NH Healthy Families Pharmacy & Therapeutics Committee 24Q1

Policy/ Coverage Criteria Guideline	Revision Summary Description
CP.PHAR.659 Vamorolone (Agamree)	Policy created.
CP.PHAR.660 Bimekizumab-bkzx (Bimzelx)	Policy created.
CP.PHAR.661 Etrasimod (Velsipity)	Policy created.
CP.PHAR.662 Mirikizumab-mrkz (Omvoh)	Policy created.
CP.PHAR.602 Atidarsagene autotemcel (OTL-200)	1Q 2024 annual review: no significant changes as drug is not yet FDA-approved; references updated.
CP.PHAR.603 Exagamglogene Autotemcel (Exa-Cel)	1Q 2024 annual review: no significant changes as drug is not yet FDA-approved; references updated.
CP.PHAR.609 Prademagene Zamikeracel (EB-101)	1Q 2024 annual review: no significant changes as drug is not yet FDA-approved; references updated.
NH.PHAR.247 Certolizumab (Cimzia)	Annual Review, No Changes
NH.PHAR.364 Guselkumab (Tremfya)	Annual Review, No Changes
NH.PHAR.149 Baclofen (Fleqsuvy, Gablofen, Lioresal, Lyvispah, Ozobax)	Annual Review, No Changes
NH.PHAR.386 Tildrakizumab-asmn (Ilumya)	Annual Review, No Changes
NH.PHAR.253 Golimumab (Simponi, Simponi Aria)	Annual Review, No Changes
NH.PHAR.261 Secukinumab (Cosentyx)	Annual Review, No Changes
NH.PHAR.264 Ustekinumab (Stelara)	Annual Review, No Changes
NH.PHAR.241 Abatacept (Orencia)	Annual Review, No Changes
NH.PMN.121 Lisdexamfetamine (Vyvanse)	Annual Review, No Changes
NH.PPA.12 Opioid Analgesics	Annual Review, No Changes
CP.PHAR.01 Omalizumab (Xolair)	1Q 2024 annual review: added off-label indications and criteria for systemic mastocytosis and immunotherapy-related pruritus per NCCN; updated formulations to include strengths of prefilled syringe and autoinjectors; references reviewed and updated.
CP.PHAR.24 Fostamatinib (Tavalisse)	1Q 2024 annual review: added Tavalisse is not prescribed concurrently with thrombopoietin receptor agonists; references reviewed and updated.
CP.PHAR.40 Octreotide Acetate (Sandostatin, Sandostatin LAR, Bynfezia, Mycapssa)	1Q 2024 annual review: removed Sandostatin LAR Depot from non-formulary list which references usage of the formulary exception policy (HIM.PA.103); for thymoma and thymic carcinoma, removed criterion, "prescribed as second-line therapy" and added octreotide scan or dotatate PET/CT is positive per NCCN; removed references to Bynfezia from policy due to product discontinuation; references reviewed and updated.
CP.PHAR.59 Zoledronic Acid (Reclast, Zometa)	1Q 2024 annual review: for osteoporosis, clarified failure of "generic" alendronate is preferred; for Paget's disease, removed initial criteria requiring failure of an oral bisphosphonate per guidelines; removed Paget's disease indication for oral bisphosphonates from Appendix B; references reviewed and updated.
CP.PHAR.63 Everolimus (Afinitor, Afinitor Disperz, Zortress)	1Q 2024 annual review: clarified oral oncology redirection language to "generic" everolimus; for DTC, removed requirement of prior therapy per NCCN; for HL, WM/LPL, thymoma, thymic carcinoma, histiocytic neoplasms, PEComa, recurrent angiomyolipoma, and lymphangioleiomyomatosis, added prescribed as single agent per NCCN; references reviewed and updated.
CP.PHAR.94 Alpha1-Proteinase Inhibitors	1Q 2024 annual review: updated FDA approved indications section to align with prescriber information for Aralast NP, Glassia, Prolastin-C, and Zemaira; added Aralast NP and Zemaira to HIM NF disclaimer statements; references reviewed and updated.

CP.PHAR.115 Pegloticase (Krystexxa)	1Q 2024 annual review: updated "Uloric" to generic "febuxostat" to clarify generic redirection is preferred; references reviewed and updated.
CP.PHAR.123 Evolocumab (Repatha)	1Q 2024 annual review: added Leqvio to list of drugs where coadministration is not allowed; added the following requirement from initial approval criteria to also require for continuation of therapy "Treatment plan does not include coadministration with Leqvio, Juxtapid or Praluent"; divided criteria with multiple elements into separate bullets for added clarity; Appendix I clarified smoking is specific to tobacco; references reviewed and updated.
