



Department of Medicaid

**30 Day Change Notice
Effective Date: January 1, 2026**

NEW PREFERRED DRUGS	
THERAPEUTIC CLASS	NO PA REQUIRED PREFERRED
Analgesic Agents: Gout	febuxostat MITIGARE
Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants	dabigatran cap
Cardiovascular Agents: Angina, Hypertension and Heart Failure	acetazolamide DIURIL SUSP indapamide methazolamide metolazone sacubitril/valsartan (gen of ENTRESTO)
Central Nervous System (CNS) Agents: Atypical Antipsychotics* LEGACY CATEGORY	ERZOFRI
Central Nervous System (CNS) Agents: Multiple Sclerosis* LEGACY CATEGORY	PLEGRIDY
Endocrine Agents: Diabetes – Insulin	FIASP HUMULIN N U-100
Endocrine Agents: Diabetes – Non-Insulin	JENTADUETO XR SYNJARDY XR
Gastrointestinal Agents: Bowel Preparations	SUFLAVE
Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea	CNS Agents: Tricyclic Antidepressants
Hyperkalemia Agents: Potassium Binders	VELTASSA
Infectious Disease Agents: Antivirals – Coronavirus Agents	PAXLOVID
Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY	SYMFI
Ophthalmic Agents: Ophthalmic Steroids	EYSUVIS
Respiratory Agents: Inhaled Agents	fluticasone/salmeterol diskus PROAIR RESPICLICK
Topical Agents: Antiparasitics	spinosad [labeler 52246]
Topical Agents: Corticosteroids	DERMA-SMOOTH OIL

NEW CLINICAL PA REQUIRED PREFERRED DRUGS	
THERAPEUTIC CLASS	CLINICAL CRITERIA REQUIRED PREFERRED
Analgesic Agents: Opioids	fentanyl patch
Immunomodulator Agents: Systemic Inflammatory Disease	adalimumab-fkjp [labeler 83257] AVSOLA (Bio of REMICADE) NEMLUVIO SKYRIZI IV SOLN STEQEYMA (Bio of STELARA)



Department of Medicaid

**30 Day Change Notice
Effective Date: January 1, 2026**

NEW CLINICAL PA REQUIRED PREFERRED DRUGS	
THERAPEUTIC CLASS	CLINICAL CRITERIA REQUIRED PREFERRED
Respiratory Agents: Hereditary Angioedema	HAEGARDA
Respiratory Agents: Inhaled Agents	AIRSUPRA
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE	CINQAIR NUCALA
Respiratory Agents: Pulmonary Fibrosis	pirfenidone

NEW STEP THERAPY REQUIRED PREFERRED DRUGS	
THERAPEUTIC CLASS	CLINICAL CRITERIA REQUIRED PREFERRED
Respiratory Agents: Inhaled Agents	BREZTRI AEROSPHERE TRELEGY ELLIPTA
Topical Agents: Immunomodulators	OPZELURA VTAMA ZORYVE CREAM, FOAM

NEW NON-PREFERRED DRUGS	
THERAPEUTIC CLASS	PA REQUIRED NON-PREFERRED
Analgesic Agents: Gout	colchicine cap
Analgesic Agents: Opioids	fentanyl buccal tab, inj, lozenge
Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors	RYZNEUTA
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY	ADVATE AFSTYLA RECOMBINATE
Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet	clopidogrel 300mg
Cardiovascular Agents: Angina, Hypertension and Heart Failure	ENTRESTO TAB HEMICLOR LOPRESSOR SOLN spironolactone susp TEZRULY
Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY	bosentan susp TADLIQ
Central Nervous System (CNS) Agents: Alzheimer's Agents* LEGACY CATEGORY	ZUNVEYL
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	SYMBRAVO
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY	escitalopram cap
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	amphetamine IR, ER tab
Dermatologic Agents: Oral Acne Products	isotretinoin



