Number	Title	Revision Log
CP.PHAR.01	Omalizumab (Xolair), Omalizumab-igec (Omlyclo)	1Q 2026 annual review: added coverage for moderate (G2) immune checkpoint inhibitor-related pruritus per NCCN; for all indications, extended initial approval duration from 6 to 12 months and for NCCN compendial uses, revised continued approval duration from 6 to 12 months; added eosinophilic esophagitis as an indication not covered in section III given lack of demonstrated efficacy and recommendation against use by the 2025 American College of Gastroenterology guideline; RT4: added newly approved 300 mg/2 mL strength for Omlyclo; references reviewed and updated.
CP.PHAR.114	Teduglutide (Gattex)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.115	Pegloticase (Krystexxa)	1Q 2026 annual review: removed losartan as a uricosuric agent as its place in therapy is an antihypertensive alternative to HCTZ; added combination use with MTX per labeling; added prevention of concomitant use with pegadricase; extended initial approval duration from 6 to 12 months; references reviewed and updated
CP.PHAR.123	Evolocumab (Repatha)	1Q 2026 annual review: for all indications, extended initial approval duration from 3 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.124	Alirocumab (Praluent)	1Q 2026 annual review: for all indications, extended Medicaid initial approval duration from 3 months to 12 months for this maintenance medication for a chronic condition; removed pediatric use in HoFH per PI; references reviewed and updated. RT4: updated indication to reflect the following revised uses: as an adjunct to exercise (rather than LDL-lowering therapy) for HeFH and HoFH and to reduce major adverse CV events in adults at increased risk for these events (rather than adults with established CV disease) per PI; revised “hyperlipidemia” to “hypercholesterolemia” throughout the criteria.
CP.PHAR.160	Alglucosidase Alfa (Lumizyme)	1Q 2026 annual review: no significant changes; updated initial auth duration from 6 months to 12 months; references reviewed and updated.
CP.PHAR.165	Ferumoxytol (Feraheme)	1Q 2026 annual review: no significant changes; revised approval durations for iron deficiency associated with CKD and cancer/chemotherapy from 3 months to 12 months; references reviewed and updated.
NH.PHAR.173	Leuprolide Acetate (Eligard, Fensolvi, Lupron Depot, Lupron Depot-Ped, Vabrinty), Leuprolide Mesylate (Camcevi, Camcevi ETM)	New Policy Created
CP.PHAR.179	Romiplostim (Nplate)	1Q 2026 annual review: added NCCN Compendium supported off label use for immune checkpoint inhibitor-related toxicities when member has had no response to corticosteroids after 1-2 weeks; references reviewed and updated.
CP.PHAR.180	Eltrombopag (Alvaiz, Promacta)	1Q 2026 annual review: for post-hematopoietic cell transplant with prolonged thrombocytopenia, added requirement that member has poor graft function per NCCN; added NCCN-supported indications of ICAHT and immunotherapy-related thrombocytopenia; for eltrombpag and Promacta, added request does not exceed health plan-approved quantity limit, if applicable; references reviewed and updated.
CP.PHAR.181	Hemin (Panhematin)	1Q 2026 annual review: added off-label indication for prevention of porphyria attacks; for acute porphyria continued therapy, added criterion to ensure member has not received more than 14 days of treatment; references reviewed and updated.
CP.PHAR.184	Aflibercept (Eylea, Eylea HD), Aflibercept-yszy (Opuviz), Aflibercept-jbvf (Yesafili), Aflibercept-mrbb (Ahzantive), Aflibercept-abzv (Enzeevu), Aflibercept-ayyh (Pavblu)	1Q 2026 annual review: combined RVO section with nAMD, DME, and DR section; for adult ophthalmic diseases, extended continued therapy duration from 6 months to 12 months for this maintenance medication for a chronic condition; for ROP, clarified 3 lifetime doses per eye; references reviewed and updated. RT4: for Eylea HD, added criteria for newly FDA-approved indication of RVO; in continued therapy, added option for every 4 week dosing if documentation supports evidence of continued disease activity.
CP.PHAR.186	Ranibizumab (Byooviz, Cimerli, Lucentis, Susvimo)	1Q 2026 annual review: for DME, DR, RVO, and nAMD, extended continued therapy duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.187	Verteporfin (Visudyne)	1Q 2026 annual review: clarified one dose every 3 months; references reviewed and updated.
CP.PHAR.188	Teriparatide (Forteo, Bonsity)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.189	Ibandronate Injection (Boniva)	1Q 2026 annual review: no significant changes; removed redirection to generic ibandronate as branded Boniva has been discontinued; references reviewed and updated.
CP.PHAR.190	Ambrisentan (Letairis)	1Q 2026 annual review: added requirement that request does not exceed health-plan approved quantity limit; extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.191	Bosentan (Tracleer)	1Q 2026 annual review: added requirement that request does not exceed health-plan approved quantity limit; extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.

CP.PHAR.192	Epoprostenol (Flolan, Veletri)	1Q 2026 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.193	Iloprost (Ventavis)	1Q 2026 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.194	Macitentan (Opsumit)	1Q 2026 annual review; added requirement that request does not exceed health-plan approved quantity limit; extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.195	Riociguat (Adempas)	1Q 2026 annual review: added requirement that request does not exceed health-plan approved quantity limit; extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.196	Selexipag (Uptravi)	1Q 2026 annual review: clarified maximum dose for concomitant administration with CYP2C8 inducers; clarified requirement for titration plan is for oral Uptravi; added requirement that request does not exceed health-plan approved quantity limit; extended initial approval duration from 6 months to 12 months
CP.PHAR.197	Sildenafil (Revatio, Liqrev)	1Q 2026 annual review; added requirement that request does not exceed health-plan approved quantity limit; extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.198	Tadalafil (Adcirca, Alyq, Tadliq)	1Q 2026 annual review; added requirement that request does not exceed health-plan approved quantity limit; extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.199	Treprostinil (Orenitram, Remodulin, Tyvaso, Tyvaso DPI)	1Q 2026 annual review: for Orenitram, added requirement that request does not exceed health-plan approved quantity limit; for Tyvaso and Tyvaso DPI, revised maximum dose criterion to member must submit a titration plan if member requires titration; extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.200	Mepolizumab (Nucala)	1Q 2026 annual review: no significant changes; for all indications, revised initial approval duration for Medicaid from 6 to 12 months; references reviewed and updated.
