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 **January 28, 2025**, and the resulting official recommendations.

NEW PRODUCTS TO MARKET

Cobenfy™

Central Nervous System – Antipsychotics, Second Generation (Atypical) and Injectable: Non-Preferred

Approval Duration: 1 year

- *Xanomeline is a M1 and M4 muscarinic acetylcholine receptor agonist in the central nervous system, influencing dopaminergic activity. Trospium is a muscarinic antagonist in the peripheral tissues, mitigating xanomeline's side effects.*

Initial Approval Criteria:

- Diagnosis of schizophrenia; **AND**
- Trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to one preferred agent; **AND**
- Prescriber attests that liver enzymes and bilirubin were measured prior to initiation; **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 clinical signs and symptoms.

Age Limit: 18 years of age or older
Quantity Limit: 2 capsules per day

Preferred Agents	Non-Preferred Agents
aripiprazole tablet CC, QL	Abilify MyCite starter kit CC, QL
asenapine tablet CC, QL	Abilify MyCite maintenance kit CC, QL
clozapine tablet CC, QL	Abilify tablet QL
lurasidone tablet CC, QL	aripiprazole ODT
olanzapine ODT CC, QL	aripiprazole solution
olanzapine tablet CC, QL	Caplyta capsule CC, QL
quetiapine tablet CC, QL	clozapine ODT QL
quetiapine ER tablet CC, QL	Clozaril tablet QL
risperidone ODT CC, QL	***Cobenfy capsule AE, CC, QL***
risperidone solution CC, QL	Fanapt tablet dose pack QL
risperidone tablet CC, QL	Fanapt tablet QL
Vraylar capsule dose pack AE, CC, QL	Geodon capsule QL

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Preferred Agents	Non-Preferred Agents
Vraylar capsule AE, CC, QL	Invega ER tablet QL
ziprasidone capsule CC, QL	Latuda tablet QL
	Lybalvi tablet AE, CC, QL
	Nuplazid capsule CC, QL
	Nuplazid tablet CC, QL
	olanzapine/fluoxetine capsule CC, QL
	Opipza film CC, QL
	paliperidone ER tablet QL
	Rexulti tablet QL
	Risperdal solution QL
	Risperdal tablet QL
	Saphris SL tablet QL
	Secuado patch QL
	Seroquel tablet QL
	Seroquel XR tablet QL
	Symbyax capsule CC, QL
	Versacloz suspension QL
	Zyprexa tablet QL
	Zyprexa Zydis ODT QL

Livdelzi®

Gastrointestinal, Bile Salts: Non-Preferred

Approval Duration: 1 year

- *Seladelpar decreases bile acid synthesis by activating peroxisome proliferator-activated receptor (PPAR)-delta. This causes downregulation of CYP7A1, an enzyme used to synthesize bile acids from cholesterol, through Fibroblast Growth Factor 21 (FGF21).*

Initial Approval Criteria:

- Diagnosis of primary biliary cholangitis (PBC); **AND**
- Prescribed by, or in consultation with, a gastroenterologist, hepatologist, or other disease state specialist; **AND**
- Patient meets one of the following:
  - Patient has had a 12-month trial and failure of ursodiol, and will take Livdelzi in addition to current therapy; **OR**
  - Patient has a contraindication or intolerance to ursodiol and will take Livdelzi as monotherapy; **AND**
- Patient has an alkaline phosphatase (ALP) level greater than 200 IU/L; **AND**
- Patient does not have decompensated cirrhosis; **AND**
- Patient meets the minimum age recommended by the package insert for the provided indication.

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Renewal Criteria:

- Documentation (e.g., progress notes, labs) of improvement or stabilization in alkaline phosphatase (ALP); **AND**
- Patient meets one of the following:
  - Patient has had a 12-month trial and failure of ursodiol and will take Livdelzi in addition to current therapy; **OR**
  - Patient has a contraindication or intolerance to ursodiol and will take Livdelzi as monotherapy.

