Department of Medicaid

30 Day Change Notice
Effective Date: April 1, 2026

NEW PREFERRED DRUGS	
THERAPEUTIC CLASS	**NO PA REQUIRED PREFERRED**
Infectious Disease Agents: Antiretrovirals (ARVs) – HIV Treatment and Prevention* LEGACY CATEGORY	YEZTUGO

NEW CLINICAL PA REQUIRED PREFERRED DRUGS	
THERAPEUTIC CLASS	**CLINICAL CRITERIA REQUIRED PREFERRED**
Immunomodulator Agents: Monoclonal Antibody Biologics/Small-Molecule Kinase Inhibitors	RHAPSIDO
Metabolic Modifiers	WEGOVY

NEW NON-PREFERRED DRUGS	
THERAPEUTIC CLASS	**PA REQUIRED NON-PREFERRED**
Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY	YUTREPIA
Central Nervous System (CNS) Agents: Alzheimer's Agents* LEGACY CATEGORY	LEQEMBI IQLIK
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	BREKIYA
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY	EXXUA
Central Nervous System (CNS) Agents: Medication Assisted Treatment of Opioid Addiction	SUBOXONE
Endocrine Agents: Diabetes – Non-Insulin	BRYNOVIN
Respiratory Agents: Hereditary Angioedema	DAWNZERA EKTERLY
Topical Agents: Immunomodulators	ANZUPGO

BRAND PREFERRED OVER GENERIC REMOVALS	
THERAPEUTIC CLASS	**DRUG NAME**
Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants	XARELTO 2.5MG TABS
Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet	BRILINTA
Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY	BANZEL EPRONTIA SPRITAM TRILEPTAL SUSP

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Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	DAYTRANA MYDAYIS
Central Nervous System (CNS) Agents: Multiple Sclerosis* LEGACY CATEGORY	COPAXONE
Central Nervous System (CNS) Agents: Neuropathic Pain	TRILEPTAL SUSP
Endocrine Agents: Diabetes – Insulin	LANTUS SOLOSTAR
Endocrine Agents: Diabetes – Non-Insulin	VICTOZA
Infectious Disease Agents: Antiretrovirals (ARVs) – HIV Treatment and Prevention* LEGACY CATEGORY	SELZENTRY
Ophthalmic Agents: Ophthalmic Steroids	PRED FORTE

THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA
Cardiovascular Agents: Angina, Hypertension and Heart Failure
Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Alzheimer's Agents* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY
Endocrine Agents: Diabetes – Insulin
Endocrine Agents: Diabetes – Non-Insulin
Gastrointestinal Agents: Bowel Preparations
Immunomodulator Agents: Monoclonal Antibody Biologics/Small-Molecule Kinase Inhibitors
Infectious Disease Agents: Antiretrovirals (ARVs) – HIV Treatment and Prevention* LEGACY CATEGORY
Respiratory Agents: Hereditary Angioedema

REVISED THERAPEUTIC CATEGORY CRITERIA	
THERAPEUTIC CLASS	**SUMMARY OF CHANGE**
Cardiovascular Agents: Angina, Hypertension and Heart Failure	**~~ADDITIONAL~~NON-PREFERRED FINERENONE (KERENDIA) CRITERIA:** • Must be prescribed by or in consultation with a cardiologist or nephrologist (or applicable specialist)**~~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~~ • For Heart Failure with Preserved Ejection Fraction (HFpEF) with LVEF >40%: o Must currently be on a SGLT2 inhibitor **OR** o 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 • For Chronic Kidney Disease associated with type 2 diabetes: ○ Must currently be on a SGLT2 inhibitor **AND** ○ Must be on a maximally tolerated dose of an angiotensin-converting enzyme inhibitor (ACEI) or angiotensin receptor blocker (ARB) **OR** have an allergy, contraindication, or intolerance to ACEI and ARB
Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY	**ADDITIONAL TREPROSTINIL INHALATION (TYVASO/YUTREPIA) CRITERIA:** • Must have had an inadequate clinical response of at least 12 weeks with ORENITRAM or treprostinil inj and indicated for diagnosis, if available
Central Nervous System (CNS) Agents: Alzheimer's Agents* LEGACY CATEGORY	**LECANEMAB-IRMB (LEQEMBI IQLIK) CRITERIA:** • Must have had at least 18 months of therapy with Leqembi IV • Continuation of therapy will be permitted for patients established on Leqembi IV **SUBSEQUENT BENZGALANTAMINE (ZUNVEYL), GALANTAMINE SOLN, LECANEMAB-IRMB (LEQEMBI IQLIK) AUTHORIZATION CRITERIA:** • Must have had a follow-up assessment including cognitive test(s) to determine if disease has not progressed to moderate or severe dementia.
Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute	**ADDITIONAL DIHYDROERGOTAMINE (BREKIYA) CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with dihydroergotamine injection or nasal spray
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY	**ADDITIONAL GEPIRONE (EXXUA) CRITERIA:** • Must have had 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)
Endocrine Agents: Diabetes – Insulin	**ADDITIONAL HIGH CONCENTRATION CRITERIA:** • Must require ≥ 80 units/dose or ≥ 200 units/day of U-100 insulin, **OR** • Patient is experiencing injection site pain due to large volume injections

