| Reference ID | Criteria Title | Revision |
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| CC.PHAR.05 | Lost, Stolen, Spilled or Broken Medication | Annual review. No changes deemed necessary. |
| CC.PHAR.07 | Pharmaceutical Management | Annual review. No changes deemed necessary. |
| CC.PHAR.10 | Preferred Drug List NH Addendum | Annual review, no changes |
| CC.PHAR.13 | Pharmacy and Therapeutics Committee NH Addendum | Annual review, no changes |
| CC.PHAR.14 | Generic Drug Additions to PDL NH Addendum | Annual review, no changes |
| CC.PHAR.16 | Pharmacy and Therapeutics Committee Member Documentation and Tracking | Annual Review. Updated wording in membership letters. Changed usage of CPTC to P&T. Updated policy reference from CC.LEGL.01 to CC.COMP.09. Added definitions. |
| CC.PHAR.17 | Conflict of Interest and Confidentiality Statement for Pharmacy and Therapeutics Committee Membership | Annual Review. Removed all reference to “CPTC” and replaced with “P&T” where applicable. Separated Conflict of Interest and Confidentiality Statement forms back into two separate attachments. |
| CC.PHAR.19 | Vacation Overrides NH Addendum | Annual review, no changes |
| CC.PHAR.23 | Clinical Pharmacy Policy Web Posting | Changed the annual review cycle to align with CP.PHAR.00 State Pharmacy Criteria Process. Removed any reference to local health plan P&T. Updated references to include CC.PHAR.00. |
| CP.PHAR.103 | Immune Globulins | 2Q 2025 annual review: for CIDP, revised diagnostic criteria from “atypical CIDP” to “CIPD variants” aligning with 2021 EAN/PNS CIDP guidelines; applied redirection language to other diagnoses/indications section; for Section III, clarified usage for “maintenance or chronic” treatment of secondary immunodeficiencies induced by biologic therapies; for Arkansas, added reference to state-specific PANS/PANDAS AR.CP.PHAR.103 policy; references reviewed and updated. |
| CP.PHAR.123 | Evolocumab (Repatha) | Per March SDC, for all indications, 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, removed ezetimibe trial criteria. |
| CP.PHAR.124 | Alirocumab (Praluent) | In Appendix B, removed ezetimibe from therapeutic alternatives because the criteria does not require trial of ezetimibe. |
| CP.PHAR.135 | Baricitinib (Olumiant) | 2Q 2025 annual review: no significant changes; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated. |
| CP.PHAR.152 | Laronidase (Aldurazyme) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.153 | Eliglustat (Cerdelga) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.154 | Imiglucerase (Cerezyme) | 2Q 2025 annual review: no significant changes; added Boxed Warning from the PI; references reviewed and updated. |
| CP.PHAR.155 | Cysteamine oral (Cystagon, Procysbi) | 2Q 2025 annual review: added prescriber requirement for nephrologist or a metabolic disease specialist experienced in management of nephropathic cystinosis (e.g., endocrinologist or urologist); references reviewed and updated. |
| CP.PHAR.156 | Idursulfase (Elaprase) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.157 | Taliglucerase Alfa (Elelyso) | 2Q 2025 annual review: no significant changes; added Boxed Warning from the PI; references reviewed and updated. |
| CP.PHAR.158 | Agalsidase Beta (Fabrazyme) | 2Q 2025 annual review: no significant changes; added requirement for documentation of member’s weight for dose calculation purposes; references reviewed and updated. |
| CP.PHAR.159 | Sebelipase Alfa (Kanuma) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.16 | Palivizumab (Synagis) | 2Q 2025 annual review: for preterm infants added clarification regarding maternal vaccine exclusion if administered ≥ 14 days prior to delivery per ACIP/AAP recommendations; removed statement regarding redirection to Beyfortus “For the 2023-2024 RSV season, supply issues are anticipated” as the AAP states shortage of Beyfortus is not expected this coming season; removed statements referencing elevated interseasonal activity as per the CDC regular seasonal patterns are now expected; references reviewed and updated. |
| CP.PHAR.161 | Galsulfase (Naglazyme) | 2Q 2025 annual review: no significant changes; added new Boxed Warning per label; references reviewed and updated. |
| CP.PHAR.162 | Elosulfase Alfa (Vimizim) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.163 | Velaglucerase Alfa (VPRIV) | 2Q 2025 annual review: no significant changes; added Boxed Warning from the PI; references reviewed and updated. |
| CP.PHAR.164 | Miglustat (Zavesca) | 2Q 2025 annual review: no significant changes; added generic redirection; added HCPCS code for miglustat; references reviewed and updated. |

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| CP.PHAR.168 | Repository Corticotropin Injection (Acthar Gel, Purified Cortrophin Gel) | 2Q 2025 annual review: no significant changes; references reviewed and updated; RT4: for Purified Cortrophin Gel added new single-dose pre-filled syringe formulation to Section VI; updated quantity limit for MS to include prefilled syringes. |
| CP.PHAR.172 | Histrelin Acetate (Vantas, Supprelin LA) | 2Q 2025 annual review: no significant changes; for gender dysphoria and gender transition continuation of therapy requests, added the following as an example of positive response: member continues to meet their individual goals of therapy for gender dysphoria; references reviewed and updated. |
| CP.PHAR.174 | Nafarelin Acetate (Synarel) | 2Q 2025 annual review: no significant changes; for gender dysphoria and gender transition continuation of therapy requests, added the following as an example of positive response: member continues to meet their individual goals of therapy for gender dysphoria; references reviewed and updated. |
| CP.PHAR.230 | AbobotulinumtoxinA (Dysport) | 2Q 2025 annual review:  for upper and lower limb spasticity, removed verbiage “staying within per limb dosing guidelines”; for focal dystonia and essential tremor, added prescriber option for orofacial pain specialist; updated Appendix B with additional agents for OAB; references reviewed and updated. |
