

Formulary Updates



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Following is the update to the Highmark Drug Formularies and pharmaceutical management procedures for September 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 September by our Pharmacy and Therapeutics Committee. These updates are effective on the dates noted throughout this document.

Please reference the guide below to navigate this communication:

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All references to "Highmark" in this document are references to the Highmark company that is providing the member's health benefits or health benefit administration and/or to one or more of its affiliated Blue companies.

Availity is an independent company that contracts with Highmark to offer provider portal services.

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

Nostrum Laboratories, Inc. Issues Voluntary Nationwide Recall of Sucralfate Tablets USP 1 Gram Within Expiry

On July 11, 2025, Nostrum Laboratories, Inc. (“Nostrum Labs”) filed Chapter 11 bankruptcy on Sept. 30, 2024. In connection with that filing, the company has ceased and shutdown operations and terminated its operational employees at all domestic U.S. sites. Nostrum Labs is initiating a voluntary recall of Sucralfate Tablets USP 1 gram, all lots within expiry, as a result of the closures and discontinuation of its Quality activities.

This recall pertains only to Sucralfate Tablets USP 1 gram, all lots with expiry, manufactured by Nostrum Labs after June 2023. No other Nostrum Labs products are affected by this recall. Nostrum Labs distributed the product at issue here to wholesalers, retailers, manufacturers, medical facilities, and repackagers. It cannot be guaranteed that any lots of this product that are still within expiry will meet all intended specifications through the labeled shelf life of the product. Further distribution or use of any remaining product on the market should cease immediately.

Continuous Glucose Monitor Receiver Recall: Dexcom, Inc. Removes Certain Dexcom G6, G7, ONE, and ONE+ Receivers Due to Speaker Malfunction That May Cause Missed Alerts for Dangerous Blood Sugar Levels

On July 17, 2025, Dexcom, Inc. is recalling certain Dexcom G6, G7, ONE, and ONE+ glucose monitoring receivers because a problem with the speaker may cause it to fail to make an alert sound when blood sugar is dangerously low or high. The use of affected product may cause serious adverse health consequences, including seizures, vomiting, loss of consciousness, and death. There have been at least 56 reported injuries. There have been no reports of death.

B. Braun Medical Issues Voluntary Nationwide Recall of Lactated Ringer’s Injection USP 1000 mL and 0.9% Sodium Chloride Injection USP 1000 mL Due to the Presence of Particulate Matter

On Aug. 19, 2025, B. Braun Medical Inc. (B. Braun) is voluntarily recalling two lots of Lactated Ringers Injection USP 1000 mL, and 0.9% Sodium Chloride Injection USP 1000 mL to the hospital level due to the presence of particulate matter inside the container. B. Braun has identified through complaints the potential for the product to contain particulate matter in solution. To date there have been no reports of serious injury, death or other adverse events associated with this issue. If the particulate matter is observed before use, a minor delay could occur while obtaining a replacement product. If the particulate matter is loose and the container is used on a patient, there is a potential for the particulate to be infused into the circulatory system. This could lead to patient harm that may require additional medical intervention and/or lead to permanent impairment or death.

Unichem Pharmaceuticals (USA) Inc. Issues Voluntary Nationwide Recall of Cyclobenzaprine Hydrochloride Tablets USP 10 mg, Due to Mislabeling

On Aug. 27, 2025, Unichem Pharmaceuticals (USA), Inc. is voluntarily recalling one lot of Cyclobenzaprine Hydrochloride Tablets USP 10 mg, to the consumer level. The Cyclobenzaprine 10mg (90ct) label was inadvertently placed on a bottle containing Meloxicam 7.5 mg tablets. For patients who unknowingly take Meloxicam, there is a reasonable probability of serious adverse

events including cardiovascular, gastrointestinal, renal, anaphylaxis, and skin reactions, particularly in those patients taking concomitant non-steroidal anti-inflammatory drugs and/or blood thinners, those who have allergies to the Meloxicam, or those with underlying illness. To date, Unichem Pharmaceuticals has not received any reports of adverse events related to this recall.

[Food and Drug Administration \(FDA\) is requiring opioid pain medicine manufacturers to update prescribing information regarding long-term use](#)

On July 31, 2025, the FDA released a drug safety communication announcing labeling changes based on findings from two post marketing requirements and discussion from the May 2025 Advisory Committee meeting. The FDA is requiring safety labeling changes for opioid pain medicines to further emphasize and characterize the risks associated with long-term use. The FDA is also requiring labeling updates to further clarify that extended-release/long-acting opioid pain medicines should only be used when alternative therapies, including immediate-release opioid pain medicines, are inadequate to manage severe and persistent pain, and to emphasize the importance of avoiding rapid dose reduction or abrupt discontinuation in patients who may be physically dependent on opioid pain medicines. In addition, the FDA is requiring labeling updates regarding the availability of opioid overdose reversal agents; revising drug-drug interactions with central nervous system depressants to include gabapentinoids; adding information about toxic leukoencephalopathy (a neurological disorder due to a variety of causes, including exposure to toxic substances) in the opioid overdose setting; and modifying warnings about gastrointestinal effects to include opioid-induced esophageal dysfunction. To help FDA track safety issues, report side effects involving opioid pain medicines to the FDA MedWatch program.

[FDA removes risk evaluation and mitigation strategy \(REMS\) program for the antipsychotic drug Clozapine](#)

On Aug. 27, 2025, the FDA released a drug safety communication announcing the removal of the risk evaluation and mitigation strategy (REMS) for clozapine (currently marketed as Clozaril, Versacloz, and generics). Clozapine, an antipsychotic medicine, can cause severe neutropenia (a low level of certain white blood cells), which can lead to serious and fatal infections. The removed REMS required enrollment of prescribers, pharmacies, and patients in a restricted distribution program and reporting of the level of certain white blood cells (i.e., the absolute neutrophil count (ANC)) to mitigate the risk of severe neutropenia. The FDA determined that the REMS was no longer necessary to ensure the benefits of clozapine outweigh the risk of severe neutropenia. Although there remains a risk of severe neutropenia with clozapine use, clozapine labeling is sufficient to mitigate this risk and maintain a positive benefit/risk profile. Eliminating the REMS is expected to improve access to clozapine and decrease the burden on the health care delivery system.

[FDA to recommend additional, earlier MRI monitoring for patients with Alzheimer's disease taking Legembi \(lecanemab\)](#)

On Aug. 28, 2025, the FDA released a drug safety communication recommending an additional, earlier magnetic resonance imaging (MRI) monitoring prior to the 3rd infusion for patients with Alzheimer's disease taking Legembi (lecanemab). The earlier monitoring can identify individuals with amyloid-related imaging abnormalities with edema (ARIA-E), which is characterized by brain swelling or fluid buildup. ARIA-E is usually asymptomatic, although serious and life-threatening events, including seizure and status epilepticus, can occur and there have been deaths. The FDA now

recommends MRI imaging before the 3rd, 5th, 7th, and 14th infusions of Leqembi. Identifying patients with ARIA-E can lead health care professionals, patients, and their families to delay or discontinue Leqembi treatment to potentially mitigate these serious and, in some cases, fatal events. To help FDA track safety issues with medicines, report side effects involving Leqembi to the FDA MedWatch program.

Highmark Formulary Update – September 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
Brukinsa tablet	zanubrutinib	Mantle cell lymphoma, Waldenström's macroglobulinemia, marginal zone lymphoma, chronic lymphocytic leukemia, follicular lymphoma
Doptelet Sprinkle	avatrombopag	Thrombocytopenia in pediatric patients 1 year to less than 6 years with persistent or chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment.
Enflonsia	clesrovimab-cfor	Prevention of RSV lower respiratory tract disease in neonates and infants who are born during or entering their first RSV season.
Yeztugo tablets	lenacapavir	Pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired human immunodeficiency virus type 1 (HIV-1) in adults and adolescents weighing at least 35 kg who are at risk for HIV-1 acquisition.

Coverage may be contingent upon plan benefits.

Table 2. Products Not Added**

Brand Name	Generic Name	Preferred Alternatives
Andembry	garadacimab-gxii	Prescriber discretion
Anzupgo	delgocitinib	clobetasol propionate 0.05% cream, betamethasone dipropionate 0.05% cream, fluocinonide 0.1% cream
Arynta	lisdexamfetamine dimesylate	dextroamphetamine-amphet ER capsule, ext release 24 hr, lisdexamfetamine dimesylate
Atmeski	methocarbamol	methocarbamol 500 mg tablets, methocarbamol 750 mg tablets
Brinsupri	brensocatic	Prescriber discretion
dicyclomine 40 mg tablet	dicyclomine	dicyclomine 10 mg capsule, dicyclomine 20 mg tablet, hyoscyamine sulf 0.125 mg tab
Egrifta WR	tesamorelin	Prescriber discretion
Ekterly	sebetralstat	icatibant, Sajazir
Harliku	nitisinone	Nityr 2 mg Tablet
Hernexeos	zongertinib	Prescriber discretion
Ibrozi	taletrectinib	Xalkori
Kirsty	insulin aspart-xjhz	Novolog, Humalog
Modeyso	dordaviprone	Prescriber discretion
nilotinib tartrate	nilotinib tartrate	nilotinib hcl
Phyrago	dasatinib	dasatinib
Sdmalo oral solution	amlodipine	amlodipine besylate oral tablet
Sepience	sepiaterin	Prescriber discretion
Tonmya sublingual tablets	cyclobenzaprine	duloxetine capsules 30 mg
Vizz ophthalmic solution	aceclidine	Prescriber discretion
Vostally	ramipril	ramipril, lisinopril tablet, benazepril hcl tablet
Vyscoxa	celecoxib	celecoxib capsule, ibuprofen suspension
Widaplik	telmisartan, amlodipine and Indapamide	amlodipine besylate oral tablet, indapamide oral tablet
Yutrepia inhalation powder	treprostinil	sildenafil citrate tablet 20 mg, ambrisentan
Zegfrovy	sunvozertinib	Prescriber discretion

Coverage may be contingent upon plan benefits.

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

Table 3. Additions to the Specialty Tier Copay Option

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

Brand Name	Generic Name
Andembry	garadacimab-gxii
Anzupgo	delgocitinib
Brinsupri	brensocatib
Brukinsa	zanubrutinib
Doptelet Sprinkle	avatrombopag
Egrifta WR	tesamorelin
Ekterly	sebetralstat
Harliku	nitisinone
Hernexeos	zongertinib
Ibtrozi	taletrectinib
Modeyso	dordaviprone
nilotinib tartrate	nilotinib tartrate
Phyrago	dasatinib
Sephience	sepiaterin
Yutrepia inhalation powder	treprostinil
Zegfrovy	sunvozertinib

Table 4. Products to Be Removed or Shifted to Higher Tier – Effective January 2026

Brand name	Generic Name	Preferred Alternatives
Only Healthcare Reform Comprehensive products		
Copaxone 40 mg/ml syringe	glatiramer acetate	glatiramer 40 mg/ml syringe,
All Commercial & Healthcare Reform Comprehensive products		
Adalimumab-adaz(CF) 10mg/0.1ml	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adaz(CF) 20mg/0.2ml	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adaz(CF) 40 mg syrg	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adaz(CF) pen 40 mg	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adaz(CF) pen 80 mg	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adbm(CF) 10 mg syrg	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adbm(CF) 20 mg syrg	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector

Brand name	Generic Name	Preferred Alternatives
Adalimumab-adbm(CF) 40 mg syrg	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adbm(CF) crhn 40mg	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adbm(CF) pen 40 mg	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adbm(CF) ps-uv 40mg	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Brilinta 60 mg tablet	ticagrelor	ticagrelor 60 mg tablet,
Brilinta 90 mg tablet	ticagrelor	ticagrelor 90 mg tablet,
Complera tablet	emtricitra/rilpivirine/tenof df	emtricit-rilp-tenof 200-25-300,
Cyltezo(CF) 10 mg/0.2 ml syrng	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Cyltezo(CF) 20 mg/0.4 ml syrng	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Cyltezo(CF) 40 mg/0.4 ml syrng	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Cyltezo(CF) 40 mg/0.8 ml syrng	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Cyltezo(CF) pen 40 mg/0.4 ml	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Cyltezo(CF) pen 40 mg/0.8 ml	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Cyltezo(CF) pen crh-uc-hs 40mg	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Cyltezo(CF) pen psoria-uv 40mg	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Entresto 24 mg-26 mg tablet	sacubitril/valsartan	sacubitril-valsartan 24-26 mg,
Entresto 49 mg-51 mg tablet	sacubitril/valsartan	sacubitril-valsartan 49-51 mg,
Entresto 97 mg-103 mg tablet	sacubitril/valsartan	sacubitril-valsartan 97-103 mg,
Flurbiprofen 100 mg tablet	flurbiprofen	diclofenac sod EC 75 mg tab, meloxicam 15 mg tablet
Humira 40 mg/0.8 ml syringe	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira pen 40 mg/0.8 ml	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira pen crohn-uc-hs 40 mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira pen ps-uv-adol hs 40 mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) 10 mg/0.1 ml syring	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) 20 mg/0.2 ml syring	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) 40 mg/0.4 ml syring	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pedi crohn 80-40 mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector

Brand name	Generic Name	Preferred Alternatives
Humira(CF) pedi crohn 80mg/0.8	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen 40 mg/0.4 ml	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen 80 mg/0.8 ml	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen crhn-uc-hs 80mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen pedi uc 80 mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen ps-uv-ahs 80-40	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) 10 mg/0.1 ml syrng	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) 20 mg/0.2 ml syrng	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) 40 mg/0.4 ml syrng	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) pedi crohn 80 mg	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) pedi crohn 80-40mg	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) pen 40 mg/0.4 ml	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) pen 80 mg/0.8 ml	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) pen crohn-uc 80 mg	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) pen psoria 80-40mg	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Jynarque 15 mg-15 mg tablet	tolvaptan	tolvaptan 15 mg-15 mg tablet,
Jynarque 30 mg-15 mg tablet	tolvaptan	tolvaptan 30 mg-15 mg tablet,
Jynarque 45 mg-15 mg tablet	tolvaptan	tolvaptan 45 mg-15 mg tablet,
Jynarque 60 mg-30 mg tablet	tolvaptan	tolvaptan 60 mg-30 mg tablet,
Jynarque 90 mg-30 mg tablet	tolvaptan	tolvaptan 90 mg-30 mg tablet,
Promacta 12.5 mg suspen packet	eltrombopag olamine	eltrombopag 12.5 mg susp pkt,
Promacta 12.5 mg tablet	eltrombopag olamine	eltrombopag 12.5 mg tablet,
Promacta 25 mg suspension pckt	eltrombopag olamine	eltrombopag 25 mg susp packet,
Promacta 25 mg tablet	eltrombopag olamine	eltrombopag 25 mg tablet,
Promacta 50 mg tablet	eltrombopag olamine	eltrombopag 50 mg tablet,
Promacta 75 mg tablet	eltrombopag olamine	eltrombopag 75 mg tablet,
Revlimid 10 mg capsule	lenalidomide	lenalidomide 10 mg capsule,

Brand name	Generic Name	Preferred Alternatives
Revlimid 15 mg capsule	lenalidomide	lenalidomide 15 mg capsule,
Revlimid 2.5 mg capsule	lenalidomide	lenalidomide 2.5 mg capsule,
Revlimid 20 mg capsule	lenalidomide	lenalidomide 20 mg capsule,
Revlimid 25 mg capsule	lenalidomide	lenalidomide 25 mg capsule,
Revlimid 5 mg capsule	lenalidomide	lenalidomide 5 mg capsule,
Spiriva handihaler 18 mcg cap	tiotropium bromide	tiotropium 18 mcg cap-inhaler,
Stelara 45 mg/0.5 ml syringe	ustekinumab	Yesintek
Stelara 45 mg/0.5 ml vial	ustekinumab	Yesintek
Stelara 90 mg/ml syringe	ustekinumab	Yesintek
Tasigna 150 mg capsule	nilotinib hcl	nilotinib 150 mg capsule,
Tasigna 200 mg capsule	nilotinib hcl	nilotinib 200 mg capsule,
Tasigna 50 mg capsule	nilotinib hcl	nilotinib 50 mg capsule,

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			
Enflonsia	clesrovimab-cfor	3	Prevention of RSV lower respiratory tract disease in neonates and infants who are born during or entering their first RSV season.
Yeztugo tablets	lenacapavir	3	Pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired human immunodeficiency virus type 1 (HIV-1) in adults and adolescents weighing at least 35 kg who are at risk for HIV-1 acquisition.
Egrifta WR	tesamorelin	4	Reduction of excess abdominal fat in HIV-infected adult patients with lipodystrophy
Items listed below were not added to the formulary			
Andembry	garadacimab-gxii	NF	Takhzyro
Anzupgo	delgocitinib	NF	clobetasol propionate 0.05% cream, betamethasone dipropionate 0.05% cream
Arynta	lisdexamfetamine dimesylate	NF	dextroamphetamine-amphet ER capsule, ext release 24 hr, lisdexamfetamine dimesylate
Atmeski	methocarbamol	NF	methocarbamol 500 mg tablets, methocarbamol 750 mg tablets
Brinsupri	brensocaticb	NF	Prescriber discretion

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
Brukinsa tablet	zanubrutinib	NF	imbruvica capsule, imbruvica tablet 420 mg, imbruvica tablet 560 mg
dicyclomine 40 mg tablet	dicyclomine	NF	dicyclomine 10 mg capsule, dicyclomine 20 mg tablet, hyoscyamine sulf 0.125 mg tab
Doptelet Sprinkle	avatrombopag	NF	eltrombopag olamine
Ekterly	sebetralstat	NF	icatibant
Harliku	nitisinone	NF	Nityr 2 mg tablet
Hernexeos	zongertinib	NF	Prescriber discretion
Ibtrozi	taletrectinib	NF	Xalkori
Kirsty	insulin aspart-xjhz	NF	Novolog, Humalog, insulin aspart
Modeyso	dordaviprone	NF	Prescriber discretion
nilotinib tartrate	nilotinib tartrate	NF	nilotinib hcl
Phyrago	dasatinib	NF	dasatinib
Sdmalo oral solution	amlodipine	NF	amlodipine besylate oral tablet
Sephience	sepiapterin	NF	sapropterin dihydrochloride
Tonmya sublingual tablets	cyclobenzaprine	NF	pregabalin capsules, duloxetine capsules 30 mg
Vizz	aceclidine ophthalmic solution	NF	Prescriber discretion
Vostally	ramipril	NF	ramipril, lisinopril tablet, benazepril HCl tablet
Vyscoxa	celecoxib	NF	celecoxib capsule
Widaplik	telmisartan, amlodipine and indapamide	NF	telmisartan oral tablet, amlodipine besylate oral tablet, indapamide oral tablet
Yutrepia	treprostinil	NF	sildenafil citrate tablet 20 mg, ambrisentan
Zegfrovoy	sunvozertinib	NF	Prescriber discretion

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.