CP.PHAR.124 Alirocumab (Praluent)	1Q 2024 annual review: added Leqvio to list of drugs where coadministration is not allowed; added the following requirement from initial approval criteria to also require for continuation of therapy "Treatment plan does not include coadministration with Juxtapid, Leqvio, or Repatha"; Appendix I clarified that smoking is specific to tobacco and revised HeFH to FH; references reviewed and updated.
CP.PHAR.168 Corticotropin (H.P. Acthar, Purified Cortrophin Gel)	1Q 2024 annual review: for infantile spasm reduced approval durations from 3 to 1 month; for Purified Cortrophin Gel added 1 mL multiple dose vial formulation to Section VI; updated HCPCS codes and revised to include J0801 and J0802; references reviewed and updated.
CP.PHAR.179 Romiplostim (Nplate)	1Q 2024 annual review: for ITP added spleen tyrosine kinase inhibitor (e.g., Tavalisse™) to list of drugs in which concurrent use is excluded; references reviewed and updated.
CP.PHAR.180 Eltrombopag (Promacta)	1Q 2024 annual review: added NCCN Compendium-supported indication of prolonged thrombocytopenia post-hematopoietic cell transplant; added exclusion of concurrent thrombopoietin receptor agonist with Promacta to aplastic anemia, chronic hepatitis C-associated thrombocytopenia, and NCCN Compendium indications; for all FDA-labeled indications added exclusion of concurrent spleen tyrosine kinase inhibitor (e.g., Tavalisse™); references reviewed and updated.
CP.PHAR.188 Teriparatide (Forteo, Bonsity)	1Q 2024 annual review: RT4: added Bonsity and revised FDA Approved Indication(s) section to align with current labeling language for both Forteo and Bonsity; added generic Forteo (620 mcg/2.4 mL formulation); added generic Bonsity (620 mcg/2.48 mL formulation); added redirection to generic Forteo for all brand requests per SDC; clarified dosage regimen in Appendix B per PI; added HCPC codes [C9399, J3490]; references reviewed and updated.
CP.PHAR.189 Ibandronate injection (Boniva)	1Q 2024 annual review: added criteria that member must use generic ibandronate injection; clarified failure of "generic" alendronate is preferred; clarified dosage regimens in Appendix B per PI; references reviewed and updated.
CP.PHAR.196 Selexipag (Uptravi)	1Q 2024 annual review: added IV Uptravi 1800 mcg/10 mL formulation and criteria for use per PI; clarified concomitant administration with CYP2C8 inducers require higher doses; updated contraindications per PI; removed commercially unavailable branded products from Appendix B; references reviewed and updated.
CP.PHAR.224 Enoxaparin (Lovenox)	1Q 2024 annual review: updated appendix D with current NCCN compendium language; references reviewed and updated.
CP.PHAR.225 Dalteparin (Fragmin)	1Q 2024 annual review: updated appendix D with current NCCN compendium language; references reviewed and updated.
CP.PHAR.226 Fondaparinux (Arixtra)	1Q 2024 annual review: updated appendix D with current NCCN compendium language; references reviewed and updated.
CP.PHAR.254 Infliximab (Avsola, Inflectra, Remicade, Renflexis, Zymfentra)	RT4: added newly approved Zymfentra to criteria; for AS, PsO, PsA, RA, Kawasaki Disease, added "request is for Avsola, Inflectra, Remicade, or Renflexis" to initial approval criteria; added Tofidence and Zymfentra to section III.B.
CP.PHAR.270 Paricalcitol Injection (Zemplar)	Replaced redirection to IV calcitriol with redirection to IV doxercalciferol since IV calcitriol is no longer commercially available.

CP.PHAR.283 Lomitapide (Juxtapid)	1Q 2024 annual review: added Leqvio to list of drugs where coadministration is not allowed; added the following requirement from initial approval criteria to also require for continuation of therapy "Treatment plan does not include coadministration with Leqvio, Repatha, or Praluent"; Appendix I clarified that smoking is specific to tobacco and revised HeFH to FH; references reviewed and updated.
CP.PHAR.288 Eteplirsen (Exondys 51)	1Q 2024 annual review: added criteria, member has not previously received gene replacement therapy for DMD (e.g., Elevidys); added Agamree to list of corticosteroids in Appendix B; references reviewed and updated.
CP.PHAR.300 Bezlotoxumab (Zinplava)	1Q 2024 annual review: updated CDI age requirement from ≥18 years to ≥ 1 year per FDA pediatric expansion; references reviewed and updated.
CP.PHAR.329 Siltuximab (Sylvant)	1Q 2024 annual review: in CRS initial criteria, added Sylant may be used to replace the second dose of Actemra OR Tofidence per NCCN; references reviewed and updated.
CP.PHAR.336 Dupilumab (Dupixent)	1Q 2024 annual review: for atopic dermatitis removed oral systemic therapy step criterion per updated guideline and competitor analysis; added off-label indication and criteria for immunotherapy-related pruritus per NCCN; references reviewed and updated.