| CP.PHAR.231 | IncobotulinumtoxinA (Xeomin) | 2Q 2025 annual review: for focal dystonia and essential tremor, added prescriber option for orofacial pain specialist; updated Appendix B with additional agents for OAB; references reviewed and updated. |
| CP.PHAR.232 | OnabotulinumtoxinA (Botox) | 2Q 2025 annual review: for focal dystonia and essential tremor, added prescriber option for orofacial pain specialist; updated Appendix B with additional agents for OAB; references reviewed and updated. |
| CP.PHAR.233 | RimabotulinumtoxinB (Myobloc) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.236 | Darbepoetin Alfa (Aranesp) | 2Q 2025 annual review: extended continuation of therapy approval duration from 6 to 12 months for Medicaid/HIM for anemia due to CKD; removed 300 mg vial from product availability per updated prescribing information; references reviewed and updated. Per March SDC, for all indications, revised Retacrit and Epogen redirection language from “failure of” to “member must use” and revised criteria from “member meets one of the following” to “member must meet both of the following”, clarified members must use Epogen if member is unable to use Retacrit. |
| CP.PHAR.238 | Methoxy Polyethylene Glycol-Epoetin Beta (Mircera) | 2Q 2025 annual review: extended continuation of therapy approval duration from 6 to 12 months for Medicaid/HIM; references reviewed and updated. Per March SDC, for all indications, revised Retacrit and Epogen redirection language from “failure of” to “member must use” and revised criteria from “member meets one of the following” to “member must meet both of the following”, clarified members must use Epogen if member is unable to use Retacrit. |
| CP.PHAR.243 | Alemtuzumab (Lemtrada) | 2Q 2025 annual review: per competitor analysis, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response; per SDC, removed notation that Extavia is the preferred interferon beta-1b product for the Medicaid line of business as it is no longer available on market; references reviewed and updated. |
| CP.PHAR.245 | Apremilast (Otezla) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.246 | Canakinumab (Ilaris) | 2Q 2025 annual review: for sJIA, added redirection to NSAID as an option per clinical practice guidelines and competitor analysis; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated. |
| CP.PHAR.248 | Dalfampridine (Ampyra) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.249 | Dimethyl Fumarate (Tecfidera), Diroximel Fumarate (Vumerity), Monomethyl Fumarate (Bafiertam) | 2Q 2025 annual review: per competitor analysis, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response; per SDC, removed notation that Extavia is the preferred interferon beta-1b product for the Medicaid line of business as it is no longer available on market; for continued therapy, updated approval duration from “if member has received < 1 year of total treatment – up to a total of 12 months of treatment and if member has received > 1 year of total treatment – 12 months” to “12 months”; references reviewed and updated. |
| CP.PHAR.251 | Fingolimod (Gilenya, Tascenso ODT) | 2Q 2025 annual review: per competitor analysis, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response; for continued therapy, modified approval duration from “if member has received < 1 year of total treatment – up to a total of 12 months of treatment and if member has received > 1 year of total treatment – 12 months” to “12 months”; references reviewed and updated. |
| CP.PHAR.257 | Ixekizumab (Taltz) | 2Q 2025 annual review: no significant changes; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated. |

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| CP.PHAR.260 | Rituximab (Rituxan), Rituximab-arrx (Riabni), Rituximab-pvvr (Ruxience), Rituximab-abbs (Truxima), Rituximab-Hyaluronidase (Rituxan Hycela) | 2Q 2025 annual review: for B-cell lymphomas initial criteria, added extranodal marginal zone (stomach or nongastric sites), histologic transformation of indolent lymphomas to DLBCL, primary mediastinal large B-cell lymphoma and removed low-grade B-cell lymphoma for non-Hodgkin's lymphoma subtypes per NCCN compendium; for NCCN compendium indications, removed "in patients who are CD20 positive" for acute lymphoblastic leukemia per NCCN compendium; for NMOSD initial criteria, added Bkemv, Epysqli, and Ultomiris to list of drugs not prescribed concurrently with Rituxan/Riabni/Ruxience/Truxima; for GPA and MPA, updated age to allow option for Riabni, Ruxience, Truxima: age ≥ 18 years; for continued therapy section, updated approval duration from 6 months to 12 months; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated. |
| CP.PHAR.262 | Teriflunomide (Aubagio) | 2Q 2025 annual review: per competitor analysis, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response; for continued therapy, modified approval duration from "if member has received < 1 year of total treatment – up to a total of 12 months of treatment and if member has received > 1 year of total treatment – 12 months" to "12 months"; references reviewed and updated. |
| CP.PHAR.263 | Tocilizumab (Actemra), Tocilizumab-bavi (Tofidence), Tocilizumab-aazg (Tyenne) | 2Q 2025 annual review: for sJIA, added redirection to NSAID as an option per clinical practice guidelines and competitor analysis; RT4: added newly approved biosimilar Avtozma to criteria; for CRS, revised criteria from "member has developed refractory CRS related to blinatumomab therapy" to "used as supportive care in severe CRS related to blinatumomab therapy" and added criteria "used as prophylaxis to reduce the risk of CRS when administering teclistamab-cqyv" per NCCN compendium; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated. |
| CP.PHAR.266 | Rilonacept (Arcalyst) | 2Q 2025 annual review: no significant changes; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated. |
