Number	Title	Revision Log
CC.PHAR.10	Preferred Drug List	Added: In the event that state regulations provide directive on the coverage of drug products, this policy will not apply to those products.
CC.PHAR.10 Addendum	Preferred Drug List	4Q 2025 annual review: no significant changes;
CC.PHAR.11	Provider Requests for Pharmacy Profiles	No changes deemed necessary.
CC.PHAR.13 Addendum	Pharmacy and Therapeutics Committee	4Q 2025 annual review: no significant changes;
CC.PHAR.14 Addendum	Generic Drug Additions to PDL	4Q 2025 annual review: no significant changes;
CC.PHAR.19	Vacation Overrides	No changes deemed necessary.
CC.PHAR.19 Addendum	Vacation Overrides	4Q 2025 annual review: no significant changes;
CC.PHAR.22	Medicaid Preferred Drug List Audit Support	No changes deemed necessary.
CC.PHAR.24	Split Fill	Criteria updated for a member to be considered new to medication: No accumulated use within the past 180 days for the requested medication at a GPI-10 level for at least 6 fills (84 or 90 Day Supply, depending on 14 or 15 day packaging). Added a sentence about the member's history reset: The new to medication status may reset if a member discontinues therapy and later resumes, meeting the above criteria again.
CP.PHAR.130	Avatrombopag (Doptelet)	4Q 2025 annual review: RT4: updated pediatric extension for ITP and added new formulation Doptelet Sprinkle (oral granules) to policy; for ITP diagnosis criterion, added option that ITP could be persistent; approval duration for ITP revised from 6 months to 12 months; references reviewed and updated.
CP.PHAR.132	Nitisinone (Nityr, Orfadin)	4Q 2025 annual review: extended initial approval durations to 12 months; references reviewed and updated.
CP.PHAR.135	Baricitinib (Olumiant)	For RA, added bypass of conventional therapies if a member has failed a biologic agent to clarify intention of not stepping back from biologic agent to conventional therapy.
CP.PHAR.136	Elagolix (Orilissa), Elagolix/Estradiol/Norethinedrone (Oriahnn)	4Q 2025 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PHAR.139	Mogamulizumab-kpkc (Poteligeo)	4Q 2025 annual review: no significant changes; extended initial approval duration from 6 months to 12 months for HIM and Medicaid; references reviewed and updated.
CP.PHAR.140	Pegvaliase-pqpz (Palynziq)	4Q 2025 annual review: added Sephience (newly FDA-approved for PKU) as an agent that should not be used concomitantly with Palynziq; references reviewed and updated.
CP.PHAR.142	Adefovir (Hepsera)	4Q 2025 annual review: removed brand Hepsera from policy as it is no longer available; added generic adefovir to policy for review; removed criteria redirecting brand Hepsera to generic adefovir; revised initial approval duration from 6 months to 12 months; references reviewed and updated.
CP.PHAR.143	Betaine (Cystadane)	4Q 2025 annual review: extended initial approval duration to 12 months; references reviewed and updated.
CP.PHAR.151	Levoleucovorin (Fusilev, Khapzory)	4Q 2025 annual review: Fusilev removed from policy as it is no longer available; revised initial approval durations for high-dose MTX therapy rescue and combination chemotherapy with 5-FU to 12 months for Medicaid and HIM lines of business; references reviewed and updated.
CP.PHAR.173	Leuprolide Acetate (Eligard, Fensolvi, Lupron Depot, Lupron Depot-Ped), Leuprolide mesylate (Camcevi)	4Q 2025 annual review: per NCCN for ovarian cancer added supported uses in malignant sex cord-stromal tumors, carcinosarcoma (malignant mixed Müllerian tumors), low-grade serous carcinoma, endometrioid carcinoma, mucinous neoplasms of the ovary; added Eligard as a product that can be used for breast cancer; added Camcevi as a product that can be used for salivary gland tumors; added criteria set for uterine sarcoma; RT4: added new strength, Camcevi ETM (21 mg); references reviewed and updated.
