25Q3 Clinical Criteria Summary Table

Number	Title	Revision Log
CC.PHAR.13	Pharmacy and Therapeutics Committe	Updated scope to include the acronym (CPS) and updated the membership to identify non-voting guests serving as ad hoc advisors.
CC.PHAR.14	Generic Drug Additions to PDL	Removed "Drugs on the formulary that change from SSB (no generic available) to MSB with a generic available will move to non-formulary status. Non-formulary drugs that change from SSB to MSB with a generic available will remain the same, as non-formulary" from the Policy section since it is explained in the Procedure section. Removed Procedure Step 3 regarding the ability to block new generic NDCs at POS due to costs or rebates because that process would be managed by SDC
CC.PHAR.15	Line Extension Additions to PDL	Changed Functional Area from Business Operations to Claims and Payment. Removed cost thresholds for lancets and alcohol swabs. Removed health plan review for addition of Flu vaccines. Changed SDC to Formulary Strategy team where applicable. Removed non-applicable definitions. Edited step 1 (a-f) with new process for line extension determinations. Removed the following lines from Step 3 and 4 as it will be either addressed at step 1, addressed at the benefit level and/or determined by health plan. a.If the new product is a new brand of an existing chemical entity, it will be non-PDL. The SDC will then consider its placement on the PDL. b.If the new product is a new strength and same dosage form of an existing PDL product, line-extend off the existing product. c.If the new product is a new dosage form of a PDL drug, it will be non-PDL. The SDC will then consider its placement on the PDL. d.If the new product is a non-first generic of a PDL drug, line-extend off the existing generics. e.If the new product is a vial, ampule, or syringe, it will be non-PDL. f.If the new product is OTC, it will be non-PDL. g.If the new product is a multi-source brand (MSB), it will be non-PDL. h.If the new product is durable medical equipment (DME), it will be non-PDL. i.If the new product is a new pen or auto-injector, it will be non-PDL. The SDC will then consider its placement on the PDL. j.If the new product is a combination of existing products, it will be non-PDL. The SDC will then consider its placement on the PDL. k.If the new product is a prescription drug that has changed to an OTC drug, SDC will consider its placement on the PDL. l.If the new product is a re-packaged product, it will be non-PDL. m.If the new product is a new package size of an existing PDL drug, it will be non-PDL. n.The following are reviewed by the health plan, and can be added as line extensions to the PDL. i.If the new product is a cough and cold generic product, it will be reviewed against current PDL cough and cold generic products for line extension. ii.If the new product is a vitamin, it will be reviewed against current PDL vitamins for line extension. iii.If the new product is a prenatal vitamin, it will be reviewed by the AWP cost of the drug. If the new prenatal vitamin cost is ≤ $15, it will be PDL
CC.PHAR.21	Precision Drug Action Committee	Updated scope to include the acronym (CPS) and updated the membership to identify non-voting guests serving as ad hoc advisors. Updated attachment A with current wholesale acquisition cost (WAC).
CC.PHARM.54	Specialty Drug List Management	Updated Functional Area from Business Operations to Claims and Payment. Updated Section 4c from "CVSC or ESI" to "CVSC and ESI" and added NDC updates to what could be included in Specialty Modules.
CP.PHAR.109	Tesamorelin (Egrifta SV)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.11	Burosumab-twza (Crysvita)	3Q 2025 annual review: for XLH, modified to allow diagnostic confirmation of PHEX gene in member or first-degree relative per competitor analysis, added requirement for documentation of member's current weight, for dose calculation purposes; references reviewed and updated.
CP.PHAR.145	Deferasirox (Exjade, Jadenu)	3Q 2025 annual review: for chronic iron overload, revised concurrent iron chelator bypass threshold from cardiacT2* < 20 ms to mT2* ≤ 10 ms per TIF guidelines; references reviewed and updated.
CP.PHAR.146	Deferoxamine (Desferal)	3Q 2025 annual review: for chronic iron overload, revised concurrent iron chelator bypass threshold from cardiac T2* < 20 ms to mT2* ≤ 10 ms per TIF guidelines; references reviewed and updated
CP.PHAR.147	Deferiprone (Ferriprox)	3Q 2025 annual review: for chronic iron overload, revised concurrent iron chelator bypass threshold from cardiac T2* < 20 ms to mT2* ≤ 10 ms per TIF guidelines; references reviewed and updated.
