Department of Medicaid

# 30 Day Change Notice
# Effective Date: January 1, 2026

| NEW PREFERRED DRUGS | |
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| **THERAPEUTIC CLASS** | **NO PA REQUIRED PREFERRED** |
| **Analgesic Agents: Gout** | febuxostat<br>MITIGARE |
| **Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants** | dabigatran cap |
| **Cardiovascular Agents: Angina, Hypertension and Heart Failure** | acetazolamide<br>DIURIL SUSP<br>indapamide<br>methazolamide<br>metolazone<br>sacubitril/valsartan (gen of ENTRESTO) |
| **Central Nervous System (CNS) Agents: Atypical Antipsychotics* LEGACY CATEGORY** | ERZOFRI |
| **Central Nervous System (CNS) Agents: Multiple Sclerosis* LEGACY CATEGORY** | PLEGRIDY |
| **Endocrine Agents: Diabetes – Insulin** | FIASP<br>HUMULIN N U-100 |
| **Endocrine Agents: Diabetes – Non-Insulin** | JENTADUETO XR<br>SYNJARDY XR |
| **Gastrointestinal Agents: Bowel Preparations** | SUFLAVE |
| **Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea** | CNS Agents: Tricyclic Antidepressants |
| **Hyperkalemia Agents: Potassium Binders** | VELTASSA |
| **Infectious Disease Agents: Antivirals – Coronavirus Agents** | PAXLOVID |
| **Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY** | SYMFI |
| **Ophthalmic Agents: Ophthalmic Steroids** | EYSUVIS |
| **Respiratory Agents: Inhaled Agents** | fluticasone/salmeterol diskus<br>PROAIR RESPICLICK |
| **Topical Agents: Antiparasitics** | spinosad [labeler 52246] |
| **Topical Agents: Corticosteroids** | DERMA-SMOOTHE OIL |

| NEW CLINICAL PA REQUIRED PREFERRED DRUGS | |
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| **THERAPEUTIC CLASS** | **CLINICAL CRITERIA REQUIRED PREFERRED** |
| **Analgesic Agents: Opioids** | fentanyl patch |
| **Immunomodulator Agents: Systemic Inflammatory Disease** | adalimumab-fkjp [labeler 83257]<br>AVSOLA (Bio of REMICADE)<br>NEMLUVIO<br>SKYRIZI IV SOLN<br>STEQEYMA (Bio of STELARA) |

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| **Respiratory Agents: Hereditary Angioedema** | HAEGARDA |
| **Respiratory Agents: Inhaled Agents** | AIRSUPRA |
| **Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE** | CINQAIR<br>NUCALA |
| **Respiratory Agents: Pulmonary Fibrosis** | pirfenidone |

| NEW STEP THERAPY REQUIRED PREFERRED DRUGS | |
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| **THERAPEUTIC CLASS** | **CLINICAL CRITERIA REQUIRED PREFERRED** |
| **Respiratory Agents: Inhaled Agents** | BREZTRI AEROSPHERE<br>TRELEGY ELLIPTA |
| **Topical Agents: Immunomodulators** | OPZELURA<br>VTAMA<br>ZORYVE CREAM, FOAM |

| NEW NON-PREFERRED DRUGS | |
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| **THERAPEUTIC CLASS** | **PA REQUIRED NON-PREFERRED** |
| **Analgesic Agents: Gout** | colchicine cap |
| **Analgesic Agents: Opioids** | fentanyl buccal tab, inj, lozenge |
| **Blood Formation, Coagulation, and Thrombosis Agents: Colony Stimulating Factors** | RYZNEUTA |
| **Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY** | ADVATE<br>AFSTYLA<br>RECOMBINATE |
| **Blood Formation, Coagulation, and Thrombosis Agents: Oral Antiplatelet** | clopidogrel 300mg |
| **Cardiovascular Agents: Angina, Hypertension and Heart Failure** | ENTRESTO TAB<br>HEMICLOR<br>LOPRESSOR SOLN<br>spironolactone susp<br>TEZRULY |
| **Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY** | bosentan susp<br>TADLIQ |
| **Central Nervous System (CNS) Agents: Alzheimer's Agents* LEGACY CATEGORY** | ZUNVEYL |
| **Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute** | SYMBRAVO |
| **Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY** | escitalopram cap |
| **Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents** | amphetamine IR, ER tab |
| **Dermatologic Agents: Oral Acne Products** | isotretinoin |