NEW NON-PREFERRED DRUGS	
THERAPEUTIC CLASS	PA REQUIRED NON-PREFERRED
Endocrine Agents: Diabetes – Insulin	insulin glargine-yfgn MERILOG (Bio of NOVOLOG) TRESIBA 200U
Endocrine Agents: Diabetes – Non-Insulin	sitagliptin
Endocrine Agents: Estrogenic Agents	estrogens, conjugated tab
Endocrine Agents: Osteoporosis – Bone Ossification Enhancers	CONEXXENCE (Bio of PROLIA) JUBBONTI (Bio of PROLIA) STOBOCLO (Bio of PROLIA)
Gastrointestinal Agents: Ulcerative Colitis	budesonide rectal foam
Genitourinary Agents: Benign Prostatic Hyperplasia	TEZRULY
Immunomodulator Agents: Systemic Inflammatory Disease	adalimumab-fkjp [labeler 49502] IMULDOSA (Bio of STELARA) LEQSELVI
Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY	EDURANT SUSP YEZTUGO
Ophthalmic Agents: Dry Eye Treatments	TRYPTYR
Ophthalmic Agents: Ophthalmic Steroids	difluprednate prednisolone acetate
Respiratory Agents: Hereditary Angioedema	ANDEMBRY
Respiratory Agents: Inhaled Agents	ADVAIR DISKUS fluticasone/salmeterol HFA
Topical Agents: Antiparasitics	spinosad [labeler 28595]

THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA
Analgesic Agents: Gout
Analgesic Agents: Opioids
Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY
Cardiovascular Agents: Angina, Hypertension and Heart Failure
Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute
Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Anticonvulsants Rescue
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Narcolepsy
Central Nervous System (CNS) Agents: Parkinson's Agents
Dermatologic Agents: Topical Acne Products
Endocrine Agents: Diabetes – Insulin
Endocrine Agents: Diabetes – Non-Insulin
Gastrointestinal Agents: Hepatic Encephalopathy
Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea



THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA

Gastrointestinal Agents: Ulcerative Colitis
Gastrointestinal Agents: Unspecified GI
Immunomodulator Agents: Systemic Inflammatory Disease
Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY
Ophthalmic Agents: Dry Eye Treatments
Ophthalmic Agents: Ophthalmic Steroids
Respiratory Agents: Cystic Fibrosis
Respiratory Agents: Hereditary Angioedema
Respiratory Agents: Inhaled Agents
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE
Respiratory Agents: Pulmonary Fibrosis
Topical Agents: Antifungals
Topical Agents: Immunomodulators

REVISED THERAPEUTIC CATEGORY CRITERIA

THERAPEUTIC CLASS	SUMMARY OF CHANGE
Analgesic Agents: Gout	ADDITIONAL COLCHICINE CAPSULE (MITIGARE) CRITERIA: <ul style="list-style-type: none"> Must have had an inadequate clinical response of 30 days with colchicine tablets
Analgesic Agents: Opioids	FENTANYL PATCH AND MORPHINE SULFATE ER (MS CONTIN) CRITERIA: <ul style="list-style-type: none"> 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 Must also meet LONG-ACTING OPIOID CRITERIA
Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents	NON-PREFERRED CRITERIA: <ul style="list-style-type: none"> Must have had an inadequate clinical response of at least 14 days with at least one two preferred drugs in this UPDL category and indicated for diagnosis ADDITIONAL DARBOPOETIN ALFA (ARANESP) CRITERIA <ul style="list-style-type: none"> Must have been receiving a preferred product for ≥ 30 days with no positive response to hemoglobin levels, OR Must have a documented allergy, contraindication, or side effect to preferred agents and has a hemoglobin level at initiation of therapy of < 11 g/dL in dialysis patients with chronic kidney disease, < 10 g/dL in non-dialysis patients with chronic kidney disease, or < 12 g/dL in patients treated for other indications
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY	CLINICAL PA CRITERIA: <ul style="list-style-type: none"> Must provide documentation of patient's body weight (for weight-based dosed medications only) For factor products, please indicate if use is for on-hand, on-demand therapy. On-hand, on-demand therapy is defined as product kept on hand for spontaneous bleeds or injuries