CP.PHAR.203	Cosyntropin (Cortrosyn)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.214	Desmopressin Acetate (DDAVP, Stimate, Nocdurna)	1Q 2026 annual review: no significant changes; ; for hemophilia and VWD surgical/acute bleeding, revised approval duration to 3 months and for initial approval durations for all other indications, revised approval durations from 6 months to 12 months; references reviewed and updated.
CP.PHAR.215	Factor VIII (Human, Recombinant)	1Q 2026 annual review: no significant changes; removed discontinued product Helixate FS from criteria; revised initial approval duration for prophylaxis and ITI from 6 months to 12 months; references reviewed and updated.
CP.PHAR.216	Factor VIII/von Willebrand Factor Complex (Human – Alphanate, Humate-P, Wilate); von Willebrand Factor (Recombinant – Vonvendi)	1Q 2026 annual review: no significant changes; updated Wilate indication to remove the vWD qualifier "in children 6 years of age and older" in the FDA-Approved Indication section, revised initial approval durations for prophylaxis from 6 months to 12 months; references reviewed and updated.
CP.PHAR.217	Anti-Inhibitor Coagulant Complex, Human (Feiba)	1Q 2026 annual review: no significant changes; revised initial approval duration for prophylaxis from 6 months to 12 months; references reviewed and updated.
CP.PHAR.218	Factor IX (Human, Recombinant)	1Q 2026 annual review: no significant changes; removed discontinued product Mononine from criteria; revised initial approval duration for prophylaxis from 6 months to 12 months; references reviewed and updated.
CP.PHAR.219	Factor IX Complex, Human (Profilnine)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.220	Factor VIIa, Recombinant (NovoSeven RT, SevenFact)	1Q 2026 annual review: for "Hemophilia, Congenital Factor VII Deficiency" indication, clarified terminology from "prevention" to FDA-labeled indication of "control" of bleeding episodes to prevent misinterpretation of criteria; references reviewed and updated.
CP.PHAR.221	Factor XIII, Human (Corifact)	1Q 2026 annual review: no significant changes; revised initial approval duration for prophylaxis from 6 months to 12 months; references reviewed and updated.
CP.PHAR.222	Factor XIII A-Subunit, Recombinant (Tretten)	1Q 2026 annual review: no significant changes; revised initial approval duration from 6 months to 12 months; references reviewed and updated.
CP.PHAR.223	Reslizumab (Cinqair)	1Q 2026 annual review: no significant changes; revised initial approval duration from 6 to 12 months; references reviewed and updated.
CP.PHAR.232	OnabotulinumtoxinA (Botox)	Per December SDC for chronic migraine removed requirement for evidence from two high quality published studies to support concurrent use of Botox and CGRP therapy.
CP.PHAR.234	Ferric Carboxymaltose (Injectafer)	1Q 2026 annual review: no significant changes; revised approval durations for iron deficiency associated with CKD, heart failure, and cancer/chemotherapy from 3 months to 12 months; references reviewed and updated.
CP.PHAR.24	Fostamatinib (Tavalisse)	1Q 2026 annual review: no significant changes; added request does not exceed health plan-approved quantity limit, if applicable; references reviewed and updated.

CP.PHAR.282	Parathyroid Hormone (Natpara)	1Q 2026 annual review: no significant changes; updated initial and continued auth durations from 6 months to 12 months; references reviewed and updated.
CP.PHAR.283	Lomitapide (Juxtapid)	1Q 2026 annual review: extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; reduced statin adherence duration from 4 months to 8 weeks; simplified statin trial and failure criteria for moderate- and low-intensity statin regimens to require insufficient therapeutic response to one high intensity statin for 8 weeks or reversible muscle-related symptoms associated with both rosuvastatin and atorvastatin; clarified failure of an 8 week trial of a preferred PCSK9 inhibitor; references reviewed and updated.
CP.PHAR.288	Eteplirsen (Exondys 51)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.300	Bezlotoxumab (Zinplava)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.329	Siltuximab (Sylvant)	1Q 2026 annual review: extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; in CRS initial criteria, added Avtozma may be used to replace the second dose of Tyenne per NCCN; for off-label UCD, revised usage from "relapsed or refractory" to "surgically unresectable/or if incomplete resection" per NCCN; for off-label CRS, removed option as replacement for second dose for immunotherapy related neurotoxicity and added option for usage in addition to toclizumab for grade 2-4 CRS per NCCN; added off-label indication for KICS per NCCN; references reviewed and updated.
CP.PHAR.330	Protein C Concentrate, Human (Ceprotin)	1Q 2026 annual review: no significant changes; revised initial approval duration from 6 months to 12 months; references reviewed and updated.
CP.PHAR.331	Deflazacort (Emflaza)	1Q 2026 annual review: added requirement that request does not exceed health plan-approved quantity limit, if applicable; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.332	Pasireotide (Signifor, Signifor LAR)	Per December SDC, added redirection to all of the following: lanreotide, octreotide acetate LAR (generic Sandostatin LAR Depot), and brand Sandostatin LAR Depot if octreotide acetate LAR (generic Sandostatin LAR Depot) is unavailable due to shortage; removed Signifor LAR from non-formulary list which references usage of the formulary exception policy.
