# 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 **October 14, 2025**, and the resulting official recommendations.

## NEW PRODUCTS TO MARKET

**Zelsuvmi™ (berdazimer)**

**Dermatologics – Topical Antiviral Agents: Non-Preferred**

**Approval Duration:** 3 months

- *Berdazimer is a nitric oxide releasing agent. Although the exact mechanism of action is unknown, nitric oxide release may interfere with viral replication, inhibiting the molluscum contagiosum virus (MCV) by disrupting viral DNA synthesis and assembly.*

**Approval Criteria:**
- Diagnosis of molluscum contagiosum (MC); **AND**
- Prescribed by, or in consultation with, a dermatologist; **AND**
- Patient has had a trial and failure (at least 3 months) of ≥ 1 of the following conventional therapies:
  - Cantharidin,
  - Silver nitrate,
  - Cryotherapy,
  - Curettage; **AND**
- Patient meets one of the following:
  - Patient has atopic dermatitis (AD); **OR**
  - Patient is immunocompromised; **OR**
  - Patient has concomitant bacterial infection; **AND**
- Patient is not on concurrent treatment for MC; **AND**
- Patient meets the minimum age recommended by the package insert for the provided indication.

**Age Limit:** 1 year of age or older

**Quantity Limit:** 1 kit (31 grams) per month

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**Vykat™ XR (diazoxide choline)**

**Non-PDL**

**Approval Duration:** 12 months initial, renewal

- *The mechanism of action of diazoxide choline in the treatment of hyperphagia in patients with Prader-Willi syndrome is unknown.*

**Approval Criteria:**
- Diagnosis of hyperphagia; **AND**
- Clinical confirmation of Prader-Willi Syndrome (PWS) documented by a genetic test identifying abnormal DNA methylation of chromosome 15q11.2Q13 region; **AND**
- Prescribed by, or in consultation with, an endocrinologist, geneticist, or other specialist in the treatment of PWS; **AND**

- Patient has had a baseline fasting plasma glucose (FPG) and HbA1c performed; **AND**
- Prescriber attests to monitoring the following during treatment:
  - FPG as clinically indicated; **AND**
  - HbA1c as clinically indicated; **AND**
  - Signs or symptoms of edema; **AND**
- Patient meets the minimum age recommended by the package insert for the provided indication.

**Quantity Limit:**
- 150 mg tablets: 3 per day
- 75 mg tablets: 3 per day
- 25 mg tablets: 2 per day

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**Tryptyr® (acoltremon)**

**Ophthalmic – Immunomodulators: Non-Preferred**

**Approval Duration:** 3 months initial, 12 months renewal

- *Acoltremon is an agonist of transient receptor potential melastatin 8 (TRPM8) thermoreceptors. TRPM8 thermoreceptor stimulation has been shown to activate trigeminal nerve signaling, leading to increased basal tear production.*

**Initial Approval Criteria:**
- Patient has diagnosis of dry eye disease (DED); **AND**
- Prescribed by or in consultation with an ophthalmologist or optometrist; **AND**
- Patient has had a trial and failure of preservative-free, nonprescription lubricating eye drops (e.g., artificial tears); **AND**
- Patient has had ≥ 1 month trial and therapeutic failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance of 2 preferred agents; **AND**
- Prescriber has documented at least 1 of the following signs of DED:
  - Corneal fluorescein staining (CFS) score of ≥ 2 points in any field on a 0-to-4-point scale; **OR**
  - Schirmer tear test (STT) of 1 to 10 mm in 5 minutes.
- Patient meets the minimum age recommended by the package insert for the provided indication.

**Renewal Criteria:**
- Patient continues to meet the above criteria; **AND**
- Patient has improvement in signs of DED, as measured by at least 1 of the following:
  - Decrease in corneal fluorescein staining score; **OR**
  - Increase in number of mm per 5 minutes using Schirmer tear test.