	<p>ADDITIONAL EXTENDED HALF-LIFE FACTOR CRITERIA</p> <ul style="list-style-type: none">• Must provide attestation that the patient is not a suitable candidate for treatment with a shorter-acting half-life drug• Must not be used as on-hand, on-demand therapy in patients receiving non-factor replacement therapies. <p>ADDITIONAL CONCIZUMAB-MTCI (ALHEMO) CRITERIA</p> <ul style="list-style-type: none">• Must have had an inadequate clinical response such as increased bleeding episodes, a need for more factor replacement therapy, OR worsening joint health, of at least <u>30 days</u> with HEMLIBRA• Must have Hemophilia A with or without factor VIII inhibitors
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY	<p>CLINICAL PA CRITERIA:</p> <ul style="list-style-type: none">• Must provide documentation of patient's body weight (for weight-based dosed medications only)• For factor products, please indicate if use is for on-hand, on-demand therapy. On-hand, on-demand therapy is defined as product kept on hand for spontaneous bleeds or injuries <p>ADDITIONAL EXTENDED HALF-LIFE FACTOR CRITERIA</p> <ul style="list-style-type: none">• Must provide attestation that the patient is not a suitable candidate for treatment with a shorter-acting half-life drug• Must not be used as on-hand, on-demand therapy in patients receiving non-factor replacement therapies.
Cardiovascular Agents: Angina, Hypertension and Heart Failure	<p>ADDITIONAL FINERENONE (KERENDIA) CRITERIA:</p> <ul style="list-style-type: none">• Must be prescribed by or in consultation with a cardiologist or nephrologist AND• Must be on a maximally tolerated dose of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker AND• Must provide documentation of an inadequate clinical response to a SGLT2 Inhibitor OR provide documentation of medical necessity beyond convenience for why the patient cannot try a SGLT2 inhibitor <p>ADDITIONAL MAVACAMTEN (CAMZYOS) CRITERIA:</p> <ul style="list-style-type: none">• Must be prescribed by or in consultation with a cardiologist AND• Must provide documentation of NYHA Class II-III symptoms and left ventricular ejection fraction $\geq 55\%$ AND• Must provide documentation of previous trial and therapy failure at maximally tolerated dose, or intolerance, or contraindication to at least <u>two of the following</u><ul style="list-style-type: none">○ Non-vasodilating beta blocker (e.g., atenolol, metoprolol, bisoprolol, propranolol);○ Non-dihydropyridine calcium channel blocker (e.g., verapamil, diltiazem);○ Combination therapy with disopyramide plus beta blocker or disopyramide plus a non-dihydro calcium channel blocker <p>ADDITIONAL AMLODIPIDE (NORLIQVA) CRITERIA:</p> <ul style="list-style-type: none">• Must have had an inadequate clinical response of at least <u>30 days</u> with KATERZIA



	<p>AR – LOPRESSOR SOLN: a PA is required for patients younger than 18 years</p>
Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY	<p>ADDITIONAL TADALAFIL (TADLIQ) CRITERIA:</p> <ul style="list-style-type: none">Must have had a documented side effect, allergy, or treatment failure of at least 30 days with sildenafil suspension <p>ADDITIONAL SELEXIPAG (UPTRAVI) AND SOTATERCEPT-CSRK (WINREVAIR) CRITERIA:</p> <ul style="list-style-type: none">Must attest the patient has WHO group 1 diagnosis ANDMust attest the patient has WHO functional class II or III, at intermediate or high risk of disease progression ANDHave tried and failed preferred pulmonary hypertension medications with at least one medication from two different sublasses for ≥ 90 days, unless contraindicated or not tolerated ORRequire add-on triple or quadruple therapy, including PDE5-inhibitor for ≥ 90 days, unless contraindicated or not tolerated
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	<p>ADDITIONAL MELOXICAM/RIZATRIPTAN (SYMBRAVO) CRITERIA:</p> <ul style="list-style-type: none">Must have had an inadequate clinical response of at least <u>14 days</u> with sumatriptan/naproxen
Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY	<p>STIRIPENTOL (DIACOMIT) CRITERIA:</p> <ul style="list-style-type: none">Exempt from Legacy rulesMust be prescribed by or in consultation with a neurologistMust be <u>concomitantly</u> <u>concurrently</u> taking clobazam (ONFI) <p>ADDITIONAL FENFLURAMINE (FINTEPLA) CRITERIA:</p> <ul style="list-style-type: none">Prescribed by or in consultation with a neurologistWhen prescribed for Lennox-Gastaut syndrome<ul style="list-style-type: none">Required trial of valproic acid (or a derivative) in combination with lamotrigine for at least 30 daysWhen prescribed for Dravet syndrome<ul style="list-style-type: none">Required trial of valproic acid (or a derivative) in combination with <u>one other preferred agent from this UPDL category</u> for at least 30 days <p>ADDITIONAL CENOBAIMATE (XCOPRI) CRITERIA:</p> <ul style="list-style-type: none">Prescribed by or in consultation with a neurologistRequired trial of <u>two</u> preferred medications from this UPDL category in combination for at least 30 days. One of the preferred agents must be: lamotrigine, levetiracetam, oxcarbazepine, carbamazepine, or topiramate
Central Nervous System (CNS) Agents:	<p>AR – LIBERVANT: a PA is required for patients 5 years and older</p>



