Commissioner for the Department for Medicaid Services Selections for Preferred Products

The following tables provide a summary of the final Preferred Drug List (PDL) selections made by the Commissioner for the Department for Medicaid Services (DMS) based on the Drug Review and Options for Consideration document prepared for the Pharmacy and Therapeutics (P&T) Advisory Committee's review on **April 15, 2025**, and the resulting official recommendations.

NEW PRODUCTS TO MARKET

Alyftrek™

Non-PDL

Approval Duration: 6 months

- *Vanzacaftor and tezacaftor work additively to increase the amount of cystic fibrosis transmembrane conductance regulator (CFTR) protein on the cell surface. Deutivacaftor increases the channel open probability of the CFTR protein at the cell surface. The three agents increase CFTR activity.*

Initial Approval Criteria:

- Patient has a documented diagnosis of cystic fibrosis with:
  - A genetic profile (e.g., gene mutation) that is considered responsive to the product based on clinical and/or in vitro data contained in the FDA labeling; **AND**
  - Confirmed by an FDA-approved diagnostic test; **AND**
- Patient meets the FDA-approved minimum age; **AND**
- Documentation (e.g., progress notes) of baseline functional status and baseline predicted FEV1.

Renewal Criteria:

- Patient has had disease response, as indicated by one or more of the following:
  - Decreased pulmonary exacerbations, as compared to pre-treatment baseline; **OR**
  - Improvement or stabilization of lung function, compared to baseline; **OR**
  - Decrease in decline of lung function; **OR**
  - Improvement in quality of life, weight gain, or growth.

Age Limit: 6 years of age or older

Quantity Limit:

- 50-20-4 mg tablets: 3 per day
- 125-50-10 mg tablets: 2 per day

Sofdra™

Non-PDL

Approval Duration: 6 months

- *Sofpironium competitively inhibits acetylcholine receptors on some peripheral tissues, including sweat glands. With receptor stimulation prevented, the rate of sweating decreases.*

Initial Approval Criteria:

- Patient has a diagnosis of primary axillary hyperhidrosis; **AND**
- Prescriber attests hyperhidrosis is significantly interfering with activities of daily living; **AND**
- Patient meets the FDA-approved minimum age.

Renewal Criteria:

- Prescriber attestation of clinically significant improvement in clinical signs and symptoms.

Age Limit: 9 years of age or older

Quantity Limit: 1 bottle per 30 days

Ryzumvi™

Non-PDL

Approval Duration: Single fill only

- *Phentolamine is a relatively non-selective alpha-1 and alpha-2 adrenergic antagonist. Muscles involved in dilating the pupil are primarily activated by these receptors to directly reduce pupil diameter, therefore reversing the mydriasis induced by specific pharmacological agents.*

Approval Criteria:

- Patient has a diagnosis of pharmacologically-induced mydriasis produced by adrenergic agonists (e.g., phenylephrine) OR parasympatholytic (e.g., tropicamide) agents; **AND**
- Prescriber attests product will be used within 24 hours of the procedure; **AND**
- Prescribed by, or in consultation with, an ophthalmologist or other specialist in the treatment of pharmacologically-induced mydriasis

Age Limit: 3 years of age or older

Quantity Limit: 1 single-patient-use vial per fill

Crenessity™

Non-PDL

Approval Duration: 6 months initial, 1 year renewal

- *Crinecerfont is a selective corticotropin-releasing factor (CRF) type 1 receptor antagonist. Crinecerfont blocks the binding of CRF to CRF type 1 receptors in the pituitary but not CRF type 2 receptors. Crinecerfont binding to CRF type 1 receptors inhibits adrenocorticotropic hormone (ACTH) secretion from the pituitary, thereby reducing ACTH-mediated adrenal androgen production.*

Initial Approval Criteria:

- Patient has a diagnosis of classic congenital adrenal hyperplasia (CAH) defined by ≥ 1 of the following:
  - Elevated 17-hydroxyprogesterone (17-OHP) level; **OR**
  - Confirmed CYP21A2 genotype; **OR**
  - Positive newborn screening with confirmatory second-tier testing (e.g., liquid chromatography – tandem mass spectrometry); **OR**
  - Cosyntropin stimulation test; **AND**
- Prescribed initially by, or in consultation with an endocrinologist; **AND**
- Crenessity (crinecerfont) will be used as an adjunct therapy with chronic glucocorticoid therapy for CAH (e.g., hydrocortisone, prednisone, prednisolone, methylprednisolone, dexamethasone) at a minimum glucocorticoid dose required for cortisol replacement; **AND**
- If prescribed concomitantly with a moderate or strong CYP3A4 inducer (e.g., phenytoin, carbamazepine, rifampin, rifabutin, rifapentine, phenobarbital, bosentan, efavirenz, etravirine, and primidone), dosages will be modified as recommended by the package insert; **AND**
- Patient meets the minimum age recommended by the package insert for the provided indication.