Table 2. Products to Be Removed or Shifted to Higher Tier – Effective January 2026

Brand Name	Generic Name	Preferred Alternatives
All Healthcare Reform Essential Products		
Adalimumab-fkjp(CF) 20 mg syrg	adalimumab-fkjp	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-fkjp(CF) 40 mg syrg	adalimumab-fkjp	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-fkjp(CF) pen 40 mg	adalimumab-fkjp	Simlandi(CF), Simlandi(CF) autoinjector

Brilinta 60 mg tablet	ticagrelor	ticagrelor 60 mg tablet,
Brilinta 90 mg tablet	ticagrelor	ticagrelor 90 mg tablet,
Calcipotriene-betameth dp susp	calcipotriene/betamethason e	betamethasone dp 0.05% lot, calcipotriene 0.005% cream
Clindacin 1% foam	clindamycin phosphate	clindamycin ph 1% gel, clindamycin phosp 1% lotion
Complera tablet	emtricitra/rilpivirine/tenof df	emtricit-rilp-tenof 200-25-300,
Desrx 0.05% gel	desonide	desonide 0.05% cream, desonide 0.05% ointment
Difcid 200 mg tablet	fidaxomicin	fidaxomicin 200 mg tablet,
Diltiazem 24h ER(la) 180 mg tb	diltiazem hcl	diltiazem 24h ER(CD) 180 mg cp, diltiazem 24hr ER 180 mg cap
Diltiazem 24h ER(la) 240 mg tb	diltiazem hcl	diltiazem 24h ER(CD) 240 mg cp, diltiazem 24hr ER 240 mg cap
Diltiazem 24h ER(la) 300 mg tb	diltiazem hcl	diltiazem 24h ER(CD) 300 mg cp, diltiazem 24hr ER 300 mg cap
Diltiazem 24h ER(la) 360 mg tb	diltiazem hcl	diltiazem 24h ER(CD) 360 mg cp, diltiazem 24hr ER 360 mg cap
Diltiazem 24h ER(la) 420 mg tb	diltiazem hcl	diltiazem 24hr ER 420 mg cap,
Diltiazem 12hr ER 120 mg cap	diltiazem hcl	diltiazem 24h ER(CD) 240 mg cp, diltiazem 24hr ER 240 mg cap
Diltiazem 12hr ER 60 mg cap	diltiazem hcl	diltiazem 24h ER(CD) 120 mg cp, diltiazem 24hr ER 120 mg cap
Diltiazem 12hr ER 90 mg cap	diltiazem hcl	diltiazem 24h ER(CD) 180 mg cp, diltiazem 24hr ER 180 mg cap
Entresto 24 mg-26 mg tablet	sacubitril/valsartan	sacubitril-valsartan 24-26 mg,
Entresto 49 mg-51 mg tablet	sacubitril/valsartan	sacubitril-valsartan 49-51 mg,
Entresto 97 mg-103 mg tablet	sacubitril/valsartan	sacubitril-valsartan 97-103 mg,
Fenofibrate 40 mg tablet	fenofibrate	fenofibrate 43 mg capsule, fenofibrate 48 mg tablet
Flurbiprofen 100 mg tablet	flurbiprofen	diclofenac sod EC 75 mg tab, meloxicam 15 mg tablet
Hadlima 40 mg/0.8 ml syringe	adalimumab-bwwd	Simlandi(CF), Simlandi(CF) autoinjector
Hadlima pushtouch 40 mg/0.8 ml	adalimumab-bwwd	Simlandi(CF), Simlandi(CF) autoinjector
Hadlima(CF) 40 mg/0.4 ml syrng	adalimumab-bwwd	Simlandi(CF), Simlandi(CF) autoinjector
Hadlima(CF) pushtouch 40mg/0.4	adalimumab-bwwd	Simlandi(CF), Simlandi(CF) autoinjector
Humira 40 mg/0.8 ml syringe	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector

Humira pen 40 mg/0.8 ml	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira pen crohn-uc-hs 40 mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira pen ps-uv-adol hs 40 mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) 10 mg/0.1 ml syring	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) 20 mg/0.2 ml syring	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) 40 mg/0.4 ml syring	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen 40 mg/0.4 ml	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen 80 mg/0.8 ml	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen crhn-uc-hs 80mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen ps-uv-ahs 80-40	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pedi crohn 80-40 mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pedi crohn 80mg/0.8	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen pedi uc 80 mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Jynarque 15 mg-15 mg tablet	tolvaptan	tolvaptan 15 mg-15 mg tablet,
Jynarque 30 mg-15 mg tablet	tolvaptan	tolvaptan 30 mg-15 mg tablet,
Jynarque 45 mg-15 mg tablet	tolvaptan	tolvaptan 45 mg-15 mg tablet,
Jynarque 60 mg-30 mg tablet	tolvaptan	tolvaptan 60 mg-30 mg tablet,
Jynarque 90 mg-30 mg tablet	tolvaptan	tolvaptan 90 mg-30 mg tablet,
Matzim la 180 mg tablet	diltiazem hcl	diltiazem 24h ER(CD) 180 mg cp, diltiazem 24hr ER 180 mg cap
Matzim la 240 mg tablet	diltiazem hcl	diltiazem 24h ER(CD) 240 mg cp, diltiazem 24hr ER 240 mg cap
Matzim la 300 mg tablet	diltiazem hcl	diltiazem 24h ER(CD) 300 mg cp, diltiazem 24hr ER 300 mg cap
Matzim la 360 mg tablet	diltiazem hcl	diltiazem 24h ER(CD) 360 mg cp, diltiazem 24hr ER 360 mg cap
Matzim la 420 mg tablet	diltiazem hcl	diltiazem 24hr ER 420 mg cap,
Nitrofurantoin 25 mg/5 ml susp	nitrofurantoin	nitrofurantoin mcr 25 mg cap,

Nitrofurantoin 50 mg/10 ml cup	nitrofurantoin	nitrofurantoin mcr 25 mg cap,
Promacta 12.5 mg suspen packet	eltrombopag olamine	eltrombopag 12.5 mg susp pkt,
Promacta 12.5 mg tablet	eltrombopag olamine	eltrombopag 12.5 mg tablet,
Promacta 25 mg suspension pckt	eltrombopag olamine	eltrombopag 25 mg susp packet,
Promacta 25 mg tablet	eltrombopag olamine	eltrombopag 25 mg tablet,
Promacta 50 mg tablet	eltrombopag olamine	eltrombopag 50 mg tablet,
Promacta 75 mg tablet	eltrombopag olamine	eltrombopag 75 mg tablet,
Revlimid 10 mg capsule	lenalidomide	lenalidomide 10 mg capsule,
Revlimid 15 mg capsule	lenalidomide	lenalidomide 15 mg capsule,
Revlimid 2.5 mg capsule	lenalidomide	lenalidomide 2.5 mg capsule,
Revlimid 20 mg capsule	lenalidomide	lenalidomide 20 mg capsule,
Revlimid 25 mg capsule	lenalidomide	lenalidomide 25 mg capsule,
Revlimid 5 mg capsule	lenalidomide	lenalidomide 5 mg capsule,
Sevelamer hcl 800 mg tablet	sevelamer hcl	sevelamer carbonate 800 mg tab,
Spiriva handihaler 18 mcg cap	tiotropium bromide	tiotropium 18 mcg cap-inhaler,
Stelara 45 mg/0.5 ml syringe	ustekinumab	Yesintek
Stelara 45 mg/0.5 ml vial	ustekinumab	Yesintek
Stelara 90 mg/ml syringe	ustekinumab	Yesintek
Tasigna 150 mg capsule	nilotinib hcl	nilotinib 150 mg capsule,
Tasigna 200 mg capsule	nilotinib hcl	nilotinib 200 mg capsule,
Tasigna 50 mg capsule	nilotinib hcl	nilotinib 50 mg capsule,
Tazorac 0.05% cream	tazarotene	tazarotene 0.05% cream,
Timolol 0.5% eye Drop	timolol maleate	timolol maleate 0.5% eye drops,
Tovet emollient 0.05% foam	clobetasol propionate/emoll	clobetasol prop 0.05% foam,
Tritocin 0.05% ointment	triamcinolone acetonide	triamcinolone 0.1% ointment, triamcinolone 0.025% oint

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			
Enflonsia	clesrovimab-cfor	3	Prevention of RSV lower respiratory tract disease in neonates and infants who are

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
			born during or entering their first RSV season.
Yeztugo tablets	lenacapavir	3	Pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired human immunodeficiency virus type 1 (HIV-1) in adults and adolescents weighing at least 35 kg who are at risk for HIV-1 acquisition.
Doptelet Sprinkle	Avatrombopag	4	Thrombocytopenia in pediatric patients 1 year to less than 6 years with persistent or chronic immune thrombocytopenia (ITP) who have had an insufficient response to a previous treatment.
Egrifta WR	tesamorelin	4	Reduction of excess abdominal fat in HIV-infected adult patients with lipodystrophy
Items listed below were not added to the formulary			
Andembry	garadacimab-gxii	NF	Takhzyro
Anzupgo	delgocitinib	NF	clobetasol propionate 0.05% cream, betamethasone dipropionate 0.05% cream
Arynta	lisdexamfetamine dimesylate	NF	dextroamphetamine-amphet ER capsule, ext release 24 hr, lisdexamfetamine dimesylate
Atmeski	methocarbamol	NF	methocarbamol 500 mg tablets, methocarbamol 750 mg tablets
Brinsupri	brensocatic	NF	Prescriber discretion
Brukinsa tablet	zanubrutinib	NF	imbruvica capsule, imbruvica tablet 420 mg, imbruvica tablet 560 mg
dicyclomine 40 mg tablet	dicyclomine	NF	dicyclomine 10 mg capsule, dicyclomine 20 mg tablet, hyoscyamine sulf 0.125 mg tab
Ekterly	sebetralstat	NF	Icatibant, sajazir
Harliku	nitisinone	NF	Nityr 2 mg tablet
Hernexeos	zongertinib	NF	Prescriber discretion
Ibtrozi	taletrectinib	NF	Xalkori
Kirsty	insulin aspart-xjhz	NF	Novolog, insulin aspart
Modeyso	dordaviprone	NF	Prescriber discretion
nilotinib tartrate	nilotinib tartrate	NF	nilotinib hcl
Phyrago	dasatinib	NF	dasatinib
Sdmalo oral solution	amlodipine	NF	amlodipine besylate oral tablet
Sephience	sepiapterin	NF	sapropterin dihydrochloride
Tonmya sublingual tablets	cyclobenzaprine	NF	duloxetine capsules 30 mg
Vizz	aceclidine ophthalmic solution	NF	Prescriber discretion

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
Vostally	ramipril	NF	ramipril, lisinopril tablet, benazepril HCl tablet
Vyscoxa	celecoxib	NF	celecoxib capsule
Widaplik	telmisartan, amlodipine and indapamide	NF	telmisartan oral tablet, amlodipine besylate oral tablet, indapamide oral tablet
Yutrepia	treprostinil	NF	sildenafil citrate tablet 20 mg, ambrisentan
Zegfrov	sunvozertinib	NF	Prescriber discretion

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).**

Table 2. Products to Be Removed or Shifted to Higher Tier – Effective January 2026

Brand Name	Generic Name	Preferred Alternatives
All Core Products		
Adalimumab-fkjp(CF) 20 mg syrg	adalimumab-fkjp	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-fkjp(CF) 40 mg syrg	adalimumab-fkjp	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-fkjp(CF) pen 40 mg	adalimumab-fkjp	Simlandi(CF), Simlandi(CF) autoinjector
Brilinta 60 mg tablet	ticagrelor	ticagrelor 60 mg tablet,
Brilinta 90 mg tablet	ticagrelor	ticagrelor 90 mg tablet,
Clindacin 1% foam	clindamycin phosphate	clindamycin ph 1% gel, clindamycin phosp 1% lotion
Complera tablet	emtricit/rilpivirine/tenof df	emtricit-rilp-tenof 200-25-300,
Entresto 24 mg-26 mg tablet	sacubitril/valsartan	sacubitril-valsartan 24-26 mg,
Entresto 49 mg-51 mg tablet	sacubitril/valsartan	sacubitril-valsartan 49-51 mg,
Entresto 97 mg-103 mg tablet	sacubitril/valsartan	sacubitril-valsartan 97-103 mg,
Flurbiprofen 100 mg tablet	flurbiprofen	diclofenac sod EC 75 mg tab, meloxicam 15 mg tablet
Hadlima 40 mg/0.8 ml syringe	adalimumab-bwwd	Simlandi(CF), Simlandi(CF) autoinjector
Hadlima pushtouch 40 mg/0.8 ml	adalimumab-bwwd	Simlandi(CF), Simlandi(CF) autoinjector
Hadlima(CF) 40 mg/0.4 ml syrng	adalimumab-bwwd	Simlandi(CF), Simlandi(CF) autoinjector
Hadlima(CF) pushtouch 40mg/0.4	adalimumab-bwwd	Simlandi(CF), Simlandi(CF) autoinjector
Humira 40 mg/0.8 ml syringe	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira pen 40 mg/0.8 ml	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector

Humira pen crohn-uc-hs 40 mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira pen ps-uv-adol hs 40 mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) 10 mg/0.1 ml syring	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) 20 mg/0.2 ml syring	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) 40 mg/0.4 ml syring	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen 40 mg/0.4 ml	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen 80 mg/0.8 ml	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen crhn-uc-hs 80mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen ps-uv-ahs 80-40	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pedi crohn 80-40 mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pedi crohn 80mg/0.8	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen pedi uc 80 mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Jynarque 15 mg-15 mg tablet	tolvaptan	tolvaptan 15 mg-15 mg tablet,
Jynarque 30 mg-15 mg tablet	tolvaptan	tolvaptan 30 mg-15 mg tablet,
Jynarque 45 mg-15 mg tablet	tolvaptan	tolvaptan 45 mg-15 mg tablet,
Jynarque 60 mg-30 mg tablet	tolvaptan	tolvaptan 60 mg-30 mg tablet,
Jynarque 90 mg-30 mg tablet	tolvaptan	tolvaptan 90 mg-30 mg tablet,
Nitrofurantoin 25 mg/5 ml susp	nitrofurantoin	nitrofurantoin mcr 25 mg cap,
Nitrofurantoin 50 mg/10 ml cup	nitrofurantoin	nitrofurantoin mcr 25 mg cap,
Promacta 12.5 mg suspen packet	eltrombopag olamine	eltrombopag 12.5 mg susp pkt,
Promacta 12.5 mg tablet	eltrombopag olamine	eltrombopag 12.5 mg tablet,
Promacta 25 mg suspension pckt	eltrombopag olamine	eltrombopag 25 mg susp packet,
Promacta 25 mg tablet	eltrombopag olamine	eltrombopag 25 mg tablet,
Promacta 50 mg tablet	eltrombopag olamine	eltrombopag 50 mg tablet,
Promacta 75 mg tablet	eltrombopag olamine	eltrombopag 75 mg tablet