CP.PHAR.150	Mecasermin (Increlex)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.169	Vigabatrin (Sabril, Vigafyde)	3Q 2025 annual review: no significant changes; added a generic redirection for brand Sabril; references reviewed and updated.
CP.PHAR.177	Ecallantide (Kalbitor)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.178	Icatibant (Firazyr)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.188	Teriparatide (Forteo, Bonsity)	Revised initial approval duration to 12 months for Medicaid/HIM.
CP.PHAR.189	Ibandronate Injection (Boniva)	Revised initial approval duration to 12 months for Medicaid/HIM.
CP.PHAR.202	C1 Esterase Inhibitors (Berinert, Cinryze, Haegarda, Ruconest)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.209	Aztreonam (Cayston)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.210	Ivacaftor (Kalydeco)	3Q 2025 annual review: added Alyftrek to list of CFTR modulator concurrent exclusion criteria; references reviewed and updated.
CP.PHAR.211	Tobramycin (Bethkis, Kitabis Pak, TOBI, TOBI Podhaler)	3Q 2025 annual review: removed brand Kitabis Pak and brand Tobi from HIM duration; references reviewed and updated.
CP.PHAR.212	Dornase Alfa (Pulmozyme)	3Q 2025 annual review: no significant changes; for Appendix D, removed supplemental information on FEV1 predicted; references reviewed and updated.
CP.PHAR.213	Lumacaftor/Ivacaftor (Orkambi)	3Q 2025 annual review: added Alyftrek to list of CFTR modulator concurrent exclusion criteria; references reviewed and updated.
CP.PHAR.27	Tolvaptan (Jynarque, Samsca)	3Q 2025 annual review: for ADPKD, added requirements for minimum eGFR and high risk for rapidly progressive disease per 2025 KDIGO guidelines and in alignment with pivotal study design and FDA labeling, respectively; for Jynarque, added redirection to generic tolvaptan; references reviewed and updated.
CP.PHAR.270	Paricalcitol Injection (Zemplar)	3Q 2025 annual review: added reference to generic in Policy/Criteria description; references reviewed and updated.
CP.PHAR.277	Cytomegalovirus Immune Globulin (CytoGam)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.28	Immunization Coverage	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.286	Pirfenidone (Esbriet)	3Q 2025 annual review: for other indications/diagnoses, revised generic redirection to allow either tablet or capsule by removing specific formulations; references reviewed and updated.
CP.PHAR.287	Obeticholic Acid (Ocaliva)	3Q 2025 annual review: no significant changes; clarified UDCA is ursodiol; references reviewed and updated.
CP.PHAR.295	Sargramostim (Leukine)	3Q 2025 annual review: per NCCN Compendium for neuroblastoma removed requirement for relapse or refractory disease, clarified combination with Danyelza should also include temozolomide and irinotecan; references reviewed and updated.
CP.PHAR.338	Cerliponase Alfa (Brineura)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.345	Abaloparatide (Tymlos)	Revised initial approval duration to 12 months for Medicaid
CP.PHAR.351	Daptomycin (Cubicin, Cubicin RF, Dapzura RT)	3Q 2025 annual review: no significant changes; removed references to Cubicin and Dapzura RT as these branded products are discontinued; added 350 mg strength to Section VI; references reviewed and updated.
CP.PHAR.377	Tezacaftor/Ivacaftor; Ivacaftor (Symdeko)	3Q 2025 annual review: added Alyftrek to list of CFTR modulator concurrent exclusion criteria; references reviewed and updated.
CP.PHAR.379	Etelcalcetide (Parsabiv)	3Q 2025 annual review: clarified redirection to Sensipar should be to generic cinacalcet; included cinacalcet as an example of a calcimimetic that should not be prescribed concurrently with Parsabiv; references reviewed and updated.
CP.PHAR.384	Lutetium Lu 177 Dotatate (Lutathera)	3Q 2025 annual review: added option for first-line use in gastrointestinal or pancreas NET with Ki-67 ≥ 10% and clinically significant tumor burden per NCCN; references reviewed and updated.