Renewal Criteria:

- Patient must continue to meet initial approval criteria; **AND**
- Patient must have disease improvement, as indicated by ≥ 1 of the following:
  - Reduction in glucocorticoid daily use; **OR**
  - Reduction in serum androstenedione (A4) levels.

Age Limit: 4 years of age or older

Quantity Limit:

- 25 mg, 50 mg, and 100mg oral capsules: 2 per day
- 50 mg/mL oral solution: 4 mL per day

Journavx™

Non-PDL

Approval Duration: 3 months (Limit to 1 fill per approval)

- *Suzetrigine is a selective blocker of the NaV1.8 voltage-gated sodium channel. NaV1.8 is expressed in peripheral sensory neurons including dorsal root ganglion neurons, where its role is to transmit pain signals. By selectively inhibiting NaV1.8 channels, suzetrigine inhibits transmission of pain signals to the spinal cord and brain.*

Approval Criteria:

- Patient has a diagnosis of moderate to severe acute pain; **AND**
- Journavx (suzetrigine) will be used for up to 14 days; **AND**

- Prescriber attests that the member's pain is unable to be managed with an NSAID, acetaminophen, or other non-opioid analgesic; **AND**
- Journavx (suzetrigine) is not being prescribed to treat chronic pain; **AND**
- Journavx (suzetrigine) is not being prescribed to treat pain associated with migraine; **AND**
- Patient does not have severe hepatic impairment (Child-Pugh Class C); **AND**
- Patient has been counseled to avoid food or drink containing grapefruit during treatment with Journavx (suzetrigine); **AND**
- Patient is not concurrently taking a strong CYP3A inhibitor; **AND**
- Patient is not concurrently taking a moderate or strong CYP3A inducer; **AND**
- Patients using hormonal contraceptives containing progestins other than levonorgestrel and norethindrone have been counseled regarding alternative or additional contraception, if appropriate, per product labeling; **AND**
- Patient meets the minimum age recommended by the package insert for the provided indication.

Age Limit: 18 years of age or older

Quantity Limit: 30 tablets per 14 days

Tryngolza™

Non-PDL

Approval Duration: 1 year

- *Olezarsen is an APOC-III-directed antisense oligonucleotide (ASO) indicated as an adjunct to diet to reduce triglycerides in adults with familial chylomicronemia syndrome (FCS).*

Initial Approval Criteria:

- Diagnosis of familial chylomicronemia syndrome (FCS) confirmed by genetic mutations in one of the following:
  - LPL gene
  - APOA5 gene
  - GPIHBP1 gene
  - LMF1 gene
  - APOC2 gene; **AND**
- Patient has a fasting triglyceride level greater than or equal to 880 mg/dL; **AND**
- Patient will follow a low-fat diet of less than or equal to 20 grams of fat per day; **AND**
- Prescribed by, or in consultation with, an endocrinologist, or other specialist in the treatment of familial chylomicronemia syndrome (FCS); **AND**
- Patient meets the minimum age recommended by the package insert for the provided indication.

Renewal Criteria:

- Prescriber attestation of clinically significant improvement or stabilization in the patient's condition.

Age Limit: 18 years of age or older

Quantity Limit: 1 autoinjector per month

Hympavzi™

Non-PDL

Approval Duration: 1 year initial, renewal.

- *Hympavzi is a non-factor, monoclonal antibody targeting and blocking tissue factor pathway inhibitor (TFPI), an anti-clotting protein. It is the first non-factor therapy approved for both hemophilia A and B but limited to only those without inhibitors.*

Initial Approval Criteria:

- Prescribed for the prophylactic treatment in patients with one of the following:
  - Hemophilia A without inhibitors to Factor 8 (FVIII); **OR**
  - Hemophilia B without inhibitors to Factor 9 (FIX).
- Documentation (e.g., an inhibitor lab result within the past year) demonstrating the absence of one of the following:
  - Factor VIII inhibitors for hemophilia A; **OR**
  - Factor IX inhibitors for hemophilia B; **AND**
- Patient meets the minimum age recommended by the package insert for the provided indication.