CP.PHAR.175	Triptorelin Pamoate (Trelstar, Triptodur)	4Q 2025 annual review: for Trelstar added NCCN compendium supported off-label uses in breast cancer, salivary gland tumors, and uterine sarcoma; references reviewed and updated.
CP.PHAR.201	Belatacept (Nulojix)	4Q 2025 annual review: revised Medicaid and HIM initial approval durations to 12 months; revised Commercial approval durations for initial and continued therapy to "6 months or to the member's renewal date, whichever is longer"; references reviewed and updated.
CP.PHAR.245	Apremilast (Otezla)	RT4: for PsA, added newly approved pediatric extension to 6 years and older; for PsO, added bypass of conventional therapies if a member has failed a biologic agent to clarify intention of not stepping back from biologic agent to conventional therapy.
CP.PHAR.246	Canakinumab (Ilaris)	For sJIA, added bypass of conventional therapies if a member has failed a biologic agent to clarify intention of not stepping back from biologic agent to conventional therapy.
CP.PHAR.257	Ixekizumab (Taltz)	For AS, nr-axSpA, and PsO, added bypass of conventional therapies if a member has failed a biologic agent to clarify intention of not stepping back from biologic agent to conventional therapy.
CP.PHAR.260	Rituximab (Rituxan), Rituximab-arrx (Riabni), Rituximab-pvvr (Ruxience), Rituximab-abbs (Truxima), Rituximab/Hyaluronidase (Rituxan Hycela)	Per SDC, added off-label criteria for bullous pemphigoid. For RA, added bypass of conventional therapies if a member has failed a biologic agent to clarify intention of not stepping back from biologic agent to conventional therapy.
CP.PHAR.263	Tocilizumab (Actemra), Tocilizumab-anoh (Avtozma), Tocilizumab-bavi (Tofidence), Tocilizumab-aazg (Tyenne)	RT4: for Avtozma, added newly approved CRS indication to criteria; RT4: for Actemra, updated indication for COVID-19 to include pediatric extension; for CRS, GCA, sJIA, and Castleman's disease, added redirection from biosimilars to preferred agent Actemra; for GCA, pJIA, RA, and sJIA, added bypass of conventional therapies if a member has failed a biologic agent to clarify intention of not stepping back from biologic agent to conventional therapy; added HCPCS code [Q5156] for Avtozma.
CP.PHAR.313	Pralatrexate (Folotyn)	4Q 2025 annual review: added NCCN off-label use for subcutaneous panniculitis-like T-cell lymphoma; for brand requests, added redirection to generic; extended initial approval duration for HIM/Medicaid from 6 to 12 months; references reviewed and updated.
CP.PHAR.328	Asfotase Alfa (Strensiq)	4Q 2025 annual review: extended initial approval duration to 12 months; references reviewed and updated.
CP.PHAR.332	Pasireotide (Signifor, Signifor LAR)	4Q 2025 annual review: no significant changes; for acromegaly, extended initial approval duration from 6 months to 12 months for Medicaid; for cushing's disease, extended initial approval duration from 6 months to 12 months for Medicaid and HIM; references reviewed and updated.
CP.PHAR.354	Testosterone (Testopel, Jatenzo, Kyzatrex, Tlando)	4Q 2025 annual review: no significant changes; for gender dysphoria modified initial approval duration from 6 to 12 months; references reviewed and updated. Added step therapy bypass for IL HIM per IL HB 5395.
CP.PHAR.375	Brodalumab (Siliq)	Added bypass of conventional therapies if a member has failed a biologic agent to clarify intention of not stepping back from biologic agent to conventional therapy.

CP.PHAR.389	Pegvisomant (Somavert)	4Q 2025 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; for initial therapy, extended duration from 6 months to 12 months for HIM and Medicaid; references reviewed and updated.
CP.PHAR.390	Cholic Acid (Cholbam)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.391	Lanreotide (Somatuline Depot and Unbranded)	4Q 2025 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; for initial therapy, extended approval duration from 6 months to 12 months for HIM and Medicaid; references reviewed and updated.