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| **Endocrine Agents: Diabetes – Insulin** | insulin glargine-yfgn<br>MERILOG (Bio of NOVOLOG)<br>TRESIBA 200U |
| **Endocrine Agents: Diabetes – Non-Insulin** | sitagliptin |
| **Endocrine Agents: Estrogenic Agents** | estrogens, conjugated tab |
| **Endocrine Agents: Osteoporosis – Bone Ossification Enhancers** | CONEXXENCE (Bio of PROLIA)<br>JUBBONTI (Bio of PROLIA)<br>STOBOCLO (Bio of PROLIA) |
| **Gastrointestinal Agents: Ulcerative Colitis** | budesonide rectal foam |
| **Genitourinary Agents: Benign Prostatic Hyperplasia** | TEZRULY |
| **Immunomodulator Agents: Systemic Inflammatory Disease** | adalimumab-fkjp [labeler 49502]<br>IMULDOSA (Bio of STELARA)<br>LEQSELVI |
| **Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY** | EDURANT SUSP<br>YEZTUGO |
| **Ophthalmic Agents: Dry Eye Treatments** | TRYPTYR |
| **Ophthalmic Agents: Ophthalmic Steroids** | difluprednate<br>prednisolone acetate |
| **Respiratory Agents: Hereditary Angioedema** | ANDEMBRY |
| **Respiratory Agents: Inhaled Agents** | ADVAIR DISKUS<br>fluticasone/salmeterol HFA |
| **Topical Agents: Antiparasitics** | spinosad [labeler 28595] |

| THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA |
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| **Analgesic Agents: Gout** |
| **Analgesic Agents: Opioids** |
| **Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents** |
| **Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY** |
| **Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY** |
| **Cardiovascular Agents: Angina, Hypertension and Heart Failure** |
| **Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY** |
| **Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute** |
| **Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY** |
| **Central Nervous System (CNS) Agents: Anticonvulsants Rescue** |
| **Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY** |
| **Central Nervous System (CNS) Agents: Narcolepsy** |
| **Central Nervous System (CNS) Agents: Parkinson's Agents** |
| **Dermatologic Agents: Topical Acne Products** |
| **Endocrine Agents: Diabetes – Insulin** |
| **Endocrine Agents: Diabetes – Non-Insulin** |
| **Gastrointestinal Agents: Hepatic Encephalopathy** |
| **Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea** |
| **Gastrointestinal Agents: Ulcerative Colitis** |

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| **Gastrointestinal Agents: Unspecified GI** |
| **Immunomodulator Agents: Systemic Inflammatory Disease** |
| **Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY** |
| **Ophthalmic Agents: Dry Eye Treatments** |
| **Ophthalmic Agents: Ophthalmic Steroids** |
| **Respiratory Agents: Cystic Fibrosis** |
| **Respiratory Agents: Hereditary Angioedema** |
| **Respiratory Agents: Inhaled Agents** |
| **Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE** |
| **Respiratory Agents: Pulmonary Fibrosis** |
| **Topical Agents: Antifungals** |
| **Topical Agents: Immunomodulators** |

