Department of Medicaid

30 Day Change Notice
Effective Date: October 1, 2025

NEW PREFERRED DRUGS	
THERAPEUTIC CLASS	**NO PA REQUIRED PREFERRED**
Analgesic Agents: Opioids	hydrocodone/APAP 2.5, 5, 7.5, 10-325mg
Cardiovascular Agents: Angina, Hypertension and Heart Failure	bumetanide chlorthalidone furosemide hydrochlorothiazide INZIRQO torsemide triamterene triamterene/HCTZ
Endocrine Agents: Diabetes – Non-Insulin	exenatide saxagliptin saxagliptin/metformin

NEW CLINICAL PA REQUIRED PREFERRED DRUGS	
THERAPEUTIC CLASS	**CLINICAL CRITERIA REQUIRED PREFERRED**
Duchenne Muscular Dystrophy Agents: Corticosteroids	EMFLAZA
Immunomodulator Agents: Systemic Inflammatory Disease	infliximab (gen of REMICADE) PYZCHIVA (Bio of STELARA) SKYRIZI SUBQ INJ
Sickle Cell Gene Therapy Agents	CASGEVY LYFGENIA

NEW NON PREFERRED DRUGS	
THERAPEUTIC CLASS	**PA REQUIRED NON PREFERRED**
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY	ALHEMO QFITLIA
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY	ALHEMO QFITLIA
Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY	eslicarbazepine perampanel topiramate soln
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY	RALDESY
Central Nervous System (CNS) Agents: Parkinson's Agents	ONAPGO
Duchenne Muscular Dystrophy Agents: Corticosteroids	AGAMREE deflazacort
Gastrointestinal Agents: Bowel Preparations	peg/NaSul/C/ sol NaCL/Pot soln
Immunomodulator Agents: Systemic	INFLECTRA (Bio of REMICADE)

Date of Notice: 9/1/2025

Inflammatory Disease	OTULFI (Bio of STELARA) STEQEYMA (Bio of STELARA) ustekinumab (gen of STELARA) ustekinumab-aekn (gen of SELARSDI) ustekinumab-ttwe (gen of PYZCHIVA) YESINTEK (Bio of STELARA)
Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY	emtricitabine/tilpivirine/tenofovir
Respiratory Agents: Inhaled Agents	fluticasone furoate

THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA
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
Central Nervous System (CNS) Agents: Parkinson's Agents
Immunomodulator Agents: Systemic Inflammatory Disease
Infectious Disease Agents: Antibiotics – Cephalosporins
Respiratory Agents: Monoclonal Antibodies-Anti-IL/Anti-IgE

REVISED THERAPEUTIC CATEGORY CRITERIA	
THERAPEUTIC CLASS	**SUMMARY OF CHANGE**
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia A, von Willebrand Disease, and Factor XIII Deficiency* LEGACY CATEGORY	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response such as increased ~~in~~ bleeding episodes, ~~**OR require**~~ a need for more factor replacement therapy, **OR** ~~demonstrate~~ worsening joint health, of at least 14 days with at least one preferred drug in this UPDL category and indicated for diagnosis **ADDITIONAL HYMPAVZI (MARSTACIMAB-HNCQ) CRITERIA** • Must have had an inadequate clinical response such as ~~an~~ increased ~~in~~ bleeding episodes, ~~**OR require**~~ a need for more factor replacement therapy, **OR** ~~demonstrate~~ worsening joint health, of at least 30 days with HEMLIBRA • Must have Hemophilia A **without** factor VIII inhibitors • Must be prescribed by or in consultation with a hematologist **ADDITIONAL ALHEMO (CONCIZUMAB-MTCI) CRITERIA** • Must have had an inadequate clinical response such as ~~an~~ increased ~~in~~ bleeding episodes, ~~**OR require**~~ a need for more factor replacement therapy, **OR** ~~demonstrate~~ worsening joint health, of at least 30 days with HEMLIBRA • Must have Hemophilia A **with** factor VIII inhibitors • Must be prescribed by or in consultation with a hematologist