**Age Limit:** 18 years of age or older

**Quantity Limit:** 60 vials per 30 days

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**Andembry® (garadacimab-gxii)**

**Non-PDL**

**Approval Duration:** 6 months initial, 12 months renewal

- *Garadacimab-gxii is a monoclonal antibody that blocks the function of activated factor XII (7), which prevents the overactivation of the kallikrein-kinin system and overproduction of bradykinin reducing or preventing hereditary*

*angioedema (HAE) attacks. It is indicated for prophylactic treatment of C1-INH HAE in patients aged 12 years and older.*

**Initial Approval Criteria:**
- Diagnosis of hereditary angioedema (HAE); **AND**
- Documentation of confirmed diagnosis of HAE by one of the following tests:
  - Complement testing, **OR**
  - C1 Inhibitor protein and functional tests; **AND**
- Prescribed for prophylactic use; **AND**
- Prescribed by, or in consultation with, an immunologist, hematologist, or other specialist in the diagnosis and treatment of HAE; **AND**
- Patient is not on concurrent treatment with alternative prophylactic agent for HAE (e.g., Takhzyro, Haegarda, Cinryze, Dawnzera, Orladeyo); **AND**
- Patient meets the minimum age recommended by the package insert for this FDA-approved indication.

**Renewal Criteria:**
- Prescriber attestation of improvement compared to baseline in hereditary angioedema attacks (i.e., reductions in attack frequency or attack severity).

**Quantity Limit:** 1.2 mL (200 mg) per month

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**Sephience™ (sepiapterin)**

**Non-PDL**

**Approval Duration:** 1 month initial, 12 months renewal

- *Sepiapterin acts as a precursor to enzymatic co-factor tetrahydrobiopterin (BH4), a natural cofactor that enhances the activity of phenylalanine hydroxylase (PAH), thereby reducing Phe levels.*

**Initial Approval Criteria:**
- Confirmed diagnosis of phenylketonuria (PKU) with elevated blood phenylalanine (Phe) levels; **AND**
- Prescribed by, or in consultation with, a metabolic disease expert or other specialist in the management of PKU; **AND**
- Provider attests that that the patient is on, and will continue, a phenylalanine-restricted diet supervised by a metabolic disease specialist or knowledgeable healthcare provider; **AND**
- Provider attests to the presence of a monitoring plan for dietary intake; **AND**
- Provider attests that the patient will have regular blood Phe level assessments as clinically indicated; **AND**
- The requested dose does not exceed the maximum FDA-approved dose for this condition based on patient weight.

**Renewal Criteria:**
- Patient must continue to meet initial approval criteria; **AND**
- Prescriber provides documentation (e.g., chart notes or summary) confirming sustained biochemical response, defined as continued ≥ 30% reduction in blood phenylalanine (Phe) levels.

**Age Limit:** 1 month of age or older

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**Anzupgo® (delgocitinib)**

**Immunomodulators – Atopic Dermatitis: Non-Preferred**

- *Delgocitinib is a Janus kinase (JAK) inhibitor that specifically targets JAK1, JAK2, JAK3, and tyrosine kinase 2 (TYK2) to offer broad JAK inhibition. Thereby preventing downstream signaling and subsequent inflammation at the site of action.*

**Initial Approval Criteria**
- Diagnosis of moderate to severe chronic hand eczema (CHE); **AND**
- Documentation of Investigator's Global Assessment for Chronic Hand Eczema (IGACHE) with a score ≥ 3; **AND**
- Prescribed by, or in consultation with, a dermatologist, allergist/immunologist, or other specialist in the treatment of chronic hand eczema; **AND**
- Trial and failure, contraindication, or intolerance to ≥ 1 agent in 2 or more of the following categories (total prior agent use of ≥ 90 days):
  - Topical corticosteroid of medium to high potency (e.g., mometasone, fluocinolone); **AND**
  - Topical calcineurin inhibitor (i.e., tacrolimus or pimecrolimus); **OR**
  - Immunosuppressive systemic agent (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil); **AND**
- Trial and failure, contraindication, or intolerance to preferred JAK inhibitor (e.g., Opzelura); **AND**
- No concurrent use of other biologics or JAK inhibitors or immunosuppressants; **AND**
- Patient must meet 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 and/or stabilization based on an objective measure.

**Quantity Limit**: 30 grams per month

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**Ekterly® (sebetralstat)**

**Non-PDL**

**Approval Duration:** 6 months initial, renewal

- *Sebetralstat is a competitive, reversible inhibitor of plasma kallikrein that reduces production of bradykinin to treat acute, episodic attack of HAE.*

**Approval Criteria**
- Diagnosis of hereditary angioedema (HAE); **AND**
- Documentation of confirmed diagnosis of HAE by one of the following tests:
  - Complement testing, **OR**
  - C1 Inhibitor protein and functional tests; **AND**
- Prescribed by, or in consultation with, an immunologist, hematologist, or other specialist in the diagnosis and treatment of HAE; **AND**
- Patient is not on concurrent acute treatment for HAE (e.g., Ruconest, Berinert, Kalbitor, Firazyr); **AND**
- Patient meets the minimum age recommended by the package insert for this FDA-approved indication.