| REVISED THERAPEUTIC CATEGORY CRITERIA | |
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| **THERAPEUTIC CLASS** | **SUMMARY OF CHANGE** |
| **Analgesic Agents: Gout** | ~~**ADDITIONAL COLCHICINE CAPSULE (MITIGARE) CRITERIA:**~~<br>• ~~Must have had an inadequate clinical response of 30 days with colchicine tablets~~ |
| **Analgesic Agents: Opioids** | **FENTANYL PATCH AND MORPHINE SULFATE ER (MS CONTIN) CRITERIA:**<br>• Unless receiving for cancer pain, palliative care, or end-of-life/hospice care, must provide documentation of an inadequate clinical response with at least one opioid formulation taken for at least 30 of the last 60 days<br>• Must also meet LONG-ACTING OPIOID CRITERIA |
| **Blood Formation, Coagulation, and Thrombosis Agents: Hematopoietic Agents** | **NON-PREFERRED CRITERIA:**<br>• Must have had an inadequate clinical response of at least ~~14~~ 30 days with at least ~~one~~ two preferred drugs in this UPDL category and indicated for diagnosis<br><br>**ADDITIONAL DARBOPOETIN ALFA (ARANESP) CRITERIA**<br>• Must have been receiving a preferred product for ≥ 30 days with no positive response to hemoglobin levels, **OR**<br>• Must have a documented allergy, contraindication, or side effect to preferred agents and has a hemoglobin level at initiation of therapy of < 11 g/dL in dialysis patients with chronic kidney disease, < 10 g/dL in non-dialysis patients with chronic kidney disease, or < 12 g/dL in patients treated for other indications |
| **Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY** | **CLINICAL PA CRITERIA:**<br>• Must provide documentation of patient's body weight (for weight-based dosed medications only)<br>• For factor products, please indicate if use is for on-hand, on-demand therapy. On-hand, on-demand therapy is defined as product kept on hand for spontaneous bleeds or injuries<br><br>**ADDITIONAL EXTENDED HALF-LIFE FACTOR CRITERIA** |

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| | • Must provide attestation that the patient is not a suitable candidate for treatment with a shorter-acting half-life drug<br>• Must not be used as on-hand, on-demand therapy in patients receiving non-factor replacement therapies.<br><br>**ADDITIONAL CONCIZUMAB-MTCI (ALHEMO) CRITERIA**<br>• Must have had an inadequate clinical response such as increased bleeding episodes, a need for more factor replacement therapy, **OR** worsening joint health, of at least 30 days with HEMLIBRA<br>• Must have Hemophilia A **with or without** factor VIII inhibitors |
| **Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY** | **CLINICAL PA CRITERIA:**<br>• Must provide documentation of patient's body weight (for weight-based dosed medications only)<br>• For factor products, please indicate if use is for on-hand, on-demand therapy. On-hand, on-demand therapy is defined as product kept on hand for spontaneous bleeds or injuries<br><br>**ADDITIONAL EXTENDED HALF-LIFE FACTOR CRITERIA**<br>• Must provide attestation that the patient is not a suitable candidate for treatment with a shorter-acting half-life drug<br>• Must not be used as on-hand, on-demand therapy in patients receiving non-factor replacement therapies. |
| **Cardiovascular Agents: Angina, Hypertension and Heart Failure** | **ADDITIONAL FINERENONE (KERENDIA) CRITERIA:**<br>• Must be prescribed by or in consultation with a cardiologist or nephrologist **AND**<br>• Must be on a maximally tolerated dose of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker **AND**<br>• Must provide documentation of an inadequate clinical response to a SGLT2 Inhibitor **OR** provide documentation of medical necessity beyond convenience for why the patient cannot try a SGLT2 inhibitor<br><br>**ADDITIONAL MAVACAMTEN (CAMZYOS) CRITERIA:**<br>• Must be prescribed by or in consultation with a cardiologist **AND**<br>• Must provide documentation of NYHA Class II-III symptoms and left ventricular ejection fraction ≥55% **AND**<br>• Must provide documentation of previous trial and therapy failure at maximally tolerated dose, or intolerance, or contraindication to at least two of the following<br>  ○ Non-vasodilating beta blocker (e.g., atenolol, metoprolol, bisoprolol, propranolol);<br>  ○ Non-dihydropyridine calcium channel blocker (e.g., verapamil, diltiazem);<br>  ○ Combination therapy with disopyramide plus beta blocker or disopyramide plus a non-dihydro calcium channel blocker<br><br>**ADDITIONAL AMLODIPIDE (NORLIQVA) CRITERIA:**<br>• Must have had an inadequate clinical response of at least 30 days with KATERZIA |