Age Limit: 18 years of age or older
Quantity Limit: 1 capsule per day

Preferred Agents	Non-Preferred Agents
ursodiol capsule	Bylvay capsule CC, QL
ursodiol tablet	Bylvay pellet CC, QL
	Chenodal tablet
	Cholbam capsule
	Iqirvo tablet CC, QL
	Livdelzi ***AE, CC, QL***
	Livmarli solution CC, QL
	Ocaliva tablet CC, QL, AE
	Reltone capsule
	Urso Forte tablet
	Urso tablet

Vyalev™

Central Nervous System – Parkinson's Disease (Antiparkinson's Agents): Non-Preferred

Approval Duration: 1 year

- *Foscarbidopa and foslevodopa are prodrugs that are converted to carbidopa and levodopa in vivo. Carbidopa inhibits peripheral levodopa from decarboxylation, allowing more levodopa to be delivered to the brain, where it is converted to dopamine.*

Initial Approval Criteria:

- Diagnosis of Parkinson's disease (PD); AND
- Receiving PD therapy with carbidopa/levodopa; AND
- Experiencing "off" episodes with carbidopa/levodopa for at least 2 hours per day; AND
  - Trial and failure of at least 2 adjunctive therapies, such as: Dopamine agonists (e.g., pramipexole, ropinirole)
  - Monoamine oxidase-B inhibitors (e.g., selegiline)
  - Catechol-O-methyltransferase inhibitors (e.g., entacapone); **AND**
- Patient will not take within two weeks of a non-selective monoamine oxidase (MAO) inhibitor (e.g., phenelzine, isocarboxazid, tranylcypromine); **AND**

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- Patient meets the minimum age recommended by the package insert for the provided indication.

Renewal Criteria:

- Patient has clinically meaningful response of treatment (e.g., patient shows a reduction in time of "off" episodes).

Age Limit: 18 years of age or older
Quantity Limit: 2 vials (20 mL) per day

Preferred Agents	Non-Preferred Agents
amantadine capsule	Azilect tablet
amantadine solution	carbidopa tablet
amantadine tablet	Comtan tablet
benztropine tablet	Crexont IR ER capsule
carbidopa/levodopa ER tablet	Dhivy tablet
carbidopa/levodopa ODT	Duopa suspension
carbidopa/levodopa tablet	Gocovri capsule
carbidopa/levodopa/entacapone tablet	Inbrija inhalation
entacapone tablet	Kynmobi film CC, QL
selegiline capsule	Lodosyn tablet
selegiline tablet	Nourianz tablet CC QL
trihexyphenidyl solution	Ongentys capsule CC, QL
trihexyphenidyl tablet	Osmolex ER tablet
	rasagiline tablet
	Rytary ER capsule
	Sinemet tablet
	Stalevo tablet
	Tasmar tablet
	Vyalev vial *AE, CC, QL*
	Xadago CC, QL
	Zelapar ODT

Ebglyss™

Immunomodulators – Atopic Dermatitis: Non-Preferred

Approval Duration: 4 months initial, 1 year renewal

- *Lebrikizumab-lbkz is an IgG4 monoclonal antibody that binds to and allows interleukin (IL)-13 to bind to IL-13R-α1, but inhibits human IL-13 signaling. IL-13 is a cytokine involved in type 2 inflammation seen in atopic dermatitis.*

Initial Approval Criteria:

- Diagnosis of moderate-to-severe atopic dermatitis (AD) with ≥ 1 of the following:
  - Involvement of at least 10% of body surface area (BSA); **OR**

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- Scoring Atopic Dermatitis (SCORAD) score of 25 or more; **OR** Investigator's Global Assessment (IGA) with a score ≥ 3; **OR**
- Eczema Area and Severity Index (EASI) score of ≥ 16; **OR**
- Incapacitation due to AD lesion location (e.g., head and neck, palms, soles, or genitalia); **AND**

- Prescribed by, or in consultation with, a dermatologist, allergist/immunologist, or other specialist in the treatment of atopic dermatitis; **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) unless inappropriate for the location (e.g., face, groin); **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 at least one preferred injectable agent (Adbry or Dupixent); **AND**
- Patient must meet the minimum age and weight 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.