CP.PHAR.361 Tisagenlecleucel (Kymriah)	1Q 2024 annual review: per NCCN for Ph+ ALL, revised requirement to include relapse or refractory disease and modified verbiage from "failure of" to "member has received 2 lines of chemotherapy that included 2 tyrosine kinase inhibitors," revised reference from AIDS to HIV consistent with NCCN; added Carvykti as an additional example of CAR T-cell immunotherapy that Kymriah should not be prescribed concurrently with or that member has previously received; references reviewed and updated.
CP.PHAR.362 Axicabtagene ciloleucel (Yescarta)	1Q 2024 annual review: added the following NCCN compendium supported uses for LBCL: monomorphic post-transplant lymphoproliferative disorders (B-cell type), extranodal marginal zone lymphoma of the stomach, extranodal marginal zone lymphoma of nongastric sites (noncutaneous), nodal marginal zone lymphoma; revised reference from AIDS to HIV consistent with NCCN; references reviewed and updated.
CP.PHAR.367 Letermovir (Prevymis)	1Q 2024 annual review: per updated prescribing information for allogeneic HSCT, added allowance for use through Day 200 post-transplantation if at risk for late CMV infection and disease; added examples of risk factors for late CMV infection and disease to Appendix D; references reviewed and updated.
CP.PHAR.402 Emapalumab-lzsg (Gamifant)	1Q 2024 annual review: added examples of possible HLH related genetic mutations; added immunologist as an additional specialist prescriber; added requirement for concurrent use with dexamethasone to continuation of therapy; references reviewed and updated.
CP.PHAR.407 Lusutrombopag (Mulpleta)	1Q 2024 annual review: added spleen tyrosine kinase inhibitor (e.g., Tavalisse™) concurrent use exclusion; references reviewed and updated.
CP.PHAR.411 Amifampridine (Firdapse)	1Q 2024 annual review: added additional option for prescribing by a neuromuscular specialist; applied exclusion for history of seizures to continued therapy requests; references reviewed and updated.
CP.PHAR.428 Romosozumab-aqqg (Evenity)	1Q 2024 annual review: added criteria to ensure the member has not received ≥ 12 months cumulative Evenity therapy before approval per PI; clarified failure of "generic" alendronate is preferred; clarified dosage regimen in Appendix B per PI; reference reviewd and updated.
CP.PHAR.453 Golodirsen (Vyondys 53)	1Q 2024 annual review: added criteria, member has not previously received gene replacement therapy for DMD (e.g., Elevidys); added Agamree to list of corticosteroids in Appendix B; references updated and reviewed.
CP.PHAR.461 Nadofaragene firadenovec-vncg (Adstiladrin)	1Q 2024 annual review: removed initial criteria requirement for clinically significant elevated liver or renal function tests per prescribing information; added oncology dosing criteria to allow doses supported by practice guidelines or literature ;removed category 2B NCCN recommendation: NMIBC characterized by Ta/T1 high-grade without concomitant CIS per NCCN; removed HCPCS code J3590 and C9399; references reviewed and updated.

CP.PHAR.464 Selumetinib (Koselugo)	1Q 2024 annual review: for glioma, removed restriction to WHO grade 1 as supported by NCCN; added criteria for failure of Mekinist or Cotellic for Langerhans cell histiocytosis per NCCN and updated Appendix B; added approval duration of 6 months and 12 months respectively for initial and continuation criteria to off-label NCCN compendium recommended indications (Section I.B and II.B); updated Appendix D; references reviewed and updated
CP.PHAR.465 Teprotumumab (Tepezza)	1Q 2024 annual review: for corticosteroid redirection added additional bypass for significant proptosis and diplopia consistent with 2022 ATA recommendations; for continuation of therapy reduced approval duration to 1 month; references reviewed and updated.
CP.PHAR.466 Valoctocogene Roxaparvovec (Roctavian)	1Q 2024 annual review: added exclusion for prior gene therapy per competitor analysis and pivotal trial exclusion criteria; references reviewed and updated.
CP.PHAR.467 Zanubrutinib (Brukinsa)	1Q 2024 annual review: added criteria for hairy cell leukemia per NCCN; updated MCL regimens in Appendix B; references reviewed and updated.
CP.PHAR.470 Casimersen (Amondys 45)	1Q 2024 annual review: added criteria, member has not previously received gene replacement therapy for DMD (e.g., Elevidys); added Agamree to list of corticosteroids in Appendix B; references reviewed and updated.
CP.PHAR.472 Brexucabtagene autoleucel (Tecartus)	1Q 2024 annual review: per NCCN for Ph+ ALL, revised requirement to include relapse or refractory disease and modified verbiage from “failure of” to “member has received 2 tyrosine kinase inhibitors”; references reviewed and updated.