CP.PHAR.336	Dupilumab (Dupixent)	1Q 2026 annual review: per NCCN for immunotherapy-related toxicity, added option for G2 pruritus, added requirement for diagnostic confirmation of BP for bullous dermatitis, and removed corticosteroid requirement for bullous dermatitis; for immunotherapy-related toxicity, revised approval durations from 6 to 12 months; references reviewed and updated.
CP.PHAR.345	Abaloparatide (Tymlos)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.361	Tisagenlecleucel (Kymriah)	1Q 2026 annual review: added NCCN Compendium supported off-label use in LBCL for Richter transformation and HIV-related plasmablastic lymphoma; references reviewed and updated.
CP.PHAR.362	Axicabtagene Ciloleucel (Yescarta)	1Q 2026 annual review: added NCCN Compendium supported off-label use for LBCL in Richter transformation, PMBCL for Age < 18 years, and HIV-related plasmablastic lymphoma; clarified for MZL disease is refractory or member has relapsed after ≥ 2 lines of systemic therapy per NCCN Compendium; references reviewed and updated.
CP.PHAR.367	Letermovir (Prevymis)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.370	Emicizumab-kxwh (Hemlibra)	1Q 2026 annual review: revised provider confirmation of discontinuation of bypassing agents and FVIII products as prophylaxis to exclusion for concurrent use of hemophilia prophylaxis agent with more examples; revised initial approval durations from 6 months to 12 months; references reviewed and updated.
CP.PHAR.371	Triamcinolone ER Injection (Zilretta)	1Q 2026 annual review: no significant changes; references reviewed and updated
CP.PHAR.372	Voretigene Neparvovec-rzyl (Luxturna)	1Q 2026 annual review: removed FST testing requirement; references reviewed and updated.
CP.PHAR.373	Benralizumab (Fasenra)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.389	Pegvisomant (Somavert)	Per December SDC, revised somatostatin analog redirection to failure of all of the following: lanreotide, octreotide acetate LAR (generic Sandostatin LAR Depot), and brand Sandostatin LAR Depot if octreotide acetate LAR (generic Sandostatin LAR Depot) is unavailable due to shortage.

CP.PHAR.391	Lanreotide (Somatuline Depot)	Per December SDC, for all indications, added redirection to octreotide acetate LAR (generic Sandostatin LAR Depot), added redirection to brand Sandostatin LAR Depot if octreotide acetate LAR is unavailable due to shortage, added member must use generic lanreotide if available for Somatuline Depot requests.
CP.PHAR.40	Octreotide Acetate (Sandostatin, Sandostatin LAR Depot, Mycapssa)	1Q 2026 annual review: added off-label criteria for Merkel cell carcinoma per NCCN; revised language for Sandostatin LAR requests, from "member has received Sandostatin Injection" to "member will receive Sandostatin Injection"; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.402	Emapalumab-lzsg (Gamifant)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.407	Lusutrombopag (Mulpleta)	1Q 2026 annual review: no significant changes; added request does not exceed health plan-approved quantity limit, if applicable; references reviewed and updated.
CP.PHAR.411	Amifampridine (Firdapse)	1Q 2026 annual review: no significant changes; revised initial approval duration from 6 to 12 months; per template added requirement that "request does not exceed health plan-approved quantity limit, if applicable"; references reviewed and updated.
CP.PHAR.421	Onasemnogene Abeparvovec (Zolgensma, Itvisma)	RT4: added newly approved dosage form, Itvisma, with the following revisions: added documentation for inability to walk independently per study protocol; defined advanced SMA for 2 years and older; added SMA type 4 in section III; required 2 or 3 SMN2 copies.
CP.PHAR.428	Romosozumab-aqqg (Evenity)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.444	Afamelanotide (Scenesse)	1Q 2026 annual review: no significant changes; moved requirement for medical justification for requests beyond 3 implants a year for seasonal coverage from approval duration to initial and continued criteria; references reviewed and updated.
CP.PHAR.445	Brolucizumab-dbll (Beovu)	1Q 2026 annual review: for all indications, extended continued therapy approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.449	Crizanlizumab-tmca (Adakveo)	1Q 2026 annual review: no significant changes; revised initial approval duration to 12 months; references reviewed and updated.
CP.PHAR.450	Luspatercept-aamt (Reblozyl)	1Q 2026 annual review: for MDS with ring sideroblasts < 15% scenario, added requirement for failure of Retacrit/Epogen unless serum erythropoietin > 200 mU/mL per NCCN and added oncology step bypass; revised initial approval duration for myelofibrosis-associated anemia and continued approval durations
CP.PHAR.451	Voxelotor (Oxbryta)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.453	Golodirsen (Vyondys 53)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.455	Enfortumab Vedotin-ejfv (Padcev)	1Q 2026 annual review: extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; added option to be prescribed in combination with Keytruda Qlex; references reviewed and updated. RT4: new indication for MIBC added per updated prescribing information.
CP.PHAR.457	Givosiran (Givlaari)	1Q 2026 annual review: revised criterion regarding recurrent porphyria attacks from "≥ 2 attacks in 6-month period" to "4 attacks per year" per AGA guidelines; added criterion, "Panhematin, as a prophylactic treatment, is not prescribed concurrently with Givlaari" to continued therapy; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.459	Iobenguane I 131 (Azedra)	Retired, Progenics Pharmaceuticals, a subsidiary of Lantheus Holdings, will no longer be producing Azedra due to lack of commercial demand. Lantheus will continue to manufacturer Azedra into the first quarter of 2024, to the extent feasible, with the goal of providing doses of Azedra to current patients so they can complete their treatment regimen. Medispan obsolete date reached.
