DEPARTMENT OF HUMAN SERVICES

Discussion Items:

MHCP Enrolled Providers – Pharmacies

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

(October 2026)

Drug	**Lyfgenia® (lovotibeglogene autotemcel) [**Genetix Biotherapeutics**]**
Therapeutic Area	Sickle Cell Disease (SCD)

Initial approval criteria:

- Patient is, or will be, at least twelve (12) years of age at the time of therapy administration, based on provider attestation; AND
- Patient has prior use of, or intolerance to hydroxyurea (per health care professional judgment) at any point in the past; AND
- Patient is clinically stable and fit for transplantation; AND
- Patient has been screened and found negative for hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus 1 & 2 (HIV-1/HIV-2) in accordance with clinical guidelines prior to collection of cells; AND
- Patient has not received other gene therapies for sickle cell disease [e.g. Casgevy® exgamglogene autotemcel)]; AND
- Patient is a candidate for autologous HSCT and has not had prior HSCT; AND
- Patient has a confirmed diagnosis of sickle cell disease with confirmatory genetic testing; AND
- Patient has experienced four (4) or more vaso-occlusive episodes (VOEs)* in the previous twenty-four (24) months (based on provider attestation) OR is currently receiving chronic blood transfusions for recurrent VOEs or sickle cell disease associated complications (based on provider attestation); AND
- Lyfgenia is prescribed in consultation with a board-certified hematologist with sickle cell disease expertise.

  *VOEs are defined as any of the following events requiring evaluation at a medical facility: •an episode of acute pain, lasting more than two hours, with no medically determined cause other than vaso-occlusion •acute chest syndrome (ACS) •acute hepatic sequestration •acute splenic sequestration •priapism requiring any level of medical attention

Duration of approval:

- Prior authorization approval is effective for twelve months from the approval date. Approval may be extended for another six months if patient is unable to receive treatment within twelve months from the approval date.

Quantity limits:

- One administration per lifetime
- Patient's most current weight (in kg) and the dose to be administered must be provided at the time of request

Billing:

- Lyfgenia must be billed on a professional claim

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(October 2026)

Drug	**Kygevvi® (doxecitine and doxribtimine) [**UCB, Inc.**]**
Therapeutic Area	Thymidine kinase 2 deficiency (TK2d)

Initial approval criteria:

- Patient has a diagnosis of thymidine kinase 2 deficiency (TK2d) confirmed with genetic testing; AND
- Symptom onset of TK2d occurred on or before age 12 years; AND
- Baseline liver transaminase (alanine aminotransferase [ALT] and aspartate aminotransferase [AST]) and total bilirubin levels should be obtained in patients prior to initiating Kygevvi; AND
- Prescriber has reviewed Kygevvi Warnings/Precautions and will monitor patient status as appropriate; AND
- The prescriber is a specialist in the area of the patient's diagnosis (e.g., neurologist, geneticist, pulmonologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis.

Renewal criteria:

- Patient must continue to meet the initial approval criteria; AND
- Patient must have disease improvement and/or stabilization OR improvement in the slope of decline (e.g., of muscle weakness, respiratory function, or feeding difficulties); AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., elevated liver transaminase levels, signs or symptoms of persistent/worsening liver injury, severe or persistent/recurring gastrointestinal adverse reactions).

Quantity limits

- Max dose: 800 mg/kg/day
- Patient's body weight (in kg) and the corresponding number of requested Kygevvi packets must be submitted at time of request

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(October 2026)

Drug	**Loargys® (pegzilarginase-nbln) [**Immedica Pharma US Inc.**]**
Therapeutic Area	Hyperagininemia

Initial approval criteria:

- Age ≥ 2 years; AND
- Confirmed diagnosis of Arginase-1 Deficiency (ARG1-D), as evidenced by ≥ 1 of the following features of disease
    - Identification of biallelic pathogenic (or likely pathogenic) variants in arginase-1 (ARG1) on molecular genetic testing; OR
    - Reduced red blood cell (RBC) arginase enzyme activity (e.g., < 1% of normal in RBC extracts); AND
- History of hyperargininemia (e.g., 2 to 3 times the upper limit of normal [ULN]); AND
- Patient's plasma arginine concentration will be obtained at baseline and will be monitored as clinically indicated thereafter (*note: plasma arginine levels should be monitored prior to Loargys dosing and weekly for 2 weeks after any dosage adjustments and as clinically indicated*); AND
- Patient will maintain a protein-restricted diet (e.g., will maintain the current level of protein consumption, including natural protein and essential amino acid [EAA] supplementation); AND
- Patient has NOT experienced a hyperammonemic episode within the 6 weeks prior to the start of therapy (defined as an event in which the patient's ammonia level was ≥ 100 micromolar with ≥ 1 symptoms related to hyperammonemia requiring hospitalization or emergency room management); AND
- Patient has NOT received a liver transplant procedure.