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| | **AR** – LOPRESSOR SOLN: a PA is required for patients younger than 18 years |
| **Cardiovascular Agents: Pulmonary Arterial Hypertension* LEGACY CATEGORY** | **ADDITIONAL TADALAFIL (TADLIQ) CRITERIA:**<br>• Must have had a documented side effect, allergy, or treatment failure of at least 30 days with sildenafil suspension<br><br>**ADDITIONAL SELEXIPAG (UPTRAVI) AND SOTATERCEPT-CSRK (WINREVAIR) CRITERIA:**<br>• Must attest the patient has WHO group 1 diagnosis **AND**<br>• Must attest the patient has WHO functional class II or III, at intermediate or high risk of disease progression **AND**<br>• Have tried and failed preferred pulmonary hypertension medications with at least one medication from two different subclasses for ≥90 days, unless contraindicated or not tolerated **OR**<br>• Require add-on triple or quadruple therapy, including PDE5-inhibitor for ≥90 days, unless contraindicated or not tolerated |
| **Central Nervous System (CNS) Agents: Anti-Migraine Agents, Acute** | **ADDITIONAL MELOXICAM/RIZATRIPTAN (SYMBRAVO) CRITERIA:**<br>• Must have had an inadequate clinical response of at least 14 days with sumatriptan/naproxen |
| **Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY** | **STIRIPENTOL (DIACOMIT) CRITERIA**<br>• Exempt from Legacy rules<br>• Must be prescribed by or in consultation with a neurologist<br>• Must be ~~concomitantly~~ concurrently taking clobazam (ONFI)<br><br>**ADDITIONAL FENFLURAMINE (FINTEPLA) CRITERIA:**<br>• Prescribed by or in consultation with a neurologist<br>• When prescribed for Lennox-Gastaut syndrome<br>  ○ Required trial of valproic acid (or a derivative) in combination with lamotrigine for at least 30 days<br>• When prescribed for Dravet syndrome<br>  ○ Required trial of valproic acid (or a derivative) in combination with one other preferred agent from this UPDL category for at least 30 days<br><br>**ADDITIONAL CENOBAMATE (XCOPRI) CRITERIA:**<br>• Prescribed by or in consultation with a neurologist<br>• Required trial of two preferred medications from this UPDL category in combination for at least 30 days. One of the preferred agents must be: lamotrigine, levetiracetam, oxcarbazepine, carbamazepine, or topiramate |
| **Central Nervous System (CNS) Agents:** | ~~**AR** – LIBERVANT: a PA is required for patients 5 years and older~~ |