Age Limit: 12 years of age or older
Quantity Limit: 1 pen/syringe (2 mL) per 28 days

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

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Xdemvy™

Non-PDL

Approval Duration: 3 months initial, 1 year renewal

- *Lotilaner is an inhibitor of the gamma-aminobutyric acid (GABA)-gated chloride channel. This drug is selective for channels present in mites, causing a paralytic action leading to death.*

Initial Approval Criteria:
- Diagnosis of Demodex Blepharitis; **AND**
- Prescribed by, or in consultation with, an ophthalmologist or other specialist for the requested condition; **AND**
- Prescriber attests that the patient currently has active disease.

Renewal Criteria:
- Patient has a diagnosis of Demodex Blepharitis [H01.00]; **AND**
- Prescribed by, or in consultation with, an ophthalmologist or other specialist for the requested condition; **AND**
- Prescriber attests patient has experienced a response to previous therapy.

Age Limit: 18 years of age or older
Quantity Limit: 1 bottle (10 mL) per month

Yorvipath™

Non-PDL

Approval Duration: 6 months initial, 1 year renewal

- *Palopegteriparatide mimics endogenous parathyroid hormone to increase serum calcium and decrease serum phosphate. This drives homeostasis and a number of downstream effects, such as maintaining appropriate laboratory levels and stimulating bone turnover.*

Initial Approval Criteria:
- Diagnosis of hypoparathyroidism; **AND**
- Prescriber attests that this medication is NOT being prescribed for acute hypoparathyroidism post-surgery; **AND**
- Patient has not received therapy with parathyroid hormone analogs (e.g. abaloparatide, teriparatide) for 24 months or more (lifetime cumulative); **AND**
- Documentation that the following labs are within normal limits:
    - **Corrected Serum Calcium:** 7.8-10.2 mg/dL; **AND**
    - **Serum Phosphate:** 2.5-4.5 mg/dL; **AND**

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- Prescriber attestation that the patient is not well-controlled despite appropriate utilization (trial and failure of 3 months) of calcium and active forms of vitamin D; **AND**
- Prescribed by, or in consultation with, an endocrinologist or other specialist for the requested condition.

Renewal Criteria:
- Patient continues to have the above listed diagnosis; **AND**
- Prescribed by, or in consultation with, an endocrinologist or other specialist for the requested condition; **AND**
- Documentation (e.g., progress note) of response to therapy.

Age Limit: 18 years of age or older
Quantity Limit: 2 pens per month

Duvyzat™

Muscular Dystrophy Agents: Nonpreferred

Approval Duration: 6 months initial, 1 year renewal

- *Givinostat is a histone deacetylase inhibitor. The precise mechanism by which givinostat exerts its effect in patients with DMD is unknown.*

Initial Approval Criteria:
- Diagnosis of Duchenne muscular dystrophy (DMD) [G71.01]; **AND**
- Platelet count within the last 30 days equals to or is greater than 150 x 10^9/L; **AND**
- Prescribed by, or in consultation with, a neuromuscular specialist with expertise in the treatment of DMD; **AND**
- Patient is ambulatory (e.g., ability to walk with or without assistive devices, not wheelchair dependent); **AND**
- Patient's baseline ambulatory function has been or will be assessed prior to therapy initiation; **AND**
  Patient has been on a stable systemic corticosteroid therapy for at least 6 months and will continue to be on the systemic corticosteroid therapy unless contraindicated or clinically significant adverse effects are experienced; **AND**
- Prescriber provides a patient weight obtained within the past 3 months; **AND**
- The requested dose meets the FDA-approved dosing recommendation.

Renewal Criteria:
- Documentation (e.g., progress note) of stabilized or improved ambulatory function from baseline; **AND**
- Patient will continue systemic corticosteroid therapy unless contraindicated or clinically significant adverse effects are experienced; **AND**
- Prescriber provides a patient weight obtained within the past 3 months; **AND**
- The requested dose meets the FDA-approved dosing recommendation.