Qsymia 11.25 mg-69 mg capsule	phentermine/topiramate	phentermine-topir ER 11.25-69,
Qsymia 15 mg-92 mg capsule	phentermine/topiramate	phentermine-topir ER 15-92 mg
Qsymia 3.75 mg-23 mg capsule	phentermine/topiramate	phentermine-topir ER 3.75-23mg
Qsymia 7.5 mg-46 mg capsule	phentermine/topiramate	phentermine-topir ER 7.5-46 mg
Revlimid 10 mg capsule	lenalidomide	lenalidomide 10 mg capsule
Revlimid 15 mg capsule	lenalidomide	lenalidomide 15 mg capsule,
Revlimid 2.5 mg capsule	lenalidomide	lenalidomide 2.5 mg capsule
Revlimid 20 mg capsule	lenalidomide	lenalidomide 20 mg capsule
Revlimid 25 mg capsule	lenalidomide	lenalidomide 25 mg capsule
Revlimid 5 mg capsule	lenalidomide	lenalidomide 5 mg capsule
Spiriva handihaler 18 mcg cap	tiotropium bromide	tiotropium 18 mcg cap-inhaler
Stelara 45 mg/0.5 ml syringe	ustekinumab	Yesintek
Stelara 45 mg/0.5 ml vial	ustekinumab	Yesintek
Stelara 90 mg/ml syringe	ustekinumab	Yesintek
Tasigna 150 mg capsule	nilotinib hcl	nilotinib 150 mg capsule,
Tasigna 200 mg capsule	nilotinib hcl	nilotinib 200 mg capsule,
Tasigna 50 mg capsule	nilotinib hcl	nilotinib 50 mg capsule,

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)			
Enflonsia	clesrovimab-cfor	2	Prevention of RSV lower respiratory tract disease in neonates and infants who are born during or entering their first RSV season.
Yeztugo tablets	lenacapavir	2	Pre-exposure prophylaxis (PrEP) to reduce the risk of sexually acquired human immunodeficiency virus type 1 (HIV-1) in adults and adolescents weighing at least 35 kg who are at risk for HIV-1 acquisition.
Yutrepia	treprostinil	2	Treatment of Pulmonary arterial hypertension (PAH; WHO Group 1) to improve exercise ability. Studies

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
			establishing effectiveness predominately included patients with NYHA Functional Class III symptoms and etiologies of idiopathic or heritable PAH (56%) or PAH associated with connective tissue diseases (33%). Treatment of Pulmonary hypertension associated with interstitial lung disease (PHILD; WHO Group 3) to improve exercise ability. The study establishing effectiveness predominately included patients with etiologies of idiopathic interstitial pneumonia (IIP) (45%) inclusive of idiopathic pulmonary fibrosis (IPF), combined pulmonary fibrosis and emphysema (CPFE) (25%), and WHO Group 3 connective tissue disease (22%).
Brukinsa tablet	zanubrutinib	2	Mantle cell lymphoma, Waldenström's macroglobulinemia, marginal zone lymphoma, chronic lymphocytic leukemia, follicular lymphoma
Egrifta WR	tesamorelin	2	For reduction of excess abdominal fat in HIV-infected adults with lipdystrophy.
Ibtrozi	taletrectinib	2	Treatment of adults with locally advanced or metastatic ROSI-positive non-small cell lung cancer (NSCLC).
Modeyso	dordaviprone	2	Treatment of patients with diffuse midline glioma harboring an H3 K27M mutation with progressive disease following prior therapy.
Items listed below were added to the formulary (Non-Preferred)			
Anzupgo*	delgocitinib	3	clobetasol propionate 0.05% cream (gram), betamethasone dipropionate 0.05% cream (gram)
Arynta*	lisdexamfetamine dimesylate	3	dextroamphetamine-amphet ER capsule, ext release 24 hr, lisdexamfetamine dimesylate
Atmeski*	methocarbamol	3	methocarbamol 500 mg tablets, methocarbamol 750 mg tablets
Brinsupri	brensocatic	3	Prescriber discretion
Doptelet Sprinkle*	avatrombopag	3	eltrombopag olamine
Hernexeos*	zongertinib	3	Prescriber discretion
Kirsty*	insulin aspart-xjhz	3	Novolog,
Phyrago*	dasatinib	3	dasatinib
Sdmalo oral solution*	amlodipine	3	amlodipine besylate oral tablet
Sephience*	sepiapterin	3	sapropterin dihydrochloride

Brand Name	Generic Name	Tier	Comments/Preferred Alternatives
Tonmya sublingual tablets*	cyclobenzaprine	3	pregabalin capsules, duloxetine capsules 30 mg
Vostally*	ramipril	3	ramipril, lisinopril tablet, benazepril HCl tablet
Vyscoxa*	celecoxib	3	celecoxib capsule
Widaplik*	telmisartan, amlodipine and indapamide	3	telmisartan oral tablet, amlodipine besylate oral tablet, indapamide oral tablet
Zegfroy*	sunvozertinib	3	Prescriber discretion
Items listed below were not added to the formulary			
Andembry*	garadacimab-gxii	NF	Takhzyro, Haegarda
dicyclomine 40 mg tablet	dicyclomine	NF	dicyclomine 10 mg capsule, dicyclomine 20 mg tablet, hyoscyamine sulf 0.125 mg tab
Ekterly	sebetralstat	NF	icatibant
Harliku	nitisinone	NF	Nityr 2 mg tablet
nilotinib tartrate	nilotinib tartrate	NF	nilotinib hcl
Vizz	aceclidine ophthalmic solution	NF	Prescriber discretion

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
Andembry	garadacimab-gxii
Anzupgo	delgocitinib
Brinsupri	brensocatib
Brukinsa tablet	zanubrutinib
Doptelet Sprinkle	avatrombopag
Egrifta WR	tesamorelin
Ekterly	sebetralstat
Harliku	nitisinone
Hernexeos	zongertinib
Ibtrozi	taletrectinib
Modeyso	dordaviprone
nilotinib tartrate	nilotinib tartrate
Phyrago	dasatinib
Sephience	sepiaterin
Yutrepia inhalation powder	treprostiniil
Zegfroy	sunvozertinib

Table 3. Products to Be Removed or Shifted to Higher Tier – Effective January 2026

Brand Name	Generic Name	Preferred Alternatives
All National Select Products		
Adalimumab-adaz(CF) 40 mg syrg	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adaz(CF) 20mg/0.2ml	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adaz(CF) 10mg/0.1ml	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adaz(CF) pen 80 mg	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adaz(CF) pen 40 mg	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adbm(CF) 40 mg syrg	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adbm(CF) 20 mg syrg	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adbm(CF) 10 mg syrg	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adbm(CF) crhn 40mg	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adbm(CF) ps-uv 40mg	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Adalimumab-adbm(CF) pen 40 mg	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Arnuity Ellipta 100 mcg inh	fluticasone furoate	Asmanex, Qvar Redihaler
Arnuity Ellipta 200 mcg inh	fluticasone furoate	Asmanex, Qvar Redihaler
Arnuity Ellipta 50 mcg inh	fluticasone furoate	Asmanex, Qvar Redihaler
Austedo 6 mg tablet	deutetrabenazine	Ingrezza
Austedo 9 mg tablet	deutetrabenazine	Ingrezza
Austedo 12 mg tablet	deutetrabenazine	Ingrezza
Austedo XR 6 mg tablet	deutetrabenazine	Ingrezza
Austedo XR 12 mg tablet	deutetrabenazine	Ingrezza
Austedo XR 24 mg tablet	deutetrabenazine	Ingrezza
Austedo XR 30 mg tablet	deutetrabenazine	Ingrezza
Austedo XR 36 mg tablet	deutetrabenazine	Ingrezza
Austedo XR 42 mg tablet	deutetrabenazine	Ingrezza
Austedo XR 48 mg tablet	deutetrabenazine	Ingrezza
Austedo XR 18 mg tablet	deutetrabenazine	Ingrezza
Austedo XR titr(12-18-24-30mg)	deutetrabenazine	Ingrezza
Austedo XR titr kt(6-12-24 mg)	deutetrabenazine	Ingrezza

Azelastin-flutic 137-50mcg spr	azelastine/fluticasone	azelastine 0.1% (137 mcg) spry, fluticasone prop 50 mcg spray
Brilinta 90 mg tablet	ticagrelor	ticagrelor 90 mg tablet
Brilinta 60 mg tablet	ticagrelor	ticagrelor 60 mg tablet
Ciclopirox 8% treatment kit	ciclopirox/urea/camph/men/euc	ciclopirox 8% solution
Crotan 10% lotion	crotamiton	permethrin 5% cream
Cyltezo(CF) 40 mg/0.8 ml syrng	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Cyltezo(CF) 10 mg/0.2 ml syrng	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Cyltezo(CF) 20 mg/0.4 ml syrng	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Cyltezo(CF) 40 mg/0.4 ml syrng	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Cyltezo(CF) pen 40 mg/0.8 ml	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Cyltezo(CF) pen 40 mg/0.4 ml	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Cyltezo(CF) pen crh-uc-hs 40mg	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Cyltezo(CF) pen psoria-uv 40mg	adalimumab-adbm	Simlandi(CF), Simlandi(CF) autoinjector
Denavir 1% cream	penciclovir	acyclovir 5% ointment, valacyclovir
Dyrenium 50 mg capsule	triamterene	amiloride hcl, spironolactone
Dyrenium 100 mg capsule	triamterene	amiloride hcl, spironolactone
Endari 5 gram powder packet	glutamine	l-glutamine 5 gram powder pkt
Epsolay 5% cream pump	benzoyl peroxide	metronidazole topical 1% gel, finacea
Fosfomycin 3 gm sachet	fosfomycin tromethamine	nitrofurantoin, sulfamethoxazole-trimethoprim
Humira 40 mg/0.8 ml syringe	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira pen 40 mg/0.8 ml	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira pen crohn-uc-hs 40 mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira pen ps-uv-adol hs 40 mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) 10 mg/0.1 ml syring	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) 20 mg/0.2 ml syring	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) 40 mg/0.4 ml syring	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen 40 mg/0.4 ml	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector

Humira(CF) pen 80 mg/0.8 ml	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen crhn-uc-hs 80mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen ps-uv-ahs 80-40	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pedi crohn 80-40 mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pedi crohn 80mg/0.8	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Humira(CF) pen pedi uc 80 mg	adalimumab	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) 40 mg/0.4 ml syrng	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) 20 mg/0.2 ml syrng	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) 10 mg/0.1 ml syrng	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) pedi crohn 80 mg	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) pedi crohn 80-40mg	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) pen 80 mg/0.8 ml	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) pen 40 mg/0.4 ml	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) pen crohn-uc 80 mg	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Hyrimoz(CF) pen psoria 80-40mg	adalimumab-adaz	Simlandi(CF), Simlandi(CF) autoinjector
Infectra 100 mg vial	infliximab-dyyb	Avsola, infliximab
Ixchiq vial	chikungunya vaccine, live/pf	Vimkunya
Kanjinti 420 mg vial	trastuzumab-anns	Hercessi, Ogivri
Kanjinti 150 mg vial	trastuzumab-anns	Hercessi, Ogivri
Kanjinti 420 mg vial w-diluent	trastuzumab-anns	Hercessi, Ogivri
Naftifine hcl 1% cream	naftifine hcl	econazole nitrate 1% cream, ketoconazole 2% cream
Naftifine hcl 2% cream	naftifine hcl	econazole nitrate 1% cream, ketoconazole 2% cream
Naftifine hcl 2% gel	naftifine hcl	econazole nitrate 1% cream, ketoconazole 2% cream
Naftin 1% gel	naftifine hcl	econazole nitrate 1% cream, ketoconazole 2% cream
Naftin 2% gel	naftifine hcl	econazole nitrate 1% cream, ketoconazole 2% cream

Nourianz 20 mg tablet	istradefylline	rasagiline, pramipexole
Nourianz 40 mg tablet	istradefylline	rasagiline, pramipexole
Onetouch ultra control soln	blood-glucose control, normal	freestyle control solution, true metrix control solution
Onetouch verio mid cntrl soln	blood-glucose control, normal	freestyle control solution, true metrix control solution
Onetouch verio high cntrl soln	blood-glucose control, high	freestyle control solution, true metrix control solution
Opium tincture 10 mg/ml	opium tincture	diphenoxylate w/atropine, loperamide hcl
Oxiconazole nitrate 1% cream	oxiconazole nitrate	econazole nitrate 1% cream, ketoconazole 2% cream
Oxtellar XR 150 mg tablet	oxcarbazepine	oxcarbazepine ER 150 mg tablet
Oxtellar XR 300 mg tablet	oxcarbazepine	oxcarbazepine ER 300 mg tablet
Oxtellar XR 600 mg tablet	oxcarbazepine	oxcarbazepine ER 600 mg tablet
Paroxetine mesylate 7.5 mg cap	paroxetine mesylate	paroxetine hcl, paroxetine er
Penciclovir 1% cream	penciclovir	acyclovir 5% ointment, valacyclovir
Prolensa 0.07% eye Drops	bromfenac sodium	bromfenac sodium 0.07% eye DRp
Promacta 25 mg suspension pckt	eltrombopag olamine	eltrombopag 25 mg susp packet
Promacta 12.5 mg suspen packet	eltrombopag olamine	eltrombopag 12.5 mg susp pkt
Promacta 12.5 mg tablet	eltrombopag olamine	eltrombopag 12.5 mg tablet
Promacta 25 mg tablet	eltrombopag olamine	eltrombopag 25 mg tablet
Promacta 50 mg tablet	eltrombopag olamine	eltrombopag 50 mg tablet
Promacta 75 mg tablet	eltrombopag olamine	eltrombopag 75 mg tablet
Pruradik 10% lotion	crotamiton	permethrin 5% cream
Rasuvo 7.5 mg/0.15 ml autoinj	methotrexate/pf	methotrexate injection
Rasuvo 10 mg/0.2 ml autoinj	methotrexate/pf	methotrexate injection
Rasuvo 12.5 mg/0.25 ml autoinj	methotrexate/pf	methotrexate injection
Rasuvo 15 mg/0.3 ml autoinj	methotrexate/pf	methotrexate injection
Rasuvo 17.5 mg/0.35 ml autoinj	methotrexate/pf	methotrexate injection
Rasuvo 20 mg/0.4 ml autoinj	methotrexate/pf	methotrexate injection
Rasuvo 22.5 mg/0.45 ml autoinj	methotrexate/pf	methotrexate injection
Rasuvo 25 mg/0.5 ml autoinj	methotrexate/pf	methotrexate injection
Rasuvo 30 mg/0.6 ml autoinj	methotrexate/pf	methotrexate injection

Revlimid 2.5 mg capsule	lenalidomide	lenalidomide 2.5 mg capsule,
Revlimid 5 mg capsule	lenalidomide	lenalidomide 5 mg capsule,
Revlimid 10 mg capsule	lenalidomide	lenalidomide 10 mg capsule,
Revlimid 15 mg capsule	lenalidomide	lenalidomide 15 mg capsule,
Revlimid 20 mg capsule	lenalidomide	lenalidomide 20 mg capsule,
Revlimid 25 mg capsule	lenalidomide	lenalidomide 25 mg capsule,
Soliris 300 mg/30 ml vial	eculizumab	Epysqli
Sprix 15.75 mg nasal spray	ketorolac tromethamine	diclofenac, meloxicam
Stelara 45 mg/0.5 ml syringe	ustekinumab	Yesintek
Stelara 45 mg/0.5 ml vial	ustekinumab	Yesintek
Stelara 90 mg/ml syringe	ustekinumab	Yesintek
Symbicort 160-4.5 mcg inhaler	budesonide/formoterol fumarate	budesonide-formoterol 160-4.5
Symbicort 80-4.5 mcg inhaler	budesonide/formoterol fumarate	budesonide-formoterol 80-4.5
Tafluprost 0.0015% eye Drop	tafluprost/pf	latanoprost, bimatoprost
Tasigna 200 mg capsule	nilotinib hcl	nilotinib 200 mg capsule
Tasigna 150 mg capsule	nilotinib hcl	nilotinib 150 mg capsule
Tasigna 50 mg capsule	nilotinib hcl	nilotinib 50 mg capsule
Telmisartan-amlodipine 40-5 mg	telmisartan/amlodipine	amlodipine besylate 5 mg tab, telmisartan 40 mg tablet
Telmisartan-amlodipine 40-10	telmisartan/amlodipine	amlodipine besylate 10 mg tab, telmisartan 40 mg tablet
Telmisartan-amlodipine 80-5 mg	telmisartan/amlodipine	amlodipine besylate 5 mg tab, telmisartan 80 mg tablet
Telmisartan-amlodipine 80-10	telmisartan/amlodipine	amlodipine besylate 10 mg tab, telmisartan 80 mg tablet
Thiola EC 300 mg tablet	tiopronin	tiopronin DR 300 mg tablet,
Thiola EC 100 mg tablet	tiopronin	tiopronin DR 100 mg tablet,
Travoprost 0.004% eye Drop	travoprost	latanoprost, bimatoprost
Trazimera 420 mg vial	trastuzumab-qyyp	Hercessi, Ogivri
Trazimera 150 mg vial	trastuzumab-qyyp	Hercessi, Ogivri
Trexall 5 mg tablet	methotrexate sodium	methotrexate
Trexall 7.5 mg tablet	methotrexate sodium	methotrexate
Trexall 10 mg tablet	methotrexate sodium	methotrexate
Trexall 15 mg tablet	methotrexate sodium	methotrexate
Triamterene 50 mg capsule	triamterene	amiloride hcl, spironolactone
Triamterene 100 mg capsule	triamterene	amiloride hcl, spironolactone
Twynéo 0.1%-3% cream pump	tretinoin/benzoyl peroxide	tretinoin 0.1% cream, adapalene-bnzyl perox 0.3-2.5%