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| **Anticonvulsants Rescue** | |
| **Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY** | ~~**ADDITIONAL DEXTROMETHORPHAN/BUPROPION (AUVELITY) CRITERIA:**~~<br>• ~~Must have an inadequate clinical response of at least 30 days with **ALL** of the following:~~<br>○ ~~ONE norepinephrine/dopamine reuptake inhibitor (NDRI)~~<br>○ ~~ONE serotonin and norepinephrine reuptake inhibitor (SNRI~~<br>○ ~~TWO selective serotonin reuptake inhibitors (SSRIs) (ONE of which must be either vilazodone (VIIBRYD) OR vortioxetine (TRINTELLIX)))~~ |
| **Central Nervous System (CNS) Agents: Narcolepsy** | **NON-PREFERRED CRITERIA:**<br>• Must have had an inadequate clinical response with at least two preferred drugs - either at least 30 days of armodafinil or modafinil; **OR** at least ~~7~~ 30 days of a preferred amphetamine or methylphenidate drug in this UPDL category and indicated for diagnosis |
| **Central Nervous System (CNS) Agents: Parkinson's Agents** | **NON-PREFERRED CRITERIA:**<br>• Must have had an inadequate clinical response of at least 30 days with at least ~~one~~ two preferred drugs within the same sub-section classification in this UPDL category and indicated for diagnosis, if available<br><br>~~**ADDITIONAL APOMORPHINE (ONAPGO) CRITERIA:**~~<br>• ~~Must have had inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category, one of which must be carbidopa/levodopa~~<br><br>**ADDITIONAL APOMORPHINE (ONAPGO) AND FOSCARBIDOPA/FOSLEVODOPA (VYALEV) CRITERIA:**<br>• Must have had inadequate clinical response of at least 30 days with at least two preferred drugs in this UPDL category, one of which must be carbidopa/levodopa<br>• Must have had uncontrolled motor symptoms with current medications with a minimum of 2.5 hours of "off" time per day as assessed by using a PD diary. |
| **Dermatologic Agents: Topical Acne Products** | ~~**ADDITIONAL CLINDAMYCIN/ADAPALENE/BENZOYL PEROXIDE (CABTREO) CRITERIA**~~<br>• ~~Must provide documentation for patient's inability to use the individual drugs in this UPDL category~~ |
| **Endocrine Agents: Diabetes – Insulin** | **ADDITIONAL INSULIN LISPRO-AABC (LYUMJEV) CRITERIA:**<br>• Must have had an inadequate clinical response (defined as the inability to reach target A1C) after at least 120 days with HUMALOG **OR** insulin lispro<br><br>**SUBSEQUENT AUTHORIZATION CRITERIA:**<br>• Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring |

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| | ~~○ Must include a patient specific A1C goal if less than 7%~~<br>○ Must submit recent hemoglobin A1C level (within 6 months)<br>○ Must include documentation showing improvement in current A1C (within last 6 months) if not already at goal A1C |
| **Endocrine Agents: Diabetes – Non-Insulin** | **ADDITIONAL TIRZEPATIDE (MOUNJARO) CRITERIA**<br>• Prior to initiation, must have hemoglobin A1C>7% **AND**<br>• Must have had an inadequate clinical response of at least 120 days with OZEMPIC **OR** must provide documentation of medical necessity for patient's inability to use OZEMPIC<br>• For medical necessity requests due to ~~the patient's inability to use~~ OZEMPIC intolerance, must submit chart documentation that the following approaches were tried for at least 30 days:<br>○ Dietary changes (e.g., eating apples, crackers, or mint- or ginger-based drinks 30 minutes after administering the GLP-1 Receptor Agonist)<br>○ Prescription antiemetics **AND**<br>○ Dose adjustment to remediate side effects experienced with higher doses of the GLP-1 Receptor Agonist<br><br>**ADDITIONAL INFORMATION**<br>• An inadequate clinical response is defined as the inability to reach A1C goal after at least 120 days of current regimen, with use of two or more drugs ~~concomitantly~~ concurrently per ADA guidelines, documented adherence, and appropriate dose escalation (must achieve maximum recommended dose or document that maximum recommended dose is not tolerated or is clinically inappropriate).<br><br>**SUBSEQUENT AUTHORIZATION CRITERIA:**<br>• Must provide documentation of patient's clinical response to treatment and ongoing safety monitoring<br>~~○ Must include a patient specific A1C goal if less than 7%~~<br>○ Must submit recent hemoglobin A1C level (within 6 months)<br>○ Must include documentation showing improvement in current A1C (within last 6 months) if not already at goal A1C |
| **Gastrointestinal Agents: Hepatic Encephalopathy** | All products are covered without a PA<br>~~**LENGTH OF AUTHORIZATIONS**: 365 Days~~<br><br>~~**STEP THERAPY CRITERIA:**~~<br>• ~~Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category~~ |
| **Gastrointestinal Agents: Irritable Bowel Syndrome (IBS) with Diarrhea** | ~~**STEP THERAPY CRITERIA:**~~<br>• ~~Must have had an inadequate clinical response of at least 14 days with at least one preferred drug in this UPDL category~~ |
| **Gastrointestinal Agents: Ulcerative Colitis** | **LENGTH OF AUTHORIZATIONS**: 365 Days~~; except UCERIS FOAM – 90 days~~ |

