3Q24 P&T Material NHHF

Reference ID	Title	Revision
CP.PHAR.109	Tesamorelin (Egrifta SV)	3Q 2024 annual review: revised clinical indicators for abdominal lipodystrophy criteria to require waist circumference and waist-hip ratio thresholds that reflect efficacy studies; per PI, revised FDA Approved Indications and contraindications, removed criteria allowing pediatric use in members with closed epiphyses; updated HCPCS codes; references reviewed and updated.
CP.PHAR.11	Burosumab-twza (Crysvita)	3Q 2024 annual review: for all indications, added requirement to Continued Therapy section that Crysvita not be used concomitantly with oral phosphate or vitamin D replacement therapy; references reviewed and updated.
CP.PHAR.135	Baricitinib (Olumiant)	Per June SDC: for RA, added Simlandi to listed examples of preferred adalimumab products.
CP.PHAR.145	Deferasirox (Exjade, Jadenu)	3Q 2024 annual review: in Policy/Criteria, clarified policy is medically necessary for all deferasirox products not only Exjade/Jadenu; references reviewed and updated.
CP.PHAR.146	Deferoxamine (Desferal)	3Q 2024 annual review: in Policy/Criteria, clarified policy is medically necessary for all deferoxamine products not only Desferal; references reviewed and updated.
CP.PHAR.147	Deferiprone (Ferriprox)	3Q 2024 annual review: clarified policy is medically necessary for all deferiprone products not only Ferriprox; added generic deferiprone redirection for ages ≥8 years; references reviewed and updated.
CP.PHAR.150	Mecasermin (Increlex)	3Q 2024 annual review: revised verbiage that Increlex is not prescribed concurrently with growth hormone (previously only Somatropin was included); references reviewed and updated
CP.PHAR.169	Vigabatrin (Sabril)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.177	Ecallantide (Kalbitor)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.178	Icatibant (Firazyr)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.202	C1 Esterase Inhibitors (Berinert, Cinryze, Haegarda, Ruconest)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.209	Aztreonam (Cayston)	3Q 2024 annual review: for initial criteria, added Kitabis Pak to list of preferred tobramycin inhalation agents; references reviewed and updated.
CP.PHAR.210	Ivacaftor (Kalydeco)	3Q 2024 annual review: for continued therapy, clarified positive response as an “improvement” (e.g., decrease) of LCL and improvement of ppFEV1 as an "increase from baseline”; for Appendix D, updated LCI supplemental information; references reviewed and updated.
CP.PHAR.211	Tobramycin (Bethkis, Kitabis Pak, TOBI, TOBI Podhaler)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.212	Dornase Alfa (Pulmozyme)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.213	Lumacaftor/Ivacaftor (Orkambi)	3Q 2024 annual review: for initial therapy, removed criterion “ppFEV1 that is between 40 – 90%” from documentation of member’s ppFEV1” to align with other CFTR modulator criteria; for continued therapy, clarified positive response as an “improvement” (e.g., decrease) of LCL and improvement of ppFEV1 as an "increase from baseline”; for Appendix D, updated LCI supplemental information and removed supplemental pediatric extension clinical trial information for patients ages 12 months to < 24 months; references reviewed and updated.
CP.PHAR.263	Tocilizumab (Actemra, Tofidence, Tyenne)	Per June SDC: for RA and pJIA, added Simlandi to listed examples of preferred adalimumab products.
CP.PHAR.27	Tolvaptan (Jynarque, Samsca)	3Q 2024 annual review: no significant changes; revised policy/ criteria section to also include generic tolvaptan; references reviewed and updated.
CP.PHAR.270	Paricalcitol Injection (Zemplar)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.277	Cytomegalovirus Immune Globulin (CytoGam)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.28	Immunization Coverage	3Q 2024 annual review: no significant changes; references reviewed and updated.

CP.PHAR.285	Nintedanib (Ofev)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.286	Pirfenidone (Esbriet)	3Q 2024 annual review: no significant changes; revised policy/ criteria section to also include generic pirfenidone; references reviewed and updated.