Renewal Criteria:

- Prescriber attests patient has experienced clinical benefit compared to baseline.
- Documentation (e.g., an inhibitor lab result within the past year) demonstrating the absence of one of the following:
  - Factor VIII inhibitors for hemophilia A; **OR**
  - Factor IX inhibitors for hemophilia B.

Age Limit: 12 years of age or older

Quantity Limit: 300 mg (2mL) per week

Alhemo®

Non-PDL

Approval Duration: 1 year initial, renewal

- *Alhemo is a non-factor, monoclonal antibody targeting and blocking tissue factor pathway inhibitor (TFPI), an anti-clotting protein. Only TFPI antagonist for use in patients WITH inhibitors.*

Initial Approval Criteria:

- Prescribed for the prophylactic treatment in patients with one of the following:
  - Hemophilia A with inhibitors to FVIII; **OR**

- Hemophilia B with inhibitors to FIX.

- Documentation (e.g., an inhibitor lab result within the past year) demonstrating one of the following:
  - Factor VIII inhibitor for hemophilia A; **OR**
  - Factor IX inhibitor for hemophilia B; **AND**
- Patient meets the minimum age recommended by the package insert for the provided indication.

Renewal Criteria:

- Prescriber attests patient has experienced clinical benefit compared to baseline.
- Documentation (e.g., an inhibitor lab result within the past year) demonstrating one of the following:
  - Factor VIII inhibitor for hemophilia A; **OR**
  - Factor IX inhibitor for hemophilia B

Age Limit: 12 years of age or older

FULL CLASS REVIEWS

Narcotics, Long-Acting

Class Selection & Guidelines

- DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Narcotics, Long-Acting class, require PA until reviewed by the P&T Committee.

Preferred Agents	Non-Preferred Agents
BuTrans CC, QL	Belbuca AE, QL
fentanyl patch 12, 25, 50, 75, 100 mcg CC, QL	buprenorphine patch QL
morphine sulfate ER tablet CC, QL	ConZip ER capsule AE, QL
OxyContin ER tablet QL	Diskets
tramadol ER tablet (generic Ultram ER) CC, AE, QL	fentanyl patch 37.5, 62.5, 87.5 mcg QL
	hydrocodone ER capsule QL
	hydrocodone ER tablet QL
	hydromorphone ER tablet QL
	Hysingla ER tablet QL
	methadone dispersible tablet CC
	methadone Intensol oral concentrate CC
	methadone oral concentrate CC
	methadone solution
	methadone tablet
	Methadose oral concentrate
	Methadose tablet

Preferred Agents	Non-Preferred Agents
	morphine sulfate ER capsule QL
	MS Contin ER tablet QL
	oxycodone ER tablet QL
	oxymorphone ER tablet QL
	tramadol ER capsule AE, QL
	tramadol ER tablet (generic Ryzolt) AE, QL

Colony Stimulating Factors

Class Selection & Guidelines

- DMS to select preferred agent(s) based on economic evaluation; however, at least 1 unique chemical entity should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Colony Stimulating Factors class, require PA until reviewed by the P&T Committee.

Preferred Agents	Non-Preferred Agents
Fulphila CC, QL	Granix QL
Fylnetra CC, QL	Leukine QL
Neupogen CC, QL	Neulasta CC, QL
Releuko CC, QL	Neulasta Onpro CC, QL
	Nivestym QL
	Nyvepria CC,QL
	Rolvedon AE, CC, QL
	Stimufend QL
	Udenyca CC, QL
	Zarxio QL
	Ziextenzo CC, QL

Erythropoiesis Stimulating Proteins

Class Selection & Guidelines

- DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Erythropoiesis Stimulating Proteins class, require PA until reviewed by the P&T Committee.

Preferred Agents	Non-Preferred Agents
Aranesp CC	Jesduvroq CC, QL
Epogen CC	Procrit
Mircera CC	Reblozyl CC, AE
Retacrit CC ***(all manufacturers)***	Vafseo

Phosphate Binders

Class Selection & Guidelines

- DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Phosphate Binders class, require PA until reviewed by the P&T Committee.

Preferred Agents	Non-Preferred Agents
calcium acetate capsule, tablet	Auryxia
Phoslyra solution	ferric citrate tablet
sevelamer carbonate powder packet, tablet	Fosrenol chewable tablet, powder packet
	lanthanum carbonate chewable tablet
	Renagel
	Renvela powder packet, tablet
	Velphoro
	Xphozah CC, AE, QL

Insulins & Related Agents

Class Selection & Guidelines

- DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Insulins & Related Agents class, require PA until reviewed by the P&T Committee.