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient must demonstrate a beneficial response to therapy compared to pretreatment baseline as evidenced by stabilization or improvement in plasma arginine levels and/or complications of disease manifestations; AND
- Patient has not experienced any treatment-restricting adverse effects (e.g., severe hypersensitivity reactions, including anaphylaxis).

Quantity limits

- 0.2 mg/kg once weekly
- Patient's body weight (in kg) must be submitted at time of request

Background

Loargys is an arginine specific enzyme indicated for the treatment of hyperargininemia in adult and pediatric patients 2 years of age and older with Arginase 1 Deficiency (ARG1-D), in conjunction with dietary protein restriction. This indication is approved under accelerated approval based on reduction of plasma arginine. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial.

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(October 2026)

Drug	**Yuviwel® (navepegritide) [**Ascendis Pharma Endocrinology, Inc.**]**
Therapeutic Area	Achondroplasia

Initial approval criteria:

- Patient is ≥ 2 years of age; AND
- Patient has a definitive diagnosis of achondroplasia (ACH) as confirmed by one of the following:
    - Clinical (e.g., proximal shortening of arms, large head, narrow chest, short fingers) and radiographic (e.g., square ilia and horizontal acetabula, narrow sacrosciatic notch, proximal radiolucency of the femurs, generalized metaphyseal abnormality, decreasing interpedicular distance caudally) features consistent with ACH; OR
    - Identification of a heterozygous pathogenic variant in the fibroblast growth factor receptor 3 (FGFR3) gene by molecular testing; AND
- Patient has open epiphyses; AND
- Patient's baseline annualized growth velocity has been measured prior to treatment with Yuviwel; AND
- Patient has NOT had limb-lengthening surgery AND does NOT plan to have limb-lengthening surgery while on Yuviwel; AND
- Yuviwel will NOT be used in combination with another growth hormone agent (e.g., vosoritide [Voxzogo], somatropin, somapacitan [Sogroya], mecasermin [Increlex]); AND
- Prescriber has reviewed Yuviwel Warnings/Precautions and will monitor patient status as appropriate; AND
- The prescriber is a specialist in the area of the patient's diagnosis (e.g., endocrinologist), or the prescriber has consulted with a specialist in the area of the patient's diagnosis.

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient does not have closure of epiphyses; AND
- Patient must have clinical benefit with treatment (e.g., improvement in height compared to pre-treatment baseline, improvement in growth velocity compared to pre-treatment baseline); AND
- Patient has not experienced any treatment-restricting adverse effects (e.g., severe hypotension).

Quantity limits

- 1.3 mg single-dose vial for reconstitution: 1 vial weekly
- 2.8 mg single-dose vial for reconstitution: 1 vial weekly
- 5.5 mg single-dose vial for reconstitution: 2 vials weekly

Background

Yuviwel is a C-type natriuretic peptide (CNP) analog indicated to increase linear growth in pediatric patients 2 years of age and older with achondroplasia with open epiphyses. This indication is approved under accelerated approval based on an improvement in annualized growth velocity. Continued approval for this indication may be contingent upon verification and description of clinical benefit in confirmatory trial(s).

MHCP Enrolled Providers – Pharmacies

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

(October 2026)

Drug	**Avlayah™ (tividenofusp alfa-eknm) [**Denali Therapeutics**]**
Therapeutic Area	Hunter syndrome

Initial approval criteria:

- Patient has a body weight of ≥ 5 kg; AND
- Patient has a definitive diagnosis of Hunter Syndrome (mucopolysaccharidosis type II; MPS II) as confirmed by one of the following:
    - Deficient or absent iduronate 2-sulfatase (IDS) enzyme activity in white cells, fibroblasts or plasma in the presence of normal activity of at least one other sulfatase; OR
    - Detection of pathogenic (or likely pathogenic) variants in the *IDS* gene by molecular genetic testing; AND
- Documented baseline age-appropriate values for one or more of the following have been obtained:
    - Patients ≥ 5 years of age: 6-minute walk test (6-MWT), percentpredicted forced vital capacity (FVC), joint range of motion, left ventricular hypertrophy, growth, quality of life measure (Childhood Health Assessment Questionnaire [CHAQ]/Health Assessment Questionnaire [HAQ]/MPS HAQ), and/or urinary glycosaminoglycan (uGAG)/urinary heparan sulfate (uHS); OR
    - Patients < 5 years of age: spleen volume, liver volume, FVC, 6-MWT, and/or uGAG/uHS; AND

  NOTE: For very young members in which FVC or 6-MWT are not suitable for measuring, requests will be reviewed on a case-by-case basis.
- Will NOT be used in combination with other enzyme replacement therapies indicated for the treatment of Hunter Syndrome (e.g., idursulfase [Elaprase]); AND
- Patient serum creatinine and urinary protein to creatinine ratio will be assessed, and patient will be monitored for the development of membranous nephropathy throughout therapy; AND
- Patient hemoglobin levels will be obtained prior to initiation of therapy, at 3 months after initiation, and periodically thereafter, as clinically indicated.