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Age Limit: 6 years of age or older
Quantity Limit: 12 mL per day

Preferred Agents	Non-Preferred Agents
Emflaza suspension AE, CC	Agamree suspension AE, CC, QL
Emflaza tablet AE, CC, QL	deflazacort suspension AE, CC
	deflazacort tablet AE, CC, QL
	Duvyzat ***AE, CC, QL***

Nemluvio®

Immunomodulators, Atopic Dermatitis Class: Nonpreferred

Approval Duration: 4 months initial, 1 year renewal

- *Nemolizumab-ilto is a humanized IgG2 monoclonal antibody that inhibits IL-31 signaling by binding selectively to IL-31 RA. IL-31 is a naturally occurring cytokine that is involved in pruritus, inflammation, epidermal dysregulation, and fibrosis. Nemolizumab-ilto inhibited IL-31-induced responses including the release of proinflammatory cytokines and chemokines.*

Initial Approval Criteria:

Atopic Dermatitis:

- Diagnosis of moderate-to-severe atopic dermatitis (AD) with ≥ 1 of the following:
  - Involvement of at least 10% of body surface area (BSA); **OR**
  - Investigator's Global Assessment (IGA) with a score ≥ 3; **OR**
  - Eczema Area and Severity Index (EASI) score of ≥ 16; **OR** Peak Pruritis Numeric Rating Scale (PP-NRS) score ≥ 4; **OR**
  - Incapacitation due to AD lesion location (e.g., head and neck, palms, soles, or genitalia); **AND**
- Prescribed by, or in consultation with, a dermatologist, allergist/immunologist, or other specialist in the treatment of atopic dermatitis; **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) unless inappropriate for the location (e.g., face, groin); **AND**
  - Topical calcineurin inhibitor (i.e., tacrolimus or pimecrolimus); **OR**
  - Immunosuppressive systemic agents (e.g., cyclosporine, azathioprine, methotrexate, mycophenolate mofetil, etc.); **AND**
- Trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance of 1 preferred injectable (Adbry, Dupixent) agent; **AND**
- Nemluvio will be taken with topical corticosteroids and/or calcineurin inhibitors (e.g., pimecrolimus, tacrolimus); **AND**
- Patient must meet the minimum age recommended by the package insert for this FDA approved indication.

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Prurigo Nodularis:

- Diagnosis of prurigo nodularis; **AND**
- At least 20 nodular lesions; **AND**
- Other causes of pruritis have been ruled out; **AND**
- Trial and failure, contraindication, or intolerance to one of the following:
    - Moderate to super potent topical corticosteroids [e.g., betamethasone dipropionate, (augmented), fluocinonide 0.1%, flurandrenolide, betamethasone dipropionate 0.05%, clobetasol propionate 0.025%, or desoximetasone 0.05%] for a minimum of 2 weeks; **OR**
    - Narrowband ultraviolet B (NBUVB) phototherapy or psoralen plus ultraviolet A (PUVA) phototherapy; **AND**
- Trial and failure, contraindication, or intolerance to Dupixent; **AND**
- Patient must meet the minimum age recommended by the package insert for this FDA-approved 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: 2 pens (60 mg) per 28 days

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

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Neffy®

Self-injectable Epinephrine: Nonpreferred

Approval Duration: 6 months initial, 1 year renewal

- *Epinephrine acts on both alpha- and beta-adrenergic receptors and is a potent vasoconstrictor via its effects on the alpha- receptors.*

Approval Criteria:

- Patient has had a trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications), or intolerance of 1 preferred agent.