CP.PHAR.393	Leucovorin Injection	4Q 2025 annual review: revised initial approval durations for high-dose MTX therapy rescue and combination chemotherapy with 5-FU to 12 months for Medicaid line of business; for continued therapy section, added continuation of care pathway for high-dose MTX rescue as part of chemotherapy or combination chemotherapy with 5-FU; references reviewed and updated.
CP.PHAR.403	Fremanezumab-vfrm (Ajovy)	4Q 2025 annual review: RT4: added pediatric extension for episodic migraine requiring redirection to topiramate; modified initial and continuation of therapy approval duration to 12 months; references reviewed and updated.
CP.PHAR.404	Galcanezumab-gnlm (Emgality)	4Q 2025 annual review: no significant changes; for migraine prophylaxis modified initial approval duration from 3 to 12 months and continuation of therapy from 6 to 12 months; for episodic cluster headaches modified initial approval duration from 3 to 6 months; references reviewed and updated.
CP.PHAR.43	Sapropterin Dihydrochloride (Kuvan, Javygtor)	Added Sephience (newly FDA-approved for PKU) as an agent that should not be used concomitantly with sapropterin; extended initial approval duration to 12 months; references reviewed and updated.
CP.PHAR.434	Bremelanotide (Vyleesi)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.438	Trientine (Cuvrior, Syprine)	4Q 2025 annual review: added trientine hydrocholoride to medically necessary statement as generic trientine hydrocholoride also requires prior authorization; for initial therapy, extended approval duration from 6 months to 12 months for Medicaid and HIM; revised step therapy to require generic trientine hydrocholoride for brand Syprine requests for IL HIM per IL HB 5395; references reviewed and updated.
CP.PHAR.442	Fedratinib (Inrebic)	4Q 2025 annual review: added off-label criteria for MPN per NCCN category 2A; added step therapy bypass for IL HIM per IL HB 5395; initial approval durations changed from 6 to 12 months for Medicaid/HIM; references reviewed and updated.
CP.PHAR.446	Flibanserin (Addyi)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.461	Nadofaragene Firadenovec-vncg (Adstiladrin)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.506	Antithymocyte Globulin (Atgam, Thymoglobulin)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.509	Triheptanoin (Dojolvi)	4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; revised initial approval duration from 6 months to 12 months; references reviewed and updated.
CP.PHAR.510	Arimoclomol (Miplyffa)	4Q 2025 annual review: Per August SDC added requirement that for members weighing ≥ 15 kg, failure of a ≥ 3-month trial of Aqneursa; added step therapy bypass for IL HIM per IL HB 5395; revised initial approval duration from 6 months to 12 months; for continued therapy, added positive response option of slowed disease progression in a domain affected by NPC; references reviewed and updated.
CP.PHAR.513	Plasminogen, Human-tvmh (Ryplazim)	4Q 2025 annual review: revised initial approval duration for Medicaid and HIM to 12 months; references reviewed and updated.
CP.PHAR.551	Anifrolumab-fnia (Saphnelo)	4Q 2025 annual review: revised Medicaid and HIM initial approval durations to 12 months; added coding implications section; references reviewed and updated.
CP.PHAR.552	Belumosudil (Rezurock)	4Q 2025 annual review: added exclusion for concomitant use with Niktimvo; references reviewed and updated.
CP.PHAR.553	Belzutifan (Welireg)	4Q 2025 annual review: revised initial approval durations for all indications to 12 months; references reviewed and updated.
CP.PHAR.556	Elivaldogene Autotemcel (Skysona)	4Q 2025 annual review: RT4: updated FDA-approved indication to include lack of an available HLA-matched donor for allogeneic HSCT; removed criterion option for having an HLA-matched donor and its accompanying criteria per PI; references reviewed and updated.