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient has demonstrated a beneficial response to therapy compared to pretreatment age-appropriate baseline values in one or more of the following:
    - Patients ≥ 5 years of age: stabilization or improvement in percent predicted FVC and/or 6-MWT, increased joint range of motion, decreased left ventricular hypertrophy, improved growth,improved quality of life (clinically meaningful change in CHAQ/HAQ/MPS HAQ disability index) and/or reduction in uGAG/uHS levels; OR
    - Patients < 5 years of age: reductions in spleen and/or liver volume, stabilization/improvement in FVC and/or 6-MWT and/or reduction in uGAG/uHS levels; AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., severe hypersensitivity reactions including anaphylaxis, severe infusion associated reactions [e.g., chills, angioedema, hypotension, tachycardia, urticaria, vomiting, wheezing, pyrexia, flushing, erythema, rash, cough, diarrhea, abdominal pain, retching, headache, irritability, papules], severe anemia, membranous nephropathy)

Quantity limits

- 15 mg/kg once weekly
- Patient's weight (in kg) must be submitted at time of request

Background

Avlayah is a hydrolytic lysosomal glycosaminoglycan (GAG)-specific enzyme indicated for the treatment of neurologic manifestations of Hunter syndrome (Mucopolysaccharidosis type II, MPS II) when initiated in presymptomatic or symptomatic pediatric patients weighing at least 5 kg prior to advanced neurologic impairment. This indication is approved under accelerated approval based on reduction of cerebrospinal fluid heparan sulfate observed in patients treated with Avlayah. Continued approval for this indication may be contingent upon verification of clinical benefit in a confirmatory trial(s). Avlayah is not recommended for use in combination with other enzyme replacement therapies.

MHCP Enrolled Providers – Pharmacies

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

(October 2026)

Drug	**Baxfendy™ (baxdrostat) [**AstraZeneca Pharmaceuticals LP**]**
Therapeutic Area	Aldosterone Antagonists

Initial approval criteria:

- Age ≥18 years; AND
- Patient has a diagnosis of hypertension AND ONE of the following:
    - Patient is still not at blood pressure goal while on triple agent therapy with three different antihypertensive therapy classes for at least four weeks; OR
    - Patient is unable to be on triple antihypertensive therapy with three different antihypertensive therapy classes; AND
- Patient will continue therapy with another antihypertensive agent(s) in combination with Baxfendy; AND
- Prescriber has reviewed Baxfendy Warnings/Precautions and Drug Interactions and will monitor patient status as appropriate.

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient must have clinical benefit with treatment (e.g., reduction in blood pressure); AND
- Patient has not experienced any treatment-restricting adverse effects (e.g., hyperkalemia, clinically significant hyponatremia).

Quantity limits

- 30 tablets per 30 days
- Maximum dose 2 mg (one tablet) daily

Provider Call Center (844) 575-7887

MHCP Enrolled Providers – Pharmacies

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

(October 2026)

Drug	**Hepcludex® (bulevirtide-gmod) [**Gilead Sciences, Inc.**]**
Therapeutic Area	Antivirals

Initial approval criteria:

- Patient is ≥ 18 years of age; AND
- Patient has a diagnosis of chronic hepatitis delta virus (HDV) infection without cirrhosis or with compensated cirrhosis as confirmed by BOTH of the following (medical records required):
    - A positive anti-HDV antibody test; AND
    - A positive or detectable HDV ribonucleic acid (RNA) test; AND
- Prescriber attestation that patient's hepatic function will be monitored closely with both clinical and laboratory follow-up, including hepatitis B virus (HBV) deoxyribonucleic acid (DNA) and HDV RNA viral load, for a minimum of 6 months if the patient discontinues Hepcludex; AND
- Prescriber is a specialist in the area of the patient's diagnosis (e.g., gastroenterologist, hepatologist, infectious disease), or the prescriber has consulted with a specialist in the area of the patient's diagnosis; AND
- Prescriber has reviewed Hepcludex Warnings/Precautions and will monitor patient status as appropriate.