Ultomiris 300 mg/3 ml vial	ravulizumab-cwvz	Enspryng, Epysqli
Ultomiris 1,100 mg/11 ml vial	ravulizumab-cwvz	Enspryng, Epysqli
Velphoro 500 mg chewable tab	sucroferric oxyhyDRoxide	calcium acetate, sevelamer carbonate
Vyvanse 10 mg capsule	lisdexamfetamine dimesylate	lisdexamfetamine 10 mg capsule
Vyvanse 20 mg capsule	lisdexamfetamine dimesylate	lisdexamfetamine 20 mg capsule
Vyvanse 30 mg capsule	lisdexamfetamine dimesylate	lisdexamfetamine 30 mg capsule
Vyvanse 40 mg capsule	lisdexamfetamine dimesylate	lisdexamfetamine 40 mg capsule
Vyvanse 50 mg capsule	lisdexamfetamine dimesylate	lisdexamfetamine 50 mg capsule
Vyvanse 60 mg capsule	lisdexamfetamine dimesylate	lisdexamfetamine 60 mg capsule
Vyvanse 70 mg capsule	lisdexamfetamine dimesylate	lisdexamfetamine 70 mg capsule
Vyvanse 10 mg chewable tablet	lisdexamfetamine dimesylate	lisdexamfetamine 10 mg tb chew
Vyvanse 20 mg chewable tablet	lisdexamfetamine dimesylate	lisdexamfetamine 20 mg tb chew
Vyvanse 30 mg chewable tablet	lisdexamfetamine dimesylate	lisdexamfetamine 30 mg tb chew
Vyvanse 40 mg chewable tablet	lisdexamfetamine dimesylate	lisdexamfetamine 40 mg tb chew
Vyvanse 50 mg chewable tablet	lisdexamfetamine dimesylate	lisdexamfetamine 50 mg tb chew
Vyvanse 60 mg chewable tablet	lisdexamfetamine dimesylate	lisdexamfetamine 60 mg tb chew
Zepbound 2.5 mg/0.5 ml vial	tirzepatide	Zepbound pens, Wegovy
Zepbound 5 mg/0.5 ml vial	tirzepatide	Zepbound pens, Wegovy
Zepbound 7.5 mg/0.5 ml vial	tirzepatide	Zepbound pens, Wegovy
Zepbound 10 mg/0.5 ml vial	tirzepatide	Zepbound pens, Wegovy
Zepbound 12.5 mg/0.5 ml vial	tirzepatide	Zepbound pens, Wegovy
Zepbound 15 mg/0.5 ml vial	tirzepatide	Zepbound pens, Wegovy

E. Updates to the Pharmacy Utilization Management Programs

1. Prior Authorization Program

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
AnDRogen Receptor Inhibitors – Commercial and Healthcare Reform	10/08/2025	Policy revised for Nubeqa (darolutamide) to remove requirement for use in combination with docetaxel for metastatic castration-sensitive prostate cancer, based on expanded FDA-approved indication.
Anti-EGFR and HER2 Kinase Inhibitors – Commercial and Healthcare Reform	10/08/2025	Policy revised to add Hernexeos (zongertinib) to require age and criteria based on FDA-approved indication. Quantity limit criteria allow for additional quantities based on FDA-approved dosing and the member's weight if the member is taking a strong CYP3A inducer.
Anti-Obesity – Commercial and Healthcare Reform	10/08/2025	Policy revised to add liraglutide 3 mg per dose as a target mirroring existing criteria for Saxenda (liraglutide). Saxenda criteria revised to require step through generic liraglutide.
Anti-Obesity (Enhanced) – Commercial and Healthcare Reform	08/06/2025	Policy revised for Wegovy (semaglutide), Zepbound (tirzepatide), and Saxenda (liraglutide) to allow approval, when all other criteria are met, for a diagnosis of prediabetes, high triglycerides, and low HDL; or a diagnosis of two cardiovascular diseases. For all applicable targets, allowable comorbidities updated to remove Metabolic Dysfunction-Associated Steatotic Liver Disease.
Anti-Obesity (Enhanced) – Commercial and Healthcare Reform	08/18/2025	Limitation of coverage added that this policy only applies to Wegovy (semaglutide) when used for treatment of obesity and treatment of cardiovascular disease in patients who are overweight or obese. For all applicable targets, allowable comorbidities updated to remove Metabolic Dysfunction-Associated Steatotic Liver Disease.
Anti-Obesity (Enhanced) – Commercial and Healthcare Reform	10/02/2025	Policy revised for Zepbound (tirzepatide) obstructive sleep apnea criteria to allow for respiratory distress index of at least 15. Policy revised to add liraglutide 3 mg

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		per dose as a target mirroring existing criteria for Saxenda (liraglutide). Saxenda criteria revised to require step through generic liraglutide.
Anti-Obesity (Enhanced) – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy revised for Wegovy (semaglutide) to require diagnosis of heart failure with preserved ejection fraction (HFpEF) with a left ventricular ejection fraction (LVEF) of at least 45%; the member is currently taking guideline recommended therapy including diuretic (or attestation that the member does not have symptoms of fluid overload), sodium-glucose cotransporter 2 inhibitor (SGLT2i), angiotensin receptor-neprilysin inhibitor (ARNI) or angiotensin receptor blocker (ARB), and mineralocorticoid receptor antagonist (MRA); documentation of healthy dietary changes and increased physical activity for at least 6 months prior to initiation and while using therapy; and that the member will not be using Wegovy in combination with a glucagon-like peptide 1 containing product. Reauthorization requiring attestation of continued need for therapy; diagnosis of HFpEF; the member is currently taking guideline recommended therapy including diuretic (or attestation that the member does not have symptoms of fluid overload), SGLT2i, ARB or ARNI, and MRA; maintenance dosing or attestation of titration to maintenance dosing; and documentation of use in combination with dietary changes and increased physical activity.
Anti-Obesity (Standard) – Commercial	08/18/2025	Limitation of coverage added that this policy only applies to Wegovy (semaglutide) when used for treatment of obesity and treatment of cardiovascular disease in patients who are overweight or obese.
Anti-Obesity (Standard) – Commercial	10/02/2025	Policy revised to add liraglutide 3 mg per dose as a target mirroring existing criteria for Saxenda (liraglutide). Saxenda criteria revised to require step through generic liraglutide.

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Anzupgo (delgocitinib) – Commercial and Healthcare Reform	10/08/2025	New policy created for Anzupgo (delgocitinib) requiring age, documentation based on FDA-approved indication (supported by additional documentation of hand eczema (HE) persisting for >3 months or recurring ≥ 2 times within 12-month time frame), in addition to therapeutic failure, contraindication, or intolerance to at least one generic, formulary medium, high, or super-high potency topical corticosteroid (TCS).
BCR-ABL Kinase Inhibitors – Commercial and Healthcare Reform	08/26/2025	Policy revised to remove step through Iclusig (ponatinib) for Scemblix (asciminib).
BCR-ABL Kinase Inhibitors – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Phyrago (dasatinib) to require age and criteria based on FDA-approved indications and therapeutic failure or intolerance to generic dasatinib. Policy revised to add nilotinib tartrate to require age and criteria based on FDA-approved indications and therapeutic failure or intolerance to generic nilotinib hyDRochloride.
Brinsupri (brensocatib) – Commercial and Healthcare Reform	10/08/2025	New policy created for Brinsupri (brensocatib) to require the member to be 12 years of age and older, the member has a diagnosis of non-cystic fibrosis bronchiectasis (NCFB) confirmed by computed tomography (CT), the member has experienced at least one of the following symptoms consistent with bronchiectasis: cough on most days of the week, chronic sputum production, or a history of recurrent respiratory infections, for members who are 18 years of age and older the member has experienced at least 2 exacerbations in the previous 12 months that has led to antibiotic treatment, and for members who are 12 years of age to < 18 years of age, the member has had at least one pulmonary exacerbation in the previous 12 months that has let to antibiotic treatment. For reauthorization, the

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		member has experienced positive clinical response to therapy.
BTK Inhibitors – Commercial and Healthcare Reform	10/08/2025	Policy revised for Brukinsa (zanubrutinib) to allow for additional quantities up to 8 capsules per day or 4 tablets per day if used with a moderate cytochrome P450 3A inducer.
Bylvay (odevixibat) – Commercial and Healthcare Reform	10/08/2025	Policy revised for Bylvay (odevixibat) to remove restriction for cirrhosis and portal hypertension to only require that the member does not have hepatic decompensation on initial and reauthorization.
CGRP Inhibitors – Commercial and Healthcare Reform	10/08/2025	Policy revised for Ajovy (fremanezumab-vfrm) to add expanded indication of preventive treatment of migraine in pediatric patients who are 6-17 years of age and ≥45 kg requiring baseline average monthly migraine days, headaches are not caused by medication rebound/overutilization/lifestyle factors, the member has tried one agent from two different prophylactic migraine medication classes or all are contraindicated (alpha agonists, angiotensin-converting-enzyme inhibitors or angiotensin II receptor blockers, anti-epileptic drugs, beta blockers, calcium channel blockers, serotonin-norepinephrine reuptake inhibitors, or tricyclic antidepressants), and if the treatment plan is to use two chemically distinct CGRP inhibitors concomitantly, the prescriber attests the benefits outweigh risks. Reauthorization requiring a reduction in number of migraine days per month by at least 50% from baseline or a reduction in migraine days per month by at least 4 days from baseline. Subsequent reauthorizations are subject to sustained improvement.
CGRP Inhibitors and Reyvow (lasmiditan) – Commercial National Select Formulary	10/08/2025	Policy revised for Ajovy (fremanezumab-vfrm) to add expanded indication of preventive treatment of migraine in pediatric patients who are 6-17 years of age and ≥45 kg requiring baseline

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		average monthly migraine days, headaches are not caused by medication rebound/overutilization/lifestyle factors, the member has tried one agent from two different prophylactic migraine medication classes or all are contraindicated (alpha agonists, angiotensin-converting-enzyme inhibitors or angiotensin II receptor blockers, anti-epileptic Drugs , beta blockers, calcium channel blockers, serotonin-norepinephrine reuptake inhibitors, or tricyclic antidepressants), and if the treatment plan is to use two chemically distinct CGRP inhibitors concomitantly, the prescriber attests the benefits outweigh risks. Reauthorization requiring a reduction in number of migraine days per month by at least 50% from baseline or a reduction in migraine days per month by at least 4 days from baseline. Subsequent reauthorizations are subject to sustained improvement.
Chronic Inflammatory Diseases – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy revised for adalimumab quantity limits exceeding FDA-approved maximum dosing (dosage escalation) for inflammatory bowel disease to additionally require therapeutic Drug monitoring demonstrating subtherapeutic Drug concentration and antibodies to adalimumab are undetectable or low. Updates also apply to NSF.
Chronic Inflammatory Diseases – Commercial and Healthcare Reform	10/08/2025	Policy revised for Otezla (apremilast) to add expanded indication of pediatric psoriatic arthritis (PsA) into existing PsA criteria with the addition of requiring weight greater than or equal to 20 kg for pediatric patients. Policy revised to include Imuldosa (ustekinumab-srlf) as a non-preferred ustekinumab product and prescriber restriction for plaque psoriasis updated to include rheumatologist as an allowed specialist.
Chronic Inflammatory Diseases – Commercial	10/08/2025	Policy revised for Otezla (apremilast) to add expanded indication of pediatric psoriatic arthritis (PsA) into existing PsA

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
National Select Formulary		criteria with the addition of requiring weight greater than or equal to 20 kg for pediatric patients. Policy revised to include Imuldosa (ustekinumab-srlf) as a non-preferred ustekinumab product and prescriber restriction for plaque psoriasis updated to include rheumatologist as an allowed specialist.
Hemophilia Products – Commercial and Healthcare Reform	10/08/2025	Policy revised for Alhemo (concizumab-mtci) to remove requirement of inhibitors. For patients without inhibitors, the member has previously taken a factor replacement therapy. If the request is for Hemophilia A, the member has severe disease; for Hemophilia B, the member has moderately severe-to-severe disease.
Coverage Outside Contract Parameters – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy revised for Wegovy (semaglutide) to add use for heart failure with preserved ejection fraction (HFpEF) as a therapy exclusion.
Cresemba (isavuconazonium sulfate) capsules – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Termination of policy.
Denosumab Products for Bone Disease and Evenity (romosozumab-aqqg) – Commercial and Healthcare Reform	10/08/2025	Policy revised for Evenity (romosozumab) to remove step through bisphosphonates for patients with very high fracture risk.
Diacomit (stiripentol) – Commercial and Healthcare Reform	10/08/2025	Policy revised for Diacomit (stiripentol) to specify that patients 6 months to 2 years and weighing at least 7 kilograms must have an inadequate response to plan-preferred clobazam monotherapy, replacing previous criteria of therapeutic failure, contraindication or intolerance.
Dificid (fidaxomicin) – Commercial and Healthcare Reform	10/08/2025	Policy revised for Dificid (fidaxomicin) to include if the request is for brand Dificid, the member has experienced therapeutic failure or intolerance to generic fidaxomicin tablets. If the request is for Dificid oral suspension, the member meets one of the following: the member has an inability to swallow

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		capsules/tablets or the member has experienced therapeutic failure or intolerance to generic fidaxomicin tablets.
Doptelet (avatrombopag) and Mulpleta (lusutrombopag) – Commercial and Healthcare Reform	10/08/2025	Policy revised to update Doptelet tablet (avatrombopag) criteria to include expanded indication of persistent or chronic immune thrombocytopenia in pediatric patients 6 years of age and older and criteria for chronic liver disease revised to include requirement of platelet count < 50 x 10 ⁹ /L.
Doptelet (avatrombopag) and Mulpleta (lusutrombopag) – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Doptelet Sprinkle (avatrombopag) to require diagnosis and age based on FDA-approved indication, tried and failed corticosteroid therapy, immunoglobulin therapy, or splenectomy, documented platelet count of < 50 x 10 ⁹ /L with risk factor or platelet count ≤ 30 x 10 ⁹ /L and reauthorization to require patient is less than 6 years of age and positive clinical response to therapy.
Dupixent (dupilumab) – Commercial and Healthcare Reform	10/08/2025	Policy revised for Dupixent (dupilumab) to add new indication of bullous pemphigoid (BP) to require age based on FDA-approved indication, specialist attestation of diagnosis, therapeutic failure, contraindication, or intolerance to high or super high potency topical corticosteroids or oral corticosteroids and reauthorization requiring the member has experienced disease control, reduction in the number of relapses, improvement in BP symptoms or reduction in oral corticosteroid use.
EGFR-Targeting Kinase Inhibitors – Commercial and Healthcare Reform	10/08/2025	Policy revised to remove Exkivity (mobocertinib) as it is no longer available.
EGFR-Targeting Kinase Inhibitors – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Zegfrovy (sunvozertinib) to require age and criteria based on FDA-approved indication.
Egrifta (tesamorelin) – Commercial and Healthcare Reform	10/08/2025	Policy revised to target Egrifta WR (tesamorelin) to require that the member is between the ages of 18 and 65 years. The member has a diagnosis of HIV and has been receiving antiretroviral therapy

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		for a minimum of 8 weeks and continues to receive antiretroviral therapy. The member has abdominal lipodystrophy supported by one of the following criteria: For males; member has a waist circumference ≥ 95 cm and the member has a hip ratio ≥ 0.94 . For females; member has a waist circumference ≥ 94 cm and the member has a hip ratio ≥ 0.88 . The member also has a fasting blood glucose of < 150 mg/dL. For reauthorization the member continues to receive antiretroviral therapy for HIV infection and the member has experienced a reduction in visceral adipose tissue.
Empaveli (pegcetacoplan) and Fabhalta (iptacopan) – Commercial and Healthcare Reform	10/08/2025	Policy revised to include criteria for newly FDA-approved indications: treatment of adult and pediatric patients aged 12 years and older with complement 3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN), to reduce proteinuria. For approval, member must have a diagnosis of C3G or IC-MPGN confirmed by biopsy, the member has a urine protein-to-creatinine ratio (UPCR) ≥ 1.0 g/g and the estimated glomerular filtration rate must be ≥ 30 mL/min/1.72 m ² . The member has experienced therapeutic failure, contraindication, intolerance or inadequate response to one (1) of the following: systemic corticosteroids, immunosuppressants, or mycophenolate mofetil, and the member is on the maximally tolerated dose or has experienced intolerance or contraindication to one of the following: angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB). For reauthorization, the member has experienced a reduction in UPCR from baseline.
Experimental and Investigational Products	09/11/2025	Policy revised to include Leqembi Iqlik (lecanemab-irmb). No exceptions will be