| CP.PHAR.335 | Ocrelizumab (Ocrevus) | 2Q 2025 annual review: per competitor analysis, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response; per SDC, removed notation that Extavia is the preferred interferon beta-1b product for the Medicaid line of business as it is no longer available on market; updated Appendix C to include Ocrevus Zunovo's hypersensitivity contraindication; added HCPCS code [J2351] for Ocrevus Zunovo and removed codes [J3590, C9399]; for continued therapy, modified HIM and Medicaid approval duration from "if member has received < 1 year of total treatment – up to a total of 12 months of treatment and if member has received > 1 year of total treatment – 12 months" to "12 months"; references reviewed and updated. |
| CP.PHAR.374 | Vestronidase Alfa-vjbk (Mepsevii) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.375 | Brodalumab (Siliq) | 2Q 2025 annual review: for contraindication section, added hypersensitivity to brodalumab or to any of the excipients per prescriber information; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated. |
| CP.PHAR.378 | Ibalizumab-uiyk (Trogarzo) | 2Q 2025 annual review: no significant changes, updated therapeutic alternatives in Appendix B; references reviewed and updated. |
| CP.PHAR.394 | Migalastat (Galafold) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.395 | Patisiran (Onpattro) | 2Q 2025 annual review: removed criteria "member has not received prior treatment with Amvuttra, Tegsedi, or Wainua" per competitor analysis and to allow alternative therapy as a result of Tegsedi market withdrawal; references reviewed and updated. |
| CP.PHAR.405 | Inotersen (Tegsedi) | 2Q 2025 annual review: removed criteria "member has not received prior treatment with Amvuttra, Onpattro, or Wainua" per competitor analysis; references reviewed and updated. |
| CP.PHAR.416 | Caplacizumab-yhdp (Cablivi) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.417 | Brexanolone (Zulresso) | 2Q 2025 annual review: in Appendix B per Clinical Pharmacology, updated dosing regimens and removed commercially unavailable branded therapeutic alternatives; references reviewed and updated. |
| CP.PHAR.419 | Elapegademase-lvlr (Revcovi) | 2Q 2025 annual review: added an additional diagnostic option to genetic testing of both deficient ADA catalytic activity and increase in adenosine or deoxyadenosine nucleotide levels; added HCPCS code section; references reviewed and updated. |

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| CP.PHAR.421 | Onasemnogene Abeparvovec (Zolgensma) | 2Q 2025 annual review: for initial approval criteria, added option of “four copies of SMN2 gene, determined by a quantitative assay that is able to distinguish between four SMN2 gene copies and five or more SMN2 gene copies” to SMN2 gene copy criteria as supported by practice guidelines; references reviewed and updated. |
| CP.PHAR.422 | Cladribine (Mavenclad) | 2Q 2025 annual review: per competitor analysis, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response; per SDC, removed notation that Extavia is the preferred interferon beta-1b product for the Medicaid line of business as it is no longer available on market; references reviewed and updated. |
| CP.PHAR.43 | Sapropterin Dihydrochloride (Kuvan, Javygtor) | 2Q 2025 annual review: no significant changes; added requirement for a redirection from Javygtor (branded generic) to unbranded generic sapropterin per an SDC recommendation; added a requirement for documentation of member’s current weight for dose calculation purposes; references reviewed and updated. |
| CP.PHAR.447 | Mercaptopurine (Purixan) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.468 | Aducanumab-avwa (Aduhelm) | 2Q 2025 annual review: no significant changes; retained policy since Medispan obsolete date is 11/12/2026 and added discontinuation statement to initial and continued criteria. |
| CP.PHAR.471 | Fosdenopterin (Nulibry) | 2Q 2025 annual review: no significant changes; Appendix D clinical and laboratory signs/symptoms were updated per 2024 consensus guidelines; references reviewed and updated. |
| CP.PHAR.474 | Remestemcel-L (Ryoncil) | 2Q 2025 annual review: drug is now FDA approved – criteria updated per FDA labeling: for continued therapy, added pathway for use in cases of GVHD recurrence following complete response and revised total number of doses allowed from 12 to 16; for both initial and continued therapy, added requirement for documentation of member’s current weight; references reviewed and updated. |
| CP.PHAR.479 | Decitabine/Cedazuridine (Inqovi) | 2Q 2025 annual review: no significant changes; removed reference to brand Dacogen since brand is obsolete; references reviewed and updated. |
| CP.PHAR.480 | Ferric Derisomaltose (Monoferric) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.481 | Idecabtagene Vicleucel (Abecma) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.482 | Isatuximab-irfc (Sarclisa) | 2Q 2025 annual review: added off-label indication for primary therapy in combination with Kryprolis, lenalidomide, and dexamethasone per NCCN Compendium; references reviewed and updated. |
| CP.PHAR.483 | Lisocabtagene Maraleucel (Breyanzi) | 2Q 2025 annual review: added bypass for age requirement for primary mediastinal LBCL per NCCN Guidelines in Pediatric Aggressive Mature B-Cell Lymphomas; added NCCN Compendium supported use in HIV-related plasmablastic lymphoma; references reviewed and updated. |
| CP.PHAR.486 | Bimatoprost Implant (Durysta) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.503 | Sutimlimab-jome (Enjaymo) | 2Q 2025 annual review: for Commercial, updated continued approval duration from “12 months” to “6 months or to the member’s renewal date, whichever is longer” per template standard injectable approval duration; references reviewed and updated. |
| CP.PHAR.504 | Voclosporin (Lupkynis) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.512 | Pegunigalsidase alfa-iwxj (Elfabrio) | 2Q 2025 annual review: no significant changes; added concomitant use exclusion to the Continued Therapy section to echo the exclusion which currently exists in the Initial Approval Criteria; added requirement for documentation of member’s weight for dose calculation purposes; references reviewed and updated. |