Renewal criteria:

- Patient must continue to meet the above criteria; AND
- Patient must have had clinical benefit with Hepcludex (e.g., decrease in HDV RNA level, improvement in alanine aminotransferase [ALT] level); AND
- Patient has NOT experienced any treatment-restricting adverse effects (e.g., clinically significant hypersensitivity reaction or anaphylaxis).

Quantity limits

- One single-dose vial (8.5mg) per day

Background

Hepcludex is a sodium taurocholate co-transporting polypeptide (NTCP)-directed HDV attachment inhibitor indicated for the treatment of chronic HDV infection in adults without cirrhosis or with compensated cirrhosis. This indication is approved under accelerated approval based on participants who achieved a decrease in HDV RNA and alanine aminotransferase (ALT) normalization. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory trial(s).

Provider Call Center (844) 575-7887

Discussion Items

ANGIOTENSIN MODULATOR COMBINATIONS section reviewed 10-21-2026

Preferred	Nonpreferred
AMLODIPINE / BENAZEPRIL (ORAL)	AMLODIPINE / OLMESARTAN (ORAL)
AMLODIPINE / VALSARTAN (ORAL)	AMLODIPINE / OLMESARTAN / HCTZ (ORAL)
AMLODIPINE / VALSARTAN / HCTZ (ORAL)	AZOR (ORAL)
	EXFORGE (ORAL)
	EXFORGE HCT (ORAL)LOTREL (ORAL)
	LOTREL (ORAL)
	OLMESARTAN/AMLODIPINE/HCTZ (ORAL)
	TELMISARTAN / AMLODIPINE (ORAL)
	TRANDOLAPRIL/VERAPAMIL (ORAL)
	TRIBENZOR (ORAL)
	WIDAPLIK (ORAL)

ANGIOTENSIN MODULATORS section reviewed 10-21-2026

Preferred	Nonpreferred
BENAZEPRIL (ORAL)	ALISKIREN (ORAL)
BENAZEPRIL HCTZ (ORAL)	ALTACE (ORAL)
CAPTOPRIL (ORAL)	ARBLI SUSPENSION (ORAL)
CAPTOPRIL HCTZ (ORAL)	ATACAND (ORAL)
ENALAPRIL (ORAL)	ATACAND HCT (ORAL)
ENALAPRIL HCTZ (ORAL)	AVALIDE (ORAL)
FOSINOPRIL (ORAL)	AVAPRO (ORAL)
FOSINOPRIL HCTZ (ORAL)	AZILSARTAN (ORAL)
IRBESARTAN (ORAL)	BENICAR (ORAL)
IRBESARTAN HCTZ (ORAL)	BENICAR HCT (ORAL)
LISINOPRIL (ORAL)	CANDESARTAN (ORAL)
LISINOPRIL HCTZ (ORAL)	CANDESARTAN HCTZ (ORAL)
LOSARTAN (ORAL)	COZAAR (ORAL)
LOSARTAN HCTZ (ORAL)	DIOVAN (ORAL)
~~MOEXIPRIL (ORAL)~~	DIOVAN HCT (ORAL)
OLMESARTAN (ORAL)	EDARBI (ORAL)
OLMESARTAN HCTZ (ORAL)	EDARBYCLOR (ORAL)
PERINDOPRIL (ORAL)	ENALAPRIL SOLUTION (ORAL)
QUINAPRIL HCTZ (ORAL)	ENTRESTO (ORAL)
RAMIPRIL (ORAL)	ENTRESTO SPRINKLE CAP (ORAL)
SACUBITRIL-VALSARTAN (ORAL)	EPANED POWDER (ORAL)
TELMISARTAN (ORAL)	EPANED SOLUTION (ORAL)
TELMISARTAN HCTZ (ORAL)	EPROSARTAN (ORAL)
TRANDOLAPRIL (ORAL)	HYZAAR (ORAL)
VALSARTAN (ORAL)	LOTENSIN (ORAL)
VALSARTAN HCTZ (ORAL)	LOTENSIN HCT (ORAL)
	MICARDIS (ORAL)
	MICARDIS HCT (ORAL)
	MOEXIPRIL (ORAL)
	QBRELIS SOLUTION (ORAL)
	QUINAPRIL (ORAL)
	TEKTURNA (ORAL)
	~~TELMISARTAN (ORAL)~~
	~~TELMISARTAN HCTZ (ORAL)~~
	VALSARTAN SOLUTION (ORAL)

Preferred	Nonpreferred
	VASERETIC (ORAL) VASOTEC (ORAL) ZESTORETIC (ORAL) ZESTRIL (ORAL)