Department of Medicaid

**30 Day Change Notice
Effective Date: January 1, 2026**

Anticonvulsants Rescue	
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY	<p>ADDITIONAL DEXTROMETHORPHAN/BUPROPION (AUVELITY) CRITERIA:</p> <ul style="list-style-type: none">Must have an inadequate clinical response of at least <u>30 days</u> with <u>ALL</u> of the following:<ul style="list-style-type: none"><u>ONE</u> norepinephrine/dopamine reuptake inhibitor (NDRI)<u>ONE</u> serotonin and norepinephrine reuptake inhibitor (SNRI)<u>TWO</u> selective serotonin reuptake inhibitors (SSRIs) (<u>ONE</u> of which must be either vilazodone (VIIBRYD) OR vortioxetine (TRINTELLIX)))
Central Nervous System (CNS) Agents: Narcolepsy	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none">Must have had an inadequate clinical response with at least <u>two</u> <u>preferred</u> drugs - either at least <u>30 days</u> of armodafinil or modafinil; OR at least <u>7-30 days</u> of a preferred amphetamine or methylphenidate drug in this UPDL category and indicated for diagnosis
Central Nervous System (CNS) Agents: Parkinson's Agents	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none">Must have had an inadequate clinical response of at least <u>30 days</u> with at least <u>one-two</u> <u>preferred</u> drugs within the same sub-section classification in this UPDL category and indicated for diagnosis, if available <p>ADDITIONAL APOMORPHINE (ONAPGO) CRITERIA:</p> <ul style="list-style-type: none">Must have had inadequate clinical response of at least <u>30 days</u> with at least <u>two</u> <u>preferred</u> drugs in this UPDL category, <u>one</u> of which must be carbidopa/levodopa <p>ADDITIONAL APOMORPHINE (ONAPGO) AND FOSCARBIDOPA/FOSLEVODOPA (VYALEV) CRITERIA:</p> <ul style="list-style-type: none">Must have had inadequate clinical response of at least <u>30 days</u> with at least <u>two</u> <u>preferred</u> drugs in this UPDL category, <u>one</u> of which must be carbidopa/levodopaMust have had uncontrolled motor symptoms with current medications with a minimum of 2.5 hours of "off" time per day as assessed by using a PD diary.
Dermatologic Agents: Topical Acne Products	<p>ADDITIONAL CLINDAMYCIN/ADAPALENE/BENZOYL PEROXIDE (CABTREO) CRITERIA</p> <ul style="list-style-type: none">Must provide documentation for patient's inability to use the individual drugs in this UPDL category
Endocrine Agents: Diabetes – Insulin	<p>ADDITIONAL INSULIN LISPRO-AABC (LYUMJEV) CRITERIA:</p> <ul style="list-style-type: none">Must have had an inadequate clinical response (defined as the inability to reach target A1C) after at least 120 days with HUMALOG OR insulin lispro <p>SUBSEQUENT AUTHORIZATION CRITERIA:</p> <ul style="list-style-type: none">Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring