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
– Commercial and Healthcare Reform		made for experimental and investigational products.
Fingolimod – Commercial and Healthcare Reform	10/08/2025	Policy revised for Tascenso ODT (fingolimod) 0.5 mg to add therapeutic failure or intolerance to generic fingolimod capsules as an option in reauthorization criteria.
Gonadotropin-Releasing Hormone (GnRH) Agonists – Commercial and Healthcare Reform	10/08/2025	Policy revised to add Vabrinty (leuprolide acetate) as a target requiring FDA-approved diagnosis and trial/failure of Eligard (leuprolide acetate). Reauthorization criteria requires positive clinical response and continued need for therapy.
Hepatitis C Oral Agents – Commercial and Healthcare Reform	10/08/2025	Policy updated for the member to meet one of the following criteria: the member has a diagnosis of hepatitis C virus (HCV) or if the request is for Mavyret (glecaprevir/pibrentasvir), the member has a diagnosis of acute or chronic HCV.
Hepatitis C Oral Agents – Commercial Core	10/08/2025	Policy updated for the member to meet one of the following criteria: the member has a diagnosis of hepatitis C virus (HCV) or if the request is for Mavyret (glecaprevir/pibrentasvir), the member has a diagnosis of acute or chronic HCV.
Hepatitis C Oral Agents – Commercial National Select	10/08/2025	Policy updated for the member to meet one of the following criteria: the member has a diagnosis of hepatitis C virus (HCV) or if the request is for Mavyret (glecaprevir/pibrentasvir), the member has a diagnosis of acute or chronic HCV.
Hereditary Angioedema – Commercial and Healthcare Reform	10/08/2025	Policy revised to add Andembry (garadacimab-gxii) and Ekterly (sebetrastat) 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 avoiding using prophylactic or acute therapies simultaneously, respectively. 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. For Ekterly, trial/failure/contraindication to generic icatibant or unable to use an injection. Additional 8 tablets -retail/ 24 tablets -mail may be authorized if the member requires additional doses of Ekterly to treat a subsequent HAE attack. Authorization duration of 12 months.
Human Growth Hormone – Commercial and Healthcare Reform	07/14/2025	Policy revised for growth hormone products for treatment of children small for gestation age to require a birth weight at least 2 standard deviations below the gestational age-appropriate mean or a birth crown-heel length at least 2 standard deviations below the gestational age-appropriate mean.
Human Growth Hormone – Commercial and Healthcare Reform	10/08/2025	Policy revised to add Skytrofa (lonapegsomatropin-tcgd) expanded indication for adults to treat growth hormone (GH) deficiency due to multiple pituitary GH deficiencies, central nervous system irradiation, or reconfirmation of GH deficiency in adulthood (epiphyseal fusion occurred, has not used GH for at least 1 month, and had a response to all of the following GH tests: arginine or macimorelin, and insulin or glucagon). Reauthorization requiring prescriber attestation that the member has experienced positive clinical response to therapy.
Human Growth Hormone – Delaware Commercial and Healthcare Reform	07/14/2025	Policy revised for growth hormone products for treatment of children small for gestation age to require a birth weight at least 2 standard deviations below the gestational age-appropriate mean or a birth crown-heel length at least 2 standard deviations below the gestational age-appropriate mean.
Human Growth Hormone – Commercial and Healthcare Reform - Delaware	10/08/2025	Policy revised to add Skytrofa (lonapegsomatropin-tcgd) expanded indication for adults to treat growth hormone (GH) deficiency due to multiple pituitary GH deficiencies, central nervous system irradiation, or reconfirmation of GH deficiency in adulthood (epiphyseal

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		fusion occurred, has not used GH for at least 1 month, and had a response to all of the following GH tests: arginine or macimorelin, and insulin or glucagon). Reauthorization requiring prescriber attestation that the member has experienced positive clinical response to therapy.
Imcivree (setmelanotide) – Commercial and Healthcare Reform	08/05/2025	Policy revised for Imcivree (setmelanotide) to require FDA-approved age.
Jynarque (tolvaptan) – Commercial and Healthcare Reform	10/08/2025	Policy revised for Jynarque (tolvaptan) to define rapid risk of disease progression as estimated glomerular filtration rate decline ≥ 3 mL/min/1.73m ² per year or Mayo classification 1C to 1E.
Kerendia (finerenone) – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy was updated based on Kerendia's new expanded indication for Heart Failure (HF). Policy criteria requires diagnosis of heart failure, left ventricular ejection fraction (LVEF) $\leq 40\%$, the member's eGFR is ≥ 25 mL/min/1.73 m ² , serum potassium is ≤ 5.0 mEq/L, and concurrent use or contraindication or intolerance to a plan-preferred sodium-glucose cotransporter-2 inhibitors. Reauthorization criteria was added requiring prescriber attestation that the member has experienced positive clinical response to therapy, the member's eGFR is ≥ 25 mL/min/1.73 m ² , member's serum potassium is ≤ 5.0 mEq/L.
Phenylalanine HyDRoxylase Activator Products – Commercial and Healthcare Reform	10/08/2025	Policy revised to add Sephience (sepiapterin) to require diagnosis based on FDA-approved indication supported by baseline phenylalanine (Phe) levels greater than 6 mg/dL, trial/failure to plan-preferred generic sapropterin dihyDRochloride and documentation supporting compliance to a Phe-restrictive diet; documentation of member's current weight; the dose does not exceed 60 mg/kg/day. Reauthorization to require either 30% or greater decrease in blood Phe levels from baseline or Phe levels within

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		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 60 mg/kg/day. Initial authorization duration 3 months; reauthorization duration 12 months.
Leqembi Iqlik (lecanemab-irmb) – Commercial and Healthcare Reform - Delaware	09/11/2025	Policy revised to require that the member has completed 18 months of IV infusions of Leqembi (lecanemab-irmb) 10 mg/kg every 2 weeks and prior to initiation of Leqembi, the member had confirmed presence of amyloid beta pathology via Positron Emission Tomography (PET) imaging.
Liquid Formulation of Amlodipine Products – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Sdamlo (amlodipine) as a target require 6 years of age or older and diagnosis of hypertension, or 18 years of age or older and diagnosis of coronary artery disease, and the inability to swallow tablets, and therapeutic failure or intolerance to plan-preferred generic amlodipine besylate tablets. For reauthorization criteria the prescriber attests that the member has experienced positive clinical response to therapy and the prescriber attests that the member continues to have an inability to swallow tablets.
Market Watch Programs – Delaware	Effective Upon Completion of Internal Review and Implementation	Policy revised to add dicyclomine 40 mg tablet to high-cost ,low-value requiring step through dicyclomine 10 mg capsule, dicyclomine 20 mg tablet, and generic hyoscyamine tablet. Policy revised to add MiCort HC 2.5% and its generic hydrocortisone acetate 2.5% cream to high cost, low value requiring step through hydrocortisone 2.5% cream.
Market Watch Programs – New York, Pennsylvania and West Virginia	Effective Upon Completion of Internal Review and Implementation	Policy revised to add dicyclomine 40 mg tablet to high-cost, low-value requiring step through dicyclomine 10 mg capsule, dicyclomine 20 mg tablet, and generic hyoscyamine tablet. Policy revised to add MiCort HC 2.5% and its generic hydrocortisone acetate 2.5% cream to

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
		high cost, low value requiring step through hydrocortisone 2.5% cream.
Metabolic-Dysfunction Associated Steatohepatitis (MASH) – Commercial and Healthcare Reform	08/18/2025	Policy revised to add Wegovy (semaglutide) as a target mirroring criteria for Rezdifra (resmetirom). In addition, for initial and reauthorization, the member will not be using Wegovy with other GLP-1 containing products, and for reauthorization, the requested dose is 1.7 mg or 2.4 mg, or attestation of titration to 1.7 mg or 2.4 mg. Initial authorization duration 6 months and reauthorization duration 12 months.
Metabolic-Dysfunction Associated Steatohepatitis (MASH) – Commercial and Healthcare Reform	10/08/2025	Policy revised to clarify F2 or F3 fibrosis stage is from the member's baseline.
Modeyso (dordaviprone) – Commercial and Healthcare Reform	10/08/2025	New policy created for Modeyso (dordaviprone) to require age and criteria based on FDA-approved indication.
Natpara (parathyroid hormone) – Commercial and Healthcare Reform	10/03/2025	Policy terminated.
Nitisinone Products – Commercial and Healthcare Reform	10/08/2025	Policy revised to add Harliku (nitisinone) and Nityr 2 mg (nitisinone) to require diagnosis of alkaptonuria (AKU) and age based on FDA-approved indication, AKU confirmed by elevated urine homogentisic acid (HGA) or homogentisate 1,2-dioxygenase (HGD) gene mutation, is used to reduce urine HGA, requests for Harliku have experienced therapeutic failure or intolerance to Nityr 2 mg tablets, and reauthorization requiring reduction in urine HGA from baseline.
NTRK and ROS1 Inhibitors – Commercial and Healthcare Reform	10/08/2025	Policy revised to add Ibtrozi (taletrectinib) to require age and criteria based on FDA-approved indication for locally advanced or metastatic ROS1-positive non-small cell lung cancer.
Primary Biliary Cholangitis – Commercial and Healthcare Reform	10/08/2025	Policy revised for Ocaliva (obeticholic acid) to add decompensated cirrhosis as a limitation of coverage.

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Parathyroid Hormone Analogs – Commercial and Healthcare Reform	10/08/2025	Policy revised to add Bonsity (teriparatide) as a target mirroring criteria for Forteo (teriparatide). For all targets, remove step through bisphosphonates for patients with very high fracture risk.
PARP Inhibitors – Commercial and Healthcare Reform	10/08/2025	Policy revised for Zejula (niraparib) to require criteria based on updated FDA-approved indication for advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer.
Pulmonary Hypertension – Commercial and Healthcare Reform	09/09/2025	Policy revised to add Yutrepia (treprostinil) to require diagnosis based on FDA-approved indication, prescribed by or in consultation with a cardiovascular or pulmonary specialist, supported by results of right heart catheterization. For a diagnosis of pulmonary arterial hypertension, if the member is a new start to therapy, trial/failure/contraindication to sildenafil or ambrisentan. For a diagnosis of pulmonary hypertension associated with interstitial lung disease, the member is a non-smoker or currently engaged in smoking cessation. Reauthorization to require positive clinical response to therapy.
Pylera (bismuth subcitrate potassium, metronidazole, tetracycline) – Commercial and Healthcare Reform	10/08/2025	Policy revised for Pylera (bismuth subcitrate potassium; metronidazole; tetracycline) to remove step through lansoprazole or omeprazole, amoxicillin or metronidazole, and clarithromycin.
Presbyopia Products – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Vizz (aceclidine) requiring diagnosis of presbyopia, age of 45 years or older, and therapeutic failure to eyeglasses or contact lenses. Reauthorization requiring positive clinical response to therapy. A generic formulation of Vuity (pilocarpine HCl) is now available. The policy was revised to add this product to the target list.
Savella (milnacipran) and Tonmya (cyclobenzaprine) –	Effective Upon Completion of Internal Review and Implementation	Policy revised to include newlyFDA-approved product, Tonmya (cyclobenzaprine, sublingual). Approval of Tonmya requires that the member is

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Commercial and Healthcare Reform		18 years of age or older, there is clinical documentation of the fibromyalgia diagnosis supported by evidence of widespread bilateral pain above and below the waist, pain duration of at least 3 months, and at least one (1) of the following fibromyalgia-related symptoms: cognitive impairment, fatigue, sleep disturbance, neurologic symptoms, or exercise intolerance. In addition, the member has experienced therapeutic failure, contraindication, or intolerance to all of the following: duloxetine and pregabalin, as well as therapeutic failure or intolerance to one of the following: amitriptyline, cyclobenzaprine oral formulation, gabapentin, or tramadol. Qualifier cyclobenzaprine product clarified as the oral formulation; Tonmya is a target with a sublingual formulation. Reauthorization requires prescriber attestation that the member has experienced positive clinical response to therapy.
Spevigo (spesolimab-sbzo) Subcutaneous – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy revised to add quantity limits for new strength Spevigo (spesolimab-sbzo) 300 mg/2 mL prefilled syringe.
Targretin (bexarotene) – Commercial and Healthcare Reform	10/08/2025	Policy revised for Targretin (bexarotene) capsules to require that member is refractory to one prior systemic therapy per FDA-approved indication. Policy revised for Targretin (bexarotene) topical gel to require that the member has experienced therapeutic failure, contraindication, or intolerance to at least one other therapy for cutaneous T-cell lymphoma per FDA-approved indication.
Testosterone (AnDRogens) – Commercial and Healthcare Reform	10/08/2025	Policy revised for testosterone products for continuation and reauthorization criteria to allow for the laboratory reference ranges and option to submit free testosterone levels.
Thrombopoiesis Stimulating Agents –	10/08/2025	Policy revised for brand Promacta (eltrombopag olamine) to require therapeutic failure or intolerance to

Policy Name*	Policy Effective Date**	Updates and/or Approval Criteria
Commercial and Healthcare Reform		generic eltrombopag olamine for reauthorization.
Tocilizumab Biosimilars – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy revised for Avtozma SC (tocilizumab-anoh) to add prescriber restriction for each indication.
Vigabatrin – Commercial and Healthcare Reform	10/08/2025	Policy revised for vigabatrin to implement and specify initial and reauthorization durations (3 and 12 months, respectively).
Yorvipath (palopegteriparatide) – Commercial and Healthcare Reform	10/08/2025	Policy reauthorization criteria revised for Yorvipath (palopegteriparatide) to require that the member has experienced normalization or improvement in total serum calcium from baseline.

*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
Additional Quantities of COVID-19 Vaccines – Commercial and Healthcare Reform	10/08/2025	Policy updated to include Nuvaxovid (COVID-19 Vaccine, Adjuvanted) and mNexspike (COVID-19 Vaccine, mRNA) to require a patient to be 12 years of age or older and for the patient to be moderately or severely immunocompromised. Policy also updated for Spikevax (COVID-19 Vaccine, mRNA) for additional quantities to be approved if the member is 6 months of age or older.
Beta Blocker Management – Commercial and Healthcare Reform	10/08/2025	Policy revised to add single source brand bisoprolol fumarate 2.5 mg as a target, requiring diagnosis of FDA-approved indication, and therapeutic failure or intolerance to two (2) additional chemically-unique, plan-preferred, generic beta-blockers or beta-blocker combinations. Reauthorization to require positive clinical response to therapy.
Brilinta (ticagrelor) – Commercial and Healthcare Reform	10/01/2025	Policy created for brand Brilinta (ticagrelor) to require age, FDA-approved indication, and therapeutic failure or intolerance to generic ticagrelor. Reauthorization requires

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
		positive clinical response to therapy and therapeutic failure or intolerance to generic ticagrelor.
Butalbital Combination Products – Commercial and Healthcare Reform	10/08/2025	Policy revised to add new butalbital/acetaminophen/caffeine oral solution (generic) as a target medication. The butalbital/acetaminophen/caffeine oral solution may be approved when the following criteria are met: the member is 12 years of age or older, the member is using the medication for the treatment of the symptom complex of tension (muscle contraction) headache, and the member has an inability to swallow tablets or capsules. Reauthorization requires that the member continues to need treatment for the symptom complex of tension (muscle contraction) headache, the prescriber attests that the member has experienced positive clinical response to therapy, and the member is still unable to swallow tablets or capsules.
Carbinoxamine Products – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy revised to add carbinoxamine maleate 4 mg/5 mL solution, Carbzah (carbinoxamine maleate), and Karbinal ER (carbinoxamine maleate) requiring age, FDA-approved diagnosis, trial/failure to generic carbinoxamine 4 mg tablets or unable to swallow, and trial/failure to two different prescription antihistamines other than carbinoxamine.
Combination Anti Hypertensive Medications – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	New policy created targeting Widaplik (telmisartan/amlodipine/indapamide), Exforge HCT (amlodipine/valsartan/hyDRochlorothiazide), and Tribenzor (olmesartan/amlodipine/hyDRochlorothiazide). For Exforge HCT (amlodipine/valsartan/hyDRochlorothiazide) criteria requires diagnosis of hypertension, therapeutic failure or intolerance to preferred generic products available separately and taken together; amlodipine, valsartan, hyDRochlorothiazide, and if the request is for brand Exforge HCT the member has therapeutic failure, contraindication, or intolerance to generic