	SUBSEQUENT AUTHORIZATION CRITERIA: • Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring 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~~ o Must include current A1C ▪ Must be from within last 6 months ▪ Must demonstrate improvement from baseline when the requested medication was initiated
Endocrine Agents: Diabetes – Non-Insulin	**LENGTH OF AUTHORIZATIONS:** 365 Days **NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response of at least 120 days with at least three preferred drugs in this UPDL category and indicated for diagnosis, if available o Must include a patient specific A1C goal if less than 7% o Must include current A1C (within last 6 months) o Two preferred drugs must be used concurrently and one of the drugs must be in the same sub-section as the ~~as the~~ requested medication o Three preferred drugs must be titrated to maximum treatment dose (must achieve maximum recommended dose for 120 days or document that maximum recommended dose is not tolerated or is clinically inappropriate) **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 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 SITAGLIPTIN (BRYNOVIN, ZITUVIO) CRITERIA** • Must have had a trial of at least 120 days with JANUVIA **OR**

	must provide documentation of medical necessity for patient's inability to use JANUVIA **ADDITIONAL GLP-1 RECEPTOR AGONISTS/COMBINATIONS INFORMATION** • For GLP-1 receptor containing medications that were discontinued due to gastrointestinal intolerance, must submit chart documentation that the following approaches were tried for at least 30 days: ○ Dietary changes (e.g., eating apples, crackers, or mint- or ginger-based drinks 30 minutes after administering the GLP-1 Receptor Agonist) **AND** ○ Prescription antiemetics **AND** ○ Dose adjustment to remediate side effects experienced with higher doses of the GLP-1 Receptor Agonist • ~~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 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).~~ ~~○ Must include a patient specific A1C goal if less than 7%~~ ○ ~~Must include current A1C (within last 6 months~~) • ~~For non-preferred drugs that have preferred drugs in the same drug class: must provide documentation that there was at least one inadequate clinical response with a drug in same drug class~~ **SUBSEQUENT AUTHORIZATION CRITERIA:** • Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring ~~○ 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~~ ○ Must include current A1C ▪ Must be from within last 6 months ▪ Must demonstrate improvement from baseline when the requested medication was initiated
Gastrointestinal Agents: Bowel Preparations	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response or an inability to tolerate a high volume preferred bowel preparation during a previous colonoscopy with at least one preferred drug in this UPDL category and indicated for diagnosis

Immunomodulator Agents: Monoclonal Antibody Biologics/Small-Molecule Kinase Inhibitors	• Must be prescribed by or in consultation with an applicable specialist (i.e., allergist/ immunologist, dermatologist, pulmonologist, or otolaryngologist) • For **Chronic Spontaneous Urticaria** – Must have had an inadequate clinical response of at least 14 days with at least two different second-generation H1 antihistamines at 4 times standard dose ○ Must continue use of second-generation H1 antihistamine
Infectious Disease Agents: Antiretrovirals (ARVs) – HIV Treatment and Prevention* LEGACY CATEGORY	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response (such as a virological failure or confirmed resistance) of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis. If applicable, the request must address the inability to use the individual components.

Respiratory Agents: Hereditary Angioedema	**NON-PREFERRED CRITERIA:**
	• Acute Treatment
	  ○ Must have had an inadequate clinical response for any one acute angioedema episode defined as requiring at least two doses of rescue medication or need to be seen in the ~~ER~~emergency department or admitted to the hospital due to persistent angioedema symptoms after the use of two rescue doses of at ~~least 3 days with at~~ least one preferred ~~acute~~ drug within the same sub-section classification in this UPDL category and indicated for diagnosis to request a non-preferred acute drug.
	  ○ Must be on prophylactic treatment
	• Prophylactic Treatment
	  ○ Must have had an inadequate clinical response such as lack of reduction of attacks based on patient report, frequency of ~~ER~~emergency department visits, or frequency of hospitalizations with use of at least 14 days with at least two preferred ~~prophylaxis~~ drugs within the same sub-section classification in this UPDL category and indicated for diagnosis to request a non-preferred prophylaxis drug.