**Renewal Criteria**
- Prescriber attestation of improvement compared to baseline in hereditary angioedema attacks (i.e., reductions in attack frequency or attack severity).

**Quantity Limit:** 4 tablets per day

## FULL CLASS REVIEWS

### Acne Agents, Oral

#### 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 Acne Agents, Oral class, require PA until reviewed by the P&T Committee.

| Preferred Agents | Non-Preferred Agents |
|---|---|
| Amnesteem | Absorica |
| Claravis | Absorica LD |
| Zenatane | isotretinoin 25 mg, 35 mg capsule |
| ***isotretinoin 10 mg, 20 mg, 30 mg, 40 mg capsule*** | |

### Antiemetics and Antivertigo 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 Antiemetics and Antivertigo Agents class, require PA until reviewed by the P&T Committee.

| Preferred Agents | Non-Preferred Agents |
|---|---|
| aprepitant capsule, capsule dose pack QL | Akynzeo capsule QL |
| Diclegis tablet CC, QL | Antivert chewable tablet, tablet |
| dronabinol capsule CC, QL | Anzemet tablet |
| meclizine tablet | ***Bonjesta tablet*** |
| metoclopramide solution, tablet | Compro suppository |
| ondansetron ODT, solution, tablet | doxylamine/pyridoxine tablet CC, QL |
| prochlorperazine tablet | Emend capsule, capsule dose pack, suspension QL |
| promethazine 12.5 mg, 25 mg suppository | Gimoti nasal spray AE, CC, QL |
| promethazine syrup, tablet | granisetron tablet |
| Promethegan 12.5 mg, 25 mg suppository | Marinol capsule CC, QL |
| scopolamine patch | prochlorperazine suppository |

| Preferred Agents | Non-Preferred Agents |
|---|---|
| | Promethegan 50 mg suppository |
| | Reglan tablet |
| | Sancuso patch CC, QL |
| | Transderm-Scop patch |
| | trimethobenzamide capsule |

## Cytokine and Cell-Adhesion Molecule (CAM) Antagonists

### Class Selection & Guidelines

- DMS to select preferred agent(s) based on economic evaluation; however, at least 2 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 Cytokine and Cell-Adhesion Molecule (CAM) Antagonists class, require PA until reviewed by the P&T Committee.

| Preferred Agents | Non-Preferred Agents |
|---|---|
| ***adalimumab-aaty*** CC, QL | Abrilada CC, QL |
| Enbrel CC, QL | Actemra CC, QL |
| Hadlima CC, QL | adalimumab-aacf CC, QL |
| Humira CC, QL | adalimumab-adaz CC, QL |
| Otezla CC, QL | adalimumab-adbm CC, QL |
| ***Pyzchiva*** CC, QL | adalimumab-fjkp CC, QL |
| Rinvoq AE, CC, QL | adalimumab-ryvk CC, QL |
| Rinvoq LQ AE, CC, QL | Amjevita CC, QL |
| ***Taltz*** CC, QL | Avsola vial CC |
| Tyenne CC, QL | Bimzelx AE, CC, QL |
| Xeljanz CC, QL | Cibinqo CC, QL |
| ***Yesintek*** CC, QL | Cimzia CC, QL |
| ***Yuflyma*** CC, QL | ***Cosentyx*** CC, QL |
| | Cyltezo CC, QL |
| | Enspryng AE, CC, QL |
| | Entyvio pen CC, QL |
| | Entyvio vial CC |
| | Hulio CC, QL |
| | Hyrimoz CC, QL |
| | Idacio CC, QL |
| | Ilaris CC, QL |

| Preferred Agents | Non-Preferred Agents |
|---|---|
| | Ilumya AE, CC, QL |
| | Imuldosa CC, QL |
| | Inflectra vial CC |
| | Infliximab vial CC |
| | Kevzara AE, CC, QL |
| | Kineret CC, QL |
| | Olumiant AE, CC, QL |
| | Omvoh AE, CC, QL |
| | Orencia CC, QL |
| | Otulfi CC, QL |
| | Remicade vial CC |
| | Renflexis vial CC |
| | Selarsdi CC, QL |
| | Siliq AE, CC, QL |
| | Simponi CC, QL |
| | Simponi Aria AE, CC, QL |
| | Simlandi CC, QL |
| | Skyrizi AE, CC, QL |
| | Sotyktu AE, CC, QL |
| | Stelara CC, QL |
| | Steqeyma CC, QL |
| | Tremfya AE, CC, QL |
| | ustekinumab CC, QL |
| | ustekinumab-aekn CC, QL |
| | ustekinumab-ttwe CC, QL |
| | Velsipity AE, CC, QL |
| | Xeljanz XR CC, QL |
| | Yusimry CC, QL |
| | Zymfentra CC, QL |