CP.PHAR.464	Selumetinib (Koselugo)	1Q 2026 annual review: for LCH, added option to be prescribed for LACI/ND and clarified trial and failure of cobimetinib or trametinib only applies to adults; revised dose limit from 25 mg/m2 per day to 50 mg/m2 per day based on BID dosing; added request does not exceed health plan-approved quantity limit, if applicable; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated. RT4: revised criteria for NF-1 to reflect adult extension with removal of upper age limit per PI.
CP.PHAR.465	Teprotumumab (Tepezza)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.466	Valoctocogene Roxaparvovec-rvox (Roctavian)	1Q 2026 annual review: no significant changes; added qualifier that the 150 EDs criterion applies to members who have had previous FVIII use; removed requirement for documentation of body weight; references reviewed and updated.

CP.PHAR.467	Zanubrutinib (Brukinsa)	1Q 2026 annual review: for CLL/SLL, added option to be prescribed in combination with Venetoclax per NCCN; added off-label indication for primary CNS lymphoma per NCCN: add request does not exceed health plan-approved quantity limit, if applicable; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.470	Casimersen (Amondys 45)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.472	Brexucabtagene Autoleucel (Tecartus)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.473	Lumasiran (Oxlumo)	1Q 2026 annual review: no significant changes; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.484	Viltolarsen (Viltepso)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.491	Setmelanotide (Imcivree)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.492	Teplizumab-mzwv (Tzield)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.499	Lonafarnib (Zokinvy)	1Q 2026 annual review: added safety criteria regarding hx of arrhythmias and QTc threshold per labeling updates; extended initial approval duration from 4 months for new starts to 12 months; references reviewed and updated.
CP.PHAR.511	Evinacumab-dgnb (Evkeeza)	1Q 2026 annual review: reduced statin adherence duration from 4 months to 8 weeks; simplified statin trial and failure criteria for moderate- and low-intensity statin regimens to require insufficient therapeutic response to one high intensity statin for 8 weeks or reversible muscle-related symptoms associated with both rosuvastatin and atorvastatin; extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.515	Avacopan (Tavneos)	1Q 2026 annual review: no significant changes; revised approval durations from 6 months to 12 months; references reviewed and updated.
CP.PHAR.516	Fostemsavir (Rukobia)	1Q 2026 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.517	Human Growth Hormone (Somapacitan, Somatrogon, Somatropin, Lonapegsomatropin-tcgd)	1Q 2026 annual review: removed Zorbtive from policy due to market discontinuation; removed criteria for short bowel syndrome due to lack of support by AGA; for HIV-associated wasting, added option for unintentional weight loss of ≥ 5% in the last 6 months while on antiretroviral and removed use of ideal body weight criteria per update 2024 consensus expert statement; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.52	Interferon Gamma- 1b (Actimmune)	1Q 2026 annual review: no significant changes; extended approval durations from 6 to 12 months for this maintenance medication for chronic conditions;
CP.PHAR.521	Avalglucosidase Alfa-ngpt (Nexviazyme)	1Q 2026 annual review: no significant changes; updated initial auth duration from 6 months to 12 months; references reviewed and updated.
CP.PHAR.522	Margetuximab-cmkb (Margenza)	1Q 2026 annual review: no significant changes; changed initial auth duration from 6 months to 12 months; references reviewed and updated.
CP.PHAR.523	Naxitamab-gqgk (Danyelza)	1Q 2026 annual review: added treatment combination option with GM-CSF, Temodar, and irinotecan per NCCN; revised initial approval duration to 12 months; references reviewed and updated.
CP.PHAR.525	Vosoritide (Voxzogo)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.555	Efgartigimod Alfa-fcab, Efgartigimod/Hyaluronidase-qvfc (Vyvgart, Vyvgart Hytrulo)	1Q 2026 annual review: for gMG, clarified that immunosuppressive therapy should be non-steroidal; for CIDP, revised “failure” to “insufficient response” for immune globulin therapy; for continued criteria, clarified that gMG response criterion for 2-point reduction can also be greater than 2 points; for concurrent therapy exclusions agents, added Imaavy; references reviewed and updated.
CP.PHAR.562	Allogeneic Cultured Keratinocytes and Dermal Fibroblasts in Murine Collagen-dsat (StrataGraft)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.563	Allogenic Processed Thymus Tissue-agdc (Rethymic)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.564	Antithrombin III (ATryn, Thrombate III)	1Q 2026 annual review: Atryn was discontinued and removed from criteria; RT4: updated Thrombate III indication for pediatric extension and removed requirement for age ≥ 18 years; revised approval durations for prevention from 6 months to 12 months; references reviewed and updated.

CP.PHAR.567	Cipaglucosidase Alfa-atga + Miglustat (Pombiliti + Opfolda)	1Q 2026 annual review: no significant changes; updated initial auth duration from 6 months to 12 months; references reviewed and updated.
CP.PHAR.568	Inclisiran (Leqvio)	1Q 2026 annual review; reduced statin adherence duration from 4 months to 8 weeks; simplified statin trial and failure criteria for moderate- and low-intensity statin regimens to require insufficient therapeutic response to one high intensity statin for 8 weeks or reversible muscle-related symptoms associated with both rosuvastatin and atorvastatin; extended initial approval duration from 9 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.570	Ropeginterferon Alfa-2b-njft (BESREMi)	1Q 2026 annual review: added bypass language for states with regulations against step therapy in certain oncology settings; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; for PV, added option for usage as for use as substitute for peginterferon alfa-2a due to product unavailability per NCCN; added off-label criterion for systemic mastocytosis, myelofibrosis, essential thrombocythemia, and CML per NCCN; references reviewed and updated.