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
		<p>amlodipine/valsartan/hydrochlorothiazide tablet. For Tribenzor (olmesartan/amlodipine/hydrochlorothiazide) criteria requires diagnosis of hypertension, therapeutic failure or intolerance to preferred generic products available separately and taken together; amlodipine, olmesartan, hydrochlorothiazide, and if the request is for brand Tribenzor the member has therapeutic failure, contraindication, or intolerance to generic olmesartan/amlodipine/hydrochlorothiazide tablet. For Widaplik (telmisartan/amlodipine/indapamide) criteria requires diagnosis of hypertension, therapeutic failure or intolerance to preferred generic products available separately and taken together; telmisartan, amlodipine, indapamide. For reauthorization the prescriber attests that the member has experienced positive clinical response to therapy, if the request is for brand Exforge HCT, the member has experienced therapeutic failure, contraindication, or intolerance to generic amlodipine/valsartan/hydrochlorothiazide tablet, and if the request is for brand Tribenzor, the member has experienced therapeutic failure, contraindication, or intolerance to generic olmesartan/amlodipine/hydrochlorothiazide tablet</p>
Cyclobenzaprine, Metaxalone, and Methocarbamol Products – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Atmeksi (methocarbamol) oral solution mirroring criteria for methocarbamol 1000 mg. In addition, requiring FDA-approved age, inability to swallow tablets, and intolerance to methocarbamol (not including methocarbamol 1000 mg).
Dicyclomine 40 mg Tablet – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	New policy created for dicyclomine 40 mg tablet to require age, FDA-approved diagnosis, therapeutic failure, contraindication, or intolerance to generic hyoscyamine sulfate tablet, therapeutic failure to dicyclomine 20 mg tablet, and

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
		member is unable to take 2 x 20 mg tablets together.
Direct Oral Anticoagulants (DOACs) – Commercial and Healthcare Reform	10/08/2025	Policy revised to add generic rivaroxaban oral solution as a target requiring member is 17 years of age or younger, diagnosis of venous thromboembolism (VTE) or thromboprophylaxis in those with congenital heart disease after Fontan procedure. The member meets one of the following; for VTE the member is ≥ 30 kg, the prescriber attests that the member has an inability to swallow Xarelto tablets or for thromboprophylaxis after the Fontan procedure, if the member is ≥ 50 kg, the prescriber attests that the member has an inability to swallow Xarelto tablets. For reauthorization the member is 17 years of age or younger, the prescriber attests that the member has experienced positive clinical response to therapy, and the member meets one of the following; for VTE the member is ≥ 30 kg, the prescriber attests that the member has an inability to swallow Xarelto tablets or for thromboprophylaxis after the Fontan procedure, if the member is ≥ 50 kg, the prescriber attests that the member has an inability to swallow Xarelto tablets.
Erectile Dysfunction Limits – Commercial, Healthcare Reform and Medicare	10/08/2025	Policy revised to remove off market products: brand Levitra (vardenafil), Muse (alprostadil), and brand Staxyn (vardenafil).
Liquid Formulations of Anti-Hypertensive Medications – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy revised to add generic valsartan oral solution and Vostally (ramipril) as a target requiring FDA-approved age, diagnosis, and trial/failure of a plan-referred alternative tablet or capsule with the same active ingredient. Reauthorization requiring positive clinical response to therapy and inability to swallow tablets or capsules.
Non-Preferred Blood Glucose Testing Products – Commercial and Select Healthcare Reform	08/17/2025	Policy revised to remove Lifescan OneTouch Products and added Trividia Health Test Strips as a plan-preferred product. Policy criteria was also updated to require therapeutic failure of two plan-preferred test strip products.

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
Non-Preferred Blood Glucose Testing Products – Commercial and Select Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Automatic approval criteria was also updated to require that the member has at least one paid prescription Drug claim within the past 365 days for two plan-preferred test strip products.
Non-preferred Rescue Inhalers – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy updated to include albuterol sulfate authorized generics (AG) to require an FDA-approved indication, the member is 4 years of age and older, and the member has experienced contraindication or intolerance to a generic albuterol product that would not be expected with the brand product. Use must be verified by pharmacy claims or documented chart notes. For reauthorization, the prescriber attests the member has experienced positive clinical response to therapy and the member has experienced contraindication or intolerance to a generic albuterol product that would not be expected with the brand product. Use must be verified by pharmacy claims or documented chart notes.
Non-Preferred CNS Stimulant Products – Commercial and Healthcare Reform	10/08/2025	Policy revised to add Amphetamine ER-ODT (brand), an authorized generic (AG) to Adzenys-ODT was added to the policy as a target medication. The criteria for Amphetamine ER-ODT mirrors that of Adzenys-ODT.
Non-Preferred CNS Stimulant Products – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Arynta (lisdexamfetamine) to require FDA-approved indication and age, for ADHD failure of 1 generic alternative (dextroamphetamine/amphetamine ER, dexmethylphenidate ER, dextroamphetamine ER, or methylphenidate ER) and generic lisdexamfetamine, and for binge eating disorder, failure of generic lisdexamfetamine. Reauthorization requires positive clinical response to therapy.
Non-Preferred Erectile Dysfunction Therapy – Commercial and Healthcare Reform	10/08/2025	Policy revised to remove off market products: brand Levitra (vardenafil) and brand Staxyn (vardenafil).
Non-Preferred NSAIDs – Commercial and Healthcare Reform	10/08/2025	Policy revised to add ibuprofen 300 mg; requires FDA-approved diagnosis and

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
		trial/failure to three (3) plan-preferred, generic products, or contraindication to all.
Non-Preferred NSAIDs – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Vyscoxa (celecoxib) oral suspension to require diagnosis based on FDA-approved indication, inability to swallow tablets and capsules, therapeutic failure or intolerance to plan-preferred, alternative tablet or capsule with the same active ingredient (for example, when crushed or capsules open and sprinkled onto applesauce), and therapeutic failure or intolerance to plan-preferred, generic ibuprofen suspension.
Non-Preferred Topiramate Products – Commercial and Healthcare Reform	10/08/2025	Policy updated to include if the request is for brand Eprontia (topiramate), the member has experienced therapeutic failure or intolerance to generic topiramate oral solution.
Nuedexta (dextromethorphan-quinidine) – Commercial and Healthcare Reform	10/08/2025	Policy revised for Nuedexta (dextromethorphan-quinidine) to update MS qualifiers under automatic approval criteria.
Topical Corticosteroids – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy updated to add MiCort HC Cream (hydrocortisone 2.5%) (brand and generic) as targets to the Low to Medium Potency Topical Corticosteroids. For approval, the prescriber must provide the condition the topical corticosteroid will be treating and the member has experienced therapeutic failure or intolerance to at least two (2) plan-preferred topical corticosteroids for the current condition. Removed Xilapak and Synalar TS 0.01% Kit from the targets. They are on the suspect list and not covered (a kit).
Viibryd (vilazodone) and Trintellix (vortioxetine) – Commercial	10/08/2025	Policy revised to require, in addition to existing criteria, that if the request is for brand Viibryd (vilazodone), the member has experienced therapeutic failure or intolerance to generic vilazodone.
Viibryd (vilazodone) and Trintellix (vortioxetine) – Healthcare Reform	10/08/2025	Policy revised to require, in addition to existing criteria, that if the request is for brand Viibryd (vilazodone), the member has experienced therapeutic failure or intolerance to generic vilazodone.

Policy Name*	Policy Effective Date**	Updates and Automatic Approval Criteria
Widaplik (telmisartan/amlodipine/indapamide) – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	New policy created targeting Widaplik (telmisartan/amlodipine/indapamide). Policy criteria requires diagnosis of hypertension, therapeutic failure or intolerance to preferred generic products available separately and taken together; telmisartan, amlodipine, indapamide. For reauthorization, the prescriber attests that the member has experienced positive clinical response to therapy.
Xifaxan (rifaximin) – Commercial and Healthcare Reform	Effective Upon Completion of Internal Review and Implementation	Policy updated for Xifaxan (rifaximin) 550 mg for a member with small intestinal bacterial overgrowth (SIBO) to have a diagnosis of SIBO confirmed by one of the following: a quantitative culture of upper gut aspirate or breathing test and to experience therapeutic failure, contraindication or intolerance to one of the following plan-preferred generic agents: amoxicillin-clavulanic acid, a fluoroquinolone, doxycycline, metronidazole, tetracycline, or trimethoprim-sulfamethoxazole. For reauthorization, the member has had a recurrence of SIBO and the member previously received an antibiotic other than Xifaxan, unless they are intolerant of or have contraindications to other antibiotic options. For Xifaxan 200 mg, quantity level limit criteria was added to include the member to have a diagnosis of SIBO confirmed by one of the following: a quantitative culture of upper gut aspirate or breathing test

*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
Andembry (garadacimab-gxii)	1.2 mL (200 mg) per 28 days	3.6 mL (600 mg) per 84 days
Anzupgo (delgocitinib)	60 grams per 30 days	180 grams per 90 days
Cosentyx Snrdy 300mg Dose-2pen	2 mL per 21 days	6 mL per 42 days
Egrifta WR (tesamorelin)	4 vials per 28 days	12 vials per 84 days
Ekterly (sebetralstat)	8 tablets per 25 days	24 tablets per 75 days
Enflonsia (clesrovimab-cfor)	2 doses (1.4 mL) per 720 days	2 doses (1.4 mL) per 720 days
Hernexeos (zongertinib)	300 tablets per 90 days	300 tablets per 90 days
Modeyso (dordaviprone)	20 capsules per 28 days	60 capsules per 84 days
Sdmalo (amlodipine) oral solution	3 cartons per 30 days	9 cartons per 90 days
Spevigo (spesolimab-sbzo) 300 mg/2 mL	1 syringe per 28 days	3 syringes per 84 days
StenDRa (avanafil)	18 tablets per 75 days	18 tablets per 75 days
Vostally (ramipril)	600 mL per 25 days	1800 mL per 75 days
Vyscoxa (celecoxib)	1,419 mL per 35 days	3,784 mL per 94 days
Yeztugo (lenacapavir) tablets	4 tablets per 28 days	12 tablets per 84 days
Yutrepia (treprostinil) inhalation powder 79.5 mcg	4 kits (28 capsules/inhaler) per 28 days	12 kits (28 capsules w/inhaler) per 84 days
Yutrepia (treprostinil) inhalation powder 106 mcg	8 kits (28 capsules/inhaler) per 28 days	24 kits (28 capsules w/inhaler) per 84 days
Yutrepia (treprostinil) inhalation powder 26.5 mcg, 53 mcg	5 kits (28 capsules w/inhaler) per 28 days	15 kits (28 capsules w/inhaler) 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
Xofluza (baloxavir marboxil) 30 mg packet	1 packet per dispensing event	1 packet per dispensing event
Xofluza (baloxavir marboxil) 40 mg packet	2 packets per dispensing event	2 packets 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
Arynta (lisdexamfetamine dimesylate)	7 mL (70 mg) per day
Atmeski (methocarbamol)	8 g (54 mL) per day
Banzel (rufinamide) 200 mg tablet	4 tablets per day
Banzel (rufinamide) 40 mg/mL suspension	80 mL per day
Banzel (rufinamide) 400 mg tablet	8 tablets per day
Brinsupri (brensocaticib)	1 tablet per day
Brukinsa (zanubrutinib) tablet	2 tablets per day
Dicyclomine 40 mg tablet	4 tablets per day
Doptelet Sprinkle (avatrombopag)	2 capsules (filled with oral granules) per day
Harliku (nitisinone)	1 tablet per day
Ibtrozi (taletrectinib)	3 capsules per day
Juxtapid (lomitapide) 20 mg and 30 mg	2 capsules per day
nilotinib tartrate	4 capsules per day
Phyrago (dasatinib) 20 mg	3 tablets per day
Phyrago (dasatinib) 50 mg, 70 mg, 80 mg, 100 mg, 140 mg	1 tablet per day
Sepience (sepiapterin) 250 mg	3 packets per day
Sprycel (dasatinib) 20 mg	3 tablets per day
Thalomid (thalidomide) 100 mg	4 capsules per day
Tonmya (cyclobenzaprine) sublingual tablets	2 tablets per day
Vizz (aceclidine ophthalmic solution)	1 vial per day
Widaplik (Telmisartan, Amlodipine and Indapamide)	1 tablet per day
Zegfrovy (sunvozertinib)	1 tablet 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
Enflonsia	clesrovimab-cfor	Prevention of RSV lower respiratory tract disease in neonates and infants who are born during or entering their first RSV season.

Table 2. Non-Preferred Products

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

Brand Name	Generic Name	Preferred Alternatives
Arynta	Lisdexamfetamine dimesylate	dextroamphetamine-amphet ER capsule, ext release 24 hr , methylphenidate hcl tablet
Atmeski	methocarbamol	methocarbamol 500 mg tablets, methocarbamol 750 mg tablets
dicyclomine 40 mg tablet	dicyclomine	dicyclomine 10 mg capsule, dicyclomine 20 mg tablet
famotidine Injection 4 mg/mL	famotidine	Prescriber discretion
Kirsty	insulin aspart-xjhz	Humalog, insulin lispro, Novolog
Sdmalo oral solution	amlodipine	amlodipine besylate oral tablet
Tonmya sublingual tablets	cyclobenzaprine	pregabalin capsules, duloxetine capsules
Vizz	aceclidine ophthalmic solution	Prescriber discretion
Vostally	ramipril	ramipril, lisinopril, benazepril
Vyscoxa	celecoxib	celecoxib capsule, ibuprofen suspension

Brand Name	Generic Name	Preferred Alternatives
Widaplik	telmisartan, amlodipine and indapamide	telmisartan oral tablet, amlodipine besylate oral tablet, indapamide oral tablet
Xifyrm	meloxicam	ibuprofen tablets, meloxicam tablets, naproxen sodium tablets

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
Enflonsia	clesrovimab-cfor	Prevention of RSV lower respiratory tract disease in neonates and infants who are born during or entering their first RSV season.

Table 2. Non-Preferred Products

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

Brand Name	Generic Name	Preferred Alternatives
Widaplik	telmisartan, amlodipine and indapamide	telmisartan oral tablet, amlodipine besylate oral tablet, indapamide oral tablet

Table 3. Products Not Added*

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

Brand Name	Generic Name	Preferred Alternatives
Andembry	garadacimab-gxii	Cinryze

Arynta	lisdexamfetamine dimesylate	dextroamphetamine-amphet ER capsule, ext release 24 hr , methylphenidate hcl tablet
Atmeski	methocarbamol	cyclobenzaprine 5 mg tablet, cyclobenzaprine 10 mg tablet
Avgemsi	gemcitabine	Prescriber discretion
Camcevi ETM	leuprolide mesylate	leuprolide (3 month)
dicyclomine 40 mg tablet	dicyclomine	dicyclomine 10 mg capsule, dicyclomine 20 mg tablet
Doptelet Sprinkle	avatrombopag	Doptelet tablet, Promacta
Egrifta WR	tesamorelin	Prescriber Discretion
Ekterly	sebetralstat	Kalbitor, icatibant, Berinert
famotidine Injection 4 mg/mL	famotidine Injection 4 mg/mL	Prescriber discretion
Harliku	nitisinone	Prescriber discretion
Kirsty	insulin aspart-xjhz	Humalog, insulin lispro, Novolog
Leqembi Iqlik	lecanemab-irmb	donepezil, galantamine, rivastigmine tartrate
nilotinib tartrate	nilotinib	nilotinib HCl
Papzimeos	zopapogene imadenovec-DRba	Prescriber discretion
Phyrago	dasatinib	dasatinib
Sdmalo oral solution	amlodipine	amlodipine besylate oral tablet
Tonmya sublingual tablets	cyclobenzaprine	pregabalin capsules, duloxetine capsules
Vizz	aceclidine ophthalmic solution	Prescriber discretion
Vostally	ramipril	ramipril, lisinopril, benazepril
Vyscoxa	celecoxib	celecoxib capsule, ibuprofen suspension
Xifyrm	meloxicam	ibuprofen tablets, meloxicam tablets, naproxen sodium tablets
Yeztugo	lenacapavir	Prescriber discretion
Yutrepia inhalation powder	treprostinil	Prescriber discretion
Zusduri	mitomycin	Prescriber discretion

*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
Andembry*	garadacimab-gxii
Anzupgo	delgocitinib
Avgemsi*	gemcitabine

Brinsupri	brensocatic
Brukinsa	zanubrutinib
Camcevi ETM*	leuprolide mesylate
Doptelet Sprinkle*	avatrombopag
Egrifta WR*	tesamorelin
Ekterly*	sebetrastat
Gammagard Liquid ERC	immune globulin infusion (human)
Harliku*	nitisinone
Hernexeos	zongertinib
Ibtrozi	taletrectinib
Leqembi Iqlik*	lecanemab-irmb
Lynozytic	linvoseltamab-gcpt
Modeyso	dordaviprone
nilotinib tartrate	nilotinib tartrate
Phyrago*	dasatinib
Sepience	sepiapterin
Yutrepia*	treprostinil
Zegfrovy	sunvozertinib

* Pertains only to Incentive and Compass Formularies.