CP.PHAR.558	Mitapivat (Pyrukynd)	4Q 2025 annual review: no significant changes; for continued therapy, clarified that reduced transfusion burden also applies to difference from baseline prior to Pyrukynd initiation; references reviewed and updated.
CP.PHAR.559	Mobocertinib (Exkivity)	4Q 2025 annual review: extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.577	Tralokinumab-ldrm (Adbry)	Per August SDC, removed Commercial and HIM line of business; extended initial approval duration from 4 months to 12 months.
CP.PHAR.578	Abrocitinib (Cibinqo)	Per August SDC, removed Commercial and HIM line of business; extended initial approval duration from 6 months to 12 months.
CP.PHAR.58	Denosumab (Prolia, Xgeva and biosimilars)	Per August SDC: for multiple myeloma or solid tumor, giant cell tumor of bone, hypercalcemia of malignancy, systemic mastocytosis, added redirection to Osenvelt and Wyost for if request is for a product other than Osenvelt and WyostXgeva requests for initial and continuation of therapy requests. RT4: added new biosimilars Bildyos and Bilprevda to criteria. Added new HCPCS codes Q5157, Q5158, Q5159. Added step therapy bypass for IL HIM per IL HB 5395
CP.PHAR.591	Tofersen (Qalsody)	4Q 2025 annual review: for continued therapy, added requirement for no tracheostomy or permanent ventilation and a positive response example of slowing of ALSFRS-R slope decline compared to baseline; references reviewed and updated.
CP.PHAR.594	Donanemab (Kisunla)	4Q 2025 annual review: updated recommended dosing regimen per the Prescribing Information; for Continued Therapy criteria, clarified that the neurocognitive testing results used for coverage redetermination should be “recent (within the last month)” to ensure that Kisunla continues to be used only for those who remain in the mild stage of disease; updated the requirement for follow-up pre-infusion MRIs to be done within the prior week instead of within the prior month, to align with the approach for Leqembi; references reviewed and updated.
CP.PHAR.596	Lecanemab-irmb (Leqembi)	4Q 2025 annual review: for Continued Therapy criteria, clarified that the neurocognitive testing results used for coverage redetermination should be “recent (within the last month)” to ensure that Leqembi continues to be used only for those who remain in the mild stage of disease; updated the requirement for follow-up pre-infusion MRIs to be done within the prior week instead of within the prior month per the updated Leqembi Prescribing Information; added dosing and auth limits for newly FDA-approved SC Leqembi Iqlik to the criteria; references reviewed and updated.
CP.PHAR.597	Leniolisib (Joenja)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.598	Lifileucel (Amtagvi)	4Q 2025 annual review: no significant changes; references reviewed and updated.

CP.PHAR.607	Deucravacitinib (Sotyktu)	Added bypass of conventional therapies if a member has failed a biologic agent to clarify intention of not stepping back from biologic agent to conventional therapy.
CP.PHAR.641	Avacincaptad Pegol (Izervay)	4Q 2025 annual review: revised Medicaid and HIM initial approval durations to 12 months; references reviewed and updated.
CP.PHAR.643	Fidanacogene Elaparvovec-dzkt (Beqvez)	4Q 2025 annual review: no significant changes to criteria; added note that manufacturer will no longer develop and commercialize Beqvez; references reviewed and updated.
CP.PHAR.647	Resmetirom (Rezdiffra)	4Q 2025 annual review: revised biopsy lookback period from 6 months to 3 years per AASLD guidance; for imaging-based biomarker examples, replaced FibroScan with VCTE as FibroScan is an example of VCTE; moved MAST, FAST, and MEFIB examples of non-invasive diagnostic scores to Appendix E; for diet and exercise criterion, removed the BMI ≥ 25 kg/m2 , revised "lifestyle modification" to "physician-directed weight loss program that involves a reduced calorie diet, increased physical activity, and behavioral modification," and clarified that member continues these strategies with Rezdiffra use per the PI; revised initial approval duration to 12 months; for continued therapy, added requirements for prescriber attestation of continued standard of care management and documentation of adherence to physician-directed weight loss program; references reviewed and updated. Per SDC: added redirection to Wegovy and exclusion for concurrent Wegovy use.