CP.PHAR.385	Corticosteroids for Ophthalmic Injection (Dexteza, Iluvien, Ozurdex, Retisert, Xipere, Yutiq)	3Q 2025 annual review: for allergic conjunctivitis, added bypass of redirection for members unable to manage regular eye drop use; for macular edema following RVO and DME clarified failure of a single intravitreal anti-VEGF agent; for non-infectious uveitis, added examples of trial and failure agents and clarified non-biologic "systemic" immunosuppressive therapy; RT4: for Dextenza, removed age requirement for ocular inflammation per FDA pediatric expansion and updated age requirement for allergic conjunctivitis from ≥ 18 years to ≥ 2 years per FDA pediatric expansion; in Appendix B, consolidated non-biologic systemic immunosuppressive therapies; updated HCPCS code description for Xipere; in Section V, updated Ozurdex and Iluvien indications per PI and updated Ozurdex maximum dose from every 6 months to every 3 months; references reviewed and updated.
CP.PHAR.388	Chloramphenicol Sodium Succinate	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.396	Lanadelumab-fylo (Takhzyro)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.401	Amikacin (Arikayce)	3Q 2025 annual review: no significant change; references reviewed and updated.
CP.PHAR.41	Enfuvirtide (Fuzeon)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.415	Ravulizumab-cwvz (Ultomiris)	3Q 2025 annual review: updated the list of therapies that Ultomiris should not be prescribed concurrently with to include Epysqli for all indications and PiaSky for PNH; for gMG, clarified that the required immunosuppressive therapy should be non-steroidal; revised continued approval duration from 6 to 12 months for all indications as they are chronic conditions; references reviewed and updated.
CP.PHAR.425	Metreleptin (Myalept)	3Q 2025 annual review: updated limitations of use per PI; clarified genes associated with congenital generalized lipodystrophy; references reviewed and updated.
CP.PHAR.428	Romosozumab-aqqg (Evenity)	Revised initial approval duration to 12 months for Medicaid; revised continuation of therapy to state member must meet the initial approval criteria.
CP.PHAR.430	Alpelisib (Piqray, Vijoice)	3Q 2025 annual review: for breast cancer, removed requirement for "locally" in "locally recurrent" and added for premenopausal female member to be treated with ovarian ablation/suppression per NCCN; references reviewed and updated.
CP.PHAR.432	Tafamidis (Vyndaqel, Vyndamax)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.440	Elexacaftor/Ivacaftor/Tezacaftor; Ivacaftor (Trikafta)	3Q 2025 annual review: added Alyftrek to list of CFTR modulator concurrent exclusion criteria; references reviewed and updated.
CP.PHAR.448	Mometasone Furoate (Sinuva)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.449	Crizanlizumab-tmca (Adakveo)	For hydroxyurea trial, added that documentation supports adherence to hydroxyurea for at least the past 6 months, examples of hydroxyurea contraindications and intolerances, and a bypass option requiring provider attestation of past adherence to hydroxyurea for ≥ 6 months at the maximum tolerated dose and ≥ 1 VOC while on the maximum tolerated dose; removed ICD-10-CM Codes section.
CP.PHAR.458	Inebilizumab-cdon (Uplizna)	3Q 2025 annual review: for NMOSD, added Epysqli to the list of therapies that Uplizna should not be prescribed concurrently with, and revised continued approval duration from 6 to 12 months as NMOSD is a chronic condition; RT4: added criteria for the newly approved indication of IgG4-RD; references reviewed and updated.

CP.PHAR.463	Satralizumab-mwge (Enspryng)	3Q 2025 annual review: added Epysqli to the list of therapies that Enspryng should not be prescribed concurrently with; revised continued approval duration from 6 to 12 months as NMOSD is a chronic condition; references reviewed and updated.
CP.PHAR.485	Berotralstat (Orladeyo)	3Q 2025 annual review: no significant changes; updated FDA, approved indication language to align with PI; references reviewed and updated.
CP.PHAR.487	Osilodrostat (Isturisa)	3Q 2025 annual review: RT4: revised FDA Approved Indication(s) to reflect expanded approval in Cushing's syndrome (previously only Cushing's disease) and modified criteria to reflect updated labeling language; removed 10 mg tablet strength as it is no longer on market; references reviewed and updated.