CP.PHAR.287	Obeticholic Acid (Ocaliva)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.295	Sargramostim (Leukine)	3Q 2024 annual review: per NCCN Compendium for high-risk neuroblastoma added additional supported combination therapies; added NCCN Compendium supported off-label use in the treatment of chemotherapy-induced febrile neutropenia; revised dosing requirements to allow guideline or NCCN supported off-label dosing; for acute radiation syndrome to confirm weight-based dosing added requirement for documentation of member's current weight (in kg); references reviewed and updated.
NH.PHAR.297	Filgrastim (Neupogen), Filgrastim-sndz (Zarxio), Tbo-filgrastim (Granix), Filgrastim-aafi (Nivestym), Filgrastim-ayow (Releuko)	New Policy Created
CP.PHAR.328	Asfotase Alfa (Strensiq)	Per June SDC, generalized initial approval diagnostic laboratory indices criteria language.
CP.PHAR.332	Pasireotide (Signifor, Signifor LAR)	Per June SDC, for acromegaly, added redirection to Sandostatin LAR Depot and Somatuline Depot. Removed reference to HIM.PA.103 for Signifor LAR requests and aligned HIM approval durations with Medicaid.
CP.PHAR.338	Cerliponase Alfa (Brineura)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.351	Daptomycin (Cubicin, Cubicin RF, Dapzura RT)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.375	Brodalumab (Siliq)	Per June SDC, added Simlandi to listed examples of preferred adalimumab products.
CP.PHAR.377	Tezacaftor/Ivacaftor; Ivacaftor (Symdeko)	3Q 2024 annual review: for initial approval criteria, removed "chart notes showing ppFEV1 that is between 40 – 90%" and revised criteria to "documentation of member's baseline precent predicted forced expiratory volume in 1 second (ppFEV1)" to align with other CFTR modulator criteria; for continued therapy, revised criteria from "stabilization in ppFEV1 if baseline was > 70%, or increase in ppFEV1 if baseline was <70%" to "stabilization or improvement (e.g., increase) in ppFEV1 from baseline" to align with other CFTR modulator criteria; revised Appendix D to remove information on advanced Cystic Fibrosis disease; references reviewed and updated.
CP.PHAR.379	Etelcalcetide (Parsabiv)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.384	Lutetium Lu 177 Dotatate (Lutathera)	3Q 2024 annual review: RT4: updated NET criteria to reflect newly approved pediatric expansion; references reviewed and updated.
CP.PHAR.385	Corticosteroids for Ophthalmic Injection (Dextenza, Iluvien, Ozurdex, Retisert, Xipere, Yutiq)	3Q 2024 annual review: no significant changes; in Appendix B, updated commercially available branded therapeutic alternatives and clarified off label indications; in Section V, revised Ozurdex maximum dose from every 4 months to every 6 months per PI references reviewed and updated.
CP.PHAR.388	Chloramphenicol Sodium Succinate	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.389	Pegvisomant (Somavert)	Per June SDC, clarified failure of somastatin analogs to Sandostatin LAR Depot and Somatuline Depot; removed Signifor LAR from Appendix B therapeutic alternatives.
CP.PHAR.391	Lanreotide (Somatuline Depot)	Per June SDC, added redirection to brand Somatuline Depot if request is for unbranded lanreotide for all indications
CP.PHAR.396	Lanadelumab-fylo (Takhzyro)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.40	Octreotide Acetate (Sandostatin, Sandostatin LAR, Bynfezia, Mycapssa)	Per June SDC, for Mycapssa, added redirection to Somatuline Depot and Sandostatin LAR Depot.
CP.PHAR.401	Amikacin (Arikayce)	3Q 2024 annual review: no significant change; references reviewed and updated.
CP.PHAR.41	Enfuvirtide (Fuzeon)	3Q 2024 annual review: no significant changes; references reviewed and updated.

CP.PHAR.415	Ravulizumab-cwvz (Ultomiris)	3Q 2024 annual review: no significant changes; updated the list of therapies that Ultomiris should not be prescribed concurrently with to include Bkemv for all indications, Fabhalta for PNH, and Rystiggo, Vyvgart Hytrulo, and Zilbrysq for gMG; references reviewed and updated.