CP.PHAR.648	Rozanolixizumab-noli (Rystiggo)	4Q 2025 annual review: for gMG, clarified that the required immunosuppressive therapy should be non-steroidal; for Medicaid and HIM, extended approval durations from 6 to 12 months as gMG is a chronic condition; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PHAR.651	DaxibotulinumtoxinA-lanm (Daxxify)	4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PHAR.654	Momelotinib (Ojjaara)	4Q 2025 annual review: added off-label criteria for MPN per NCCN category 2A; initial approval duration changed from 6 to 12 months; references reviewed and updated.
CP.PHAR.655	Motixafortide (Aphexda)	4Q 2025 annual review: added transplant specialist as a prescriber option; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PHAR.660	Bimekizumab-bkzx (Bimzelx)	For PsO, AS, and HS, added bypass of conventional therapies if a member has failed a biologic agent to clarify intention of not stepping back from biologic agent to conventional therapy.
CP.PHAR.661	Etrasimod (Velsipity)	For UC, added option for Mayo Endoscopic Score > 2 to define moderate-to-severe UC; added bypass of conventional therapies if a member has failed a biologic agent to clarify intention of not stepping back from biologic agent to conventional therapy.
CP.PHAR.662	Mirikizumab-mrkz (Omvoh)	For UC, added option for Mayo Endoscopic Score > 2 to define moderate-to-severe UC; for CD and UC, added bypass of conventional therapies if a member has failed a biologic agent to clarify intention of not stepping back from biologic agent to conventional therapy.
CP.PHAR.673	Garadacimab (Andembry)	Per August SDC, added redirection to one of the following: Haegarda, Takhzyro, or Orladeyo.
CP.PHAR.678	Afamitresgene Autoleucel (Tecelra)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.682	Levacetylleucine (Aqneursa)	4Q 2025 annual review: revised initial approval duration from 6 months to 12 months; for continued therapy, added positive response option of slowed disease progression in a domain affected by NPC; references reviewed and updated.
CP.PHAR.691	Axatilimab-csfr (Niktimvo)	4Q 2025 annual review: clarified systemic immunosuppressant as non-steroidal; added step therapy bypass for IL HIM per IL HB 5395; extended initial approval duration for Medicaid and HIM from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.692	Crinecerfont (Crenessity)	4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; extended continued approval duration from 6 to 12 months for this chronic condition; references reviewed and updated.
CP.PHAR.696	Palopegteriparatide (Yorvipath)	4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; extended continued approval duration from 6 to 12 months for Medicaid and HIM; references reviewed and updated.
CP.PHAR.697	Revakinagene Taroretcel-lwey (Encelto)	4Q 2025 annual review: no significant changes; added HCPCS code [J3403] and removed HCPCS codes [J3590, C9399]; references reviewed and updated.
CP.PHAR.698	Seladelpar (Livdelzi)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.700	Vanzacaftor/Tezacaftor/Deutivacaftor (Alyftrek)	4Q 2025 annual review: no significant changes; for initial approval, extended approval duration from 6 months to 12 months; references reviewed and updated.
CP.PHAR.701	Diazoxide Choline (Vykat XR)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.702	Inavolisib (Itovebi)	4Q 2025 annual review: added option for regionally advanced disease or recurrent disease per NCCN; clarified ovarian ablation or ovarian suppression is required if members are premenopausal or perimenopausal; added requirement to be prescribed in combination with an agent that suppresses testicular steroidogenesis if members are male; extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.703	Nemolizumab-ilto (Nemluvio)	4Q 2025 annual review: Extended initial approval duration to 12 months; references reviewed and updated. Per August SDC, removed Commercial and HIM line of business.
CP.PHAR.704	Lebrikizumab (Ebglyss)	4Q 2025 annual review: extended initial approval duration from 6 months to 12 months; for continued therapy, added "including but not limited to" to allow additional options for positive response; references reviewed and updated. Per August SDC, removed Commercial and HIM line of business.