CP.PHAR.488	Apomorphine (Apokyn)	3Q 2025 annual review: added HCPCS code [J3490, C9399]; references reviewed and updated.
CP.PHAR.494	Capmatinib (Tabrecta)	3Q 2025 annual review: for initial criteria: added option for "used as a single-agent for brain metastases" per NCCN; updated EGFR mutant with high-level MET amplifications criteria from "Tabrecta is used with Tagrisso" to "Tabrecta can be administered with continuation of Tagrisso" per NCCN guideline; references reviewed and updated.
CP.PHAR.495	Mitomycin for Pyelocalyceal Solution (Jelmyto)	3Q 2025 annual review: removed requirement for cancer location above the ureteropelvic junction per NCCN; removed exclusion for "recent history of carcinoma in situ in the urinary tract, invasive urothelial carcinoma, or high-grade papillary urothelial carcinoma" as this is not excluded per NCCN or the FDA indication; added requirement for use as monotherapy per NCCN; references reviewed and updated.
CP.PHAR.497	Tucatinib (Tukysa)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.518	Mannitol (Bronchitol)	3Q 2025 annual review: no significant changes; for Appendix D, removed supplemental information on hypertonic saline and dornase alfa; references reviewed and updated.
CP.PHAR.524	Pegcetacoplan (Empaveli, Syfovre)	3Q 2025 annual review: for PNH, added Epysqli and PiaSky to the list of therapies that Empaveli should not be prescribed concurrently with, added improvement of extravascular hemolysis as an example of positive response to therapy, and revised continued approval duration from 6 to 12 months as PNH is a chronic condition; updated Syfovre contraindications in Appendix C to include hypersensitivity per updated prescribing information; references reviewed and updated.
CP.PHAR.543	Maralixibat (Livmarli)	3Q 2025 annual review: for ALGS initial and continued therapy and PFIC continued therapy, added exclusion for concurrent use with other IBAT inhibitors; RT4: added new tablet formulation [10 mg, 15 mg, 20 mg, 30 mg] for ALGS and PFIC; for ALGS, updated criteria from "request is for oral solution 9.5 mg/mL" to "if request is for oral solution, request is for 9.5 mg/mL strength"; for PFIC, updated criteria from "request is for oral solution 19 mg/mL" to "request is for oral solution, request is for 19 mg/mL strength"; for both indications, added criteria "if request is for tablets, documentation of member's current body weight ≥ 25 kg"; for section V, updated ALGS and PFIC sections with tablet dosage by weight; references reviewed and updated.
CP.PHAR.545	Betibeglogene Autotemcel (Zynteglo)	3Q 2025 annual review: no significant changes; added template statement requiring medical director review; added criterion for documentation of member's body weight for verification of weight-based dose; references reviewed and updated.
CP.PHAR.548	Palovarotene (Sohonos)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.578	Abrocitinib (Cibinqo)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.586	Olipudase Alfa-rpcp (Xenpozyme)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.592	Beremagene geperpavec-svdt (Vyjuvek)	3Q 2025 annual review: added exclusion of concomitant use with Zevaskyn; references reviewed and updated.
CP.PHAR.609	Prademagene Zamikeracel (Zevaskyn)	Drug is now FDA approved – criteria updated per FDA labeling; for initial therapy: for diagnosis of RDEB criteria, removed "immunofluorescence mapping, transmission electron microscopy, antigenic mapping" as EB diagnostic criteria is not specific to only RDEB and to align with Vyjuvek criteria; removed criteria "member has no evidence of immune response to COL7 as evidence by immunofluorescence (e.g., member is not positive for anti-COL7 antibodies at baseline)" as supported by prescribing information and specialist feedback; added requirement that Zevaskyn is not prescribed concurrently with Vyjuvek or Filsuvez; updated criteria from "wound sites must be stage 2 chronic wound" to "wound sites must be chronic open wounds (e.g., stage 2 chronic wound)"; revised maximum dosing from does not exceed 6 sheets to does not exceed 12 sheets per one-time surgical application; for Appendix E, removed supplemental diagnostic information on immunofluorescence mapping, transmission electron microscopy, antigenic mapping; for continued therapy, removed criteria "continued therapy will not be reauthorized as EB-101 is indicated to be a one-time surgical application" and added "Re-authorization is not permitted. Members must meet the initial approval criteria if request is for previously untreated or newly developed wounds"; references reviewed and updated.