ANTIEMETIC/ANTIVERTIGO AGENTS section reviewed 10-21-2026

Preferred	Nonpreferred
DICLEGIS (ORAL) ONDANSETRON ODT 4 MG, 8 MG (ORAL) ONDANSETRON SOLUTION (ORAL) ONDANSETRON TABLETS (ORAL) SCOPOLAMINE (TRANSDERM) ~~TRANSDERM-SCOP (TRANSDERM)~~	AKYNZEO (ORAL) ANZEMET (ORAL) BONJESTA (ORAL) DOXYLAMINE SUCCINATE/VIT B6 (DICLEGIS) (ORAL) GIMOTI (NASAL) GRANISETRON (ORAL) METOCLOPRAMIDE ODT (ORAL) NEREUS CAPSULE (ORAL) ONDANSETRON ODT 16 MG (ORAL) SANCUSO (TRANSDERMAL) ~~SCOPOLAMINE (TRANSDERM)~~ TRANSDERM-SCOP (TRANSDERM)

ANTIFUNGALS, TOPICAL section reviewed 10-21-2026

Preferred	Nonpreferred
CICLOPIROX SUSPENSION (TOPICAL) CICLOPIROX CREAM (TOPICAL) CICLOPIROX SOLUTION (TOPICAL) CLOTRIMAZOLE-BETAMETHASONE CREAM (TOPICAL) CLOTRIMAZOLE CREAM OTC (TOPICAL) CLOTRIMAZOLE CREAM RX(TOPICAL) CLOTRIMAZOLE SOLUTION RX (TOPICAL) ECONAZOLE CREAM (TOPICAL) KETOCONAZOLE CREAM (TOPICAL) KETOCONAZOLE SHAMPOO (TOPICAL) MICONAZOLE CREAM OTC (TOPICAL) MICONAZOLE POWDER OTC (TOPICAL) NYSTATIN CREAM (TOPICAL) NYSTATIN OINTMENT (TOPICAL) NYSTATIN POWDER (TOPICAL) NYSTATIN-TRIAMCINOLONE CREAM (TOPICAL) TERBINAFINE CREAM OTC (TOPICAL) TOLNAFTATE CREAM OTC (TOPICAL)	CICLOPIROX GEL (TOPICAL) CICLOPIROX SHAMPOO (TOPICAL) CLOTRIMAZOLE-BETAMETHASONE LOTION (TOPICAL) CLOTRIMAZOLE SOLUTION OTC (TOPICAL) ECONAZOLE NITRATE FOAM (ECOZA) (TOPICAL) ERTACZO (TOPICAL) JUBLIA (TOPICAL) KERYDIN (TOPICAL) KETOCONAZOLE FOAM (TOPICAL) LOPROX (TOPICAL) LULICONAZOLE (TOPICAL) LUZU (TOPICAL) MICONAZOLE NITRATE/ZINC OXIDE/PETROLATUM (VUSION) (TOPICAL) NAFTIFINE CREAM (TOPICAL) NAFTIFINE GEL (TOPICAL) NAFTIN CREAM (TOPICAL) NAFTIN GEL (TOPICAL) NYSTATIN-TRIAMCINOLONE OINTMENT (TOPICAL) OXICONAZOLE CREAM (TOPICAL) OXISTAT LOTION (TOPICAL) TAVABOROLE (TOPICAL) TOLNAFTATE SOLUTION OTC (TOPICAL) VUSION (TOPICAL)

CALCIUM CHANNEL BLOCKERS section reviewed 10-21-2026

Preferred	Nonpreferred
AMLODIPINE (ORAL)	CARDAMYST (NASAL)

Preferred	Nonpreferred
DILTIAZEM CAPSULE ER (ORAL) DILTIAZEM TABLET (ORAL) FELODIPINE ER (ORAL) NIFEDIPINE ER (ORAL) NIFEDIPINE IR (ORAL) VERAPAMIL CAPSULE ER (ORAL) VERAPAMIL TABLET (ORAL) VERAPAMIL TABLET ER (ORAL)	CARDIZEM (ORAL) CARDIZEM CD (ORAL) CARDIZEM CD 360 MG (ORAL) CARDIZEM LA (ORAL) DILTIAZEM TABLET ER (LA) (ORAL) ISRADIPINE (ORAL) KATERZIA (ORAL) LEVAMLODIPINE MALEATE (ORAL) MATZIM LA (ORAL) NICARDIPINE (ORAL) NIMODIPINE (ORAL) NISOLDIPINE (ORAL) NORLIQVA (ORAL) NORVASC (ORAL) NYMALIZE (ORAL) ~~PROCARDIA (ORAL)~~ PROCARDIA XL (ORAL) SDAMLO SOLUTION (ORAL) SULAR (ORAL) TIAZAC (ORAL) TIAZAC 420 MG (ORAL) VERAPAMIL 360 MG CAPSULE (ORAL) VERAPAMIL ER PM (ORAL) VERELAN PM (ORAL)