CP.PHAR.425	Metreleptin (Myalept)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.430	Alpelisib (Piqray, Vijoice)	3Q 2024 annual review: no significant changes; RT4: added oral granules dosage form per updated prescribing information; references reviewed and updated.
CP.PHAR.432	Tafamidis (Vyndaqel, Vyndamax)	3Q 2024 annual review: removed Tegsedi from criteria as agent will be discontinued September 2024 per Sobi manufacturer; revised Vyndaqel/Vyndamax is “not prescribed concurrently with Onpattro and Tegsedi” to “not prescribed concurrently with Onpattro and Amvuttra”; updated Appendix D by removing Tegsedi and adding Amuvttra supplemental information on concurrent use; references reviewed and updated.
CP.PHAR.440	Elexacaftor/Ivacaftor/Tezacaftor; Ivacaftor (Trikafta)	3Q 2024 annual review: for continued therapy, clarified positive response as an “improvement” (e.g., decrease) of LCL and improvement of ppFEV1 as an "increase from baseline”; for Appendix D, updated LCI supplemental information; references reviewed and updated.
CP.PHAR.448	Mometasone Furoate (Sinuva)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.458	Inebilizumab-cdon (Uplizna)	3Q 2024 annual review: no significant changes; added Bkemv and Ultomiris to the list of therapies that Uplizna should not be prescribed concurrently with; references reviewed and updated.
CP.PHAR.463	Satralizumab-mwge (Enspryng)	3Q 2024 annual review: no significant changes; added Bkemv and Ultomiris to the list of therapies that Enspryng should not be prescribed concurrently with; references reviewed and updated.
CP.PHAR.485	Berotralstat (Orladeyo)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.487	Osilodrostat (Isturisa)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.488	Apomorphine (Apokyn, Kynmobi)	3Q 2024 annual review: removed Kynmobi formulation from policy due to market withdrawal by manufacturer due to low utilization; references reviewed and updated.
CP.PHAR.494	Capmatinib (Tabrecta)	3Q 2024 annual review: for initial criteria: added option for “if EGFR mutant with high-level MET amplifications, Tabrecta is used with Tagrisso” per NCCN; removed “member does not have symptomatic CNS metastases” as Tabrecta may be used in CNS brain metastases per NCCN; references reviewed and updated.
CP.PHAR.495	Mitomycin for Pyelocalyceal Solution (Jelmyto)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.497	Tucatinib (Tukysa)	3Q 2024 annual review: added POLE/POLD1 mutation option if member is ineligible for, or disease has progressed on, checkpoint inhibitor immunotherapy in colorectal cancers; added off-label criteria for NCCN-supported biliary tract cancers; added note that prior authorization may be required for combination therapy for all indications; references reviewed and updated.
CP.PHAR.512	Pegunigalsidase Alfa-iwxj (Elfabrio)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.518	Mannitol (Bronchitol)	3Q 2024 annual review: no significant changes; for Appendix D, defined FEV1 and ppFEV1; references reviewed and updated.
CP.PHAR.524	Pegcetacoplan (Empaveli, Syfovre)	3Q 2024 annual review: for PNH, added Fabhalta, Voydeya, and Bkemv to the list of therapies that Empaveli should not be prescribed concurrently with; for GA, clarified that diagnostic characteristics must be confirmed on fundus autofluorescence imaging per health plan request and in alignment with pivotal study design; revised Empaveli contraindications in Appendix C per updated prescribing information; references reviewed and updated.
CP.PHAR.543	Maralixibat (Livmarli)	3Q 2024 annual review: for initial criteria, added exclusions for portal hypertension and history of a hepatic decompensation event for both PFIC and ALGS per competitor analysis and to align with other PFIC and ALGS criteria; references reviewed and updated.

CP.PHAR.545	Betibeglogene Autotemcel (Zynteglo)	3Q 2024 annual review: revised lower age limit to age ≥ 4 years and removed accompanying age < 5 criteria; removed age qualifier of ≥ 12 years for receipt of ≥ 8 transfusions of pRBC per year; added clarification for time component and documentation within the last 6 months for negative HIV test; approval duration extended from 3 months to 6 months to allow for member preparation and adequate time for gene therapy manufacture; added clarification of a one-time dose only for continued authorization; corrected template language for continued therapy; references reviewed and updated.