D. Updates to the Pharmacy Utilization Management Programs

1. Prior Authorization Program

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Administrative Prior Authorizations for Medicare Part D Plans – Medicare	07/29/2025	removed Onapgo from BvD Drugs
ALK-Targeting Kinase Inhibitors – Medicare	10/08/2025	Policy revised for Alecensa (alectinib), Alunbrig (brigatinib), Lorbrena (lorlatinib), and Xalkori (crizotinib) to require use of an FDA-approved test based on FDA-approved indication.
Amyloid beta-Directed Antibodies for Alzheimer’s Disease – Medicare	10/08/2025	Policy revised to include Leqembi Iqlik (lecanemab-irmb) requiring FDA-approved diagnosis, the member has completed 18 months of IV infusions of Leqembi 10 mg/kg every 2 weeks, the prescriber has ruled out all other possible causes of cognitive impairment, prior to initiation of Leqembi IV, the member had confirmed presence of amyloid beta pathology via Positron Emission Tomography (PET) imaging and obtained a baseline brain MRI. Reauthorization requires mild cognitive impairment or mild dementia stage of Alzheimer's disease at treatment initiation, a

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		reduction from baseline in amyloid beta plaque levels via PET imaging, and positive clinical response as evidenced by slowed decline in cognition.
AnDRogen Receptor Inhibitors – Medicare	10/08/2025	Policy revised for Nubeqa (darolutamide) to remove requirement for use in combination with docetaxel for metastatic castration-sensitive prostate cancer, based on expanded FDA-approved indication.
Anti-EGFR and HER2 Kinase Inhibitors – Medicare	10/08/2025	Policy revised to add Hernexeos (zongertinib) to require criteria based on FDA-approved indication.
Anzupgo (delgocitinib) – Medicare	10/08/2025	New policy created for Anzupgo (delgocitinib) requiring diagnosis of chronic hand eczema (CHE) (supported by additional diagnosis of hand eczema [HE] persisting for >3 months or recurring ≥2 times within 12-month time frame), in addition to therapeutic failure, contraindication, or intolerance to at least one generic, formulary medium, high, or super-high potency topical corticosteroid (TCS).
Apomorphine Products – Medicare	07/10/2025	Policy revised for Onapgo (apomorphine) to remove criteria requiring the product has been determined to be eligible for coverage under Part D per policy J-0030.
BCR-ABL Kinase Inhibitors – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Phyrago (dasatinib) to require criteria based on FDA-approved indications and therapeutic failure or intolerance to generic dasatinib. Policy revised to add nilotinib tartrate to require age and criteria based on FDA-approved indications and therapeutic failure or intolerance to generic nilotinib hydrochloride.
Bispecific Monoclonal Antibodies for Multiple Myeloma – Medicare	10/08/2025	New policy for Lynozyfic (linvoseltamab-gcpt) to require criteria based on FDA-approved indication. Policies J-1309, J-1263, and J-1308 combined into this policy. Criteria for Tecvayli (teclistamab-cqyv) revised to require that the member has received at least four prior therapies, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 monoclonal antibody, per FDA-approved indication.
Brinsupri (brensocatib) – Medicare	10/08/2025	New policy created for Brinsupri (brensocatib) to require the member to have a diagnosis of

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		non-cystic fibrosis bronchiectasis (NCFB) confirmed by computed tomography (CT) and the member has experienced at least one of the following symptoms consistent with bronchiectasis: cough on most days of the week, chronic sputum production, a history of recurrent respiratory infections, dyspnea, wheezing, rhinosinusitis, hemoptysis, or recurrent pleurisy.
Bylvay (odevixibat) – Medicare	10/08/2025	Policy revised for Bylvay (odevixibat) to remove restriction for cirrhosis and portal hypertension to only require that the member does not have hepatic decompensation on initial and reauthorization. Policy revised to remove confirmation by genetic testing for progressive familial intrahepatic cholestasis.
Bylvay (odevixibat) – Medicare	Effective upon Completion of Internal Review and Implementation	Policy revised for Bylvay (odevixibat) to require diagnosis of progressive familial intrahepatic cholestasis or Alagille syndrome be confirmed by genetic testing.
Carbinoxamine – Medicare	10/08/2025	Policy revised to add Carbzah (carbinoxamine maleate) oral solution requiring diagnosis based on FDA-approved indication. The member has experienced therapeutic failure, contraindication, or intolerance to two (2) different antihistamines.
CGRP Inhibitors and Reyvow – Medicare	10/08/2025	Policy revised for Ajovy (fremanezumab-vfrm) to add expanded indication of preventive treatment of migraine in pediatric patients who are 6-17 years of age and ≥45 kg requiring baseline average monthly migraine days and headaches are not caused by medication rebound/overutilization/lifestyle factors. Reauthorization requiring the prescriber attests that the member has experienced a reduction in migraine frequency.
CGRP Inhibitors and Reyvow – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised for Ajovy (fremanezumab-vfrm) for members 18 years of age or older to try 2 of the following Drugs: Aimovig (erenumab-aooe), Emgality (galcanezumab-gnlm), or Qulipta (atogepant). Criteria requiring trial of 2 different prophylactic migraine classes removed.

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Chronic Inflammatory Diseases – Medicare	10/01/2025	Policy revised for Otezla (apremilast) to add expanded indication of pediatric psoriatic arthritis (PsA) into existing PsA criteria with the addition of requiring weight greater than or equal to 20 kg for pediatric patients. Policy revised to include Imuldosa (ustekinumab-srlf) as a non-preferred ustekinumab product, move Yesintek (ustekinumab-kfce) and Steqeyma (ustekinumab-stba) to preferred ustekinumab products and move Hadlima (adalimumab-bwwd) and Simlandi (adalimumab-ryvk) to preferred adalimumab products.
Cialis (tadalafil) and Entadfi (finasteride/tadalafil) – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to remove dutasteride/tamsulosin and silodosin as alternatives.
Concomitant Dipeptidyl Peptidase-4 (DPP-4) Inhibitors and Glucagon-Like Peptide-1 Receptor Agonists (GLP-1 RAs) Therapy – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Brynovin (sitagliptin) as a target.
Cresemba (isavuconazonium sulfate) capsules – Medicare	Effective Upon Completion of Internal Review and Implementation	Termination of policy.
Datroway (datopotamab deruxtecan-dlnk) – Medicare	10/08/2025	Policy revised for Datroway (datopotamab deruxtecan-dlnk) to require criteria based on expanded FDA-approved indication for EGFR-mutated non-small cell lung cancer.
Dicyclomine 40 mg Tablet – Medicare	10/08/2025	New policy created for dicyclomine 40 mg tablet to require FDA-approved diagnosis, therapeutic failure to dicyclomine 20 mg tablet, and member is unable to take 2 x 20 mg tablets together.
Dificid (fidaxomicin) – Medicare	Effective Upon Completion of Internal Review and Implementation	New policy for brand Dificid (fidaxomicin) tablets requiring the member has experienced intolerance to generic fidaxomicin tablets.
Dificid (fidaxomicin) – Medicare	Effective Upon Completion of Internal	Policy updated for brand Dificid (fidaxomicin) tablets or oral suspension to require a diagnosis of Clostridium difficile confirmation

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
	Review and Implementation	with 3 or more unexplained and new-onset loose bowel movements in < 24 hours and one of the following: a positive nucleic acid amplification test (NAAT) or polymerase chain reaction (PCR) result for C. difficile, a positive glutamate dehydrogenase (GDH) test result, a positive enzyme immunoassay (EIA) for C. difficile toxin, or a positive stool culture for C. difficile and if the request is for Difucid oral suspension, the member has an inability to swallow capsules/tablets or the member has experienced intolerance to generic fidaxomicin tablets. For reauthorization, the member has a recurrence of Clostridium difficile confirmed by an episode of symptom onset and one of the following: a positive NAAT or PCR result for C. difficile, a positive GDH test result, a positive EIA for C. difficile toxin, or a positive stool culture for C. difficile and if the request is for brand Difucid, the member has experienced intolerance to generic fidaxomicin tablets. If the request is for Difucid oral suspension, the member has an inability to swallow capsules/tablets or the member has experienced intolerance to generic fidaxomicin tablets.
Doptelet (avatrombopag) and Mulpleta (lusutrombopag) – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised for to add Doptelet Sprinkle (avatrombopag) to require diagnosis and age based on FDA-approved indication, tried and failed corticosteroid therapy, immunoglobulin therapy, or splenectomy, documented platelet count of $\leq 50 \times 10^9/L$ with risk factor or platelet count $\leq 30 \times 10^9/L$.
Doptelet (avatrombopag) and Mulpleta (lusutrombopag) – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised for Doptelet Tablet (avatrombopag) criteria for chronic liver disease to require platelet count of $< 50 \times 10^9/L$ and for Doptelet Tablet and Sprinkle for immune thrombocytopenia platelet count of $50 \times 10^9/L$ updated from \leq to $<$.
Doptelet (avatrombopag) and Mulpleta (lusutrombopag) – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to update Doptelet tablet (avatrombopag) criteria to include expanded indication of persistent or chronic immune thrombocytopenia in pediatric patients 6 years of age and older.

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Dupixent (dupilumab) – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised for Dupixent (dupilumab) to add new indication of bullous pemphigoid (BP) to require therapeutic failure, contraindication, or intolerance to high or super high potency topical corticosteroids or oral corticosteroids and reauthorization requiring the member has experienced disease control, reduction in the number of relapses, improvement in BP symptoms or reduction in oral corticosteroid use.
EGFR-Targeting Kinase Inhibitors – Medicare	10/08/2025	Policy revised to remove Exkivity (mobocertinib) as it is no longer available.
EGFR-Targeting Kinase Inhibitors – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Zegfrovy (sunvozertinib) to require criteria based on FDA-approved indication.
Egrifta (tesamorelin) – Medicare	10/08/2025	Policy revised to target Egrifta WR (tesamorelin) to require the member has a diagnosis of HIV and abdominal lipodystrophy. The member is also being actively treated with an antiretroviral therapy. For reauthorization the member continues to receive antiretroviral therapy for HIV infection and the member has experienced a reduction in visceral adipose tissue.
Elrexio (elranatamab-bcmm) – Medicare	TERMED 10/08/2025	Policy to be terminated. Criteria transferred to new policy, J-XXXX Bispecific Monoclonal Antibodies for Multiple Myeloma - Medicare.
Empaveli (pegcetacoplan) – Medicare	08/11/2025	Policy revised for Empaveli (pegcetacoplan) to remove that the product has been determined to be eligible for coverage under Part D.
Empaveli (pegcetacoplan) – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to include criteria for newlyFDA-approved indications: treatment of adult and pediatric patients aged 12 years and older with complement 3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN), to reduce proteinuria. For approval member must have a diagnosis of C3G or IC-MPGN confirmed by biopsy, the member must have a urine protein-to-creatinine ratio (UPCR) ≥ 1.0 g/g, and the member is on the maximally tolerated dose of one of the following: angiotensin converting enzyme (ACE) inhibitor

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		or angiotensin receptor blocker (ARB). For reauthorization, the member has experienced a reduction in UPCR from baseline.
Eprontia (topiramate) – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy updated to include if the request is for brand Eprontia (topiramate), the member has experienced intolerance to generic topiramate oral solution.
Evenity (romosozumab-aqqg) – Medicare	10/08/2025	Policy revised for Evenity (romosozumab) to remove step through bisphosphonates for patients with very high fracture risk.
Fumarate Products – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised for fumarate products to shorten authorization duration to 2 years
Gamifant (emapalumab-lzsg) – Medicare	10/08/2025	Policy revised for Gamifant (emapalumab-lzsg) to add new indication for hemophagocytic lymphohistiocytosis (HLH)/macrophage activation syndrome (MAS) in known or suspected Still’s disease, meets diagnostic lab values, failure on high-dose glucocorticoids or recurrent MAS and reauthorization criteria of improvement in clinical symptoms or laboratory parameters.
General Non-Formulary Request Criteria (12-month authorization) – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to exclude products found in policy J-0561 (Chronic Inflammatory Diseases – Medicare).
Hepatitis C Oral Agents – Medicare	10/08/2025	Policy updated for the member to meet one of the following criteria: the member has a diagnosis of hepatitis C virus (HCV) or if the request is for Mavyret (glecaprevir/pibrentasvir), the member has a diagnosis of acute or chronic HCV.
Hereditary Angioedema – Medicare	10/08/2025	Policy revised to add Andembry (garadacimab-gxii) and Ekterly (sebetralstat) 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 avoiding using prophylactic or acute therapies simultaneously,

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		respectively. For Ekterly, trial/failure/contraindication to generic icatibant or unable to use an injection. Authorization duration of 12 months.
Human Growth Hormone – Medicare	10/08/2025	Policy revised to add Skytrofa (lonapegsomatropin-tcgd) expanded indication for adults to treat growth hormone (GH) deficiency due to multiple pituitary GH deficiencies, central nervous system irradiation, or reconfirmation of GH deficiency in adulthood (epiphyseal fusion occurred, has not used GH for at least 1 month, and had a response to all of the following GH tests: arginine or macimorelin and insulin or glucagon).
Human Growth Hormone – Medicare	07/14/2025	Policy revised for growth hormone products for treatment of children small for gestation age to require a birth weight at least 2 standard deviations below the gestational age-appropriate mean or a birth crown-heel length at least 2 standard deviations below the gestational age-appropriate mean.
Interleukin (IL)-5 Antagonists – Medicare	10/08/2025	Policy revised to include quantity level limits for Fasentra (benralizumab) for patients with eosinophilic granulomatosis with polyangiitis to allow one (30 mg) prefilled syringe or auto-injector every 4 weeks.
Itraconazole – Medicare	10/08/2025	Policy updated to change the authorization duration for all FDA-approved indications besides onychomycosis, for 12 months.
Jynarque (tolvaptan) – Medicare	08/07/2025	Policy revised for Jynarque (tolvaptan) to define rapid risk of disease progression as estimated glomerular filtration rate decline ≥ 3 mL/min/1.73m ² per year or Mayo classification 1C to 1E.
Kerendia (finerenone) – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy was updated based on Kerendia's new expanded indication for Heart Failure (HF). Policy criteria requires diagnosis of heart failure and left ventricular ejection fraction (LVEF) $\leq 40\%$, and concurrent use or contraindication or intolerance to a plan-preferred sodium-glucose cotransporter-2 inhibitors. Reauthorization criteria was added requiring prescriber attestation that the

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		member has experienced positive clinical response to therapy.
Phenylalanine HyDRoxylase Activator Products – Medicare	10/08/2025	Policy revised to add Sepience (sepiapterin) to require diagnosis based on FDA-approved indication supported by baseline phenylalanine (Phe) levels greater than 6 mg/dL, trial/failure to generic sapropterin dihyDRochloride, provider attestation of member's current weight, and the dose does not exceed 60 mg/kg/day. Reauthorization to require either decrease in blood Phe levels from baseline or Phe levels within targeted Phe levels; provider attestation of the member's current weight; and the dose does not exceed 60 mg/kg/day. Initial authorization duration 3 months; reauthorization duration 12 months.
Liquid Formulation of Amlodipine Products – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Sdamlo (amlodipine) as a target requiring diagnosis of hypertension or coronary artery disease and the inability to swallow amlodipine tablets.
Modeyso (dordaviprone) – Medicare	10/08/2025	New policy created for Modeyso (dordaviprone) to require criteria based on FDA-approved indication.
Natpara (parathyroid hormone) – Medicare	TERMED 10/02/2025	Policy terminated.
)Nitisinone Products – Medicare	10/08/2025	Policy revised to add Harliku (nitisinone) to require diagnosis of alkaptonuria (AKU), AKU confirmed by elevated urine homogentisic acid (HGA) or homogentisate 1,2-dioxygenase (HGD) gene mutation, Harliku is used to reduce urine HGA, and reauthorization requiring reduction in urine HGA from baseline.
Non-Formulary Requests (plan-year authorization) – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy created matching criteria of Non-Formulary policy (J-0061) to indicate a plan year authorization duration to products also found in policy J-0561 (Chronic Inflammatory Diseases – Medicare).
NTRK and ROS1 Inhibitors – Medicare	10/08/2025	Policy revised to add Ibtrozi (taletrectinib) to require criteria based on FDA-approved indication for locally advanced or metastatic ROS1-positive non-small cell lung cancer.
Parathyroid Hormone Analogs – Medicare	10/08/2025	Policy revised for all targets to remove step through bisphosphonates for patients with very

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		high fracture risk. For Bonsity (teriparatide) and Forteo (teriparatide), criteria revised to require intolerance to teriparatide. For Bonsity, criteria revised requiring cumulative duration of therapy not exceed 24 months, or attestation of high risk for fracture. For Tymlos (abaloparatide), cumulative duration criteria revised to remove Bonsity.
PARP Inhibitors – Medicare	10/08/2025	Policy revised for Zejula (niraparib) to require criteria based on updated FDA-approved indication for advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer.
PCSK9 Inhibitors – Medicare	10/08/2025	Policy revised for Leqvio (inclisiran) to remove requirement that the member will be using Leqvio as adjunct to statin therapy, unless the member is statin intolerant.
Presbyopia Products – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Vizz (aceclidine) requiring diagnosis of presbyopia.
Presbyopia Products – Medicare	10/08/2025	Policy revised to remove age requirement.
Primary Biliary Cholangitis – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised for Ocaliva (obeticholic acid) to add decompensated cirrhosis as a limitation of coverage.
Programmed Death Receptor Therapies – Medicare	10/08/2025	Policy revised for Keytruda (pembrolizumab) to require criteria based on expanded FDA-approved indication for head and neck squamous cell cancer and updated indications for gastric cancer, esophageal cancer, and cervical cancer.
Provigil (modafinil) & Nuvigil (armodafinil) – Medicare	10/08/2025	Policy revised to allow for use of respiratory disturbance index (RDI) for obstructive sleep apnea.
Pulmonary Hypertension – Medicare	09/09/2025	Policy revised to add Yutrepia (treprostinil) to require diagnosis based on FDA-approved indication and supported by results of right heart catheterization.
Pulmonary Hypertension – Medicare	Effective Upon Completion of Internal	Policy revised for Upravi (selexipag) to require therapeutic failure, intolerance, or contraindication to Opsumit (macitentan).