COPD AGENTS section reviewed 10-21-2026

Preferred	Nonpreferred
ANORO ELLIPTA (INHALATION) ATROVENT HFA (INHALATION) COMBIVENT RESPIMAT (INHALATION) IPRATROPIUM / ALBUTEROL (INHALATION) IPRATROPIUM NEBULIZER (INHALATION) ROFLUMILAST (ORAL) SPIRIVA (INHALATION) SPIRIVA RESPIMAT (INHALATION) STIOLTO RESPIMAT (INHALATION)	BEVESPI AEROSPHERE (INHALATION) DALIRESP (ORAL) DUAKLIR PRESSAIR (INHALATION) INCRUSE ELLIPTA (INHALATION) IPRATROPIUM BROMIDE HFA (INHALATION) OHTUVAYRE (INHALATION) TIOTROPIUM (SPIRIVA) (INHALATION) TUDORZA PRESSAIR (INHALATION) UMECLIDINIUM ELLIPTA (INHALATION) UMECLIDINIUM-VILANTEROL ELLIPTA (INHALATION) YUPELRI (INHALATION)

GROWTH HORMONE section reviewed 10-21-2026

Preferred	Nonpreferred
GENOTROPIN CARTRIDGE (INJECTION) GENOTROPIN DISP SYRIN (INJECTION) NORDITROPIN PEN (INJECTION) ~~ZOMACTON VIAL (INJECTION)~~	~~GENOTROPIN CARTRIDGE (INJECTION)~~ ~~GENOTROPIN DISP SYRIN (INJECTION)~~ ~~HUMATROPE CARTRIDGE (INJECTION)~~ ~~HUMATROPE VIAL (INJECTION)~~ NGENLA (INJECTION) OMNITROPE CARTRIDGE (INJECTION) OMNITROPE VIAL (INJECTION) SAIZEN CARTRIDGE (INJECTION) SAIZEN VIAL (INJECTION) SEROSTIM VIAL (INJECTION) SKYTROFA CARTRIDGE (SUBCUTANEOUS)

Preferred	Nonpreferred
	SOGROYA (SUBCUTANEOUS) ZOMACTON VIAL (INJECTION) ~~ZORBTIVE VIAL (INJECTION)~~

HAE TREATMENTS section reviewed 10-21-2026

Preferred	Nonpreferred
BERINERT (INTRAVEN) ~~CINRYZE (INTRAVEN)~~ HAEGARDA (SUB-Q) ICATIBANT (SUB-Q)	ANDEMBRY (SUB-Q) CINRYZE (INTRAVEN) DAWNZERA (SUB-Q) EKTERLY (ORAL) FIRAZYR (SUB-Q) ~~HAEGARDA (SUB-Q)~~ KALBITOR (SUB-Q) ORLADEYO (ORAL) RUCONEST (INTRAVEN) TAKHZYRO (SUB-Q)

OPHTHALMIC ANTIBIOTICS section reviewed 10-21-2026

Preferred	Nonpreferred
CIPROFLOXACIN SOLUTION (OPHTHALMIC) MOXIFLOXACIN (VIGAMOX) (OPHTHALMIC) OFLOXACIN (OPHTHALMIC)	AZASITE (OPHTHALMIC) BACITRACIN (OPHTHALMIC) BESIFLOXACIN (OPHTHALMIC) BESIVANCE (OPHTHALMIC) CILOXAN OINTMENT (OPHTHALMIC) GATIFLOXACIN (OPHTHALMIC) LEVOFLOXACIN (OPHTHALMIC) MOXIFLOXACIN (MOXEZA) (OPHTHALMIC) NATACYN (OPHTHALMIC) NEOMYCIN-POLYMYXIN-GRAMICIDIN (OPHTHALMIC) OCUFLOX (OPHTHALMIC) SULFACETAMIDE OINTMENT(OPHTHALMIC) VIGAMOX (OPHTHALMIC)

OPIATE DEPENDENCE TREATMENTS section reviewed 10-21-2026

Preferred	Nonpreferred
BUPRENORPHINE/NALOXONE FILM (SUBLINGUAL) BUPRENORPHINE/NALOXONE TAB SUBLINGUAL) KLOXXADO SPRAY (NASAL) NALOXONE SPRAY OTC (NASAL) NALOXONE SYRINGE (INJECTION) NALOXONE VIAL (INJECTION) NARCAN SPRAY (RX) (NASAL) NARCAN SPRAY (OTC) (NASAL) ~~REXTOVY SPRAY (NASAL)~~ ~~SUBOXONE FILM (SUBLINGUAL)~~	BRIXADI MONTHLY (SUBCUTANEOUS) BRAXADI WEEKLY (SUBCUTANEOUS) BUPRENORPHINE HCL (SUBLINGUAL) ~~BUPRENORPHINE/NALOXONE FILM (SUBLINGUAL)~~ NALOXONE SPRAY (NASAL) OPVEE SPRAY (NASAL) REXTOVY SPRAY (NASAL) REZENOPY SPRAY (NASAL) SUBLOCADE (SUBCUTANEOUS) SUBOXONE FILM (SUBLINGUAL) ~~ZIMHI (INJECTION)~~ ZUBSOLV (SUBLINGUAL) ZURNAI (INJECTION)