CP.PHAR.473 Lumasiran (Oxlumo)	1Q 2024 annual review: for Commercial line of business changed approval duration to “6 months or duration of request, whichever is less;”, for reauthorization added decrease from baseline in POx levels along with symptomatic improvement as a pathway for reauthorization; references reviewed and updated.
CP.PHAR.484 Viltolarsen (Viltepso)	1Q 2024 annual review: added criteria, member has not previously received gene replacement therapy for DMD (e.g., Elevidys); added Agamree to list of corticosteroids in Appendix B; references reviewed and updated.
CP.PHAR.492 Teplizumab-mzwv (Tzield)	1Q 2024 annual review: removed HCPCS code [J3590]; updated Appendix D; references reviewed and updated.
CP.PHAR.511 Evinacumab-dgnb (Evkeeza)	1Q 2024 annual review: for redirection to Praluent added requirement for 8 week trial duration; added Leqvio to list of potential co-administered drugs along with Juxtapid, Praluent, and Repatha; divided criteria with multiple elements into separate bullets for added clarity; Appendix H clarified smoking is specific to tobacco; references reviewed and updated.
CP.PHAR.515 Avacopan (Tavneos)	1Q 2024 annual review: clarified that concomitant standard therapy include at least one of the listed drugs per pivotal trial study and competitor criteria; references reviewed and updated.
NH.PHAR.555 Human Growth Hormone (Somapacitan, Somatropin)	1Q 2024 annual review: for HIV-associated wasting or cachexia, added options for member to meet criteria if weight < 90% of the lower limit of ideal body weight or BMI ≤ 20 kg/m^2; added HCPCS/CPT code [C9399, J3590]; references reviewed and updated.
CP.PHAR.562 Allogeneic cultured keratinocytes and dermal fibroblasts (StrataGraft)	1Q 2024 annual review: clarified that initial approval duration is for “one application only per thermal burn occurrence”; references reviewed and updated.
CP.PHAR.567 Cipaglucosidase alfa-atga--miglustat (Pombiliti-Opfolda)	1Q 2024 annual review: drug is now FDA-approved – description section updated per FDA labeling; criteria updated per FDA labeling: added requirement that Pombiliti and Opfolda be prescribed together in both initial approval and continued therapy sections, added exclusion against concurrent use with Lumizyme and Nexviazyme for Continued Therapy; updated HCPCS codes: [C9399] and [J3590]; references reviewed and updated.
CP.PHAR.568 Inclisiran (Leqvio)	1Q 2024 annual review: for redirection to a preferred PCSK9 inhibitor added requirement for 8 week trial duration; added the following requirement from initial approval criteria to also require for continuation of therapy “Treatment plan does not include coadministration with Juxtapid, Repatha, or Praluent”; divided criteria with

	multiple elements into separate bullets for added clarity; Appendix I clarified smoking is specific to tobacco; references reviewed and updated.
CP.PHAR.590 Omaveloxolone (Skyclarys)	For genetic testing, added that it shows a GAA triplet-repeat expansion in the FXN gene; modified baseline mFARs score by removing 20 to 80 score requirement; removed member does not have history of clinically significant left sided heart disease or cardiac disease; removed exclusion for pes cavus as not excluded in PI or Moxie trial; removed requirement that member has ability to swallow capsules; for continued therapy, revised language from "improvement in any of the following parameters" to "improvement or stabilization in any of the following parameters" and changed approval duration from 6 months to 12 months.
CP.PHAR.597 Leniolisib (Joenja)	Extended initial approval duration from 3 months to 6 months to allow sufficient time for full clinical response to meet reauthorization criteria; extended continued therapy approval duration from 6 months to 12 months; references reviewed and updated.
CP.PHAR.605 Adagrasib (Krazati)	1Q 2024 annual review: Per NCCN: for NSCLC added monotherapy criterion and added brain metastases as exception to having received ≥ 1 prior therapy; added off-label criteria for pancreatic adenocarcinoma and colorectal cancer; references reviewed and updated.
CP.PHAR.616 Zilucoplan (Zilbrysq)	1Q 2024 annual review: RT4: drug is now FDA approved – dosing criteria updated per FDA labeling; references reviewed and updated.
CP.PHAR.655 Motixafortide (Aphexda)	Added redirection to plerixafor.
CP.PMN.03 DPP-4 inhibitors	1Q 2024 annual review: RT4: added newly approved Zituvimet to criteria; references reviewed and updated.
NH.PMN.22 Brand Name Override	1Q 2024 annual review: added requirement that request is not for a benefit excluded use; references reviewed and updated.
CP.PMN.57 Febuxostat (Uloric)	1Q 2024 annual review: added redirection to generic febuxostat; updated boxed warning with "cardiovascular death" to align with prescriber information; references reviewed and updated.
