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-SMOOTHE 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)

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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

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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

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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:**~~ • ~~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:** • 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:** • Must have had an inadequate clinical response of at least ~~14~~ 30 days with at least ~~one~~ two preferred drugs in this UPDL category and indicated for diagnosis **ADDITIONAL DARBOPOETIN ALFA (ARANESP) CRITERIA** • 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:** • 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

	ADDITIONAL EXTENDED HALF-LIFE FACTOR CRITERIA • 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. **ADDITIONAL CONCIZUMAB-MTCI (ALHEMO) CRITERIA** • 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 30 days with HEMLIBRA • Must have Hemophilia A **with or without** factor VIII inhibitors
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY	**CLINICAL PA CRITERIA:** • 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 **ADDITIONAL EXTENDED HALF-LIFE FACTOR CRITERIA** • 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	**ADDITIONAL FINERENONE (KERENDIA) CRITERIA:**
	• 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
	
	ADDITIONAL MAVACAMTEN (CAMZYOS) CRITERIA:
	• 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 ≥55% **AND**
	• Must provide documentation of previous trial and therapy failure at maximally tolerated dose, or intolerance, or contraindication to at least two of the following
	  ○ 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
	
	ADDITIONAL AMLODIPIDE (NORLIQVA) CRITERIA:
	• Must have had an inadequate clinical response of at least 30 days with KATERZIA

	AR – LOPRESSOR SOLN: a PA is required for patients younger than 18 years
Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY	**ADDITIONAL TADALAFIL (TADLIQ) CRITERIA:** • Must have had a documented side effect, allergy, or treatment failure of at least 30 days with sildenafil suspension **ADDITIONAL SELEXIPAG (UPTRAVI) AND SOTATERCEPT-CSRK (WINREVAIR) CRITERIA:** • Must attest the patient has WHO group 1 diagnosis **AND** • Must attest the patient has WHO functional class II or III, at intermediate or high risk of disease progression **AND** • Have tried and failed preferred pulmonary hypertension medications with at least one medication from two different subclasses for ≥90 days, unless contraindicated or not tolerated **OR** • Require 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	**ADDITIONAL MELOXICAM/RIZATRIPTAN (SYMBRAVO) CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with sumatriptan/naproxen

Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY	**STIRIPENTOL (DIACOMIT) CRITERIA**
	• Exempt from Legacy rules
	• Must be prescribed by or in consultation with a neurologist
	• Must be ~~concomitantly~~ concurrently taking clobazam (ONFI)
	
	ADDITIONAL FENFLURAMINE (FINTEPLA) CRITERIA:
	• Prescribed by or in consultation with a neurologist
	• When prescribed for Lennox-Gastaut syndrome
	  ○ Required trial of valproic acid (or a derivative) in combination with lamotrigine for at least 30 days
	• When prescribed for Dravet syndrome
	  ○ Required trial of valproic acid (or a derivative) in combination with one other preferred agent from this UPDL category for at least 30 days
	
	ADDITIONAL CENOBAMATE (XCOPRI) CRITERIA:
	• Prescribed by or in consultation with a neurologist
	• Required trial of two 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:	~~**AR** – LIBERVANT: a PA is required for patients 5 years and older~~

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Anticonvulsants Rescue	
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY	~~**ADDITIONAL DEXTROMETHORPHAN/BUPROPION (AUVELITY) CRITERIA:**~~ • ~~Must have an inadequate clinical response of at least 30 days with **ALL** of the following:~~ ○ ~~ONE norepinephrine/dopamine reuptake inhibitor (NDRI)~~ ○ ~~ONE serotonin and norepinephrine reuptake inhibitor (SNRI~~ ○ ~~TWO selective serotonin reuptake inhibitors (SSRIs) (ONE of which must be either vilazodone (VIIBRYD) OR vortioxetine (TRINTELLIX)))~~
Central Nervous System (CNS) Agents: Narcolepsy	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response with at least two preferred drugs - either at least 30 days of armodafinil or modafinil; **OR** at least ~~7~~ 30 days of a preferred amphetamine or methylphenidate drug in this UPDL category and indicated for diagnosis
Central Nervous System (CNS) Agents: Parkinson's Agents	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least ~~one~~ two preferred drugs within the same sub-section classification in this UPDL category and indicated for diagnosis, if available ~~**ADDITIONAL APOMORPHINE (ONAPGO) CRITERIA:**~~ • ~~Must have had inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category, one of which must be carbidopa/levodopa~~ **ADDITIONAL APOMORPHINE (ONAPGO) AND FOSCARBIDOPA/FOSLEVODOPA (VYALEV) CRITERIA:** • Must have had inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category, one of which must be carbidopa/levodopa • Must 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	~~**ADDITIONAL CLINDAMYCIN/ADAPALENE/BENZOYL PEROXIDE (CABTREO) CRITERIA**~~ • ~~Must provide documentation for patient's inability to use the individual drugs in this UPDL category~~
Endocrine Agents: Diabetes – Insulin	**ADDITIONAL INSULIN LISPRO-AABC (LYUMJEV) CRITERIA:** • 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 **SUBSEQUENT AUTHORIZATION CRITERIA:** • Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring

	~~o Must include a patient specific A1C goal if less than 7%~~ ~~o~~ Must submit recent hemoglobin A1C level (within 6 months) ~~o~~ Must include documentation showing improvement in current A1C (within last 6 months) if not already at goal A1C
Endocrine Agents: Diabetes – Non-Insulin	**ADDITIONAL TIRZEPATIDE (MOUNJARO) CRITERIA** • 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 30 days: o Dietary changes (e.g., eating apples, crackers, or mint- or ginger-based drinks 30 minutes after administering the GLP-1 Receptor Agonist) o Prescription antiemetics **AND** o Dose adjustment to remediate side effects experienced with higher doses of the GLP-1 Receptor Agonist **ADDITIONAL INFORMATION** • 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). **SUBSEQUENT AUTHORIZATION CRITERIA:** • Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring ~~o Must include a patient specific A1C goal if less than 7%~~ ~~o~~ Must submit recent hemoglobin A1C level (within 6 months) ~~o~~ 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~~-~~ ~~**STEP THERAPY CRITERIA:**~~ • ~~Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category~~
Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea	~~**STEP THERAPY CRITERIA:**~~ • ~~Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category~~
Gastrointestinal Agents: Ulcerative Colitis	**LENGTH OF AUTHORIZATIONS**: 365 Days~~; except UCERIS FOAM – 90 days~~

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Gastrointestinal Agents: Unspecified GI	ADDITIONAL ~~METHYLNALTREXONE (RELISTOR) AND~~ NALDEMEDINE (SYMPROIC) CRITERIA: ADDITIONAL RIFAMYCIN DELAYED-RELEASE (AEMCOLO) CRITERIA: • 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	ADDITIONAL NEMOLIZUMAB (NEMLUVIO) CRITERIA: • Must have had an inadequate clinical response of at least 90 days with DUPIXENT and indicated for prurigo nodularis ADDITIONAL ATOPIC DERMATITIS CRITERIA: • Must have at least 10% body surface area (BSA) involvement with an inadequate clinical response of at least ~~90~~ 45 days with two of the following: topical corticosteroids or topical calcineurin inhibitors [e.g., ~~ELIDEL~~ tacrolimus, pimecrolimus] unless atopic dermatitis is severe and involves >25% BSA
Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY	AR – EDURANT SUSP: a PA is required for patients 12 years and older
Ophthalmic Agents: Dry Eye Treatments	LENGTH OF AUTHORIZATIONS: ~~14 days for EYSUVIS;~~ 365 days ~~for all other drugs~~ ADDITIONAL ACOLTREMON (TRYPTYR) AND CYCLOSPORINE (VEVYE) CRITERIA: • Must have had an inadequate clinical response of at least 30 days with CEQUA and indicated for diagnosis
Ophthalmic Agents: Ophthalmic Steroids	NON-PREFERRED CRITERIA: • Must have had an inadequate clinical response of at least ~~7~~ 10 days with at least two preferred drugs in this UPDL category and indicated for diagnosis
Respiratory Agents: Cystic Fibrosis	CLINICAL PA CRITERIA: • Must be prescribed by or in consultation with a pulmonologist or infectious disease specialist • For a CFTR Modulator, must provide documentation of the specific Cystic Fibrosis Transmembrane Conductance Regular (CFTR) genetic mutation

Respiratory Agents: Hereditary Angioedema	CLINICAL PA CRITERIA:
	• Acute Treatment
	  ○ 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:
	  ▪ C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by laboratory testing; OR
	  ▪ C1-INH functional level below the lower limit of normal as defined by laboratory testing

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	• Prophylactic Treatment ○ Must not be used in combination with other prophylaxis agents **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 3 days with at least one preferred 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 14 days with at least one two preferred prophylaxis drugs in this UPDL category and indicated for diagnosis to request a non-preferred prophylaxis drug.
Respiratory Agents: Inhaled Agents	**CLINICAL PA CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with an albuterol containing product **STEP THERAPY CRITERIA:** • Must have had an inadequate clinical response of at least 30 days with at least one inhaled corticosteroid (ICS) **AND** at least one long-acting beta-agonist (LABA) **AND** at least one long-acting muscarinic-antagonist (LAMA) concurrently in this UPDL category and indicated for diagnosis, if available ~~**ADDITIONAL BUDESONIDE/ALBUTEROL (AIRSUPRA) CRITERIA:**~~ • ~~Must have had an inadequate clinical response of at least 14 days with either DULERA or SYMBICORT~~ **AR** – fluticasone propionate: a PA is required for patients 18 years and older

Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE	• For **Chronic Obstructive Pulmonary Disease (COPD)**:
	  ○ The patient must have an eosinophilic count of greater than or equal to 300 150 cells per mcL within 12 months prior to initiation of therapy **AND**
	  ○ The patient has a history of uncontrolled disease, as indicated by ~~greater than or equal to 2 COPD exacerbations 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.
	
	NON-PREFERRED CRITERIA:
	• Must have had an inadequate clinical response of at least 90 days with at least one two preferred drugs in this UPDL category and indicated for diagnosis

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Respiratory Agents: Pulmonary Fibrosis	~~**NON-PREFERRED CRITERIA:**~~ • 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:**~~ • ~~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:** • 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:** • 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:**~~ • ~~**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~~ • ~~**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~~ • ~~**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)~~ **AR** – ELIDEL, ~~tacrolimus~~ and pimecrolimus~~, and tacrolimus~~: a PA is required for patients younger than 2 years old

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

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