Consent Agenda Items

ANTICONVULSANTS, OTHER section reviewed 10-21-2026 no change

Preferred	Nonpreferred
DIAZEPAM (RECTAL)	LIBERVANT (BUCCAL)
DIAZEPAM DEVICE (RECTAL)	
VALTOCO (NASAL)	
NAYZILAM (NASAL)	

ANTIFUNGALS, ORAL section reviewed 10-21-2026

Preferred	Nonpreferred
FLUCONAZOLE SUSPENSION (ORAL)	~~ANCOBON (ORAL)~~
FLUCONAZOLE TABLET (ORAL)	~~BREXAFEMME (ORAL)~~
ITRACONAZOLE CAPSULE (ORAL)	CRESEMBA (ORAL)
NYSTATIN SUSPENSION (ORAL)	DIFLUCAN SUSPENSION (ORAL)
TERBINAFINE (ORAL)	DIFLUCAN TABLET (ORAL)
VORICONAZOLE TABLET (ORAL)	FLUCYTOSINE (ORAL)
	~~GRIS-PEG (ORAL)~~
	GRISEOFULVIN SUSPENSION (ORAL)
	GRISEOFULVIN TABLETS (ORAL)
	GRISEOFULVIN ULTRAMICROSIZE (ORAL)
	ITRACONAZOLE SOLUTION (ORAL)
	KETOCONAZOLE (ORAL)
	NOXAFIL SUSPENSION (ORAL)
	NOXAFIL TABLETS (ORAL)
	NYSTATIN TABLET (ORAL)
	~~ONMEL (ORAL)~~
	ORAVIG (BUCCAL)
	POSACONAZOLE TABLET AND SUSPENSION (ORAL)
	SPORANOX CAPSULE (ORAL)
	SPORANOX SOLUTION (ORAL)
	TOLSURA (ORAL)
	VFEND TABLET (ORAL)
	VFEND SUSPENSION (ORAL)
	VIVJOA CAPSULE (ORAL)
	VORICONAZOLE SUSPENSION (ORAL)

ANTIVIRALS, GENERAL section reviewed 10-21-2026 no change

Preferred	Nonpreferred
PAXLOVID TAB DOSE PACK (ORAL)	NONE

ANTIVIRALS, ORAL section reviewed 10-21-2026

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

ANTIVIRALS, TOPICAL section reviewed 10-21-2026 no change

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

BONE RESORPTION SUPPRESSION AND RELATED AGENTS section reviewed 10-21-2026

Preferred	Nonpreferred
ALENDRONATE SOLUTION (ORAL)	ACTONEL (ORAL)
ALENDRONATE TABLETS (ORAL)	ATELVIA (ORAL)
CALCITONIN SALMON (NASAL)	AUKELSO VIAL (SUBCUTANEOUS)
ENOBY SYRINGE (SUBCUTANEOUS)	BILDYOS (SUBCUTANE.)
FORTEO (SUBCUTANEOUS)	BILPREVDA (SUBCUTANE.)
IBANDRONATE TABLETS (ORAL)	BINOSTO (ORAL)
~~MIACALCIN (NASAL)~~	BOMYNTRA (SUBCUTANE.)
RALOXIFENE (ORAL)	BONSITY (SUBCUTANE.)
XTRENBO VIAL (SUBCUTANEOUS)	BOSAYA SYRINGE (SUBCUTANEOUS)
	CONEXXENCE (SUBCUTANE.)
	EVENITY (SUBCUTANEOUS)
	EVISTA (ORAL)
	FOSAMAX (ORAL)
	FOSAMAX PLUS D (ORAL)
	JUBBONTI (SUBCUTANE.)
	JUBEREQ VIAL (SUBCUTANEOUS)
	OSENVELT (SUBCUTANE.)
	OSVYRTI SYRINGE (SUBCUTENOUS)
	PROLIA (SUBCUTANE.)
	RISEDRONATE (ACTONEL) (ORAL)
	RISEDRONATE (ATELVIA) (ORAL)
	STOBOCLO (SUBCUTANE.)
	TERIPARATIDE (SUBCUTANEOUS)
	TYMLOS (SUBCUTANE.)
	WYOST (SUBCUTANE.)
	XGEVA (SUBCUTANE.)