CP.PHAR.572	Budesonide (Tarpeyo)	1Q 2026 annual review: removed requirement of one alternative systemic corticosteroid and revised criterion for proteinuria ≥ 0.5 g/day per updated KDIGO 2025 guidance; references reviewed and updated.
CP.PHAR.574	Sirolimus Protein-Bound Particles (Fyarro), Topical Gel (Hyftor)	1Q 2026 annual review: per competitor analysis, for facial angiofibroma associated with tuberous sclerosis added requirement that member has three or more facial angiofibromas that are at least 2 mm in diameter with redness in each; for PEComa revised initial approval duration to 12 months; references reviewed and updated.
CP.PHAR.576	Tezepelumab-ekko (Tezspire)	1Q 2026 annual review: no significant changes; for asthma, revised initial approval duration from 6 to 12 months; references reviewed and updated.
CP.PHAR.58	Denosumab (Prolia, Xgeva), Denosumab-bbdz (Jubbonti, Wyost), Denosumab-dssb (Ospomyv, Xbryk), Denosumab-bmwo	1Q 2026 annual review: per competitor analysis for MM, removed requirement that member is receiving or initiating therapy (e.g., chemotherapy, transplant) for symptomatic disease; for giant cell tumor of the bone, added additional approval pathway for resectable disease where surgical resection is likely to result in severe morbidity; for initial approval revised approval duration from 6 to 12 months for all oncology related indications; RT4: added new biosimilars Osvyrti and Jubereq to criteria; references reviewed and updated. Per December SDC, added Bilprevda as an additional preferred biosimilar.
CP.PHAR.580	Etranacogene Dezaparvovec-drlb (Hemgenix)	1Q 2026 annual review: added qualifier that the 150 EDs criterion applies to members who have had previous factor IX use; removed requirement for documentation of body weight; references reviewed and updated.11.24.2502.26
CP.PHAR.581	Faricimab-svoa (Vabysmo)	1Q 2026 annual review: for nAMD and DME, extended continued therapy duration from 6 months to 12 months for this maintenance medication for a chronic condition; clarified initial approval for RVO is for a total of 6 months of therapy (6 doses); references reviewed and updated.
CP.PHAR.59	Zoledronic Acid (Reclast)	1Q 2026 annual review: per competitor analysis for MM, removed requirement that member is receiving or initiating therapy (e.g., chemotherapy, transplant) for symptomatic disease; for initial approval revised approval duration from 6 to 12 months for MM, solid tumor, systemic mastocytosis, and histiocytic neoplasms; references reviewed and updated.
NH.PHAR.595	Eladocagene Exuparvovec-tneq (Kebilidi)	New policy created
CP.PHAR.602	Atidarsagene Autotemcel (Lenmeldy)	1Q 2026 annual review: no significant changes; references reviewed and updated
CP.PHAR.605	Adagrasib (Krazati)	1Q 2026 annual review: added small bowel adenocarcinoma and appendiceal neoplasms as off-label indications per NCCN; revised initial approval durations to 12 months; references reviewed and updated.
CP.PHAR.608	Furosemide (Furoscix)	1Q 2026 annual review: RT4: added new dosage form Lasix ONYU; references reviewed and updated.
CP.PHAR.610	Sodium Thiosulfate (Pedmark)	1Q 2026 annual review: no significant changes; extended initial approval duration from 6 to 12 months; references reviewed and updated.
CP.PHAR.613	Fecal Microbiota, Live-jslm (Rebyota)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.615	Olutasidenib (Rezlidhia)	1Q 2026 annual review: added requirement for use as a single agent and added option for use for lower intensity therapy per NCCN; extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.616	Zilucoplan (Zilbrysq)	1Q 2026 annual review: clarified that the required immunosuppressive therapy should be non-steroidal; added Imaavy and Vyvgart Hytrulo to the list of therapies that Zilbrysq should not be prescribed concurrently with; extended approval durations from 6 to 12 months; references reviewed and updated.

CP.PHAR.617	Mirvetuximab Soravatansine-gynx (Elahere)	1Q 2026 annual review: no significant changes; revised initial approval durationto 12 months; references reviewed and updated
CP.PHAR.618	Mosunetuzumab-axgb (Lunsumio)	1Q 2026 annual review: per NCCN Compendium added off-label use in additional B-cell lymphomas subtypes; references reviewed and updated.
CP.PHAR.619	Nedosiran (Rivfloza)	1Q 2026 annual review: no significant changes; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.627	Lovotibeglogene Autotemcel (Lyfgenia)	1Q 2026 annual review: added coverage for additional SCD genotypes βS/β0 (HbS β0) and βS/β+ (HbS β+); removed requirement for documentation of body weight; references reviewed and updated.
CP.PHAR.63	Everolimus (Afinitor, Afinitor Disperz, Zortress)	1Q 2026 annual review: no significant changes; extended initial approval durations from 6 to 12 months for this maintenance medication for a chronic condition; added request does not exceed health plan-approved quantity limit, if applicable; references reviewed and updated.
CP.PHAR.635	ADAMTS13, Recombinant-krhn (Adzynma)	1Q 2026 annual review: removed requirement for plasma therapy failure per updated guideline; revised initial approval duration for prophylaxis to 12 months; references reviewed and updated.
CP.PHAR.657	Sotatercept (Winrevair)	1Q 2026 annual review; extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; added HCPCS codes J3590 and C9399; references reviewed and updated.
CP.PHAR.659	Vamorolone (Agamree)	1Q 2026 annual review: no significant changes; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.663	Capivasertib (Truqap)	1Q 2026 annual review: no significant changes; added use of Truqap for recurrence within 12 months of adjuvant therapy to align with its original FDA approval; updated initial auth duration from 6 months to 12 months; references reviewed and updated.