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| **Gastrointestinal Agents: Unspecified GI** | **ADDITIONAL ~~METHYLNALTREXONE (RELISTOR) AND~~ NALDEMEDINE (SYMPROIC) CRITERIA:**<br><br>**ADDITIONAL RIFAMYCIN DELAYED-RELEASE (AEMCOLO) CRITERIA:**<br>• Must have the inability to take, or failure of **ALL** of the following: azithromycin, ciprofloxacin, levofloxacin, or ofloxacin~~, or rifaximin~~ |
| **Immunomodulator Agents: Systemic Inflammatory Disease** | **ADDITIONAL NEMOLIZUMAB (NEMLUVIO) CRITERIA:**<br>• Must have had an inadequate clinical response of at least 90 days with DUPIXENT and indicated for prurigo nodularis<br><br>**ADDITIONAL ATOPIC DERMATITIS CRITERIA:**<br>• Must have at least 10% body surface area (BSA) involvement with an inadequate clinical response of at least ~~90~~ 45 days with two of the following: topical corticosteroids or topical calcineurin inhibitors [e.g., ~~ELIDEL~~ tacrolimus, pimecrolimus] unless atopic dermatitis is severe and involves >25% BSA |
| **Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY** | **AR** – EDURANT SUSP: a PA is required for patients 12 years and older |
| **Ophthalmic Agents: Dry Eye Treatments** | **LENGTH OF AUTHORIZATIONS**: ~~14 days for EYSUVIS;~~ 365 days ~~for all other drugs~~<br><br>**ADDITIONAL ACOLTREMON (TRYPTYR) AND CYCLOSPORINE (VEVYE) CRITERIA:**<br>• Must have had an inadequate clinical response of at least 30 days with CEQUA and indicated for diagnosis |
| **Ophthalmic Agents: Ophthalmic Steroids** | **NON-PREFERRED CRITERIA:**<br>• Must have had an inadequate clinical response of at least ~~7~~ 10 days with at least two preferred drugs in this UPDL category and indicated for diagnosis |
| **Respiratory Agents: Cystic Fibrosis** | **CLINICAL PA CRITERIA:**<br>• Must be prescribed by or in consultation with a pulmonologist or infectious disease specialist<br>• For a CFTR Modulator, must provide documentation of the specific Cystic Fibrosis Transmembrane Conductance Regular (CFTR) genetic mutation |
| **Respiratory Agents: Hereditary Angioedema** | **CLINICAL PA CRITERIA:**<br>• Acute Treatment<br>  ○ Must provide documentation that diagnosis is verified by a C4 level below the lower limit of normal as defined by laboratory testing AND one of the following:<br>  ▪ C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by laboratory testing; OR<br>  ▪ C1-INH functional level below the lower limit of norma as defined by laboratory testing |