	<ul style="list-style-type: none">⊖ Must include a patient-specific A1C goal if less than 7%⊖ Must submit recent hemoglobin A1C level (within 6 months)⊖ Must include documentation showing improvement in current A1C (within last 6 months) if not already at goal A1C
Endocrine Agents: Diabetes – Non-Insulin	<p>ADDITIONAL TIRZEPATIDE (MOUNJARO) CRITERIA</p> <ul style="list-style-type: none">• Prior to initiation, must have hemoglobin A1C > 7% AND• Must have had an inadequate clinical response of at least 120 days with OZEMPIC OR must provide documentation of medical necessity for patient's inability to use OZEMPIC• For medical necessity requests due to the patient's inability to use OZEMPIC intolerance, must submit chart documentation that the following approaches were tried for at least <u>30 days</u>:<ul style="list-style-type: none">◦ Dietary changes (e.g., eating apples, crackers, or mint- or ginger-based drinks 30 minutes after administering the GLP-1 Receptor Agonist)◦ Prescription antiemetics AND◦ Dose adjustment to remediate side effects experienced with higher doses of the GLP-1 Receptor Agonist <p>ADDITIONAL INFORMATION</p> <ul style="list-style-type: none">• An inadequate clinical response is defined as the inability to reach A1C goal after at least 120 days of current regimen, with use of two or more drugs concomitantly-concurrently per ADA guidelines, documented adherence, and appropriate dose escalation (must achieve maximum recommended dose or document that maximum recommended dose is not tolerated or is clinically inappropriate). <p>SUBSEQUENT AUTHORIZATION CRITERIA:</p> <ul style="list-style-type: none">• Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring<ul style="list-style-type: none">⊖ Must include a patient-specific A1C goal if less than 7%⊖ Must submit recent hemoglobin A1C level (within 6 months)⊖ Must include documentation showing improvement in current A1C (within last 6 months) if not already at goal A1C
Gastrointestinal Agents: Hepatic Encephalopathy	All products are covered without a PA LENGTH OF AUTHORIZATIONS: 365 Days <p>STEP THERAPY CRITERIA:</p> <ul style="list-style-type: none">• Must have had an inadequate clinical response of at least <u>14 days</u> with at least one preferred drug in this UPDL category
Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea	<p>STEP THERAPY CRITERIA:</p> <ul style="list-style-type: none">• Must have had an inadequate clinical response of at least <u>14 days</u> with at least one preferred drug in this UPDL category
Gastrointestinal Agents: Ulcerative Colitis	LENGTH OF AUTHORIZATIONS: 365 Days; except UCERIS FOAM – 90 days



**Department of
Medicaid**

**30 Day Change Notice
Effective Date: January 1, 2026**

Gastrointestinal Agents: Unspecified GI	<p>ADDITIONAL METHYLNALTREXONE (RELISTOR) AND NALDEMEDINE (SYMPROIC) CRITERIA:</p> <p>ADDITIONAL RIFAMYCIN DELAYED-RELEASE (AEMCOLO) CRITERIA:</p> <ul style="list-style-type: none">Must have the inability to take, or failure of ALL of the following: azithromycin, ciprofloxacin, levofloxacin, or ofloxacin, or rifaximin
Immunomodulator Agents: Systemic Inflammatory Disease	<p>ADDITIONAL NEMOLIZUMAB (NEMLUVIO) CRITERIA:</p> <ul style="list-style-type: none">Must have had an inadequate clinical response of at least <u>90 days</u> with <u>DUPIXENT</u> and indicated for prurigo nodularis <p>ADDITIONAL ATOPIC DERMATITIS CRITERIA:</p> <ul style="list-style-type: none">Must have at least 10% body surface area (BSA) involvement with an inadequate clinical response of at least <u>90 days</u> with <u>two</u> of the following: topical corticosteroids or topical calcineurin inhibitors [e.g., <u>ELIDEL</u> tacrolimus, pimecrolimus] unless atopic dermatitis is severe and involves >25% BSA
Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY	<p>AR – EDURANT SUSP: a PA is required for patients 12 years and older</p>
Ophthalmic Agents: Dry Eye Treatments	<p>LENGTH OF AUTHORIZATIONS: <u>14 days for EYSUVIS</u>; <u>365 days for all other drugs</u></p> <p>ADDITIONAL ACOLTREMON (TRYPTYR) AND CYCLOSPORINE (VEVYE) CRITERIA:</p> <ul style="list-style-type: none">Must have had an inadequate clinical response of at least <u>30 days</u> with <u>CEQUA</u> and indicated for diagnosis
Ophthalmic Agents: Ophthalmic Steroids	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none">Must have had an inadequate clinical response of at least <u>7 days</u> with <u>at least two preferred drugs</u> in this UPDL category and indicated for diagnosis
Respiratory Agents: Cystic Fibrosis	<p>CLINICAL PA CRITERIA:</p> <ul style="list-style-type: none">Must be prescribed by or in consultation with a pulmonologist or infectious disease specialistFor a CFTR Modulator, must provide documentation of the specific Cystic Fibrosis Transmembrane Conductance Regular (CFTR) genetic mutation
Respiratory Agents: Hereditary Angioedema	<p>CLINICAL PA CRITERIA:</p> <ul style="list-style-type: none">Acute Treatment<ul style="list-style-type: none">Must provide documentation that diagnosis is verified by a C4 level below the lower limit of normal as defined by laboratory testing AND one of the following:<ul style="list-style-type: none">C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by laboratory testing; ORC1-INH functional level below the lower limit of normal as defined by laboratory testing