CP.PHAR.666	Fruquintinib (Fruzaqla)	1Q 2026 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.667	Repotrectinib (Augtyro)	1Q 2026 annual review: clarified age restriction does not apply to pediatric diffuse high-grade glioma; for all indications, extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition, added required use as a single agent; per NCCN compendium– for NTRK fusion-positive cancer, added bypass for ampullary adenocarcinoma, brain metastases, esophageal and esophagogastric junction cancers, gastric cancer, pediatric diffuse high-grade glioma, and uterine sarcoma; references reviewed and updated.
CP.PHAR.668	Toripalimab-tpzi (Loqtorzi)	1Q 2026 annual review: added NCCN recommended off-label indications for anal carcinoma, small bowel adenocarcinoma, appendiceal neoplasms and cancers, colon cancer and rectal cancer per NCCN; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.669	Birch Triterpenes (Filsuvez)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.670	Eflornithine (Iwilfin)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.671	Nirogacestat (Ogsiveo)	1Q 2026 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.672	Travoprost Implant (iDose TR)	1Q 2026 annual review; references reviewed and updated.
CP.PHAR.674	Marstacimab-hncq (Hympavzi)	1Q 2026 annual review: added clarification that requirement for hemophilia severity associated with factor level is taken at baseline prior to use of factor products for routine prophylaxis; revised provider confirmation of discontinuation of factor products as prophylaxis to exclusion for concurrent use of hemophilia prophylaxis agent with more examples; revised initial approval duration from 6 months to 12 months; references reviewed and updated.
CP.PHAR.675	Obecabtagene Autoleucel (Aucatzyl)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PHAR.706	Fitusiran (Qfitlia)	1Q 2026 annual review: revised provider confirmation of discontinuation of bypassing agents and factor products as prophylaxis to exclusion for concurrent use of hemophilia prophylaxis agent with more examples; revised initial approval duration from 6 months to 12 months; references reviewed and updated.
CP.PHAR.708	Sepiapterin (Sephience)	1Q 2026 annual review: added adherent to Phe-restricted diet per labeling and plan feedback; added step therapy bypass for IL HB 5395; references reviewed and updated.

CP.PHAR.711	Cosibelimab-Ipdl (Unloxcyt)	1Q 2026 annual review: added option for satellitosis/in-transit metastasis per NCCN; added criterion, prescribed as a single agent per NCCN; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PHAR.712	Ensartinib (Ensacove)	1Q 2026 annual review: extended initial approval duration from 6 to 12 months; added that agent is prescribed as a single agent for continued therapy; references reviewed and updated.
CP.PHAR.713	Zenocutuzumab-zbco (Bizengri)	1Q 2026 annual review: extended initial approval duration from 6 to 12 months; added minimum LVEF requirements per labeling; references reviewed and updated.
CP.PHAR.721	Plozasiran (Redemplo)	Drug is now FDA approved – criteria updated per FDA labeling; consolidated FCS diagnostic criteria; added requirement for "history of elevated triglycerides in excess of 1,000 mg/dL at least three times" for clinically suggestive FCS per clinical trial design; removed failure of fibrates and omega-3 fatty acids; references reviewed and updated.
CP.PHAR.738	Doxecitine and doxribtimine (Kygevvi)	Drug is now FDA approved – criteria updated per FDA labeling; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; removed specific measures of positive response; references reviewed and updated.
CP.PHAR.751	Rilzabrutinib (Wayrilz)	Per December SDC, added redirection to generic Promacta for ITP, removed redirection to immune globulin if intolerant or contraindicated to systemic corticosteroid.
CP.PHAR.755	Paltusotide (Palsonify)	Per December SDC, added redirection to Mycapssa and one of lanreotide or generic octreotide acetate LAR (or brand Sandostatin LAR Depot if generic octreotide acetate LAR is unavailable due to shortage).
CP.PHAR.94	Alpha1-Proteinase Inhibitors (Aralast NP, Glassia, Prolastin-C, Zemaira)	1Q 2026 annual review: added off-label indication of steroid-refractory acute GVHD per NCCN; extended initial approval duration from 6 to 12 months for these maintenance medications for a chronic condition; references reviewed and updated.
CP.PHAR.96	Naltrexone (Vivitrol)	1Q 2026 annual review: no significant changes; for Medicaid, extended initial approval duration from 6 to 12 months for this maintenance medication for a
CP.PHAR.97	Eculizumab (Soliris, Bkemv, Epysqli)	Per December SDC, added redirection to Ultomiris.
CP.PMN.03	Dipeptidyl Peptidase-4 (DPP-4) Inhibitors	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.04	Non-Calcium Phosphate Binders	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.05	Rifapentine (Priftin)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.100	Risedronate (Actonel, Atelvia)	1Q 2026 annual review: no significant changes; added requirement that request does not exceed health plan-approved quantity limit, if applicable; references reviewed and updated.
CP.PMN.103	Secnidazole (Solosec)	1Q 2026 annual review: no significant changes; added allowable time elapsed for bacterial vaginosis and trichomoniasis retreatment from continued therapy within initial criteria; added request does not exceed health plan-approved quantity limit, if applicable; references reviewed and updated.
CP.PMN.105	Tavaborole (Kerydin)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.107	Topical Immunomodulators	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.113	Safinamide (Xadago)	1Q 2026 annual review: removed "idiopathic" as a PD qualifier from diagnostic criterion; corrected reference from Appendix B to Appendix D for "off" time definition; revised initial approval duration from 6 months to 12 months; for continued therapy, aligned initial therapy requirement for concurrent treatment with carbidopa/levodopa; references reviewed and updated.
CP.PMN.123	Colchicine (Colcrys, Lodoco)	1Q 2026 annual review: removed brand Colcrys from policy due to product discontinuation and its corresponding indications [familial mediterranean fever, treatment of acute gout attack, gout anti-inflammatory prophylaxis, pericarditis (off-label)]; references reviewed and updated.