CP.PHAR.548	Palovarotene (Sohonos)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.572	Budesonide (Tarpeyo)	Revise redirection to require one alternative systemic corticosteroid.
CP.PHAR.578	Abrocitinib (Cibinqo)	3Q 2024 annual review: no significant changes; for Appendix D, updated therapeutic options with place in therapy per current guidelines; references reviewed and updated.
CP.PHAR.586	Olipudase Alfa-rpcp (Xenpozyme)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.587	Pegzilarginase (AEB1102) - PEPP	3Q 2024 annual review: no significant changes as drug is not yet FDA-approved; references reviewed and updated.
CP.PHAR.589	Bulevirtide (Hepcludex) -PEPP	3Q 2024 annual review: no significant changes as drug is still not FDA approved; references reviewed and updated.
CP.PHAR.592	Beremagene geperpavec-svdt (Vyjuvek)	3Q 2024 annual review: for Appendix E, updated Decode DEB testing program information and website link; references reviewed and updated.
CP.PHAR.593	Delandistrogene Moxeparvovec-rokl (Elevidys)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.602	Atidarsagene autotemcel (Lenmeldy)	RT1: drug is now FDA approved – criteria updated per FDA labeling: clarified diagnostic criteria to only require 24-hour urine collection if novel alleles are identified, added coverage for children between 7 to 17 years of age as long as onset of symptoms began before age 7, revised MLD forms to align with terminology used in the PI, clarified that walking independently means without support and modified IQ requirement from 70 to 85, updated dosing to include minimum and maximum recommendations; added physician specialized in bone marrow transplantation as a prescriber option per specialist feedback; added allowance for prior receipt of allogeneic hematopoietic stem cell transplant in alignment with study protocol; references reviewed and updated.
CP.PHAR.607	Deucravacitinib (Sotyktu)	Per June SDC, added Simlandi to listed examples of preferred adalimumab products.
CP.PHAR.61	Cinacalcet (Sensipar)	3Q 2024 annual review: for all indications, added criteria to use generic cinacalcet over brand Sensipar; references reviewed and updated.
CP.PHAR.614	Nirsevimab-alip (Beyfortus)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.632	Fecal Microbiota Spores, Live-brpk (Vowst)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.633	Eplontersen (Wainua)	3Q 2024 annual review: removed Tegsedi® from criteria as agent will be discontinued September 2024 per Sobi manufacturer; references reviewed and updated.
CP.PHAR.637	Debamestrocel (NurOwn) - PEPP	3Q 2024 annual review: no significant changes as drug is not yet FDA-approved; updated generic name from MSC- neurotrophic factor cells to debamestrocel; references reviewed and updated.
CP.PHAR.638	Nalmefene (Opvee)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.643	Fidanacogene Elaparvovec-dzkt (Beqvez)	RT1: Drug is now FDA approved – criteria updated per FDA labeling: clarified documentation of negative test for neutralizing antibodies to AAVRh74var; added medical director review; removed criterion for subsequent negative factor IX inhibitor test if member has an initial positive test result per PI; added criteria for documentation of HIV test with minimum CD4+ cell count or maximum viral load for positive HIV test per PI; added criterion that member does not have current liver-related conditions per PI; added criterion for hepatologist attestation of Beqvez eligibility if sustained liver enzymes or radiological liver abnormalities present per PI; added criterion for documentation of member's body weight to allow verification of weight based dose; added information in Appendix E on dose calculation for weight based doses; references reviewed and updated.

CP.PHAR.644	Givinostat (Duvyzat)	RT4: Duvyzat is now FDA approved – criteria updated per FDA labeling: added option for positive muscle biopsy for diagnosis of DMD if genetic studies negative per DMD Care Considerations Working Group; removed age restriction of < 18 years at therapy initiation; revised ambulatory criteria with removal of 4SC ≤ 8 seconds requirement; removed QTcF, triglycerides and LVEF contraindications from criteria; added documentation of member's baseline ambulatory function as evidenced by motor function tests; for continued therapy, added improvement or stabilization in member's ambulatory function from baseline as example of responding positively to therapy; references reviewed and updated.