FLUOROQUINOLONES, ORAL section reviewed 10-21-2026

Preferred	Nonpreferred
CIPROFLOXACIN TABLET (ORAL)	BAXDELA (ORAL)
LEVOFLOXACIN SOLUTION (ORAL)	CIPRO SUSPENSION (ORAL)
LEVOFLOXACIN TABLET (ORAL)	CIPRO TABLET (ORAL)
MOXIFLOXACIN (ORAL)	CIPROFLOXACIN SUSPENSION (ORAL)
	~~MOXIFLOXACIN (ORAL)~~
	OFLOXACIN (ORAL)

GLUCOCORTICOIDS, INHALED section reviewed 10-21-2026

Preferred	Nonpreferred
ADVAIR DISKUS (INHALATION)	AIRDUO RESPICLICK (INHALATION)
ADVAIR HFA (INHALATION)	AIRSUPRA (INHALATION)
ARNUITY ELLIPTA (INHALATION)	ALVESCO (INHALATION)

Preferred	Nonpreferred
ASMANEX (INHALATION) ASMANEX HFA (INHALATION) BUDESONIDE 0.25, 0.5 MG RESPULES (INHALATION) BUDESONIDE 1 MG RESPULES (INHALATION) DULERA (INHALATION) FLUTICASONE HFA (AG) (INHALATION) PULMICORT FLEXHALER (INHALATION) QVAR REDIHALER (INHALATION) SYMBICORT (INHALATION)	BECLOMETHASONE DIPROPIONATE HFA (INHALATION) BREO ELLIPTA (INHALATION) BREYNA (INHALATION) BREZTRI AEROSPHERE (INHALATION) BUDESONIDE/FORMOTEROL (SYMBICORT) (AG) (INHALATION) FLUTICASONE (FLOVENT DISKUS) (AG) (INHALATION) FLUTICASONE FUROATE (ARNUITY ELLIPTA) (AG) (INHALATION) FLUTICASONE/SALMETEROL (ADVAIR DISKUS) (INHALATION) FLUTICASONE/SALMETEROL (ADVAIR HFA) (INHALATION) FLUTICASONE/SALMETEROL (AIRDUO) (AG) (INHALATION) FLUTICASONE/VILANTEROL (BREO) (INHALATION) PULMICORT 0.25, 0.5 MG RESPULES (INHALATION) PULMICORT 1 MG RESPULES (INHALATION) TRELEGY ELLIPTA (INHALATION)

HEPATITIS B AGENTS section reviewed 10-21-2026 no change

Preferred	Nonpreferred
LAMIVUDINE HBV TABLET (ORAL) BARACLUDE SOLUTION (ORAL) ENTECAVIR TABLET (ORAL)	ADEFOVIR DIPIVOXIL (ORAL) BARACLUDE TABLET (ORAL) VEMLIDY (ORAL)

HEPATITIS C AGENTS section reviewed 10-21-2026

Preferred	Nonpreferred
MAVYRET PELLET PACK (ORAL) MAVYRET TABLET (ORAL) PEGASYS SYRINGE (SUB-Q) PEGASYS VIAL (SUBCUTANE.) RIBAVIRIN CAPSULE (ORAL) RIBAVIRIN TABLET (ORAL)	EPCLUSA PELLET PACK (ORAL) EPCLUSA TABLET (ORAL) HARVONI PELLET PACK (ORAL) HARVONI TABLET (ORAL) LEDIPASVIR/SOFOSBUVIR (AG) (ORAL) ~~RIBAVIRIN DOSE PACK (ORAL)~~ SOFOSBUVIR/VELPATASVIR (AG) (ORAL) SOVALDI PELLET PACK (ORAL) SOVALDI TABLET (ORAL) VOSEVI (ORAL) ZEPATIER (ORAL)

HYPOGLYCEMICS, SGLT2 section reviewed 10-21-2026

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

Preferred	Nonpreferred

OTIC ANTIBIOTICS section reviewed 10-21-2026

Preferred	Nonpreferred
CIPRO HC (OTIC) CIPROFLOXACIN/DEXAMETHASONE (OTIC) CIPROFLOXACIN/DEXAMETHASONE (AG) (OTIC) OFLOXACIN (OTIC) NEOMYCIN/POLYMYXIN/HC SOLN/SUSP (OTIC)	CIPROFLOXACIN (OTIC) CIPROFLOXACIN/FLUOCINOLONE (AG) (OTIC) CIPROFLOXACIN/HYDROCORTISONE (OTIC) CORTISPORIN-TC (OTIC)