| CP.PHAR.526 | Fibrinogen Concentrate [Human] (Fibryga, RiaSTAP) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.528 | Odevixibat (Bylvay) | 2Q 2025 annual review: for initial and continued therapy, added exclusion for concurrent use with other IBAT inhibitors; for exclusion of pathologic variations of the ABCB11 gene that predict complete absence of the BSEP protein, clarified this is specific to PFIC type 2; references reviewed and updated. |
| CP.PHAR.529 | Relugolix (Orgovyx), Relugolix/Estradiol/Norethinedrone (Myfembree) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.533 | Ciltacabtagene Autoleucel (Carvykti) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.534 | Insulin Delivery Systems (V-Go, Omnipod, InPen) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |

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| CP.PHAR.536 | Ophthalmic Riboflavin (Photrexa, Photrexa Viscous) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.537 | Ponesimod (Ponvory) | 2Q 2025 annual review: per competitor analysis, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response; per SDC, removed notation that Extavia is the preferred interferon beta-1b product for the Medicaid line of business as it is no longer available on market; for continued therapy, modified approval duration from “if member has received < 1 year of total treatment – up to a total of 12 months of treatment and if member has received > 1 year of total treatment – 12 months” to “12 months”; references reviewed and updated. |
| CP.PHAR.538 | Tivozanib (Fotivda) | 2Q 2025 annual review: no significant changes; references reviewed and updated |
| CP.PHAR.550 | Vutrisiran (Amvuttra) | 2Q 2025 annual review: removed criteria “member has not received prior treatment with Onpattro, Tegsedi, or Wainua” per competitor analysis and to allow alternative therapy as a result of Tegsedi market withdrawal; references reviewed and updated. |
| CP.PHAR.577 | Tralokinumab-ldrm (Adbry) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.582 | Lutetium Lu 177 vipivotide tetraxetan (Pluvicto) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.583 | Pacritinib (Vonjo) | 2Q 2025 annual review: revised section I.B title to NCCN Compendium Indications; added off-label diagnosis for accelerated/blast please myeloproliferative neoplasms per NCCN; references reviewed and updated. |
| CP.PHAR.584 | Sodium Phenylbutyrate/Taurursodiol (Relyvrio) | 2Q 2025 annual review: no significant changes; retaining policy as Medispan obsolete date is 11/1/26; references reviewed and updated. |
| CP.PHAR.590 | Omaveloxolone (Skyclarys) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.596 | Lecanemab-irmb (Leqembi) | Updated the maintenance dosing regimen to include the option for every 4 week dosing after the initial 18 months of therapy, per the Prescribing Information. |
| CP.PHAR.600 | Trofinetide (Daybue) | 2Q 2025 annual review: removed the requirement from the Initial Approval Criteria and the Continued Therapy sections for symptom rating scales such as the Rett Syndrome Behavioral Questionnaire and the Clinical Global Impressions-Severity and -Improvement scales as providers do not routinely use these scales in clinical practice for Rett syndrome management; references reviewed and updated. |
| CP.PHAR.601 | Velmanase Alfa-tycv (Lamzede) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.606 | Spesolimab-sbzo (Spevigo) | 2Q 2025 annual review: no significant changes; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated. |
| CP.PHAR.607 | Deucravacitinib (Sotyktu) | 2Q 2025 annual review: no significant changes; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated. |
| CP.PHAR.625 | Concizumab-tci (Alhemo) | 2Q 2025 annual review: added Hemlibra redirection for hemophilia A with inhibitors indication; moved Appendix D examples of positive response to therapy into continued therapy criteria section; references reviewed and updated. |
| CP.PHAR.626 | Pozelimab-bbfg (Veopoz) | 2Q 2025 annual review: added criterion to prevent duplicative therapy with other complement inhibitors; references reviewed and updated. |
| CP.PHAR.629 | Retifanlimab-dlwr (Zynyz) | 2Q 2025 annual review: added criteria for small bowel adenocarcinoma, colon cancer, and rectal cancer per NCCN 2A recommendation; for anal carcinoma, added option to be prescribed in combination with carboplatin and paclitaxel; references reviewed and updated. |
| CP.PHAR.631 | Sparsentan (Filspari) | 2Q 2025 annual review: added to continuation of therapy requirement that Filspari is not prescribed concurrently with RAAS inhibitors, endothelin receptor antagonists (ERAs), or aliskiren; references reviewed and updated. |
| CP.PHAR.633 | Eplontersen (Wainua) | 2Q 2025 annual review: removed criteria “member has not received prior treatment with, Onpattro or Amvuttra” per competitor analysis; references reviewed and updated. |
| CP.PHAR.650 | Zuranolone (Zurzuvae) | 2Q 2025 annual review: in Appendix B per Clinical Pharmacology, updated dosing regimens and removed commercially unavailable branded therapeutic alternatives; references reviewed and updated. |
| CP.PHAR.660 | Bimekizumab-bkzx (Bimzelx) | 2Q 2025 annual review: for HS, added “contraindicated or clinically significant adverse effects are experienced” bypass for preferred adalimumab product redirection; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated. |

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| CP.PHAR.661 | Etrasimod (Velsipity) | 2Q 2025 annual review: for initial criteria, added option for documentation of modified Mayo Score ≥ 5; removed redirection to preferred adalimumab products as adalimumab is not recommended due to low efficacy per 2024 AGA guidelines; revised redirection to Zeposia with bypass allowance stating member must use Zeposia unless member has had history of failure of biological disease-modifying antirheumatic drug or Janus kinase inhibitor as supported by 2024 AGA guidelines; for Appendix E, added supplemental information on modified Mayo Score; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated. |