	<ul style="list-style-type: none">• Prophylactic Treatment<ul style="list-style-type: none">○ Must not be used in combination with other prophylaxis agents
	<p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none">• Must have had an inadequate clinical response of at least <u>3 days</u> with at least <u>one preferred</u> acute drug in this UPDL category and indicated for diagnosis to request a non-preferred acute drug.• Must have had an inadequate clinical response such as lack of reduction of attacks based on patient report, frequency of ER visits, or frequency of hospitalizations with use of at least <u>14 days</u> with at least <u>one two preferred</u> prophylaxis drugs in this UPDL category and indicated for diagnosis to request a non-preferred prophylaxis drug.
Respiratory Agents: Inhaled Agents	<p>CLINICAL PA CRITERIA:</p> <ul style="list-style-type: none">• Must have had an inadequate clinical response of at least <u>14 days</u> with an albuterol containing product <p>STEP THERAPY CRITERIA:</p> <ul style="list-style-type: none">• Must have had an inadequate clinical response of at least <u>30 days</u> with at least <u>one inhaled corticosteroid (ICS) AND at least one long-acting beta-agonist (LABA) AND at least one long-acting muscarinic-antagonist (LAMA) concurrently</u> in this UPDL category and indicated for diagnosis, if available <p>ADDITIONAL BUDESONIDE/ALBUTEROL (AIRSUPRA) CRITERIA:</p> <ul style="list-style-type: none">• Must have had an inadequate clinical response of at least <u>14 days</u> with either DULERA or SYMBICORT <p>AR – fluticasone propionate: a PA is required for patients 18 years and older</p>
Respiratory Agents: Monoclonal Antibodies- Anti-IL/Anti-IgE	<ul style="list-style-type: none">• For Chronic Obstructive Pulmonary Disease (COPD):<ul style="list-style-type: none">○ The patient must have an eosinophilic count of greater than or equal to <u>300</u> <u>150</u> cells per mL within 12 months prior to initiation of therapy AND○ The patient has a history of uncontrolled disease, as indicated by <u>greater than or equal to 2 COPD exacerbations</u> or greater than or equal to 1 COPD exacerbation resulting in a hospitalization despite being on standard of care, defined as triple therapy (LAMA+LABA+ICS) for at least 3 months prior to request, and at a stable dose for at least 1 month prior. <p>NON-PREFERRED CRITERIA:</p> <ul style="list-style-type: none">• Must have had an inadequate clinical response of at least <u>90 days</u> with at least <u>one two preferred</u> drugs in this UPDL category and indicated for diagnosis



Respiratory Agents: Pulmonary Fibrosis	NON-PREFERRED CRITERIA: <ul style="list-style-type: none">Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Topical Agents: Antifungals	ADDITIONAL EFINAConazole (JUBLIA) CRITERIA: <ul style="list-style-type: none">Must have had an inadequate clinical response of at least 48 weeks of ciclopirox AND 6 weeks of oral terbinafine (if fingernail) OR 12 weeks of oral terbinafine (if toenail)
Topical Agents: Immunomodulators	STEP THERAPY CRITERIA: <ul style="list-style-type: none">Must have had an inadequate clinical response of at least 30-90 days with at least one preferred drug in this UPDL category OR documentation why patient is unable to take product not requiring step therapy NON-PREFERRED CRITERIA: <ul style="list-style-type: none">Must have had an inadequate clinical response of at least 30-90 days with at least one preferred drug and one step therapy drug of different mechanisms of action in this UPDL category and indicated for diagnosis ADDITIONAL ROFLUMILAST (ZORYVE) CRITERIA: <ul style="list-style-type: none">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 inhibitor0.3% CREAM: Must have had an inadequate clinical response of at least 30 days with at least one preferred topical corticosteroid OR topical calcipotrieneFOAM: 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) <p>AR – ELIDEL, tacrolimus and pimecrolimus, and tacrolimus: a PA is required for patients younger than 2 years old</p>

NEW THERAPEUTIC CATEGORIES

Infectious Disease Agents: Antivirals – Coronavirus Agents

NEW THERAPEUTIC CATEGORY CRITERIA

THERAPEUTIC CLASS	SUMMARY OF CHANGE
Infectious Disease Agents: Antivirals – Coronavirus Agents	All products are covered without a PA