Department of Medicaid

# 30 Day Change Notice
# Effective Date: April 1, 2025

| NEW PREFERRED DRUGS | |
|---|---|
| **THERAPEUTIC CLASS** | **NO PA REQUIRED PREFERRED** |
| **Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY** | VIGAFYDE |
| **Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY** | desvenlafaxine succ ER (gen of PRISTIQ) |
| **Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents** | ONYDA XR SUSP |
| **Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY** | emtricitabine |

| NEW CLINICAL PA REQUIRED PREFERRED DRUGS | |
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| **THERAPEUTIC CLASS** | **CLINICAL CRITERIA REQUIRED PREFERRED** |
| **Immunomodulator Agents: Systemic Inflammatory Disease** | adalimumab-adaz (gen of HYRIMOZ)<br>EBGLYSS<br>TREMFYA |

| NEW NON-PREFERRED DRUGS | |
|---|---|
| **THERAPEUTIC CLASS** | **PA REQUIRED NON-PREFERRED** |
| **Cardiovascular Agents: Angina, Hypertension and Heart Failure** | TRYVIO |
| **Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY** | desvenlafaxine ER (gen of KHEDEZLA) |
| **Central Nervous System (CNS) Agents: Atypical Antipsychotics* LEGACY CATEGORY** | COBENFY |
| **Central Nervous System (CNS) Agents: Parkinson's Agents** | CREXONT |
| **Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine** | TANLOR |
| **Immunomodulator Agents: Systemic Inflammatory Disease** | HYRIMOZ (Bio of HUMIRA) |
| **Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY** | EMTRIVA |
| **Topical Agents: Corticosteroids** | diflorasone diacetate |
| **Topical Agents: Immunomodulators** | ZORYVE CREAM, FOAM |

| THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA |
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| **Analgesic Agents: Opioids** |
| **Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants** |
| **Cardiovascular Agents: Angina, Hypertension and Heart Failure** |
| **Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY** |
| **Central Nervous System (CNS) Agents: Anticonvulsants Rescue** |

Date of Notice: 3/1/2025

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| **Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents** |
| **Endocrine Agents: Endometriosis** |
| **Respiratory Agents: Inhaled Agents** |
| **Topical Agents: Antifungals** |
| **Topical Agents: Immunomodulators** |

| REVISED THERAPEUTIC CATEGORY CRITERIA | |
|---|---|
| **THERAPEUTIC CLASS** | **SUMMARY OF CHANGE** |
| **Analgesic Agents: Opioids** | **MORPHINE SULFATE ER (~~KADIAN,~~ MS CONTIN) ~~& TAPENTADOL ER (NUCYNTA)~~ CRITERIA:**<br>• Unless receiving for cancer pain, palliative care, or end-of-life/hospice care, must provide documentation of an inadequate clinical response with at least one opioid formulation taken for at least 30 of the last 60 days<br>• Must also meet LONG-ACTING OPIOID CRITERIA |
| **Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants** | **AR** – PRADAXA PELLET PAK, XARELTO SUSP: a PA is required for patients ~~older than~~ 12 years ~~old~~ and older |
| **Cardiovascular Agents: Angina, Hypertension and Heart Failure** | **ADDITIONAL APROCITENTAN (TRYVIO) CRITERIA:**<br>• Must have had an inadequate clinical response of at least 30 days of at least four different classes of antihypertensive medications concurrently without adequate blood pressure control |
| **Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY** | **AR** – BRIVIACT SOLUTION: a PA is required for patients 12 years and older<br>**AR** – EPRONTIA SOLUTION: a PA is required for patients 12 years and older<br>**AR** – vigabatrin powder: a PA is required for patients ~~3~~ 2 years and older<br>**AR** – VIGAFYDE SOLUTION: a PA is required for patients 2 years and older |
| **Central Nervous System (CNS) Agents: Anticonvulsants Rescue** | **AR** – LIBERVANT: a PA is required for patients ~~older than~~ 5 years ~~old~~ and older |
| **Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents** | **AR** – ONYDA XR SUSP: a PA is required for patients 12 years and older |
| **Endocrine Agents: Endometriosis** | **ADDITIONAL INFORMATION:**<br>• A total lifetime duration of therapy of 730 days between ~~Oriahnn~~ ORILISSA and MYFEMBREE or 365 days for LUPRON DEPOT will be authorized |

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| **Respiratory Agents: Inhaled Agents** | **ADDITIONAL BUDESONIDE/ALBUTEROL (AIRSUPRA) CRITERIA:**<br>• Must have had an inadequate clinical response of at least 14 days with either DULERA or SYMBICORT |
| **Topical Agents: Antifungals** | ~~**ADDITIONAL INFORMATION**~~<br>• ~~Requests may be authorized if:~~<br>○ ~~The infection is caused by an organism resistant to preferred antifungal drugs (note diagnosis and any culture/sensitivity results)~~ |
| **Topical Agents: Immunomodulators** | **ADDITIONAL ROFLUMILAST (ZORYVE) CRITERIA:**<br>• **0.15% CREAM:** Must have had an inadequate clinical response of at least 30 days with at least one preferred topical corticosteroid OR topical calcineurin inhibitor<br>• **0.3% CREAM:** Must have had an inadequate clinical response of at least 30 days with at least one preferred topical corticosteroid OR topical calcipotriene<br>• **FOAM:** Must have had an inadequate clinical response of at least 30 days with at least one preferred agent indicated for Seborrheic Dermatitis (such as a topical antifungal, topical calcineurin inhibitor, or topical corticosteroid) |