RAPID- AND SHORT-ACTING INSULINS

Preferred Agents	Non-Preferred Agents
Humulin R vial	Admelog and Admelog Solostar CC
Humulin R U-500 vial and KwikPen	Afrezza
insulin aspart cartridge, vial, and pen	Apidra vial and Solostar
insulin lispro pen, vial, and Jr. KwikPen	Fiasp vial, pen, pumpcart, and FlexTouch CC
	Humalog 200 unit/mL KwikPen
	Humalog cartridge, vial, and KwikPen
	Humalog Junior (Jr) KwikPen
	Humalog Tempo Pen
	Lyumjev pen, Tempo Pen, and vial CC
	Novolin R vial, pen
	Novolog vial, cartridge, and FlexPen
	Symlin AE, CC

INTERMEDIATE-ACTING INSULINS

Preferred Agents	Non-Preferred Agents
Humalog Mix 50-50 KwikPen	***Humalog Mix vial and KwikPen***
Humulin 70/30 vial and KwikPen	Humulin N KwikPen
Humulin N vial	Novolin 70/30 vial, pen
insulin aspart/insulin aspart protamine penvial	Novolin N pen
insulin lispro/insulin lispro protamine KwikPen	Novolog Mix via
insulin lispro protamine mix	
Novolin N vial	
Novolog Mix FlexPen	

LONG-ACTING INSULINS

Preferred Agents	Non-Preferred Agents
Insulin glargine vial	Basaglar KwikPen, Tempo Pen CC
insulin glargine Solostar U100 (generic for Lantus Solostar)	insulin degludec pen and vial
Lantus and Lantus Solostar	insulin glargine Solostar and Max Solostar (generic for Toujeo)
Levemir vial, FlexTouch, Flexpen	insulin glargine-yfgn pen and vial CC
	Rezvoglar Kwikpen
	Semglee (yfgn) pen and vial CC
	Toujeo Solostar and Max Solostar
	Tresiba vial, FlexTouch

Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors

Class Selection & Guidelines

- DMS to select preferred agent(s) based on economic evaluation; however, at least 1 unique chemical entity should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Sodium Glucose Co-Transporter 2 (SGLT2) Inhibitors class, require PA until reviewed by the P&T Committee.

Preferred Agents	Non-Preferred Agents
Farxiga CC, QL	dapagliflozin QL
Jardiance CC, QL	dapagliflozin-metformin ER QL
Synjardy CC, QL	Inpefa CC, AE, QL
Xigduo XR CC, QL	***Invokamet*** CC, QL
	Invokamet XR QL
	Invokana CC, QL
	Segluromet AE, QL
	Steglatro AE, QL

	Synjardy XR QL

Growth Hormones

Class Selection & Guidelines

- DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Growth Hormones class, require PA until reviewed by the P&T Committee.

Preferred Agents	Non-Preferred Agents
Genotropin cartridge, syringe CC	Humatrope cartridge CC
Norditropin Flexpro CC	Ngenla CC, AE
Skytrofa cartridge CC	***Nutropin AQ NuSpin*** CC
	Omnitrope cartridge, vial CC
	Serostim vial CC
	Sogroya CC, QL
	Zomacton vial CC

CONSENT AGENDA REVIEWS

For the following therapeutic classes, the P&T Committee had no recommended changes to the currently posted Preferred Drug List (PDL) status. However, the **Glucagon Agent** therapeutic class was removed from the consent agenda pursuant to committee recommended changes.

Therapeutic Classes
• **Narcotic Agonist/Antagonists**
• **Narcotics, Fentanyl Buccal Products**
• **Narcotics, Short-Acting**
• **Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)**
• **Opiate Dependence Treatments**
• **Antihyperuricemics**
• **Sickle Cell Anemia Treatments**
• **Thrombopoiesis Stimulating Proteins**
• **Alpha-Glucosidase Inhibitors**
• **Dipeptidyl Peptidase-4 (DPP-4) Inhibitors**
• **Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists**
• **Meglitinides**
• **Metformins**
• **Sulfonylureas**
• **Thiazolidinediones (TZDs)**
• **Androgenic Agents**
• **Bone Resorption Suppression & Related Agents**

Therapeutic Classes
• Pancreatic Enzymes • Progestins for Cachexia • Steroids, Oral • Uterine Disorder Treatments