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
	Review and Implementation	
Pulmonary Hypertension – Medicare	10/08/2025	Policy revised for Letairis (ambrisentan), Revatio (sildenafil), and Tracleer (bosentan) to require intolerance to their generic versions.
Rituximab Products – Medicare	10/08/2025	Policy revised to add expanded indication for Truxima (rituximab-abbs), Ruxience (rituximab-pvvr), and Riabni (rituximab-arrx) for moderate to severe pemphigus vulgaris (PV) in adult patients requiring FDA-approved diagnosis. If the request is for brand Rituxan or Riabni, the member has experienced trial/failure or intolerance to Truxima (rituximab-abbs) or Ruxience (rituximab-pvvr).
Savella (milnacipran) and Tonmya (cyclobenzaprine) – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to include newlyFDA-approved product, Tonmya (cyclobenzaprine). For approval of Tonmya, the member must have a diagnosis of fibromyalgia, the prescriber must attest that the member has widespread bilateral pain above and below the waist for > 3 months duration as well as fibromyalgia-related symptoms (for example: cognitive impairment, fatigue, sleep disturbance, neurologic symptoms, and/or exercise intolerance), and the member has experienced therapeutic failure, contraindication, or intolerance to both duloxetine and pregabalin.
Savella (milnacipran) and Tonmya (cyclobenzaprine) – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to include newlyFDA-approved product, Tonmya (cyclobenzaprine). Member must have a diagnosis of fibromyalgia, the prescriber must attest that the member has widespread bilateral pain above and below the waist for > 3 months duration as well as fibromyalgia-related symptoms (for example: cognitive impairment, fatigue, sleep disturbance, neurologic symptoms, and/or exercise intolerance). For Tonmya, the member has experienced therapeutic failure, contraindication, or intolerance to both duloxetine and pregabalin. For Savella, the member has experienced therapeutic failure, contraindication, or intolerance to duloxetine.
Spevigo (spesolimab-sbzo) – Medicare	10/08/2025	Policy revised to add quantity limits for new strength Spevigo (spesolimab-sbzo) 300 mg/2 mL prefilled syringe.

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Sunosi (solriamfetol) – Medicare	10/08/2025	Policy revised for Sunosi (solriamfetol) to allow for use of respiratory disturbance index (RDI) for obstructive sleep apnea.
SynDROS (DRonabinol oral solution) – Medicare	TERMED 10/07/2025	Policy terminated for SynDROS (DRonabinol) as MedD=N
Talvey (talquetamab-tgvs) – Medicare	TERMED 10/08/2025	Policy to be terminated. Criteria transferred to new policy, J-XXXX Bispecific Monoclonal Antibodies for Multiple Myeloma - Medicare.
Tecvayli (teclistamab-cqyv) – Medicare	TERMED 10/08/2025	Policy to be terminated. Criteria transferred to new policy, J-XXXX Bispecific Monoclonal Antibodies for Multiple Myeloma – Medicare.
Tocilizumab Biosimilars – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised for Avtozma (tocilizumab-anoh) to add new indication chimeric antigen receptor (CAR) T cell-induced severe or life-threatening cytokine release syndrome requiring age and diagnosis based on FDA-approved indication, and therapeutic failure or intolerance to Actemra (tocilizumab). Limitations of coverage revised to include that Avtozma IV for treatment of COVID-19 in hospitalized patients is not eligible for Medicare Part D coverage.
Viberzi (eluxadoline) – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised for Viberzi (eluxadoline) to add reauthorization criteria requiring irritable bowel syndrome with diarrhea symptoms continue to persist and member has experienced positive clinical response to therapy.
Wegovy (semaglutide) and Zepbound (tirzepatide) – Medicare	10/08/2025	Policy revised for Zepbound (tirzepatide)'s obstructive sleep apnea criteria to allow for respiratory disturbance index of at least 15 events per hour.
Wegovy (semaglutide) and Zepbound (tirzepatide) – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised for Wegovy (semaglutide) to require diagnosis of heart failure with preserved ejection fraction (HFpEF) with a left ventricular ejection fraction (LVEF) of at least 40%; if the member has an LVEF greater than 50%, currently taking guideline recommended therapy including diuretic (or attestation that the member does not have symptoms of fluid overload), sodium-glucose cotransporter 2 inhibitor (SGLT2i), and renin-angiotensin-aldosterone system (RAAS) inhibitor; attestation of use in combination with diet and exercise; and that the member will not be using Wegovy in combination with a glucagon-

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		<p>like peptide 1 containing product. Reauthorization requiring attestation of continued need for therapy; diagnosis of HFpEF; if the member has an LVEF greater than 50%, currently taking guideline recommended therapy including diuretic (or attestation that the member does not have symptoms of fluid overload), SGLT2i, and RAAS inhibitor; maintenance dosing or attestation of titration to maintenance dosing; and attestation of use in combination with diet and exercise.</p>
<p>Wegovy (semaglutide) and Zepbound (tirzepatide) – Medicare</p>	<p>Effective Upon Completion of Internal Review and Implementation</p>	<p>Policy revised for Wegovy (semaglutide) to allow approval for treatment of metabolic dysfunction–associated steatohepatitis requiring diagnosis with liver biopsy within 3 years or non-invasive testing (NIT) within 6 months demonstrating F2 or F3 fibrosis, one cardiometabolic risk factor (BMI \geq 25 kg/m² or ethnicity adjusted, or for females, \geq 80 cm ethnicity adjusted; fasting serum glucose \geq 100 mg/dL; 2-hour post-prandial serum glucose \geq 140 mg/dL; HbA1c \geq 5.7%; diagnosis of type 2 diabetes or is on treatment for type 2 diabetes; plasma triglycerides \geq 150 mg/dL or is on lipid lowering treatment; plasma HDL \leq 40 mg/dL (males) or \leq 50 mg/dL (female) or is on lipid lowering treatment; or blood pressure \geq 130/85 mmHg or is on treatment for hypertension), use in conjunction with diet and exercise, alcohol consumption \leq 20 grams/day for females or \leq 30 grams/day for males, and that Wegovy will not be used with another glucagon-like peptide-1 receptor agonist containing product. Reauthorization requiring attestation of improvement or stabilization demonstrated by NIT, use in conjunction with diet and exercise, member has not progressed to stage F4 fibrosis and does not have cirrhosis, hepatic decompensation, or hepatocellular carcinoma, alcohol consumption \leq 20 grams/day for females or \leq 30 grams/day for males, and the requested dose is 1.7 mg or 2.4 mg, or attestation of titration to 1.7 mg or 2.4 mg.</p>

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Wegovy (semaglutide) and Zepbound (tirzepatide) – Medicare	08/18/2025	Policy revised for Wegovy (semaglutide) to require liver biopsy or non-invasive testing demonstrate the presence of stage F2 or F3 fibrosis, specifically at baseline.
Yorvipath (palopegteriparatide) – Medicare	10/08/2025	Policy reauthorization criteria revised for Yorvipath (palopegteriparatide) to require that the member has experienced normalization or improvement in total serum calcium from baseline.

*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
Brand ADHD Step Therapy – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Arynta (lisdexamfetamine) to require medically accepted indication. For the diagnosis ADHD a trial and failure of 2 of the following generic medications is required: methylphenidate, dextroamphetamine/amphetamine, atomoxetine and dexmethylphenidate. Policy revised to add Amphetamine ER-ODT (brand), an authorized generic (AG) to Adzenys-ODT was added to the policy as a target medication. The criteria for Amphetamine ER-ODT mirrors that of Adzenys-ODT.
Celebrex and Vyscoxa (celecoxib) Step Therapy – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Vyscoxa (celecoxib) oral suspension to require diagnosis based on FDA-approved indication and therapeutic failure or intolerance to two generic NSAIDs.
Colony-Stimulating Factors – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Fulphila (pegfilgrastim-jmdb), Neulasta (pegfilgrastim), and Ziextenzo (pegfilgrastim-bmez) as targets. For Fulphila (pegfilgrastim-jmdb), Nyvepria (pegfilgrastim-apgf), Rolvedon (eflapegrastim-xnst), and Ryzneuta (efbemalenograstim alfa-vuxw), trial/failure of Nivestym (filgrastim-aafi) and Zarxio (filgrastim-sndz). For Fylnetra (pegfilgrastim-pbbk), Neulasta (pegfilgrastim), Stimufend (pegfilgrastim-fpgk), Udenyca (pegfilgrastim-cbvq), and Ziextenzo (pegfilgrastim-bmez), trial/failure of Nivestym

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
		(filgrastim-aafir) and Zarxio (filgrastim-sndz) for use in decreasing the incidence of infection as manifested by febrile neutropenia; for hematopoietic subsyndrome of acute radiation syndrome, trial/failure of Zarxio (filgrastim-sndz).
Epinephrine Products – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to add brand EpiPen (epinephrine) as a target. All non-preferred epinephrine products require intolerance to generic epinephrine injection.
Gonadotropin-releasing Hormone (GnRH) Agonists – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to target Lupron Depot (leuprolide acetate) 7.5 mg, 22.5 mg, 30 mg, and 45 mg, requiring FDA-approved diagnosis and trial/failure of leuprolide acetate depot 22.5 mg.
Gonadotropin-releasing Hormone (GnRH) Agonists – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Camcevi ETM (leuprolide mesylate) to require FDA-approved diagnosis and trial/failure of leuprolide acetate depot 22.5 mg or Lupron Depot (leuprolide acetate).
Gonadotropin-releasing Hormone (GnRH) Agonists – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to add Vabrinty (leuprolide acetate) as a target mirroring criteria for Eligard (leuprolide acetate).
Long-Acting Muscarinic Agents – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy updated to remove Spiriva HandiHaler (tiotropium bromide inhalation powder) as a qualifier and add Spiriva HandiHaler as a target requiring the member has a diagnosis of chronic obstructive pulmonary disease and the member has experienced therapeutic failure, contraindication, or intolerance to Spiriva Respimat (tiotropium bromide).
Non-preferred Rescue Inhalers – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy updated to include Proair HFA (albuterol sulfate) authorized generic inhaler to require the medication is being prescribed for the treatment or prevention of bronchospasm in patients with reversible obstructive airway disease or prevention of exercise-induced bronchospasm and the member has experienced intolerance to generic albuterol.
Non-Preferred Dipeptidyl Peptidase IV (DPP-IV) and Sodium-	Effective Upon Completion of Internal Review	Policy terminated, criteria moved to J-1121.

Policy Name	Policy Effective Date*	Updates and/or Approval Criteria
Glucose Co-Transporter 2 (SGLT2) Inhibitors – Medicare Compass	and Implementation	
Non-Preferred Dipeptidyl Peptidase IV (DPP-IV) Inhibitors – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to switch Januvia (sitagliptin phosphate), Janumet (sitagliptin/metformin), Janumet XR (sitagliptin/metformin) extended release from qualifiers to targets.
Non-Preferred Dipeptidyl Peptidase IV (DPP-IV) Inhibitors and Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy revised to remove Medicare Compass formulary restriction
Non-preferred Inhaler Products – Medicare	Effective Upon Completion of Internal Review and Implementation	Policy updated for the authorized generic of AirDuo RespiClick (fluticasone propionate/salmeterol) to remove "for Compass only" as this will now apply to both Incentive and Compass Medicare plans.
Non-Preferred Rapid-Acting Insulins – Medicare Compass	10/08/2025	Policy revised to add Kirsty (insulin aspart) requiring a diagnosis of diabetes mellitus and therapeutic failure or intolerance to one of the following insulin products utilized for the same age and indication: Humalog product (insulin lispro) or insulin lispro.
Non-Preferred Rapid-Acting Insulins – Medicare Incentive	10/08/2025	Policy revised to add Kirsty (insulin aspart) requiring a diagnosis of diabetes mellitus and therapeutic failure or intolerance to one of the following insulin products utilized for the same age and indication: Humalog product (insulin lispro), insulin lispro, Fiasp (insulin aspart), Novolog (insulin aspart), or insulin aspart.

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)
Amzeeq (minocycline)	1 can (30 gm) per 28 days
Andembry (garadacimab-gxii)	1.2 mL (200 mg) per 28 days
Anzupgo (delgocitinib)	60 grams per 30 days
Arynta (lisdexamfetamine dimesylate)	7 mL (70 mg) per day
Atmeski (methocarbamol)	8 g (54 mL) per day
Banzel (rufinamide) 200 mg tablet	4 tablets per day

Drug Name	Retail Quantity Limit (31 days)
Banzel (rufinamide) 40 mg/mL suspension	80 mL per day
Banzel (rufinamide) 400 mg tablet	8 tablets per day
Brinsupri (brensocatic)	1 tablet per day
Brukinsa (zanubrutinib) tablet	2 tablets per day
Camcevi ETM (leuprolide mesylate)	1 syringe (21 mg) per 84 days
Dicyclomine 40 mg tablet	4 tablets per day
Doptelet Sprinkle (avatrombopag)	2 capsules (filled with oral granules) per day
Egrifta WR (tesamorelin)	4 vials per 28 days
Ekterly (sebetralstat)	8 tablets (2 attacks) per 31 days
Enflonsia (clesrovimab-cfor)	2 doses (1.4 mL) per 720 days
Erzofri (paliperidone palmitate) 351 mg	2 kits per 365 days
Erzofri (paliperidone palmitate) 39 mg, 78 mg, 117 mg, 156 mg, 234 mg	1 kit per 30 days
Fasenra (benralizumab)	One (30 mg) syringe or auto-injector every 28 days
Harliku (nitisinone)	1 tablet per day
Hernexeos (zongertinib)	3 tablets per day
Ibtrozi (taletrectinib)	3 capsules per day
Juxtapid (lomitapide) 20 mg and 30 mg	2 capsules per day
Leqembi Iqlik (lecanemab-irmb)	4 autoinjectors (7.2 mL) per 28 days
Lumakras (sotorasib) 240 mg	4 tablets per day
Modeyso (dordaviprone)	20 capsules per 28 days
nilotinib tartrate	4 capsules per day
Phyrago (dasatinib) 20 mg	3 tablets per day
Phyrago (dasatinib) 50 mg, 70 mg, 80 mg, 100 mg, 140 mg	1 tablet per day
Sdmalo (amlodipine) oral solution	3 cartons per 30 days
Sephience (sepiapterin) 250 mg	3 packets per day
Spevigo (spesolimab-sbzo) 300 mg/2 mL	1 syringe per 28 days
Sprycel (dasatinib) 20 mg	3 tablets per day
Thalomid (thalidomide) 100 mg	4 capsules per day
Tonmya (cyclobenzaprine) sublingual tablets	60 sublingual tablets per 30 days
Vizz (aceclidine ophthalmic solution)	1 single use vial per day
Vostally (ramipril)	20 mL per day
Vyscoxa (celecoxib)	40 mL per day
Widaplik (Telmisartan, Amlodipine and Indapamide)	1 tablet per day
Xofluza (baloxavir marboxil) 30 mg packet	9 packets per 365 days
Xofluza (baloxavir marboxil) 40 mg packet	18 packets per 365 days
Yutrepia (treprostinil) inhalation powder 79.5 mcg	4 kits (28 capsules w/inhaler) per 28 days

Drug Name	Retail Quantity Limit (31 days)
Yutrepia (treprostinil) inhalation powder 106 mcg	8 kits (28 capsules w/inhaler) per 28 days
Yutrepia (treprostinil) inhalation powder 26.5 mcg, 53 mcg	5 kits (28 capsules w/inhaler) per 28 days
Zegfrovoy (sunvozertinib)	1 tablet per day