## Immunomodulators, Atopic Dermatitis

### 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 Immunomodulators, Atopic Dermatitis class, require PA until reviewed by the P&T Committee.

| Preferred Agents | Non-Preferred Agents |
|---|---|
| Adbry autoinjector AE, CC, QL | Elidel |
| Adbry syringe AE, CC, QL | ***Opzelura cream*** ***AE, CC, QL*** |
| Dupixent pen CC, QL | Vtama AE, CC, QL |
| Dupixent syringe CC, QL | |
| ***Ebglyss*** ***AE, CC, QL*** | |
| Eucrisa CC, QL | |
| ***Nemluvio*** ***AE, CC, QL*** | |
| pimecrolimus cream | |
| tacrolimus ointment | |

## Stimulants and 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 Stimulants & Related Agents class, require PA until reviewed by the P&T Committee.

| Preferred Agents | Non-Preferred Agents |
|---|---|
| Adderall XR capsule CC, QL | Adderall capsule QL |
| atomoxetine capsule CC, QL | Adzenys XR-ODT tablet AE, CC, QL |
| clonidine ER tablet CC, QL | amphetamine sulfate tablet QL |
| Concerta tablet CC, QL | Aptensio XR sprinkle capsule QL |
| dexmethylphenidate ER tablet CC, QL | Azstarys capsule QL |
| dexmethylphenidate tablet CC, QL | Cotempla XR-ODT tablet AE, QL |
| dextroamphetamine sulfate tablet CC, QL | Daytrana patch QL |
| dextroamphetamine/amphetamine ER capsule CC, QL | Desoxyn tablet QL |
| dextroamphetamine/amphetamine tablet CC, QL | Dexedrine capsule ER QL |
| dextroamphetamine sulfate 5 mg, 10 mg, 15 mg | dextroamphetamine ER capsule QL |
| guanfacine ER tablet CC, QL | dextroamphetamine solution QL |
| ***Jornay PM capsule*** ***AE, QL*** | dextroamphetamine sulfate tablet 2.5 mg, 7.5 mg, 20 mg, 30 mg QL |
| Methylin solution CC, QL | Dyanavel XR suspension AE, QL |
| methylphenidate solution CC, QL | Dyanavel XR tablet AE, QL |

| Preferred Agents | Non-Preferred Agents |
|---|---|
| methylphenidate ER tablet 10 mg, 20 mg CC, QL | Evekeo ODT QL |
| methylphenidate tablet CC, QL | Evekeo tablet QL |
| Qelbree ER capsule CC, QL | Focalin tablet QL |
| Vyvanse capsule CC, QL | Focalin XR capsule QL |
| Vyvanse chewable tablet CC, QL | Intuniv ER tablet QL |
| | lisdexamfetamine capsule QL |
| | lisdexamfetamine chewable tablet QL |
| | methamphetamine tablet QL |
| | methylphenidate CD capsule QL |
| | methylphenidate ER capsule QL |
| | methylphenidate ER tablet 18 mg, 27 mg, 36 mg, 54 mg, 63 mg, 72 mg tablet QL |
| | methylphenidate ER sprinkle capsule QL |
| | methylphenidate LA capsule QL |
| | methylphenidate ER OROS QL |
| | methylphenidate chewable tablet QL |
| | methylphenidate patch QL |
| | Mydayis ER capsule AE, QL |
| | Onyda XR suspension AE, QL |
| | ProCentra solution QL |
| | QuilliChew ER tablet AE, QL |
| | Quillivant XR QL |
| | Relexxii tablet QL |
| | Ritalin LA capsule QL |
| | Ritalin tablet QL |
| | Strattera capsule QL |
| | Xelstrym patch QL |
| | Zenzedi QL |

## Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists

### 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 Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists class, require PA until reviewed by the P&T Committee.

| Preferred Agents | Non-Preferred Agents |
|---|---|
| Byetta CC, QL | Bydureon BCise QL |
| Ozempic AE, CC, QL | exenatide CC, QL |
| Trulicity CC, QL | liraglutide CC, QL |
| Victoza CC, QL | Mounjaro AE, QL |
| | Rybelsus CC, QL |
| | Soliqua AE, CC, QL |
| | Xultophy AE, CC, QL |

***The committee voted to postpone review of the Glucagon-Like Peptide-1 (GLP-1) Receptor Antagonists until the next P&T meeting in January.***

## Antivirals, Oral

### 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 Antivirals, Oral class, require PA until reviewed by the P&T Committee.

### Antivirals: Herpes

| Preferred Agents | Non-Preferred Agents |
|---|---|
| acyclovir | Valtrex |
| famciclovir | Zovirax oral suspension |
| valacyclovir | |

### Antivirals: Influenza

| Preferred Agents | Non-Preferred Agents |
|---|---|
| oseltamivir QL | Flumadine |
| | Relenza |
| | rimantadine |
| | Tamiflu QL |
| | Xofluza AE, CC, QL |

### Antivirals: COVID-19

| Preferred Agents | Non-Preferred Agents |
|---|---|
| ***Paxlovid*** | |

## Chronic Obstructive Pulmonary Disease (COPD) 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 Chronic Obstructive Pulmonary (COPD) Agents class, require PA until reviewed by the P&T Committee.

| Preferred Agents | Non-Preferred Agents |
|---|---|
| albuterol-ipratropium inhalation solution QL | Bevespi Aerosphere QL |
| Anoro Ellipta QL | Daliresp tablet AE, CC, QL |
| Atrovent HFA QL | Duaklir Pressair |
| Breztri Aerosphere AE, QL | Incruse Ellipta QL |
| Combivent Respimat QL | Ohtuvayre AE, CC, QL |
| ipratropium inhalation solution QL | Spiriva Respimat QL |
| roflumilast tablet CC, QL | tiotropium QL |
| Spiriva Handihaler QL | Tudorza Pressair QL |
| Stiolto Respimat QL | umeclidinium-vilanterol QL |
| ***Trelegy Ellipta*** ***AE, CC, QL*** | Yupelri solution AE, CC, QL |

## 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 **Laxatives and Cathartics** therapeutic class was removed from the consent agenda pursuant to committee-recommended changes.

| Therapeutic Classes |
|---|
| • **Acne Agents, Topical**<br>• **Antibiotics, Topical**<br>• **Antifungals, Topical**<br>• **Antiparasitics, Topical**<br>• **Antipsoriatics, Oral**<br>• **Antipsoriatics, Topical**<br>• **Antivirals, Topical**<br>• **Rosacea Agents, Topical**<br>• **Steroids, Topical**<br>• **Anticholinergics/Antispasmodics**<br>• **Antidiarrheals**<br>• **Anti-Ulcer Protectants**<br>• **Bile Salts** |

| Therapeutic Classes |
| --- |
| • GI Motility, Chronic<br>• H. Pylori Treatment<br>• Histamine II Receptor Blockers<br>• Proton Pump Inhibitors<br>• Ulcerative Colitis Agents<br>• Immunomodulators, Asthma<br>• Immunosuppressives, Oral<br>• Multiple Sclerosis Agents<br>• Muscular Dystrophy Agents<br>• Spinal Muscular Atrophy<br>• Ophthalmics, Antibiotics<br>• Ophthalmics, Antibiotic-Steroid Combinations<br>• Ophthalmics, Antihistamines<br>• Ophthalmics, Anti-Inflammatory Steroids<br>• Ophthalmics, Antivirals<br>• Ophthalmics, Beta Blockers<br>• Ophthalmics, Carbonic Anhydrase Inhibitors<br>• Ophthalmics, Combinations for Glaucoma<br>• Ophthalmics, Glaucoma Agents (Other)<br>• Ophthalmics, Immunomodulators<br>• Ophthalmics, Mast Cell Stabilizers<br>• Ophthalmics, Mydriatic<br>• Ophthalmics, NSAIDs<br>• Ophthalmics, Prostaglandin Agonists<br>• Ophthalmics, Sympathomimetics<br>• Otics, Anesthetics and Anti-Inflammatories<br>• Otic Antibiotics |