| CP.PHAR.662 | Mirikizumab-mrkz (Omvoh) | 2Q 2025 annual review: for initial criteria, added option for documentation of modified Mayo Score ≥ 5; removed redirection to preferred adalimumab products as adalimumab is not recommended due to low efficacy per 2024 AGA guidelines; revised redirection to Zeposia with bypass allowance stating member must use Zeposia unless member has had history of failure of biological disease-modifying antirheumatic drug or Janus kinase inhibitor as supported by 2024 AGA guidelines; for Appendix E, added supplemental information on modified Mayo Score; RT4: added newly approved Crohn's disease indication to criteria; added new dosage forms [single-dose prefilled pen 200 mg/2 mL and single-dose syringe 200 mg/2 mL]; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated |
| CP.PHAR.676 | Aprocitentan (Tryvio) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.677 | Vadadustat (Vafseo) | 2Q 2025 annual review: added requirement that Vafseo is not prescribed concurrently with Jesduvroq; extended continuation of therapy approval duration from 6 to 12 months for Medicaid/HIM; references reviewed and updated. Per March SDC, modified to require redirection to both Retacrit and Epogen (if member is unable to use Retacrit). |
| CP.PHAR.679 | Mavorixafor (Xolremdi) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PHAR.700 | Vanzacaftor/Tezacaftor/Deutivacaftor (Alyftrek) | RT4: Drug is now FDA approved – criteria updated per FDA labeling; added redirection to Trikafta unless there is presence of mutation in CFTR gene that is not responsive to Trikafta; added Appendix E with CFTR gene mutations that are responsive to Alyftrek. |
| CP.PHAR.718 | Mirdametinib (Gomekli) | Policy created |
| CP.PHAR.725 | Tiopronin Delayed-Release (Thiola EC) | Policy created (adapted from CP.PCH.50, to be retired); added Medicaid line of business; references reviewed and updated. |
| CP.PHAR.78 | Thalidomide (Thalomid) | 2Q 2025 annual review: consolidated criteria for MCD, Kaposi sarcoma, and histiocytic neoplasms into one section of off-label NCCN Compendium Indications; in off-label NCCN compendium indications, added criteria for pediatric medulloblastoma per NCCN 2A recommendation; in continued therapy, clarified continuity of care does not apply to ENL, aphthous stomatitis, or aphthous ulcers and only applies to oncological indications; updated Appendix B per Clinical Pharmacology; references reviewed and updated. |
| CP.PHAR.88 | Belimumab (Benlysta) | 2Q 2025 annual review: no significant changes; clarified SLE SC dosing for weight ≥ 40 kg applies to pediatric members; references reviewed and updated. |
| CP.PHAR.92 | Tetrabenazine (Xenazine) | 2Q 2025 annual review: no significant changes; updated Appendix definitions per updated DSM-5-TR; references reviewed and updated. |
| CP.PMN.117 | Naproxen/Esomeprazole (Vimovo) | 2Q 2025 annual review: clarified generic naproxen-esomeprazole applies to policy; references reviewed and updated. |
| CP.PMN.119 | Ozenoxacin (Xepi) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.120 | Ibuprofen/Famotidine (Duexis) | 2Q 2025 annual review: clarified generic famotidine-ibuprofen applies |
| CP.PMN.122 | Celecoxib (Celebrex, Elyxyb) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.125 | Milnacipran (Savella) | 2Q 2025 annual review: added gabapentin redirection option to fibromyalgia criteria; references reviewed and updated. |
| CP.PMN.127 | Fentanyl IR (Actiq, Fentora, Lazanda, Subsys) | 2Q 2025 annual review: removed initial approval criteria for cancer pain due to discontinuation of all TIRF products by manufacturers; removed table regarding state regulations against redirections against cancer and updated with TIRF product discontinuation information; references reviewed and updated. |
| CP.PMN.128 | Dutasteride (Avodart), Dutasteride/Tamsulosin (Jalyn) | 2Q 2025 annual review: no significant changes; added reference to generic dutasteride in the Policy/Criteria description as criteria would apply; references reviewed and updated. |

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| CP.PMN.130 | Cysteamine Ophthalmic (Cystaran, Cystadrops) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.136 | Mecamylamine (Vecamyl) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.137 | Carbamazepine ER (Equetro) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.138 | Age Limit Override (Codeine, Tramadol, Hydrocodone) | 2Q 2025 annual review: added by-passing of redirection if state regulations do not allow step therapy in certain oncology settings along with Appendix D; references reviewed and updated. |
| CP.PMN.154 | Isavuconazonium (Cresemba) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.191 | Age Limit for Topical Tretinoin | 2Q 2025 annual review: no significant changes; removed tretinoin cream 0.0375% and 0.075% strengths due to removed commercial availability; references reviewed and updated. |
| CP.PMN.192 | Brimonidine Tartrate (Mirvaso) | 2Q 2025 annual review: no significant changes; removed the 30 mg/month max dose restriction; references reviewed and updated. |
| CP.PMN.193 | Hydroxyurea (Siklos, Xromi) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.194 | Prucalopride (Motegrity) | Per March SDC, added redirection to generic prucalopride for initial approval criteria and continued therapy. |
| CP.PMN.196 | Rifamycin (Aemcolo) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.197 | Clomipramine (Anafranil) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.209 | Solriamfetol (Sunosi) | 2Q 2025 annual review: for narcolepsy, updated indication in initial approval criteria to FDA-approved indication of “Narcolepsy with EDS” to align with prescriber information and competitor analysis; added criteria for documentation of MSLT with mean sleep latency ≤ 8 minutes with evidence of two or more SOREMPs or at least one SOREMP on MSLT and a SOREMP (less than 15 minutes) on the preceding overnight PSG and daily periods of irrepressible need to sleep or daytime lapses into sleep occurring for at least 3 months to align with other narcolepsy with EDS criteria; references reviewed and updated. |