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| | • Prophylactic Treatment<br>  ○ Must not be used in combination with other prophylaxis agents<br><br>**NON-PREFERRED CRITERIA:**<br>• Must have had an inadequate clinical response of at least 3 days with at least one preferred acute drug in this UPDL category and indicated for diagnosis to request a non-preferred acute drug.<br>• Must have had an inadequate clinical response such as lack of reduction of attacks based on patient report, frequency of ER visits, or frequency of hospitalizations with use of at least 14 days with at least ~~one~~ two preferred prophylaxis drugs in this UPDL category and indicated for diagnosis to request a non-preferred prophylaxis drug. |
| **Respiratory Agents: Inhaled Agents** | **CLINICAL PA CRITERIA:**<br>• Must have had an inadequate clinical response of at least 14 days with an albuterol containing product<br><br>**STEP THERAPY CRITERIA:**<br>• Must have had an inadequate clinical response of at least 30 days with at least one inhaled corticosteroid (ICS) **AND** at least one long-acting beta-agonist (LABA) **AND** at least one long-acting muscarinic-antagonist (LAMA) concurrently in this UPDL category and indicated for diagnosis, if available<br><br>~~**ADDITIONAL BUDESONIDE/ALBUTEROL (AIRSUPRA) CRITERIA:**~~<br>• ~~Must have had an inadequate clinical response of at least 14 days with either DULERA or SYMBICORT~~<br><br>**AR** – fluticasone propionate: a PA is required for patients 18 years and older |
| **Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE** | • For **Chronic Obstructive Pulmonary Disease (COPD)**:<br>  ○ The patient must have an eosinophilic count of greater than or equal to ~~300~~ 150 cells per mcL within 12 months prior to initiation of therapy **AND**<br>  ○ The patient has a history of uncontrolled disease, as indicated by ~~greater than or equal to 2 COPD exacerbations or~~ greater than or equal to 1 COPD exacerbation resulting in a hospitalization despite being on standard of care, defined as triple therapy (LAMA+LABA+ICS) for at least 3 months prior to request, and at a stable dose for at least 1 month prior.<br><br>**NON-PREFERRED CRITERIA:**<br>• Must have had an inadequate clinical response of at least 90 days with at least ~~one~~ two preferred drugs in this UPDL category and indicated for diagnosis |
| **Respiratory Agents: Pulmonary Fibrosis** | ~~**NON-PREFERRED CRITERIA:**~~<br>• ~~Must have had an inadequate clinical response of at least 30 days with at least one preferred drug in this UPDL category and~~ |

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| | ~~indicated for diagnosis~~ |
| **Topical Agents: Antifungals** | **~~ADDITIONAL EFINACONAZOLE (JUBLIA) CRITERIA:~~**<br>• ~~Must have had an inadequate clinical response of at least 48 weeks of ciclopirox AND 6 weeks of oral terbinafine (if fingernail) **OR** 12 weeks of oral terbinafine (if toenail)~~ |
| **Topical Agents: Immunomodulators** | **STEP THERAPY CRITERIA:**<br>• Must have had an inadequate clinical response of at least ~~30~~ 90 days with at least one preferred drug in this UPDL category **OR** documentation why patient is unable to take product not requiring step therapy<br><br>**NON-PREFERRED CRITERIA:**<br>• Must have had an inadequate clinical response of at least ~~30~~ 90 days with at least one preferred drug and one step therapy drug of different mechanisms of action in this UPDL category and indicated for diagnosis<br><br>**~~ADDITIONAL ROFLUMILAST (ZORYVE) CRITERIA:~~**<br>• ~~**0.15% CREAM:** Must have had an inadequate clinical response of at least 30 days with at least one preferred topical corticosteroid OR topical calcineurin inhibitor~~<br>• ~~**0.3% CREAM:** Must have had an inadequate clinical response of at least 30 days with at least one preferred topical corticosteroid OR topical calcipotriene~~<br>• ~~**FOAM:** Must have had an inadequate clinical response of at least 30 days with at least one preferred agent indicated for Seborrheic Dermatitis (such as a topical antifungal, topical calcineurin inhibitor, or topical corticosteroid)~~<br><br>**AR** – ~~ELIDEL,~~ tacrolimus and pimecrolimus~~, and tacrolimus~~: a PA is required for patients younger than 2 years old |

| NEW THERAPEUTIC CATEGORIES |
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| **Infectious Disease Agents: Antivirals – Coronavirus Agents** |

| NEW THERAPEUTIC CATEGORY CRITERIA | |
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| **THERAPEUTIC CLASS** | **SUMMARY OF CHANGE** |
| **Infectious Disease Agents: Antivirals – Coronavirus Agents** | All products are covered without a PA |