Quantity Limit: 2 bottles per fill

Preferred Agents	Non-Preferred Agents
epinephrine 0.3 mg autoinjector (all manufacturers) QL	Auvi-Q autoinjector QL
epinephrine 0.15 mg autoinjector (all manufacturers) QL	***Neffy*** QL
EpiPen QL	Symjepi QL
EpiPen Jr. QL	

Miplyffa ™

Non-PDL

Approval Duration: 6 months initial, 1 year renewal

- *Miplyffa is a first-in-class oral heat shock protein (HSP) amplifier that can stabilize lysosomal membranes and improve lysosomal function so that cells can clear away waste.*

Initial Approval Criteria:

- Diagnosis of Niemann-Pick Disease Type C (NPC) [ICD-10 code E75.242]; **AND**
- Confirmed diagnosis of NPC by ≥ 1 of the following:
  - Positive genetic test for mutations on both alleles of NPC1 or NPC2; **OR**
  - Positive genetic test for mutations on one allele NPC1 or NPC2; **AND**
    - Elevated biomarker; **OR**
    - Positive filipin staining; **AND**
- Prescribed by, or in consultation with, a neurologist or geneticist or other specialist in the treatment of Niemann-Pick Disease Type C; **AND**
- Prescriber attests patient presents with at least one neurological symptom of the disease (e.g., hearing loss, ataxia, dystonia, seizures, speech delay); **AND**
- Prescriber attests medication will be used in combination with miglustat; **AND**
- Patient must meet the minimum age recommended by the package insert.

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Renewal Criteria:

- Prescriber provides documentation (i.e., NPC Neurologic Severity Scale, cognitive function tests, motor function assessment, etc.) that patient has experienced disease improvement or stabilization or a reduction in disease progression

Age Limit: 2 years of age or older
Quantity Limit: 3 capsules per day

Aqneursa ™

Non-PDL

Approval Duration: 3 months initial, 1 year renewal

- *Aqneursa is modified amino acid (acetylleucine) kilograms. Once ingested, ubiquitous monocarboxylate transporters deliver Aqneursa to all tissues and is thought to serve as a neuroprotectant that reduces neuroinflammation and stabilizes the nerve cells responsible for balance and the coordination of movement.*

Initial Approval Criteria:

- Diagnosis of Niemann-Pick Disease Type C (NPC) [ICD-10 code E75.242]; **AND**
- Confirmed diagnosis of NPC by ≥ 1 of the following:
    - Positive genetic test for mutations on both alleles of NPC1 or NPC2; **OR**
    - Positive genetic test for mutations on one allele NPC1 or NPC2; **AND**
        - Elevated biomarker; **OR**
        - Positive filipin staining; **AND**
- Prescribed by, or in consultation with, a neurologist or geneticist or other specialist in the treatment of Niemann-Pick Disease Type C; **AND**
- Prescriber attests patient presents with at least one neurological symptom of the disease (e.g., hearing loss, ataxia, dystonia, seizures, speech delay); **AND**
- Patient must meet the minimum age and weight recommended by the package insert for the provided indication
    - ≥ 4 years of age
    - ≥ 15 kg

Renewal Criteria:

- Prescriber provides documentation (i.e., NPC Neurologic Severity Scale, cognitive function tests, motor function assessment, etc.) that patient has experienced disease improvement or stabilization or a reduction in disease progression

Age Limit: 4 years of age or older
Quantity Limit:4 packets (4 grams) per day

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FULL CLASS REVIEWS

Antibiotics: Gastrointestinal

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 Antibiotics, Gastrointestinal class, require PA until reviewed by the P&T Committee.

Preferred Agents	Non-Preferred Agents
metronidazole 250 mg, 500 mg tablet	Aemcolo
neomycin	Dificid suspension, tablet CC, QL
tinidazole	***Firvanq*** CC
vancomycin capsule, ***solution*** CC	Flagyl
Xifaxan CC, QL	Likmez
	metronidazole capsule
	metronidazole 125 mg tablet
	nitazoxanide
	paromomycin
	Solosec AE, CC, QL
	Vancocin
	Vowst AE, CC, QL

Antibiotics: Vaginal

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 Antibiotics, Vaginal class, require PA until reviewed by the P&T Committee.

Preferred Agents	Non-Preferred Agents
Cleocin Ovule	Cleocin cream
clindamycin vaginal 2% cream	***Clindesse vaginal cream***
metronidazole vaginal 0.75% gel	metronidazole vaginal 1.30% gel
Nuvessa gel	Vandazole gel
	Xaciato gel

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Antibiotics: Penicillins

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 Antibiotics, Penicillins class, require PA until reviewed by the P&T Committee.