CP.PHAR.656	Iptacopan (Fabhalta)	3Q 2024 annual review: no significant changes; added Voydeya and Bkemv to the list of therapies that Fabhalta should not be prescribed concurrently with; references reviewed and updated.
CP.PHAR.660	Bimekizumab-bkzx (Bimzelx	Per June SDC, added Simlandi to listed examples of preferred adalimumab products.
CP.PHAR.661	Etrasimod (Velsipity)	Per June SDC, added Simlandi to listed examples of preferred adalimumab products.
CP.PHAR.662	Mirikizumab-mrkz (Omvoh)	Per June SDC, added Simlandi to listed examples of preferred adalimumab products.
CP.PHAR.665	Danicopan (Voydeya)	3Q 2024 annual review: no significant changes; added Bkemv (Soliris biosimilar) as another C5 inhibitor option; references reviewed and updated.
CP.PHAR.82	Collagenase Clostridium Histolyticum (Xiaflex)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.89	Peginterferon Alfa-2a (Pegasys)	3Q 2024 annual review: updated definition of significant fibrosis from stage 3-4 to stage 2-4 per 2024 WHO CHB guidelines; references reviewed and updated.
CP.PHAR.95	Thyrotropin Alfa (Thyrogen)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PHAR.97	Eculizumab (Soliris)	3Q 2024 annual review: RT4: added newly approved biosimilar, Bkemv; updated the list of therapies that Soliris/Bkemv should not be prescribed concurrently with to include Rystiggo, Vyvgart Hytrulo, and Zilbrysq for gMG, Fabhalta for PNH, and Ultomiris for NMOSD; revised contraindications in Appendix C per updated Soliris prescribing information; references reviewed and updated.
CP.PMN.08	Lidocaine Transdermal (Lidoderm, ZTlido)	3Q 2024 annual review: for diabetic neuropathy, added desvenlafaxine as an example SNRI per AAN and ADA guidelines; revised Lidoderm/ZTlido to generic transdermal lidocaine in Policy/Criteria; for continued therapy, added requirement of a trial of generic lidocaine patches; in Appendix B, removed commercially unavailable brand alternatives; references reviewed and updated.
CP.PMN.102	Rolapitant (Varubi)	3Q 2024 annual review: no significant changes; added HCPCS code J2797; references reviewed and updated.
CP.PMN.111	House Dust Mite Allergen Extract (Odactra)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.115	Delafloxacin (Baxdela)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.125	Milnacipran (Savella)	Revised continued therapy criteria to allow continuity of care in antidepressants for all indications
CP.PMN.132	Tadalafil BPH - ED (Cialis)	3Q 2024 annual review: no significant changes; for BPH split redirection and dosing limits requirement into separate requirements for added clarity; references reviewed and updated.
CP.PMN.141	Dolasetron (Anzemet)	3Q 2024 annual review: no significant changes; removed 100 mg strength from Section VI as product is discontinued; references reviewed and updated.
CP.PMN.143	Isotretinoin (Absorica, Absorica LD, Amnesteem, Claravis, Myorisan, Zenatane)	Added off-label criteria for hidradenitis suppurativa per local market request.
CP.PMN.144	Epinephrine (Auvi-Q, EpiPen, EpiPen Jr) Quantity Limit Override	3Q 2024 annual review: no significant changes; references reviewed and updated
CP.PMN.145	Vilazodone (Viibryd)	3Q 2024 annual review: revised continued therapy to allow continuity of care for antidepressants; in Appendix B, added Wellbutrin SR to therapeutic alternatives and clarified that fluvoxamine used in depression is off-label; references reviewed and updated.
CP.PMN.152	Lofexidine (Lucemyra)	3Q 2024 annual review: no significant changes; references reviewed and updated.

CP.PMN.155	Lacosamide (Motpoly XR, Vimpat)	3Q 2024 annual review: added revisions for the newly FDA-approved indication for Motpoly XR for generalized tonic-clonic seizures which align with the existing criteria for the same indication for Vimpat; references reviewed and updated.