NEW THERAPEUTIC CATEGORIES
Metabolic Modifiers

NEW THERAPEUTIC CATEGORY CRITERIA	
THERAPEUTIC CLASS	**SUMMARY OF CHANGE**
Metabolic Modifiers	**LENGTH OF AUTHORIZATIONS**: 180 days

Date of Notice: 3/1/2026

CLINICAL PA CRITERIA:

- Initial review for diagnosis of **Major Adverse Cardiovascular Events (MACE)**
  - Age ≥18 years
  - BMI ≥27 kg/m^2
  - The prescriber must attest that the requested medication will not be received in combination with any other GLP-1, GLP-1/GIP
  - Documentation (chart notes) must be submitted to show that the patient has history of one of the following ~~and provides documentation (chart notes):~~
    - Prior myocardial infarction
    - Prior stroke
    - Symptomatic peripheral artery disease (PAD) as evidenced by one or more of the following:
      - Intermittent claudication with an ankle-brachial index (ABI) less than 0.85 (at rest)
      - Peripheral arterial revascularization procedure (e.g., endarterectomy, angioplasty, stenting)
      - Amputation due to atherosclerotic cardiovascular disease (ASCVD)
  - ~~Documentation (chart notes) must be submitted to show the patient does not have type 1 or 2 diabetes. The A1C must be less than 6.5%.~~ Wegovy will not be authorized for patients with type 1 or type 2 diabetes. (For patients with type 1 or 2 diabetes, please see the Endocrine Agents: Non-Insulin Agents category)
  - The patient is receiving standard of care for the treatment of cardiovascular disease (CVD), as appropriate/indicated, including an antiplatelet agent (aspirin or platelet aggregation inhibitor), lipid-lowering drug (statin, ezetimibe, fibrate, and/or PCSK-9 inhibitor), and an antihypertensive (beta blocker, ACEI, ARB). Documentation (chart notes) must be submitted to support current medication use or contraindications to these treatments (as applicable)
- Initial review for diagnosis of **Metabolic Dysfunction-Associated Steatohepatitis (MASH)**
  - Age ≥18 years
  - Must have documented noncirrhotic MASH with moderate to advanced liver fibrosis (stage F2 or F3) confirmed by liver biopsy within the prior 24 months **OR**

	○ Must have documented noncirrhotic MASH and moderate to advanced liver fibrosis (stage F2 or F3) confirmed by **TWO** of the following: ▪ Fibrosis-4 index greater than 1.3, magnetic resonance elastography (MRE), MRI aspartate aminotransferase (MAST), liver stiffness measurement (LSM) by vibration controlled transient elastography (e.g., Fibroscan) ○ Must attest that the patient has received instruction on a reduced calorie diet and increased physical activity and is adherent to these lifestyle modifications ○ Must attest that the patient has optimized care for concomitant related conditions, including coronary artery disease, dyslipidemia, hypertension ○ Not currently on another treatment for MASH (e.g., resmetirom) ○ Not currently on another GLP-1 Receptor Agonist containing agent **SUBSEQUENT AUTHORIZATION CRITERIA:** • **Major Adverse Cardiovascular Events (MACE)** ○ The prescriber attests that the patient is being monitored for efficacy and safety ○ Documentation (chart notes) must be submitted to show weight loss from baseline greater than or equal to 5% ○ Adherence documented by claims supporting an 80% proportion of days covered ○ ~~Documentation (chart notes) must be submitted to show the patient does not have type 1 or 2 diabetes. The A1C must be less than 6.5%.~~ Wegovy will not be authorized for patients with type 1 or type 2 diabetes. (For patients with type 1 or 2 diabetes, please see the Endocrine Agents: Non-Insulin Agents category) • **Metabolic Dysfunction-Associated Steatohepatitis (MASH)** ○ Weight loss from baseline of 5% or greater ○ ~~Has the p~~Patient has experienced a positive clinical response from Wegovy as defined by the following: ▪ Resolution of steatohepatitis and no worsening of liver fibrosis, **OR** ▪ At least one stage improvement in liver fibrosis and no worsening of steatohepatitis ○ Must have been adherent with using Wegovy, with claims supporting an 80% proportion of days covered