CP.PHAR.705	Zolbetuximab-clzb (Vyloy)	4Q 2025 annual review: added options for use in recurrent disease and as palliative therapy in members who are not surgical candidates per NCCN; extended initial approval duration for HIM/Medicaid from 6 to 12 months; revised approval durations for Commercial from 6/12 months to standard injectable authorization of "6 months or to the member's renewal date, whichever is longer"; references reviewed and updated.
CP.PHAR.744	Delgocitinib (Anzupgo)	Policy created
CP.PHAR.751	Rilzabrutinib (Wayrilz)	Policy created

CP.PHAR.93	Bevacizumab (Alymsys, Avastin, Avzivi, Jobevne, Mvasi, Vegzelma, Zirabev)	4Q 2025 annual review: for all indications, added step therapy bypass for IL HIM per IL HB 5395, extended initial approval duration for Medicaid and HIM from 6 months to 12 months for this maintenance medication for a chronic condition; for the following oncology indications, revised the following per NCCN: for epithelial ovarian, fallopian tube, and primary peritoneal cancer, added option for combination use in platinum-resistant persistent disease with carboplatin and paclitaxel, carboplatin and gemcitabine, or carboplatin and liposomal doxorubicin; added additional off-label use in primary spinal cord tumors; for ophthalmology uses, revised diabetic retinopathy to allow any cause and stage; references reviewed and updated.
CP.PMN.109	Suvorexant (Belsomra)	4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.112	Naldemedine (Symproic)	4Q 2025 annual review: updated initial approval duration from 6 to 12 months; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.116	L-glutamine (Endari)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.142	Lubiprostone (Amitiza)	4Q 2025 annual review: for OIC, updated initial approval duration from 6 to 12 months; for continued therapy, added criterion for OIC, member continues to receive opioid therapy; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated
CP.PMN.143	Isotretinoin (Absorica, Absorica LD, Amnesteem, Claravis, Myorisan, Zenatane)	4Q 2025 annual review: removed obsolete brand Myorisan; for all indications, added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.153	Alosetron (Lotronex)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.161	Methadone Hydrochloride	4Q 2025 annual review: updated Appendix E with revised language and exception for Tennessee; references reviewed and updated.
CP.PMN.165	Fluorouracil Cream (Tolak)	4Q 2025 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.167	Neomycin/Fluocinolone Cream (Neo-Synalar)	4Q 2025 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.168	Ospemifene (Osphena)	4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.169	Methylnaltrexone Bromide (Relistor)	4Q 2025 annual review: updated approval duration for initial and continued for Medicaid/HIM and commercial tablets from 6 to 12 months; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.17	Droxidopa (Northera)	4Q 2025 annual review: no significant changes; added droxidopa to medically necessary statement as generic also requires prior authorization; for continued therapy, extended approval duration from 6 months to 12 months; references reviewed and updated.
CP.PMN.170	Eluxadoline (Viberzi)	4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.171	Naloxegol (Movantik)	4Q 2025 annual review: changed initial approval duration from 6 to 12 months; references reviewed and updated.
CP.PMN.172	Zolpidem Tartrate (Edluar, Zolpimist)	4Q 2025 annual review: removed Zolpimist as product is discontinued; for Medicaid, extended initial approval duration from 6 months to 12 months; references reviewed and updated.
CP.PMN.173	Ramelteon (Rozerem)	4Q 2025 annual review: for Medicaid, extended initial approval duration from 6 to 12 months; references reviewed and updated
CP.PMN.174	Perindopril/Amlodipine (Prestalia)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.175	Doxepin (Silenor)	4Q 2025 annual review: for Medicaid, extended initial approval duration from 6 to 12 months; references reviewed and updated.