CP.PMN.129	Pramlintide (Symlin)	1Q 2026 annual review: no significant changes; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PMN.14	Sodium-Glucose Co-Transporter 2 (SGLT2) Inhibitors	1Q 2026 annual review: for diabetes, removed bypass for trial of dapagliflozin for canagliflozin-containing product requests for members with multiple risk factors for CV disease; references reviewed and updated.
CP.PMN.151	Blood Glucose Test Strip Quantity Limit - Not Receiving Insulin	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.166	Luliconazole Cream (Luzu)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.186	Cenegermin-bkbj (Oxervate)	1Q 2026 annual review: added diagnostic requirement for documented evidence of decreased corneal sensitivity; added requirement that disease is refractory to at least one conventional non-surgical treatment; for continuation of therapy, for a second 8 week treatment course added requirement that member did not achieve complete corneal healing or has recurrence of neurotrophic keratitis in the affected eye that requires retreatment; for initial approval criteria added requirement if member previously received Oxervate, member has not received ≥ 16 weeks total of Oxervate treatment per affected eye; references reviewed and updated.

CP.PMN.187	Icosapent Ethyl (Vascepa)	1Q 2026 annual review: for all indications, added request does not exceed health-plan approved quantity limit, extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; for reduction of CVD risk, reduced statin adherence duration from 4 months to 8 weeks, simplified statin trial and failure criteria for moderate- and low-intensity statin regimens to require insufficient therapeutic response to one high intensity statin for 8 weeks or reversible muscle-related symptoms associated with both rosuvastatin and atorvastatin; references reviewed and updated
CP.PMN.189	Sarecycline (Seysara)	1Q 2026 annual review: added step therapy bypass for IL HB 5395; added requirement for non-nodular and moderate-to-severe acne per labeling; references reviewed and updated.
CP.PMN.20	Aspirin/Dipyridamole (Aggrenox)	1Q 2026 annual review: no significant changes; added requirement that request does not exceed health plan-approved quantity limit, if applicable; references reviewed and updated.
CP.PMN.212	Bedaquiline (Sirturo)	1Q 2026 annual review: revised age limit for use with pretomanid down to 14 years of age (from 15 years) per IDSA; removed allowance for use up to 9 months as these extended regimens only recommend bedaquiline be used for 24-26 weeks, not the entire extended treatment duration; per template added requirement that "request does not exceed health plan-approved quantity limit, if applicable"; references reviewed and updated.
CP.PMN.217	Istradefylline (Nourianz)	1Q 2026 annual review: revised initial approval duration and continued approval duration for all lines of business to 12 months; for continued therapy, aligned initial therapy requirement for concurrent treatment with carbidopa/levodopa; references reviewed and updated.
CP.PMN.218	Lasmiditan (Reyvow)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.222	Pretomanid	1Q 2026 annual review: revised age limit down to 14 years of age (from 15 years) per IDSA; references reviewed and updated.
CP.PMN.223	Rifabutin (Mycobutin)	1Q 2026 annual review: no significant changes; for H. pylori infection extended approval duration from 10 to 14 days; references reviewed and updated.
CP.PMN.224	Tenapanor (Ibsrela, Xphozah)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.225	Trifarotene (Aklief)	1Q 2026 annual review: added step therapy bypass per IL HB 5395; references reviewed and updated.
CP.PMN.227	Edoxaban (Savaysa)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.231	Cenobamate (Xcopri)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.234	Early and Periodic Screening, Diagnostic, and Treatment Benefit for Pediatric Members	Moved definition of medical necessity from Appendix E into approval criteria; moved example categories covered by Section 1905(a) and/or 1905(r) of the Social Security Act from approval criteria into Appendix D
CP.PMN.237	Bempedoic Acid (Nexletol), Bempedoic Acid/Ezetimibe (Nexlizet)	1Q 2026 annual review: for increased risk of CV events; references reviewed and updated. RT4: updated indication to reflect the following revised uses: as an adjunct to exercise (rather than LDL-lowering therapy) for HeFH for Nexlizet and to reduce major adverse CV events in adults at increased risk for these events (rather than adults with established CV disease) for both Nexlizet and Nexletol per PI; revised "hyperlipidemia" to "hypercholesterolemia" throughout the criteria.
CP.PMN.24	Ciclopirox Topical Solution 8%	1Q 2026 annual review: no significant changes; references reviewed and updated
CP.PMN.25	Efinaconazole (Jublia)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.257	Clascoterone (Winlevi)	1Q 2026 annual review: added step therapy bypass per IL HB 5395; references reviewed and updated.
CP.PMN.258	Conjugated Estrogens/Bazedoxifene (Duavee)	1Q 2026 annual review: no significant changes; revised initial approval duration from 6 to 12 months; references reviewed and updated.
CP.PMN.261	Dichlorphenamide (Keveyis)	1Q 2026 annual review: no significant changes; added requirement that request does not exceed health plan-approved quantity limit; references reviewed and updated.
CP.PMN.271	Maribavir (Livtencity)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.274	Diclofenac (Pennsaid)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.286	Glaucoma Agents	1Q 2026 annual review: references reviewed and updated.
CP.PMN.299	Xanomeline-trospium chloride (Cobenfy)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.304	Elinzanetant (Lynkuet)	Policy created.
CP.PMN.305	Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists Weight Management Benefit for Pediatric Members	Policy created.
CP.PMN.34	Ranolazine (Ranexa, Aspruzyo Sprinkle)	1Q 2026 annual review: removed branded Ranexa due to market discontinuation; references reviewed and updated.