| CP.PMN.221 | Pitolisant (Wakix) | 2Q 2025 annual review: for narcolepsy with cataplexy, clarified if member is > 65 years then trial of tricyclic antidepressants are not required apply to clomipramine and protriptyline only and removed “antidepressant” classification for redirected agents atomoxetine (although a SNRI) is not considered an antidepressant; references reviewed and updated. |
| CP.PMN.224 | Tenapanor (Ibsrela, Xphozah) | Per March SDC, removed Commercial and added HIM line of business; for IBS-C added redirection to Linzess and Trulance (adapted from HIM.PA.174 that will be retired to align Medicaid with the existing HIM strategy), applied similar redirections from initial to continuation of therapy requests. |
| CP.PMN.234 | Early and Periodic Screening, Diagnostic, and Treatment Benefit for Pediatric Members | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.235 | Emtricitabine/Tenofovir Alafenamide (Descovy) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.262 | Quinine Sulfate (Qualaquin) | 2Q 2025 annual review: no significant changes; removed Appendix D with supplemental links on malaria and babesiosis; references reviewed and updated. |
| CP.PMN.264 | Viloxazine (Qelbree) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.275 | Levoketoconazole (Recorlev) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.276 | Pentosan Polysulfate Sodium (Elmiron) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.277 | Ulcer Therapy Products | 2Q 2025 annual review: for H. pylori infection, removed required redirection to generic Prevpac for all agents except for Omeclamox-Pak; for Talicia, added redirection to bismuth quadruple therapy; for Voquezna and Voquezna Triple/Dual Pak if request is for a clarithromycin-containing regimens, added requirement that H. pylori is clarithromycin-sensitive; for Voquezna, added requirement that it is prescribed in combination with amoxicillin or amoxicillin and clarithromycin; references reviewed and updated. |
| CP.PMN.278 | Ganaxolone (Ztalmy) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.287 | Nabumetone Double-Strength (Relafen DS) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |

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| CP.PMN.293 | Berdazimer (Zelsuvmi) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.294 | Budesonide (Eohilia, Uceris) | 2Q 2025 annual review: for Eohilia, updated product availability from “single-dose stick packs” to “unit-dose packets” per prescriber information; updated Appendix D to include 2025 ACG guidelines for EoE; references reviewed and updated. |
| CP.PMN.33 | Pregabalin (Lyrica, Lyrica CR) | 2Q 2025 annual review: for neuropathic pain associated with treatment of cancer, revised maximum dosage from 300 mg/day to 600 mg/day per NCCN; references reviewed and updated. |
| CP.PMN.35 | Armodafinil (Nuvigil) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.39 | Modafinil (Provigil) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.42 | Sodium Oxybate (Xyrem, Lumryz) and Calcium, Magnesium, Potassium, and Sodium Oxybate (Xywav) | 2Q 2025 annual review: for narcolepsy with cataplexy: clarified if member is > 65 years then trial of tricyclic antidepressants are not required apply to clomipramine and protriptyline only, added “if member is ≥ 18 years of age” to trial of Wakix; for narcolepsy with EDS: added “if member is ≥ 18 years of age” to trial of Sunosi; for IH, removed criteria requiring minimal scoring for ESS or IHSS to align with competitor analysis; for Appendix D, removed supplemental information on ESS and IHSS; references reviewed and updated. |
| CP.PMN.58 | Propranolol HCl Oral Solution (Hemangeol) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| CP.PMN.61 | ACEI and ARB Duplicate Therapy | 2Q 2025 annual review: no significant changes; removed discontinued brand products from section V and VI; references reviewed and updated. |
| CP.PMN.79 | Doxycycline Hyclate (Acticlate, Doryx), Doxycycline (Oracea) | 2Q 2025 annual review: no significant changes; added references to generic Oracea and Doryx; references reviewed and updated. |
| CP.PMN.80 | Minocycline ER (Solodyn, Ximino, Minolira), Microspheres (Arestin), Foam (Zilxi) | 2Q 2025 annual review: no significant changes; added reference to minocycline ER (generic Solodyn and Ximino); references reviewed and updated. |
| CP.PMN.86 | Oxymetazoline (Rhofade, Upneeq) | 2Q 2025 annual review: no significant changes; for Upneeq revised the approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less; for Rhofade removed the 30 mg/month max dose restriction within the approval criteria since this doesn’t reflect the actual recommended dosing of Rhofade; removed the 30 gm pump and the 60 gm pump and tube formulations of Rhofade from Product Availability per the most recent PI; references reviewed and updated. |
| NH.PHAR.02 | Approval of Brand Name Override | Annual review. |
| NH.PHAR.14 | Pharmacy lock in program | Annual review, no changes |
| NH.PHAR.15 | Continuity of Care | Annual review, no changes |
| NH.PHAR.237 | Epoetin Alfa (Epogen, Procrit), Epoetin Alfa-epbx (Retacrit) | 2Q 2025 annual review: extended continuation of therapy approval duration from 6 to 12 months for anemia due to CKD and zidovudine in HIV-infected patients. |
| NH.PHAR.241 | Abatacept (Orencia) | 2Q 2025 annual review: for pJIA: removed criteria for minimum cJADAS-10 score > 8.5 for documentation of high disease activity and “baseline 10-joint clinical juvenile arthritis disease activity score” in initial criteria to align with competitor analysis; removed criteria for “member is responding positively to therapy as evidence by decrease in cJADAS-10 from baseline” in continued therapy. |