CP.PMN.156	Perampanel (Fycompa)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.157	Rufinamide (Banzel)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.158	Netupitant and Palonosetron (Akynzeo), Fosnetupitant and Palonosetron (Akynzeo IV)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.159	Dronabinol (Marinol, Syndros)	3Q 2024 annual review: no significant changes; for anorexia clarified Marinol dose and quantity limits as separate requirements; references reviewed and updated.
NH.PMN.16	Request for Non-Preferred Medically Necessary	Annual review, no changes
CP.PMN.163	Sodium Zirconium Cyclosilicate (Lokelma)	3Q 2024 annual review: no significant changes; for initial approval criteria, clarified dose does not exceed both initial and maintenance regimens; references reviewed and updated.
CP.PMN.164	Cannabidiol (Epidiolex)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.188	Omadacycline (Nuzyra)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.19	Aprepitant (Aponvie, Emend, Cinvanti), Fosaprepitant (Emend for injection, Focinvez)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.197	Clomipramine (Anafranil)	Revised continued therapy criteria to allow continuity of care for all indications.
CP.PMN.205	Patiromer (Veltassa)	3Q 2024 annual review: for section VI, removed “1 g” as strength is discontinued per FDA website and Medispan; references reviewed and updated.
CP.PMN.207	Triclabendazole (Egaten)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.208	Halobetasol Propionate/Tazarotene (Duobrii)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.211	Midazolam (Nayzilam)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.219	Lefamulin (Xenleta)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.220	Peanut Allergen Powder-dnfp (Palforzia)	3Q 2024 annual review: no significant changes; references reviewed and updated.
NH.PMN.226	Pancrelipase (Perzyte, Viokace, Pancreaze)	Annual review, no changes
CP.PMN.232	Lumateperone (Caplyta)	3Q 2024 annual review: for Schizophrenia, changed to “failure of one of the following generic atypical antipsychotics…” (previously was failure of two) to align with other atypical antipsychotics; references reviewed and updated.
CP.PMN.236	Amisulpride (Barhemsys)	3Q 2024 annual review: added age requirement per prescribing information; revised approval duration from one time “approval” to “dose”; references reviewed and updated.
CP.PMN.238	Carbidopa/Levodopa ER Capsules (Rytary), Enteral Suspension (Duopa), IR Tablets (Dhivy)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.239	Chenodiol (Chenodal)	3Q 2024 annual review: no significant changes; updated FDA Approved Indications section to align with most current prescriber information wording; references reviewed and updated
CP.PMN.240	Gabapentin ER (Gralise, Horizant)	3Q 2024 annual review: for all indications, added asterisk stating that prior authorization may be required for pregabalin, clarified failure of generic gabapentin is required; for PHN, revised wording of age limit for failure of a TCA; in Appendix B, clarified off-label indications and maximum dosing; references reviewed and updated.
CP.PMN.242	Minocycline Micronized Foam (Amzeeq)	3Q 2024 annual review: no significant changes; references reviewed and updated

CP.PMN.243	Progesterone (Crinone, Endometrin, Milprosa)	3Q 2024 annual review: removed Milprosa from policy due to product discontinuation; evidence of coverage for infertility/fertility preservation language added for HIM line of business (AR, CA, Il, LA, NV, NJ, NC, and all other states); references reviewed and updated.
CP.PMN.245	Opicapone (Ongentys)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.246	Fenfluramine (Fintepla)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.247	Rivaroxaban (Xarelto)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.263	Estradiol Vaginal Ring (Femring)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.269	Ivermectin (Stromectol, Sklice)	3Q 2024 annual review: for Appendix C, updated contraindications section for Stromectol to align with prescriber information; for Appendix D, updated supplemental information for ivermectin's use in COVID-19; for table V, updated dosing regimen for Sklice; references reviewed and updated.
CP.PMN.27	Linezolid (Zyvox)	3Q 2024 annual review: added requirement if request is for orally administered brand Zyvox, member must use generic linezolid; references reviewed and updated.
CP.PMN.272	Mavacamten (Camzyos)	3Q 2024 annual review: no significant changes; removed upper limit for left ventricular thickness for familial disease or positive genetic test as thickness above 15 mm is diagnostic regardless of familial status/genetic testing; added Appendix D with examples of genes that can cause familial HCM; references reviewed and updated.