CP.PMN.52	Omega-3-Acid Ethyl Esters (Lovaza)	1Q 2026 annual review: clarified policy applies to generic omega-3-acid ethyl esters; extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
CP.PMN.57	Febuxostat (Uloric)	1Q 2026 annual review: added request does not exceed health plan-approved quantity limit, if applicable; for Medicaid, changed approval duration from length of benefit to 12 months; references reviewed and updated.

CP.PMN.70	Ivabradine (Corlanor)	1Q 2026 annual review: no significant changes; added requirement that request does not exceed health plan-approved quantity limit, if applicable; references reviewed and updated.
CP.PMN.82	Buprenorphine Sublingual Tablet	Retired, Product is now generic and on formulary for all lines of business (except Georgia Medicaid still requires PA, but general criteria can be used)
CP.PMN.88	Alendronate (Binosto, Fosamax Plus D)	1Q 2026 annual review: no significant changes; added requirement that request does not exceed health plan-approved quantity limit, if applicable; references reviewed and updated.
CP.PMN.89	Amantadine ER (Gocovri, Osmolex ER)	1Q 2026 annual review: removed Osmolex ER from policy due to discontinuation; for PD with "off" episodes, moved the failure of immediate-release amantadine within the overall failure of two PD adjunct drugs; for continued therapy, aligned initial therapy requirement for concurrent treatment with carbidopa/levodopa; references reviewed and updated.
CP.PMN.90	Benznidazole	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.93	Dextromethorphan-Quinidine (Nuedexta)	1Q 2026 annual review: no significant changes; per template added requirement that "Request does not exceed health plan-approved quantity limit, if applicable"; references reviewed and updated.
CP.PMN.96	Ibandronate Oral (Boniva)	1Q 2026 annual review: no significant changes; references reviewed and updated.
CP.PMN.99	Prasterone (Intrarosa)	1Q 2026 annual review: no significant changes; references reviewed and updated.
NH.PHAR.02	Approval of Brand Name Override	Retire. Replaced with NH.PMN.22 Brand Name Override Policy.
NH.PHAR.101	Mifepristone (Korlym)	1Q 2026 annual review: no significant changes; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
NH.PHAR.206	Carglumic Acid (Carbaglu)	1Q 2026 annual review: no significant changes; for UCD initial approval revised from 6 to 12 months; references reviewed and updated.
NH.PHAR.207	Glycerol Phenylbutyrate (Ravicti)	1Q 2026 annual review: added requirement for dietary protein restriction per labeling; extended initial approval duration from 6 to 12 months; references reviewed and updated.
NH.PHAR.208	Sodium Phenylbutyrate (Buphenyl, Pheburane, Olpruva)	1Q 2026 annual review: RT4: added pediatric age extension to 1 year old for Olpruva; added requirement for dietary protein restriction per labeling; extended initial approval duration from 6 to 12 months; references reviewed and updated.
NH.PHAR.224	Enoxaparin (Lovenox)	1Q 2026 annual review: no significant changes; references reviewed and updated
NH.PHAR.225	Dalteparin (Fragmin)	1Q 2026 annual review: no significant changes; references reviewed and updated.
NH.PHAR.226	Fondaparinux (Arixtra)	1Q 2026 annual review: no significant changes; references reviewed and updated.
NH.PHAR.296	Pegfilgrastim (Neulasta and biosimilars)	Replaced Nyvepria with Fulphila as a preferred biosimilar example in criteria
NH.PHAR.603	Exagamglogene Autotemcel (Casgevy)	1Q 2026 annual review: added option of SCD genotype βS/β+ (HbS β+) for SCD; added genotype descriptors of HbSS and HbS β0; references reviewed and updated.
NH.PMN.104	Tasimelteon (Hetlioz, Hetlioz LQ)	1Q 2026 annual review: no significant changes; per template added requirement that "Request does not exceed health plan-approved quantity limit, if
NH.PMN.183	Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists	1Q 2026 annual review: no significant changes; removed Adlyxin as it is no longer commercially available; references reviewed and updated.
NH.PMN.22	Brand Name Override	1Q 2026 annual review: no significant changes; references reviewed and updated.
NH.PMN.259	Inhaled Agents for Asthma and COPD	1Q 2026 annual review: no significant changes; removed the following off-market products: Flovent Diskus, Flovent HFA, Lonhala Magnair, Seebri Neohaler, Utibron Neohaler; references reviewed and updated.
NH.PMN.260	Loteprednol etabonate (Eysuvis)	1Q 2026 annual review: references reviewed and updated.
NH.PMN.273	Varenicline (Tyrvaya)	1Q 2026 annual review: extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references
NH.PMN.72	Metformin ER (Fortamet, Glumetza)	1Q 2026 annual review: no significant changes; references reviewed and updated.
NH.PMN.73	Lifitegrast (Xiidra)	1Q 2026 annual review: references reviewed and updated.
NH.PMN.81	Buprenorphine/Naloxone (Suboxone, Zubsolv)	1Q 2026 annual review: revised maximum dose limitation to 32 mg/8 mg for suboxone and 22.8 mg/5.8 mg for Zubsolv with option for usage exceeding 32 mg per day or 22.8 mg per day (buprenorphine component) for Suboxone or Zubsolv, respectively, with medical justification; references reviewed and updated.
NH.PMN.92	CNS Stimulants	1Q 2026 annual review: no significant changes; per template added requirement that "Request does not exceed health plan-approved quantity limit, if
NH.PST.01	Step Therapy	1Q 2026 annual review: no changes

NH.PHAR.285	Nintedanib (Ofev)	1Q 2026 annual review: no changes
NH.PHAR.09	Pharmacy Program	Updated policy to remove generic required substitution and added qualifying claim language. Added language around PDL compliance to new brand preferred strategy and reporting assigned to it. Added language around USPSTF Grade A and B services.