| NH.PHAR.242 | Adalimumab (Humira), Adalimumab-afzb (Abrilada), Adalimumab-atto (Amjevita), Adalimumab-adbm (Cyltezo), Adalimumab-bwwd (Hadlima), Adalimumab-fkjp (Hulio), Adalimumab-adaz (Hyrimoz), Adalimumab-aacf (Idacio), Adalimumab-ryvk (Simlandi), Adalimumab-aaty (Yuflyma), Adalimumab-aqvh (Yusimry) | 2Q 2025 annual review: for UC initial criteria, added option for documentation of modified Mayo Score ≥ 5; for Appendix F, added supplemental information on modified Mayo Score; for pJIA: removed criteria for minimum cJADAS-10 score > 8.5 for documentation of high disease activity and “baseline 10-joint clinical juvenile arthritis disease activity score” in initial criteria to align with competitor analysis; removed criteria for “member is responding positively to therapy as evidence by decrease in cJADAS-10 from baseline” in continued therapy; for Appendix J, added pJIA disease activity information per 2019 ACR guidelines; for continued therapy section, removed “if new dosing regimen, approve for 6 months” for approval duration |
| NH.PHAR.244 | Anakinra (Kineret) | 2Q 2025 annual review: no significant changes. |

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| NH.PHAR.247 | Certolizumab (Cimzia) | 2Q 2025 annual review: for pJIA: removed criteria for minimum cJADAS-10 score > 8.5 for documentation of high disease activity and “baseline 10-joint clinical juvenile arthritis disease activity score” in initial criteria to align with competitor analysis. |
| NH.PHAR.250 | Etanercept (Enbrel) | 2Q 2025 annual review: for pJIA: removed criteria for minimum cJADAS-10 score > 8.5 for documentation of high disease activity and “baseline 10-joint clinical juvenile arthritis disease activity score” in initial criteria to align with competitor analysis; removed criteria for “member is responding positively to therapy as evidence by decrease in cJADAS-10 from baseline” in continued therapy. |
| NH.PHAR.252 | Glatiramer Acetate (Copaxone, Glatopa) | 2Q 2025 annual review: per competitor analysis, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response; for continued therapy, modified approval duration from “if member has received < 1 year of total treatment – up to a total of 12 months of treatment and if member has received > 1 year of total treatment – 12 months” to “12 months” |
| NH.PHAR.253 | Golimumab (Simponi, Simponi Aria) | 2Q 2025 annual review: for UC initial criteria, added option for documentation of modified Mayo Score ≥ 5; for pJIA: removed criteria for minimum cJADAS-10 score > 8.5 for documentation of high disease activity and “baseline 10-joint clinical juvenile arthritis disease activity score” in initial criteria to align with competitor analysis; removed criteria for “member is responding positively to therapy as evidence by decrease in cJADAS-10 from baseline” in continued therapy |
| NH.PHAR.254 | Infliximab (Remicade), Infliximab-axxq (Avsola), Infliximab-dyyb (Inflectra, Zymfentra), and Infliximab-abda (Renflexis) | 2Q 2025 annual review: for UC initial criteria, added option for documentation of modified Mayo Score ≥ 5; for Appendix F, added supplemental information on modified Mayo Score; for Kawasaki disease, updated maximum dose from 5 mg/kg given over 2 hours to 10 mg/kg given over 2 hours; for continued therapy section, removed “if new dosing regimen, approve for 6 months” for approval duration; |
| NH.PHAR.255 | Interferon Beta-1a (Avonex, Rebif) | 2Q 2025 annual review: per competitor analysis, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response; for continued therapy, modified HIM and Medicaid approval duration from “if member has received < 1 year of total treatment – up to a total of 12 months of treatment and if member has received > 1 year of total treatment – 12 months” to “12 months” |
| NH.PHAR.256 | Interferon Beta-1b (Betaseron, Extavia) | 2Q 2025 annual review: per competitor analysis, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response; for continued therapy, modified approval duration from “if member has received < 1 year of total treatment – up to a total of 12 months of treatment and if member has received > 1 year of total treatment – 12 months” to “12 months” |
| NH.PHAR.259 | Natalizumab (Tysabri), Natalizumab-sztn (Tyruko) | 2Q 2025 annual review: for MS, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response per competitor analysis; for MS continued therapy, modified approval duration from “if member has received < 1 year of total treatment – up to a total of 12 months of treatment and if member has received > 1 year of total treatment – 12 months” to “12 months” |
| NH.PHAR.261 | Secukinumab (Cosentyx) | 2Q 2025 annual review: for continued therapy section, removed “if new dosing regimen, approve for 6 months” for approval duration |
| NH.PHAR.264 | Ustekinumab (Stelara), Ustekinumab-ttwe (Pyzchiva), Ustekinumab-aekn (Selarsdi), Ustekinumab-auub (Wezlana) | 2Q 2025 annual review: for UC initial criteria, added option for documentation of modified Mayo Score ≥ 5; removed redirection to preferred adalimumab products as adalimumab is not recommended due to low efficacy per 2024 AGA guidelines; revised redirection to one preferred product. |
| NH.PHAR.265 | Vedolizumab (Entyvio) | 2Q 2025 annual review: for UC initial criteria, added option for documentation of modified Mayo Score ≥ 5; |
| NH.PHAR.267 | Tofacitinib (Xeljanz, Xeljanz XR) | 2Q 2025 annual review: for UC initial criteria, added option for documentation of modified Mayo Score ≥ 5; for pJIA: removed criteria for minimum cJADAS-10 score ≥ 8.5 for documentation of high disease activity and “baseline 10-joint clinical juvenile arthritis disease activity score” in initial criteria to align with competitor analysis; removed criteria for “member is responding positively to therapy as evidence by decrease in cJADAS-10 from baseline” in continued therapy; |
| NH.PHAR.271 | Peginterferon Beta-1a (Plegridy) | 2Q 2025 annual review: per competitor analysis, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response; for continued therapy, modified approval duration from “if member has received < 1 year of total treatment – up to a total of 12 months of treatment and if member has received > 1 year of total treatment – 12 months” to “12 months” |