CP.PHAR.61	Cinacalcet (Sensipar)	3Q 2025 annual review: for primary HPT, added requirement that member has failed or is unable to undergo a parathyroidectomy per FDA-labeled indication; included Parsabiv as an example of a calcimimetic that should not be prescribed concurrently with cinacalcet; for secondary HPT; references reviewed and updated.
CP.PHAR.614	Nirsevimab-alip (Beyfortus)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.632	Fecal Microbiota Spores, Live-brpk (Vowst)	3Q 2025 annual review: no significant changes; references reviewed and updated
CP.PHAR.638	Nalmefene (Opvee, Zurnai)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.644	Givinostat (Duvyzat)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.656	Iptacopan (Fabhalta)	3Q 2025 annual review: for PNH, added Epysqli and PiaSky to the list of therapies that Fabhalta should not be prescribed concurrently with, and revised continued approval duration from 6 to 12 months as PNH is a chronic condition; references reviewed and updated. Per June SDC: for IgAN, added redirection to Filspari or Vanrafia in initial approval criteria.
CP.PHAR.664	Crovalimab-akkz (PiaSky)	3Q 2025 annual review: removed example of improved extravascular hemolysis to demonstrate positive response to therapy given PiaSky's mechanism of action; revised continued approval duration from 6 to 12 months as PNH is a chronic condition; references reviewed and updated.
CP.PHAR.665	Danicopan (Voydeya)	3Q 2025 annual review: added Epysqli (Soliris biosimilar) as another C5 inhibitor option; added requirement for no concurrent use with Empaveli, Fabhalta, or PiaSky; references reviewed and updated
CP.PHAR.682	Levacetylleucine (Aqneursa)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.683	Acoramidis (Attruby)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.688	Elafibranor (Iqirvo)	3Q 2025 annual review: no significant changes; clarified UDCA is ursodiol; references reviewed and updated.
CP.PHAR.689	Olezarsen (Tryngolza)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.690	Imetelstat (Rytelo)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.739	Acoltremon (Tryptyr)	Policy created.
CP.PHAR.82	Collagenase Clostridium Histolyticum (Xiaflex)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.89	Peginterferon Alfa-2a (Pegasys)	3Q 2025 annual review: for primary cutaneous CD30+ T-cell lymphoproliferative disorder, clarified diagnosis as primary cutaneous anaplastic large cell lymphoma and added requirement for monotherapy use per NCCN; references reviewed and updated
CP.PHAR.95	Thyrotropin Alfa (Thyrogen)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PHAR.97	Eculizumab (Soliris)	3Q 2025 annual review: RT4: updated FDA approved indication for Bkemv to include adult patients with gMG who are AChR antibody positive; for PNH, added PiaSky to the list of therapies that Soliris/Bkemv/Epysqli should not be prescribed concurrently with; for gMG, clarified that the required immunosuppressive therapy should be non-steroidal; revised continued approval duration from 6 to 12 months for all indications as they are chronic conditions; references reviewed and updated.
CP.PMN.08	Lidocaine Transdermal (Lidoderm, ZTlido)	3Q 2025 annual review: for postherpetic neuralgia, references reviewed and updated.
CP.PMN.102	Rolapitant (Varubi)	3Q 2025 annual review: no significant changes; referenced reviewed and updated.
CP.PMN.111	House Dust Mite Allergen Extract (Odactra)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.115	Delafloxacin (Baxdela)	3Q 2025 annual review: no significant changes; referenced reviewed and updated.
CP.PMN.132	Tadalafil BPH - ED (Cialis, Chewtadzy)	3Q 2025 annual review: added reference to tadalafil as criteria would apply for generic requests; references reviewed and updated.
CP.PMN.141	Dolasetron (Anzemet)	3Q 2025 annual review: no significant changes; referenced reviewed and updated.
CP.PMN.144	Epinephrine (Auvi-Q, EpiPen, EpiPen Jr) Quantity Limit Override	3Q 2025 annual review: updated Auvi-Q indication and added weight minimum in initial criteria per FDA labeled indication; references reviewed and updated.