Date of Notice: 9/1/2025

	ADDITIONAL QFITLIA (FITUSIRAN) CRITERIA • Must have had an inadequate clinical response such as ~~an~~ increased ~~in~~ bleeding episodes, ~~**OR** require~~ a need for more factor replacement therapy, **OR** ~~demonstrate~~ worsening joint health, of at least 30 days with HEMLIBRA • Must have Hemophilia A **with or without** factor VIII inhibitors • Must be prescribed by or in consultation with a hematologist
Blood Formation, Coagulation, and Thrombosis Agents: Hemophilia B* LEGACY CATEGORY	**NON-PREFERRED CRITERIA:** • Must have had an inadequate clinical response such as ~~an~~ increased ~~in~~ bleeding episodes, **OR** ~~require~~ a need for more factor replacement therapy, **OR** ~~demonstrate~~ worsening joint health, of at least 14 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Cardiovascular Agents: Angina, Hypertension and Heart Failure	**ADDITIONAL FINERENONE (KERENDIA) CRITERIA:** • Must be on a maximally tolerated dose of an angiotensin-converting enzyme inhibitor or angiotensin receptor blocker **AND** • 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 ~~(i.e., chronic kidney disease diagnosis)~~ **AR** – INZIRQO SOLN: a PA is required for patients 12 years and older
Central Nervous System (CNS) Agents: Parkinson's Agents	**ADDITIONAL APOMORPHINE (ONAPGO) CRITERIA:** • Must have had an 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
Immunomodulator Agents: Systemic Inflammatory Disease	**CLINICAL PA CRITERIA:** • Authorization of dosing regimens (loading/maintenance) will be based upon diagnosis. Document the requested loading and maintenance dosing on PA form, if applicable • Must not have a current, active infection • Must provide ~~evidence~~date of negative TB test within the past 365 days prior to initiation of biologic therapy, if required by labeling **ADDITIONAL CHRONIC SPONTANEOUS URTICARIA CRITERIA:** • Must be prescribed by or in consultation with a specialist (i.e. allergist/ immunologist , dermatologist, rheumatologist) • Must have had an inadequate clinical response of at least 14 days with at least two different second-generation antihistamines at 4 times standard dose
Infectious Disease Agents: Antibiotics – Cephalosporins	~~**AR** – cephalexin susp: a PA is required for patients 12 years and older~~
Respiratory Agents: Monoclonal	**CLINICAL PA CRITERIA:**

Date of Notice: 9/1/2025

Antibodies-Anti-IL/Anti-IgE	• Must be prescribed by or in consultation with an applicable specialist (i.e., allergist/ immunologist, pulmonologist, or otolaryngologist) • For **Asthma** – Must have had uncontrolled asthma symptoms and/or exacerbations despite at least 30 days with: ○ Medium dose preferred ICS/LABA inhaler for 6 years and older **OR** medium dose preferred ICS/LABA inhaler with tiotropium or high dose ICS/LABA inhaler if 12 years and older • For **Chronic Rhinosinusitis with Nasal Polyposis** – Must have had an inadequate clinical response of at least 30 days to at least one oral corticosteroid AND one nasal corticosteroid spray • For **Chronic Spontaneous Urticaria** – Must have had an inadequate clinical response of at least 14 days with at least two different second-generation antihistamines at 4 times standard dose

NEW THERAPEUTIC CATEGORIES
Duchenne Muscular Dystrophy Agents: Corticosteroids
Sickle Cell Gene Therapy Agents

NEW THERAPEUTIC CATEGORY CRITERIA	
THERAPEUTIC CLASS	**SUMMARY OF CHANGE**
Duchenne Muscular Dystrophy Agents: Corticosteroids	**LENGTH OF AUTHORIZATIONS:** 365 Days **CLINICAL PA CRITERIA:** • Must be prescribed by or in consultation with a neurologist or specialist in Duchenne Muscular Dystrophy • Must have documented DMD diagnosis confirmed by genetic testing or muscle biopsy with dystrophin absent results • Must have had an inadequate clinical response of at least 180 days or contraindication to prednisone • Must provide documentation of patient's weight **NON-PREFERRED CRITERIA:** Must have had unmanageable side effects, such as significant weight gain/obesity, persistent psychiatric/behavioral conditions, diabetes, growth delay, cataracts, hypertension, or ~~C~~cushingoid appearance **OR** intolerance of at least 30 days with at least one preferred drug in this UPDL category and indicated for diagnosis
Sickle Cell Gene Therapy Agents	**LENGTH OF AUTHORIZATIONS:** 365 Days **CLINICAL PA CRITERIA:** • Please see the Prior Authorization Form for criteria