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| NH.PHAR.296 | Pegfilgrastim (Neulasta, Neulasta Onpro), Pegfilgrastim-jmdb (Fulphila), Pegfilgrastim-pbbk (Fylnetra), Pegfilgrastim-apgf (Nyvepria), Eflapegrastim-xnst (Rolvedon), Efbemalenograstim alfa-vuxw (Ryzneuta), Pegfilgrastim-fpgk (Stimufend), Pegfilgrastim-cbqv (Udenyca, Udenyca Onbody), Pegfilgrastim-bmez (Ziextenzo) | Annual review, no significant changes |
| NH.PHAR.297 | Filgrastim (Neupogen), Filgrastim-sndz (Zarxio), Tbo-filgrastim (Granix), Filgrastim-aafi (Nivestym), Filgrastim-ayow (Releuko) | Annual review, no significant changes |
| NH.PHAR.327 | Nusinersen (Spinraza) | 2Q 2025 annual review: for initial criteria stating four copies of SMN2 gene, removed “documentation indicates presence of SMA symptoms” as four copies of SMN2 gene without symptoms is supported by practice guidelines; references reviewed and updated. |
| NH.PHAR.340 | Valbenazine (Ingrezza) | 2Q 2025 annual review: revised continued approval duration from 6 months to 12 months for VMAT2 inhibitors criteria alignment |
| NH.PHAR.341 | Deutetrabenazine (Austedo, Austedo XR) | 2Q 2025 annual review: no significant changes. |
| NH.PHAR.343 | Edaravone (Radicava, Radivaca ORS) | 2Q 2025 annual review: added edaravone to the Policy/Criteria applicability section; added generic redirection for IV Radicava request to initial and continued criteria |
| NH.PHAR.346 | Sarilumab (Kevzara) | 2Q 2025 annual review: added indication for pJIA |
| NH.PHAR.364 | Guselkumab (Tremfya) | 2Q 2025 added UC indication |
| NH.PHAR.386 | Tildrakizumab-asmn (Ilumya) | 2Q 2025 annual review: no significant changes |
| NH.PHAR.426 | Risankizumab-rzaa (Skyrizi) | 2Q 2025 annual review: added UC criteria; for Appendix F, added supplemental information on modified Mayo Score; updated section III.B with Spevigo and biosimilar verbiage; references reviewed and updated. |
| NH.PHAR.427 | Siponimod (Mayzent) | 2Q 2025 annual review: per competitor analysis, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response; for continued therapy, modified approval duration from “if member has received < 1 year of total treatment – up to a total of 12 months of treatment and if member has received > 1 year of total treatment – 12 months” to “12 months” |
| NH.PHAR.443 | Upadacitinib (Rinvoq, Rinvoq LQ) | 2Q 2025 annual review: for UC initial criteria, added option for documentation of modified Mayo Score ≥ 5; added indication for pJIAsis; removed criteria for “member is responding positively to therapy as evidence by decrease in cJADAS-10 from baseline” in continued therapy; |
| NH.PHAR.462 | Ozanimod (Zeposia) | Q 2025 annual review: for MS, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response per competitor analysis; for MS continued therapy, modified approval duration from “if member has received < 1 year of total treatment – up to a total of 12 months of treatment and if member has received > 1 year of total treatment – 12 months” to “12 months”; for UC, added option for documentation of modified Mayo Score ≥ 5; |
| CP.PHAR.477 | Risdiplam (Evrysdi) | 2Q 2025 annual review: for initial criteria stating four copies of SMN2 gene, removed “documentation indicates presence of SMA symptoms” as four copies of SMN2 gene without symptoms is supported by practice guidelines; RT4: added new tablet dosage formulation [5 mg] to criteria with requirement that member must be age ≥ 2 years and weight ≥ 20 kg; references reviewed and updated. |
| NH.PHAR.55 | Human Growth Hormone (Somapacitan, Somatrogon, Somatropin, Lonapegsomatropin-tcgd) | Annual review, no significant changes |
| NH.PHAR.593 | Delandistrogene Moxeparvovec-rokl (Elevidys) | Policy created |
| NH.PHAR.603 | Exagamglogene Autotemcel (Casgevy) | Annual review, no significant changes |

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| NH.PHAR.621 | Ublituximab-xiiy (Briumvi) | 2Q 2025 annual review: per competitor analysis, removed requirements for documentation of baseline relapses/expanded disability status score and specific measures of positive response; for continued therapy, modified approval duration from “if member has received < 1 year of total treatment – up to a total of 12 months of treatment and if member has received > 1 year of total treatment – 12 months” to “12 months”; reviewed and updated. |
| NH.PHAR.622 | Lenacapavir (Sunlenca) | 2Q 2025 annual review: no significant changes, |
| NH.PHAR.630 | Zavegepant (Zavzpret) | Annual review, no significant changes |
| NH.PMN.110 | Crisaborole (Eucrisa) | 2Q 2025 annual review: no significant changes |
| NH.PMN.124 | Itraconazole (Sporanox, Tolsura) | 2Q 2025 annual review: no significant changes; references reviewed and updated. |
| NH.PMN.16 | Request for Non-Preferred Medically Necessary Drug - Not on PDL | Annual review, no significant changes |
| NH.PMN.183 | GLP-1 Receptor Agonists | Annual review, no significant changes |
| NH.PMN.198 | Overactive Bladder Agents | 2Q 2025 annual review: no significant changes |
| NH.PMN.199 | Esketamine (Spravato) | 2Q 2025 annual review: revised continued approval duration from 6 months to 12 months; |
| NH.PMN.226 | Pancrelipase (Perzyte, Viokace, Pancreaze) | Annual review, no significant changes |
| NH.PMN.295 | Semaglutide (Wegovy) | 2Q 2025 annual review: no significant changes; |
| NH.PMN.298 | Tirzepatide (Zepbound) | Policy created for OSA indication |
| NH.PMN.48 | Cyclosporine (Cequa, Restasis, Verkazia, Vevye, Klarity-C) | 2Q 2025 annual review: removed note regarding Commercial formulary status of Restasis because generic Restasis is preferred; revised policy/criteria section to include generic cyclosporine; references reviewed and updated. |
| NH.PMN.49 | Dabigatran (Pradaxa) | Annual review, no significant changes |
| NH.PMN.56 | Atypical Antipsychotics | Annual review, no significant changes |
| NH.PMN.87 | Plecanatide (Trulance) | Annual review, no significant changes |
| NH.PMN.97 | Opioid Analgesics | 2Q 2025 annual review: no significant changes; |