CP.PMN.145	Vilazodone (Viibryd)	3Q 2025 annual review: clarified policy applies to generic vilazodone; clarified failure of two antidepressants from at least two different drug classes; in Appendix B, updated therapeutic alternatives per Clinical Pharmacology; references reviewed and updated.
CP.PMN.152	Lofexidine (Lucemyra)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.155	Lacosamide (Motpoly XR, Vimpat)	3Q 2025 annual review: no significant changes; referenced reviewed and updated.
CP.PMN.156	Perampanel (Fycompa)	3Q 2025 annual review: no significant changes; referenced reviewed and updated.
CP.PMN.157	Rufinamide (Banzel)	3Q 2025 annual review: no significant changes; generic redirection added to Continued Therapy section; references reviewed and updated.
CP.PMN.158	Netupitant and Palonosetron (Akynzeo), Fosnetupitant and Palonosetron (Akynzeo IV)	3Q 2025 annual review: no significant changes; referenced reviewed and updated.
CP.PMN.159	Dronabinol (Marinol, Syndros)	3Q 2025 annual review: per NCCN Compendium and competitor analysis removed off-label use in anorexia associated with cancer; updated Appendix E with revised language and exception for Tennessee; references reviewed and updated.
CP.PMN.163	Sodium Zirconium Cyclosilicate (Lokelma)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.164	Cannabidiol (Epidiolex)	3Q 2025 annual review: no significant changes; referenced reviewed and updated.
CP.PMN.188	Omadacycline (Nuzyra)	3Q 2025 annual review: no significant changes; referenced reviewed and updated.
CP.PMN.19	Aprepitant (Aponvie, Emend, Cinvanti), Fosaprepitant (Emend for injection, Focinvez)	3Q 2025 annual review: added references to generics to Policy/Criteria description and age limits; updated Appendix E with revised language and exception for Tennessee; references reviewed and updated.
CP.PMN.205	Patiromer (Veltassa)	3Q 2025 annual review: for section VI, added "1 g" strength as supported by clinical pharmacology and still active in Medispan; references reviewed and updated.
CP.PMN.207	Triclabendazole (Egaten)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.208	Halobetasol Propionate/Tazarotene (Duobrii)	3Q 2025 annual review: no significant changes; for Appendix B, updated tazarotene dosing regimen; references reviewed and updated.
CP.PMN.211	Midazolam (Nayzilam)	3Q 2025 annual review: no significant changes; referenced reviewed and updated.
CP.PMN.215	Non-preferred blood glucose monitors and test strips	Per June SDC, clarified re-authorization is not permitted and members must meet the initial approval criteria; in Appendix B, revised preferred products from OneTouch to Accu-check.
CP.PMN.219	Lefamulin (Xenleta)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.220	Peanut Allergen Powder-dnfp (Palforzia)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.232	Lumateperone (Caplyta)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.236	Amisulpride (Barhemsys)	3Q 2025 annual review: no significant changes; references reviewed and updated.

CP.PMN.238	Carbidopa/Levodopa ER Capsules (Rytary), Enteral Suspension (Duopa), IR Tablets (Dhivy)	3Q 2025 annual review: no significant changes; added HCPCS code [J7356]; references reviewed and updated.
CP.PMN.239	Chenodiol (Chenodal)	3Q 2025 annual review: for CTX, added that diagnosis must be confirmed by genetic testing and added specialist prescriber requirement for this rare genetic disease; references reviewed and updated.
CP.PMN.240	Gabapentin ER (Gralise, Horizant)	3Q 2025 annual review: for PHN, added member must use generic Gralise if available; in Appendix B, updated dosing regimens and clarified listed therapeutics alternatives have evidence supporting their use in the indications covered by this policy; references reviewed and updated.
CP.PMN.242	Minocycline Micronized Foam (Amzeeq)	3Q 2025 annual review: no significant changes; for Appendix B, updated benzoyl peroxide dosing regimen from maximum dose of "BID" to "TID"; references reviewed and updated.
CP.PMN.243	Progesterone (Crinone, Endometrin)	3Q 2025 annual review: for prevention of preterm birth, removed criterion regarding concurrent usage with Makena due to product discontinuation; evidence of coverage for infertility/fertility preservation language added for HIM line of business (AZ, DE, GA, IN, KS, KY, MI, MO, NE, NY, NH, OH, OK, PA, SC, TN, TX); references reviewed and updated.