CP.PMN.90 Benznidazole	1Q 2024 annual review: removed Commercial line of business as criteria does not apply; references reviewed and reviewed.
CP.PMN.92 CNS Stimulants	1Q 2024 annual review: added "abuse, misuse, and addiction" for boxed warnings for Adzenys XR-ODT, Aptensio XR, Azstarys, Cotempla XR-ODT, Daytrana, Dyanavel XR, Evekeo ODT, Focalin XR, Jornay PM, Mydayis, Quillichew ER, Quillivant XR, Relexxii, Xelstrym per prescriber information; for Daytrana, removed "marked anxiety, tension, or agitation; glaucoma; tics or family history of Tourette's syndrome" in contraindications section per prescribing information; references reviewed and updated.
CP.PMN.93 Dextromethorphan-Quinidine (Nuedexta)	1Q 2024 annual review: added neuropsychologist and psychiatrist as optional specialist prescribers; in Appendix C updated link to CNS-LS questionnaire; references reviewed and updated.
CP.PMN.96 Ibandronate Oral (Boniva)	1Q 2024 annual review: added criteria "for brand name Boniva request, member must use generic ibandronate"; clarified failure of "generic" alendronate is preferred; updated contraindication in Appendix C per PI; references reviewed and updated.
CP.PMN.100 Risedronate (Actonel, Atelvia)	1Q 2024 annual review: in approval criteria, clarified Actonel dose limit per week and per month; added redirection to generic risedronate; added criteria to ensure Atelvia is prescribed for PMO per PI; clarified failure of "generic" alendronate is preferred; references reviewed and updated.
NH.PMN.104 Tasimelteon (Hetlioz)	1Q 2024 annual review: applied generic tasimelteon capsule redirection for brand Hetlioz capsule requests to SMS indication; added the following examples for positive response to therapy: increase in nighttime sleep, decrease in daytime nap time, improvement in sleep quality; for criteria specific to Hetlioz capsules, clarified this also applies to the generic tasimelteon capsules; for redirection to ramelteon added clarification that generic is preferred when referencing brand Rozerem product; references reviewed and updated.

CP.PMN.123 Colchicine (Colcrys, Lodoco)	1Q 2024 annual review: for Gout Anti-Inflammatory Prophylaxis, updated "unless contraindicated" to "unless contraindicated or clinically significant adverse effects are experienced"; references reviewed and updated.
CP.PMN.186 Cenegermin-bkbj (Oxervate)	1Q 2024 annual review: added optometrist as an additional prescriber option; references reviewed and updated.
CP.PMN.218 Lasmiditan (Reyvow)	1Q 2024 annual review: added pain specialist prescriber option; clarified redirection should be to *generic* $5HT_{1B/1D}$-agonist migraine medications; add to continuation of therapy similar requirement for dose increase requests for quantities greater than two doses per month as required currently for initial requests; references reviewed and updated.
CP.PMN.257 Clascoterone (Winlevi)	1Q 2024 annual review: for initial approval criteria, updated "failure of ≥ 2 of the following topical preparations" to "failure of ≥ 2 of the following generic formulary topical preparations"; updated dosing for benzoyl peroxide in Appendix B; references reviewed and updated.
CP.PMN.271 Maribavir (Livtencity)	1Q 2024 annual review: added requirement that Livtencity is not prescribed concurrently with ganciclovir or valganciclovir; references reviewed and updated.
CP.PMN.272 Mavacamten (Camzyos)	Revised the requirement for a prior trial of all three of a beta-blocker, a calcium channel blocker, and disopyramide to require only two of those three alternatives.
CP.PMN.277 Ulcer Therapy Products (Omeclamox Pak, Pylera, Talicia, Voquezna)	RT4: added Voquezna with corresponding criteria set for erosive esophagitis; updated Appendix C with Voquezna Triple/Dual Pak contraindications; renamed policy from Ulcer Therapy Combinations to Ulcer Therapy Products.
CP.PHAR.52 Interferon Gamma- 1b (Actimmune)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.58 Denosumab (Prolia, Xgeva)	1Q 2024 annual review: no significant changes; for osteoporosis initial criteria, clarified "failure" of generic alendronate is preferred; references reviewed and updated.
CP.PHAR.96 Naltrexone (Vivitrol)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.101 Mifepristone (Korlym)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.165 Ferumoxytol (Feraheme)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.181 Hemin (Panhematin)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.184 Aflibercept (Eylea, Eylea HD)	1Q 2024 annual review: no significant changes; added HCPCS codes for Eylea HD [J3590, C9399]; references reviewed and updated.
