet	1 tablet per day
Otezla XR (apremilast) starter pack	2 starter packs (82 tablets) per 365 days
Palsonify (paltusotine)	two tablets per day
Rhapsido (Remibrutinib)	2 tablets per day
Subvenite (lamotrigine) suspension	70 mL per day
Wayrilz (rilzabrutinib) (ad hoc)	2 tablets per day
Wegovy (semaglutide) oral tablet (ad-hoc)	Maintenance dose per FDA label
Zanaflex 8 mg capsule	120 capsules per 30 days
Zolymbus (bimatoprost ophthalmic gel)	30 single-use drop dispenser per 30 days, dropperette
Zoryve (roflumilast) 0.05% cream	60 grams per 28 days