CP.PMN.176	Amlodipine/Atorvastatin (Caduet)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.177	Glycopyrronium (Qbrexza)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.179	Megestrol Acetate	4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.180	Halobetasol Propionate (Bryhali, Lexette, Ultravate)	4Q 2025 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.181	Calcipotriene/Betamethasone Dipropionate Foam (Enstilar)	4Q 2025 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.182	Betamethasone Dipropionate Spray (Sernivo)	4Q 2025 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.184	Stiripentol (Diacomit)	4Q 2025 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.185	Baloxavir Marboxil (Xofluza)	4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.194	Prucalopride (Motegrity)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.210	Acyclovir Buccal Tablet (Sitavig)	4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.213	Ferric Maltol (Accrufer)	4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.214	Continuous Glucose Monitors	4Q 2025 annual review: per August SDC, removed option for management with oral agents for type 2 diabetes; per GA regulation and August SDC, added options for gestational diabetes and history of problematic hypoglycemia; updated FreeStyle Libre redirection to apply to age ≥ 2 years; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.215	Non-Preferred Blood Glucose Monitors/Test Strips	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.216	Diazepam (Libervant, Valtoco)	4Q 2025 annual review: extended initial auth duration from 6 months to 12 months; added redirection bypass for members in a State with limitations on step therapy in certain settings along with Appendix E; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.226	Pancrelipase (Creon, Pancreaze, Pertzye, Viokace, Zenpep)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.244	Tazarotene (Arazlo, Fabior, Tazorac)	4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.249	Ciprofloxacin/Fluocinolone (Otovel)	4Q 2025 annual review: for otitis media with tympanostomy tubes, revised systemic antibiotic requirement to otic antibiotic; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.250	Colesevelam (Welchol)	4Q 2025 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; extended initial approval duration from 6 months to 12 months as primary hyperlipidemia and type 2 diabetes mellitus are chronic conditions; references reviewed and updated.
CP.PMN.251	Lactic Acid/Citric Acid/Potassium Bitartrate (Phexxi)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.252	Metoclopramide (Gimoti)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.255	No Coverage Criteria, Recent Label Changes Pending Clinical Policy Update	4Q 2025 annual review: no significant changes; references reviewed and updated.

CP.PMN.256	Nifurtimox (Lampit)	4Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.266	Finerenone (Kerendia)	4Q 2025 annual review: RT4: added new heart failure indication and accompanying 40 mg dosage strength; for CKD, added criterion requiring serum potassium ≤ 5.0 mEq/L per PI; references reviewed and updated.
CP.PMN.267	Levodopa Inhalation Powder (Inbrija)	4Q 2025 annual review: removed the exclusion qualifier of "early morning" from "off" time requirement; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.268	Tenofovir Alafenamide Fumarate (Vemlidy)	4Q 2025 annual review: revised initial approval duration from 6 months to 12 months; references reviewed and updated.
CP.PMN.270	Pilocarpine (Qlosi, Vuity)	4Q 2025 annual review: removed requirement that member does not have glaucoma or ocular hypertension per PI and current literature; extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; added step therapy bypass for IL HIM per IL HB 5395; added requirement that pilocarpine is not prescribed concurrently with Vizz; references reviewed and updated.
CP.PMN.282	Ketorolac Nasal Spray (Sprix)	4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; reference reviewed and updated.
CP.PMN.283	Tapinarof (Vtama)	4Q 2025 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.284	Dextromethorphan/Bupropion (Auvelity)	4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.286	Glaucoma Agents	Added Simbrinza (adopted from HIM.PA.15, policy to retire) to this policy; added step therapy bypass for IL HIM per IL HB 5395
CP.PMN.291	Lotilaner (Xdemvy)	4Q 2025 annual review: added optometrist or ophthalmologist prescriber requirement; references reviewed and updated.
CP.PMN.297	Brivaracetam (Briviact)	4Q 2025 annual review: added redirection bypass for members in a State with limitations on step therapy in certain settings along with Appendix D; added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.302	Aceclidine (Vizz)	Policy created
CP.PMN.303	Brensocatib (Brinsupri)	Policy created
CP.PMN.47	Rifaximin (Xifaxan)	4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; for HE, updated initial approval duration from 6 to 12 months for Medicaid/HIM line of business; references reviewed and updated.