CP.PHAR.186 Ranibizumab (Lucentis, Susvimo), Lucentis Biosimilars	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.187 Verteporfin (Visudyne)	1Q 2024 annual review: no significant changes; in Appendix B, added Eylea HD dosing information; references reviewed and updated.
CP.PHAR.190 Ambrisentan (Letairis)	1Q 2024 annual review: no significant changes; removed commercially unavailable branded products from Appendix B; references reviewed and updated.
CP.PHAR.191 Bosentan (Tracleer)	1Q 2024 annual review: no significant changes; removed commercially unavailable branded products from Appendix B; references reviewed and updated.
CP.PHAR.192 Epoprostenol (Flolan, Veletri)	1Q 2024 annual review: no significant changes; removed commercially unavailable branded products from Appendix B; clarified Veletri product availability description to describe a "powder for reconstitution" per PI; references reviewed and updated.
CP.PHAR.193 Iloprost (Ventavis)	1Q 2024 annual review: no significant changes; removed commercially unavailable branded producnts from Appendix B; references reviewed and updated.
CP.PHAR.194 Macitentan (Opsumit)	1Q 2024 annual review: no significant changes; removed commercially unavailable branded products from Appendix B; references reviewed and updated
CP.PHAR.195 Riociguat (Adempas)	1Q 2024 annual review: no significant changes; removed commercially unavailable branded products from Appendix B; references reviewed and updated.

CP.PHAR.197 Sildenafil (Revatio, Liqrev)	1Q 2024 annual review: no significant changes; removed commercially unavailable branded products from Appendix B; references reviewed and updated.
CP.PHAR.198 Tadalafil (Adcirca, Alyq, Tadliq)	1Q 2024 annual review: no significant changes; removed commercially unavailable branded products from Appendix B; references reviewed and updated.
CP.PHAR.199 Treprostinil (Orenitram, Remodulin, Tyvaso)	1Q 2024 annual review: no significant changes; revised language in FDA approved indication(s) to align with PI; removed commercially unavailable branded products from Appendix B; clarified HCPC code [J8499] is also applicable to Tyvaso DPI; removed inactive HCPC code [J7699]; references reviewed and updated.
CP.PHAR.200 Mepolizumab (Nucala)	1Q 2024 annual review: no significant changes; clarified Churg-Strauss was a previous name for EGPA; references reviewed and updated.
CP.PHAR.203 Cosyntropin (Cortrosyn)	1Q 2024 annual review: no significant changes; clarified Churg-Strauss was a previous name for EGPA; references reviewed and updated
CP.PHAR.208 Sodium phenylbutyrate (Buphenyl, Pheburane, Olpruva)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.214 Desmopressin (DDAVP, Stimate, Nocdurna)	1Q 2024 annual review: no significant changes; added update that central diabetes insipidus is referred to as arginine vasopressin deficiency with further information in Appendix D; references reviewed and updated.
CP.PHAR.223 Reslizumab (Cinqair)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.234 Ferric Carboxymaltose (Injectafer)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.282 Parathyroid hormone (Natpara)	1Q 2024 annual review: no significant changes; added HCPCS code [C9399]; references reviewed and updated.
CP.PHAR.327 Nusinersen (Spinraza)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.330 Protein C Concentrate Human (Ceprotin)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.331 Deflazacort (Emflaza)	1Q 2024 annual review: no significant changes; added criterion “documentation of member’s current weight in kg” to initial and continued approval criteria; references reviewed and updated.
CP.PHAR.345 Abaloparatide (Tymlos)	1Q 2024 annual review: no significant changes; clarified failure of “generic” alendronate is preferred; clarified dosage regimen in Appendix B per PI; reference reviewd and updated.
CP.PHAR.370 Emicizumab-kxwh (Hemlibra)	1Q 2024 annual review: no significant changes; updated sites of serious bleeds per WFH guideline in Appendix D; references reviewed and updated.
CP.PHAR.371 Triamcinolone ER Injection (Zilretta)	1Q 2024 annual review: no significant changes; in Appendix B, added ketoprofen ER and diclofenac 2% solution and removed commercially unavailable branded products; references reviewed and updated.
CP.PHAR.372 Voretigene neparvovec-rzyl (Luxturna)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.373 Benralizumab (Fasenra)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.405 Inotersen (Tegsedi)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.444 Afamelanotide (Scenesse)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.445 Brolucizumab (Beovu)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.449 Crizanlizumab-tmca (Adakveo)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.450 Luspatercept-aamt (Reblozyl)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.451 Voxelotor (Oxbryta)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.455 Enfortumab Vedotin-ejfv (Padcev)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.457 Givosiran (Givlaari)	1Q 2024 annual review: no significant changes; added criteria “documentation of member’s current body weight (in kg);” references reviewed and updated.
CP.PHAR.459 Iobenguane I 131 (Azedra)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.477 Risdiplam (Evrysdi)	1Q 2024 annual review: no significant changes; references reviewed and updated.