CP.PMN.279	Long-term Antibiotic Treatment for Tick-borne Diseases	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.280	Compounded Medications	3Q 2024 annual review: no significant changes.
CP.PMN.281	Topiramate Extended-Release (Qudexy XR, Trokendi XR)	3Q 2024 annual review: no significant changes; revised "Failure of a trial" language to template "Member must use" language; references reviewed and updated.
CP.PMN.284	Dextromethorphan-bupropion (Auvelity)	Revised continued therapy section to allow continuity of care.
CP.PMN.288	Nirmatrelvir and Ritonavir (Paxlovid)	3Q 2024 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 2024 annual review: no significant changes; in Appendix B, removed commercially unavailable brand alternatives; references reviewed and updated.
CP.PMN.290	Perfluorohexyloctane (Miebo)	3Q 2024 annual review: no significant changes; clarified "non-prescription wetting agents" to artificial tears; revised Appendix B to list commercially available example products and added note that ophthalmic NSAIDs are not indicated for DED; references reviewed and updated.
CP.PMN.292	Gepirone (Exxua)	Revised continued therapy to allow continuity of care for antidepressants
CP.PMN.296	Ketamine (Ketalar)	Policy created.
CP.PMN.40	Acitretin (Soriatane)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.44	Pyrimethamine (Daraprim)	3Q 2024 annual review: no significant changes; references reviewed and updated
CP.PMN.46	Roflumilast (Daliresp, Zoryve)	3Q 2024 annual review: no significant changes; revised policy/ criteria section to also include generic roflumilast; references reviewed and updated.
NH.PMN.56	Atypical Antipsychotics	Annual review, no changes
CP.PMN.60	SSRI/SNRI Duplicate Therapy	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.62	Tedizolid (Sivextro)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.65	Vortioxetine (Trintellix)	3Q 2024 annual review: revised continued therapy to allow continuity of care for antidepressants; in Appendix B, added Wellbutrin SR to therapeutic alternatives and clarified that fluvoxamine used in depression is off-label; references reviewed and updated.

CP.PMN.67	Sacubitril-Valsartan (Entresto	Per June SDC, revised redirection from Jardiance to dapagliflozin (Farxiga authorized generic).
CP.PMN.74	Granisetron (Sancuso, Sustol)	3Q 2024 annual review: no significant changes; for PONV modified approval duration to state “one time dose” instead of “one time approval”; removed inactive HCPCS code J3490 used for Sancuso; references reviewed and updated.
CP.PMN.76	Calcifediol (Rayaldee)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.83	Short Ragweed Pollen Allergen Extract (Ragwitek)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.84	Timothy Grass Pollen Allergen Extract (Grastek)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.85	Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens Allergen Extract (Oralair)	3Q 2024 annual review: no significant changes; references reviewed and updated.
CP.PMN.95	Fluticasone propionate (Xhance)	3Q 2024 annual review: no significant changes; references reviewed and updated. Per June SDC, added criteria for CRSsNP and requiring trial of two intranasal corticosteroids and one intranasal saline agent; updated Appendix B with therapeutic alternatives for CRSsNP and intranasal saline agents.
CC.PHAR.14	Generic Drug Additions to PDL	Annual Review- Changed all “PDL” references to “formulary”.
CC.PHAR.14 Addendum	Generic Drug Additions to PDL NH Healthy Families Addendum	Annual Review, No Updates
CC.PHAR.15	Line Extension Additions to PDL Updates	Annual Review- No changes deemed necessary.
CC.PHAR.23	Clinical Pharmacy Criteria Web Posting	Updated 2.b.i. The health plan designee should review the pharmacy criteria web posting folder monthly, aligning with monthly changes, to ensure.
CC.PHARM.54	Specialty Drug List Management	Removed “Pharmacy Services may offer a variable drug list based on client needs” since there is only one Global Specialty Drug List. Added Express Scripts (ESI) as a Pharmacy Claims Processor. Networks team now updates the Network Requirement Document (NRD) with any caveats, instead of the old process where FABM updated caveats on the Benefit Master Grid (BMG).