CP.PMN.53	Off-Label Use	4Q 2025 annual review: added requirements if request is for experimental or investigational use with resources to the attestation form per CMS requirements; references reviewed and updated.
CP.PMN.54	Clobazam (Onfi, Sympazan)	4Q 2025 annual review: added step therapy bypass for IL HIM per IL HB 5395; references reviewed and updated.
CP.PMN.59	Quantity Limit Override and Dose Optimization	4Q 2025 annual review: added quantity limit exception criteria specific to acute therapies, with requirements for epinephrine (adopted from CP.PMN.144 that will be retired) and other acute therapies; removed criteria set for opioid QL exceptions as section I.A. will be applied; references reviewed and updated.
CP.PMN.71	Linaclotide (Linzess)	4Q 2025 annual review: no significant changes; references reviewed and updated.
NH.PHAR.09	Pharmacy Program	4Q 2025 annual review: no significant changes;
NH.PHAR.128	Erenumab-aooe (Aimovig)	4Q 2025 annual review: no significant changes; modified initial approval duration from 3 to 12 months; for continuation of therapy revised approval duration from 6 to 12 months; references reviewed and updated.
NH.PHAR.149	Baclofen (Fleqsuvy, Gablofen, Lioresal, Lyvispah, Ozobax/Ozobax DS)	4Q 2025 annual review: for Gablofen and Lioresal updated approval duration for initial and continued therapy to 12 months
NH.PHAR.200	Hepatitis C Agents	4Q 2025 annual review: no significant changes;
NH.PHAR.20	Medication Therapy Management Program	4Q 2025 annual review: no significant changes;
NH.PHAR.476	Ubrogepant (Ubrelvy)	4Q 2025 annual review: no significant changes; revised initial approval duration from 6 to 12 months; references reviewed and updated.
NH.PHAR.489	Eptinezumab-jjmr (Vyepti)	4Q 2025 annual review: no significant changes; modified initial and continuation approval duration from 6 to 12 months; references reviewed and updated.
NH.PHAR.490	Rimegepant (Nurtec ODT)	4Q 2025 annual review: no significant changes; revised all approval durations to 12 months; references reviewed and updated.
NH.PHAR.566	Atogepant (Qulipta)	4Q 2025 annual review: no significant changes; revised approval duration to 12 months; references reviewed and updated.
NH.PHAR.630	Zavegepant (Zavzpret)	4Q 2025 annual review: no significant changes; revised initial approval duration from 6 to 12 months; references reviewed and updated.
NH.PMN.273	Varenicline (Tyrvaya)	4Q 2025 annual review: no significant changes;
NH.PMN.295	Semaglutide (Wegovy)	Adjusted to excluded benefit for weight management as of 1/1/26. Added new indication for MASH – criteria updated per FDA labeling: revised biopsy lookback period from 6 months to 3 years per AASLD guidance; for imaging-based biomarker examples, replaced Fibroscan with VCTE as FibroScan is an example of VCTE; moved MAST, FAST, and MEFIB examples of non-invasive diagnostic tests to Appendix E; for members with concurrent T2DM, for diet and exercise criterion, clarified that member continues diet and exercise with concomitant Wegovy; for continued therapy, moved location of criterion regarding tolerance to maintenance dose of ≥ 1.7 mg once weekly after at least 17 weeks of Wegovy therapy; references reviewed and updated.
NH.PMN.298	Tirzepatide (Zepbound)	For OSA, updated PAP criterion to require continued symptoms of OSA despite adherence to PAP therapy, unless a member is not a candidate for PAP therapy. Removed trial and failure of other agents as Zepbound is now preferred. Adjusted to exclude weight management as a benefit as of 1/1/26.
NH.PMN.50	Anti-Obesity Medications	Retiring Policy as of 1/1/2026 due to benefit exclusion change.