CP.PHAR.491 Setmelanotide (Imcivree)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.499 Lonafarnib (Zokinvy)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.516 Fostemsavir (Rukobia)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.522 Margetuximab-cmkb (Margenza)	1Q 2024 annual review: no significant changes; referenced reviewed and updated.
CP.PHAR.523 Naxitamab-gqgk (Danyelza)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.525 Vosoritide (Voxzogo)	1Q 2024 annual review: RT4: updated criteria with pediatric age extension; added appendix D general information on use in pediatric population; references reviewed and updated.
CP.PHAR.555 Efgartigimod alfa, efgartigimod-hyaluronidase (Vyvgart, Vyvgart Hytrulo)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.563 Allogenic processed thymus tissue-agdc (Rethymic)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.570 Ropeginterferon alfa-2b-njft (Besremi)	1Q 2024 annual review: no significant changes; for Appendix D, added Besremi as preferred regimen for cytoreductive therapy for high risk PCV; added HCPCS codes [C9399, J9999]; references reviewed and updated.
CP.PHAR.572 Budesonide (Tarpeyo)	1Q 2024 annual review: no significant changes; clarified 1 g/day is associated with proteinuria rather than UPCR; for continuation of therapy revised approval duration from 6 months to “up to a total treatment duration 38 weeks”; references reviewed and updated.
CP.PHAR.573 Cabotegravir, Cabotegravir-Rilpivirine (Apretude Cabenuva)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.574 Sirolimus Protein-Bound Particles (Fyarro), topical gel (Hyftor)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.576 Tezepelumab (Tezspire)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.606 Spesolimab-sbzo (Spevigo)	1Q 2024 annual review: no significant changes; added Tofidence to section III.B; removed expired HCPCS codes for Spevigo [C9399, J3590]; references reviewed and updated.
CP.PHAR.607 Deucravacitinib (Sotyktu)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.608 Furosemide (Furoscix)	1Q 2024 annual review: no significant changes; in Appendix B, removed thiazide diuretics (metolazone and chlorothiazide) since there are no thiazide-related redirection in criteria and added commercially available brand names; references reviewed and updated.
CP.PHAR.610 Sodium thiosulfate (Pedmark)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.613 Fecal microbiota, live-jslm (Rebyota)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.615 Olutasidenib (Rezlidhia)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.617 Mirvetuximab soravtansine-gynx (Elahere)	1Q 2024 annual review: no significant changes; in Appendix B, updated formatting and removed commercially unavailable products per Clinical Pharmacology; references reviewed and updated.
CP.PHAR.618 Mosunetuzumab-axgb (Lunsumio)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.04 Non-Calcium Phosphate Binders (Auryxia, Fosrenol, Renagel, Renvela, Velphoro)	1Q 2024 annual review: no significant changes; for iron deficiency anemia separated requirement that member is not on dialysis for added clarity; references reviewed and updated.
CP.PMN.05 Rifapentine (Priftin)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.14 SGLT2 inhibitors	1Q 2024: no significant changes; for Appendix C, added Brenzavvy as product exception for renal impairment contraindication to align with prescriber information; updated Appendix D; references reviewed and updated.
CP.PMN.20 Aspirin-dipyridamole (Aggrenox)	1Q 2024 annual review: no significant changes; clarified generic aspirin is preferred; references reviewed and updated.
CP.PMN.24 Ciclopirox Topical Solution	1Q 2024 annual review: no significant changes; removed references to Penlac as branded product is discontinued; references reviewed and updated.

CP.PMN.25 Efinaconazole (Jublia)	1Q 2024 annual review: no significant changes; added note that prior authorization may be required for ciclopirox 8% topical solution; references reviewed and updated.
CP.PMN.34 Ranolazine (Ranexa, Aspruzyo Sprinkle)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.52 Omega-3-Acid Ethyl Esters	1Q 2024 annual review: no significant changes; references reviewed and updated
CP.PMN.67 Sacubitril-Valsartan (Entresto)	1Q 2024 annual review: no significant changes; updated contraindications to include concomitant use with aliskiren per PI; references reviewed and updated
CP.PMN.70 Ivabradine (Corlanor)	1Q 2024 annual review: no significant changes; removed commercially unavailable branded therapeutic alternatives; references reviewed and updated.
CP.PMN.72 Metformin ER (Glumetza, Fortamet)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.81 Buprenorphine-naloxone (Suboxone, Zubsolv)	1Q 2024 annual review: no significant changes; removed references to Bunavail and cassipa due to product discontinuation; references reviewed and updated.
CP.PMN.82 Buprenorphine (Subutex)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.88 Alendronate (Binosto, Fosamax plus D)	1Q 2024 annual review: no significant changes; clarified failure of a “generic” alendronate is preferred; references reviewed and updated.