CP.PMN.245	Opicapone (Ongentys)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.246	Fenfluramine (Fintepla)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.247	Rivaroxaban (Xarelto)	3Q 2025 annual review: for initial criteria, require trial of preferred Eliquis agent for "treatment of VTE and risk reduction of recurrent VTE in pediatric patients < 18 years after at least 5 days of initial parenteral anticoagulant treatment"; for Appendix B, added Eliquis dosing for treatment of VTE and risk reduction of recurrent VTE in pediatric patients; references reviewed and updated.
CP.PMN.263	Estradiol Vaginal Ring (Femring)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.268	Tenofovir Alafenamide Fumarate (Vemlidy)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.27	Linezolid (Zyvox)	3Q 2025 annual review: no significant changes; added references to generic linezolid in Policy/Criteria description as criteria would apply; references reviewed and updated.
CP.PMN.272	Mavacamten (Camzyos)	3Q 2025 annual review: no significant changes; per labeling updates, revised Appendix C (removed contraindication with moderate CYP2C19 inhibitors and strong CYP3A4 inhibitors) and Section V (for maintenance dosing, revised frequency of required echo monitoring from once every 12 weeks to every 6 months for LVEF ≥ 55% and a Valsalva LVOT gradient < 30 mmHg); references reviewed and updated.
CP.PMN.280	Compounded Medications	3Q 2025 annual review: added route of administration, in addition to the indication, for requirement that acceptable compendium supports efficacy and safety.
CP.PMN.281	Topiramate Extended-Release (Qudexy XR, Trokendi XR)	3Q 2025 annual review: no significant changes; extended the generic redirection requirement to the Continued Therapy section for seizures; references reviewed and updated.
CP.PMN.288	Nirmatrelvir and Ritonavir (Paxlovid)	3Q 2025 annual review: no significant changes; updated the list of the CDC's risk factors for progression to severe disease in Appendix D; references reviewed and updated.
CP.PMN.289	Fezolinetant (Veozah)	3Q 2025 annual review: updated black box warning for risks of hepatotoxicity per PI; for Appendix B, removed estropiate due to product unavailability; references reviewed and updated.
CP.PMN.290	Perfluorohexyloctane (Miebo)	3Q 2025 annual review: no significant changes; in appendix B, clarified agents used off-label for DED; references reviewed and updated.
CP.PMN.296	Ketamine (Ketalar)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.40	Acitretin (Soriatane)	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.44	Pyrimethamine (Daraprim)	3Q 2025 annual review: for initial therapy for toxoplasmosis active disease, for toxoplasmosis prophylaxis, clarified member must use TMP-SMX unless contraindicated or clinically significant adverse effects are experienced; in continued therapy for chronic maintenance following initial therapy for active disease, increased duration of approval from 6 months to 12 months; in Appendix B, clarified dosing regimen per guideline; updated Section V per guidelines; references reviewed and updated.
CP.PMN.46	Roflumilast (Daliresp, Zoryve)	3Q 2025 annual review: RT4: added newly FDA-approved indication of plaque psoriasis for Zoryve foam; for COPD, removed econazole, luliconazole, oxiconazole, and sulconazole from Appendix B as there is insufficient evidence for the use of these agents in seborrheic dermatitis; references reviewed and updated.
CP.PMN.60	SSRI/SNRI Duplicate Therapy	3Q 2025 annual review: no significant changes; references reviewed and updated.
CP.PMN.62	Tedizolid (Sivextro)	3Q 2025 annual review: RT4: added pediatric extension to include use in members at least 26 weeks gestational age and weight at least 1 kg; updated to include pediatric specific weight-based dosing; references reviewed and updated.
CP.PMN.65	Vortioxetine (Trintellix)	3Q 2025 annual review: clarified failure of two antidepressants from at least two different drug classes; in Appendix B, updated therapeutic alternative per Clinical Pharmacology; references reviewed and updated.
CP.PMN.74	Granisetron (Sancuso, Sustol)	3Q 2025 annual review: no significant changes; references reviewed and updated.