Preferred Agents	Non-Preferred Agents
amoxicillin	amoxicillin/clavulanate ER
amoxicillin/clavulanate chewable tablet, tablet, suspension	Augmentin
Ampicillin capsule	Augmentin XR
Dicloxacillin capsule	
penicillin V potassium tablet, suspension	

Antibiotics: Sulfonamides, Folate Antagonists

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 Antibiotics: Sulfonamides, Folate Antagonists class, require PA until reviewed by the P&T Committee.

Preferred Agents	Non-Preferred Agents
sulfamethoxazole/trimethoprim	Bactrim
Sulfatrim suspension	Bactrim DS
trimethoprim	sulfadiazine

Antifungal, Oral

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

Preferred Agents	Non-Preferred Agents
clotrimazole troche	Ancobon
fluconazole suspension, tablet	Brexafemme CC, QL

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Preferred Agents	Non-Preferred Agents
griseofulvin suspension	Cresemba
itraconazole capsule CC, QL	Diflucan
ketoconazole	flucytosine
nystatin suspension, tablets	griseofulvin microsize tablet, ultramicrosize tablet
terbinafine	itraconazole solution
	Noxafil
	Oravig
	posaconazole
	Sporanox QL
	Tolsura
	Vfend
	Vivjoa CC, QL
	voriconazole

Hepatitis C Agents: Interferons and Ribavirins

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 Immunological and Genetic Hepatitis C Agents: Interferons and Ribavirins class, require PA until reviewed by the P&T Committee.

Preferred Agents	Non-Preferred Agents
PEGASYS syringe, ***vial*** CC, QL	
ribavirin capsule, tablet CC	

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 Disease (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 CC, QL
Atrovent HFA QL	Duaklir Pressair
Breztri Aerosphere CC, 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	

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Preferred Agents	Non-Preferred Agents
Stiolto Respimat QL	Trelegy Ellipta CC, QL
	Tudorza Pressair QL
	Yupelri solution CC, QL

Epinephrine, Self-Injectable

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 Epinephrine, Self-Injectable class, require PA until reviewed by the P&T Committee.

Preferred Agents	Non-Preferred Agents
epinephrine 0.3 mg autoinjector (all manufacturers) QL	Auvi-Q autoinjector QL
epinephrine 0.15 mg autoinjector (all manufacturers) QL	***Neffy*** QL
EpiPen QL	Symjepi QL
EpiPen Jr. QL	

Glucocorticoids, Inhaled

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 Glucocorticoids, Inhaled class, require PA until reviewed by the P&T Committee.

Preferred Agents	Non-Preferred Agents
Asmanex Twisthaler QL	Alvesco QL
budesonide inhalation suspension AE, QL	ArmonAir Digihaler QL
Flovent HFA QL	Arnuity Ellipta QL
fluticasone propionate HFA QL	Asmanex HFA QL
Pulmicort Flexhaler QL	Flovent Diskus QL
	Pulmicort Respules QL
	Qvar Redihaler

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CONSENT AGENDA REVIEWS

For the following therapeutic classes, there were no changes in PDL status:

Therapeutic Classes
• **Antibiotics, Cephalosporins 1st Generation** • **Antibiotics, Cephalosporins 2nd Generation** • **Antibiotics, Cephalosporins 3rd Generation** • **Antibiotics, Inhaled** • **Antibiotics, Macrolides** • **Antibiotics, Oxazolidinones** • **Antibiotics, Quinolones** • **Antibiotics, Tetracyclines** • **Antihistamines, Minimally Sedating** • **Antiretrovirals, HIV/AIDS** • **Antivirals, Oral** • **Bronchodilators, Beta Agonist** • **Hepatitis B Agents** • **Hepatitis C Agents: Direct-Acting Antivirals** • **Intranasal Rhinitis Agents** • **Leukotriene Modifiers**

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