CP.PMN.89 Amantadine ER (Gocovri,Osmolex ER)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.99 Prasterone (Intrarosa)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.101 Rivastigmine (Exelon)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.103 Secnidazole (Solosec)	1Q 2024 annual review: no significant changes; for BV added notification that tinidazole may require PA (as also stated within the trichomoniasis criteria); references reviewed and updated.
CP.PMN.105 Tavaborole (Kerydin)	1Q 2024 annual review: no significant changes; added note that prior authorization may be required for ciclopirox 8% topical solution; references reviewed and updated.
CP.PMN.107 Topical Immunomodulators	1Q 2024 annual review: no significant changes; clarified trial and failure is “topical” corticosteroids; references reviewed and updated.
CP.PMN.113 Safinamide (Xadago)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.129 Pramlintide (Symlin)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.151 QL of Blood Glucose Test Strips Not Receiving Insulin	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.166 Luliconazole cream (Luzu)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.187 Icosapent ethyl (Vascepa)	1Q 2024 annual review: no significant changes; references reviewed and updated
CP.PMN.189 Sarecycline (Seysara)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.212 Bedaquiline (Sirturo)	1Q 2024 annual review: no significant changes; updated linezolid dosing from 1,200 mg to 600 mg per updated CDC recommendations; references reviewed and updated.
CP.PMN.217 Istradefylline (Nourianz)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.222 Pretomanid	1Q 2024 annual review: no significant changes; updated linezolid dosing from 1,200 mg to 600 mg per updated CDC recommendations; references reviewed and updated.
CP.PMN.223 Rifabutin (Mycobutin)	1Q 2024 annual review: no significant changes; added specific requirement that "request is for MAC prophylaxis in member with HIV” to support labeled indication; for off-label use in tuberculosis, added to continuation of therapy the following to support existing approval duration: “member has not received more than 12 months of therapy”; for added clarity with requests for H.pylori added the following note “for Talicia requests, see CP.PMN.277 Ulcer Therapy Combinations”; references reviewed and updated.
CP.PMN.224 Tenapanor (Ibsrela)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.225 Trifarotene (Aklief)	1Q 2024 annual review: no significant changes; references reviewed and updated.

CP.PMN.227 Edoxaban (Savaysa)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.231 Cenobamate (Xcopri)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.232 Lumateperone (Caplyta)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.237 Bempedoic acid (Nexletol), bempedoic acid-ezetimibe (Nexlizet)	1Q 2024 annual review: no significant changes; added the following requirement from initial approval criteria to also require for continuation of therapy "Treatment plan does not include coadministration with Repatha or Praluent;" Appendix I clarified that smoking is specific to tobacco and revised HeFH to FH; references reviewed and updated.
CP.PMN.258 Conjugated estrogens-bazedoxifene (Duavee)	1Q 2024 annual review: no significant changes; for osteoporosis initial criteria, added "generic" before alendronate to clarify that generic is preferred; for Appendix B, removed estropiate due to product unavailability and updated and updated dosing regimen; references reviewed and updated.
CP.PMN.259 Inhaled asthma and COPD agents	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.260 Loteprednol etabonate (Eysuvis)	1Q 2024 annual review: no significant changes; in Appendix B, clarified OTC artificial tears examples are non-inclusive list; references reviewed and updated
CP.PMN.261 Dichlorphenamide (Keveyis)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.273 Varenicline (Tyrvaya)	1Q 2024 annual review: no significant changes; in Appendix B, clarified OTC artificial tears examples are non-inclusive list, removed commercially unavailable branded products, and clarified ophthalmic NSAIDs are not indicated; references reviewed and updated.
CP.PMN.274 Diclofenac (Pennsaid)	1Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.286 Glaucoma Agents (Omlonti, Rhopressa, Rocklatan, Vyzulta)	1Q 2024 annual review: no significant changes; references reviewed and updated
NH.PST.01 Step Therapy	1Q 2024 annual review: no significant changes; removed Temixys as product is discontinued; for exemestane added letrozole as an example of a PDL aromatase inhibitor; references reviewed and updated
CC.PHAR.01 Hour Emergency Supply of Medication	Annual Review – Removed Nurse Advice Line processes.
CC.PHAR.08 NHHF Addendum	Annual Review, no changes
NH.PHAR.09 Pharmacy Program	Annual Review, no changes
CC.PHAR.13 NHHF Addendum	Annual Review, no changes
CC.PHAR.20 Less Than Effective (LTE) Desi Drugs	Annual Review- Removed an FDA webpage from the References section since that page is no longer maintained by the FDA.
NH.PHAR.20 Medication Therapy Management Program	Annual Review, no changes
CC.PHAR.23 Clinical Pharmacy Policy Web Posting	Annual Review- Minor grammatical revisions.