HIM Regulatory Effective Date (Delayed Implementation States only)	Number	Title	Revision Log
6/1/2026	CP.PCH.07	Sildenafil for ED (Viagra)	2Q 2026 annual review: no significant changes; references reviewed and updated. RT4: added Vybrique to criteria; references reviewed and updated.
6/1/2026	CP.PCH.12	Bupropion/Naltrexone (Contrave)	Replaced by CP.CPA.366 Bupropion/Naltrexone (Contrave) by removing HIM LOB due to formulary status change
6/1/2026	CP.PCH.13	Phentermine (Adipex-P, Lomaira)	2Q 2026 annual review: for continued therapy, clarified positive response as evidenced by weight loss for adults and added reduction of BMI for pediatrics; references reviewed and updated.
6/1/2026	CP.PCH.40	Teriflunomide (Aubagio)	2Q 2026 annual review: no significant changes; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PCH.42	Deutetrabenazine (Austedo, Austedo XR)	2Q 2026 annual review: no significant changes; added Ingrezza Sprinkle to the concurrent use exclusion; revised initial approval durations from 6 to 12 months for HIM; references reviewed and updated.
6/1/2026	CP.PCH.45	Apalutamide (Erleada)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PCH.46	Interferon Beta-1b (Betaseron, Extavia)	2Q 2026 annual review: no significant changes; for HIM, extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PCH.47	Phendimetrazine	2Q 2026 annual review: for continued therapy, clarified positive response as evidenced by weight loss for adults and added reduction of BMI for pediatrics; references reviewed and updated.
6/1/2026	CP.PCH.51	Propranolol HCl Oral Solution (Hemangeol)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PCH.60	Tralokinumab-ldrm (Adbry)	2Q 2026 annual review: no significant changes; added Ebglyss and Nemluvio as examples of biologic medications for which concurrent use is excluded; references reviewed and updated.
6/1/2026	CP.PCH.61	Abaloparatide (Tymlos)	Policy created per March SDC [adapted from CP.PHAR.345].
6/1/2026	CP.PCH.62	Teriparatide (Forteo, Bonsity)	Policy created per March SDC [adapted from CP.PHAR.188].
6/1/2026	CP.PHAR.105	Bosutinib (Bosulif)	2Q 2026 annual review: no significant changes; for Medicaid/HIM revised initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.107	Regorafenib (Stivarga)	2Q 2026 annual review: per NCCN, revised the following – for CRC, specified that POLE/POLD1 mutation should have ultra-hypermutated phenotype; for appendiceal carcinoma, moved out of CRC criteria to its own criteria set to reflect additional disease-specific recommendations for use; for GIST, allowed resectable disease if SDH-deficient, and for combination therapy with Stivarga+everolimus, added disease qualifiers, requirement that disease is imatinib-sensitive KIT or PDGFRA mutant, and requirement for prior use of Stivarga as a single agent; for soft tissue sarcoma, added borderline/malignant phyllodes tumor of the breast, epithelioid hemangioendothelioma, and pediatric rhabdomyosarcoma; for uterine sarcoma, corrected "PEGoma" to "PEComa"; removed off-label criteria for central nervous system cancers; for all indications for Medicaid and HIM, extended initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.108	Omacetaxine (Synribo)	Retire, product discontinued
6/1/2026	CP.PHAR.112	Ponatinib (Iclusig)	2Q 2026 annual review: no significant changes; for Medicaid/HIM revised initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.116	Pomalidomide (Pomalyst)	2Q 2026 annual review: for KS, added option for off-label use in KSHV-associated inflammatory cytokine syndrome if prescribed in combination with rituximab per NCCN; for all indication, extended Medicaid and HIM initial approval duration from 6 months to 12 months for this maintenance medication for chronic conditions; references reviewed and updated.
6/1/2026	CP.PHAR.127	Encorafenib (Braftovi)	2Q 2026 annual review: for melanoma, added option for use in stage III melanoma as neoadjuvant therapy; for colon and rectal cancer, simplified to combination use with or without chemotherapy (capecitabine- or fluorouracil-based) per NCCN; RT4: updated FDA Approved Indication(s) section for mCRC from accelerated approval to full approval per PI; added off-label criteria for small bowel adenocarcinoma and appendiceal neoplasms and cancer per NCCN compendium; for all indications, extended Medicaid and HIM initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.152	Laronidase (Aldurazyme)	2Q 2026 annual review: no significant changes; updated initial approval duration from 6 months to 12 months; for Continued Therapy added examples of positive treatment response that were already outlined in Appendix D and previously referred to within the criteria; references reviewed and updated.
6/1/2026	CP.PHAR.153	Eliglustat (Cerdelga)	2Q 2026 annual review: no significant changes; updated initial approval duration from 6 months to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.154	Imiglucerase (Cerezyme)	2Q 2026 annual review: removed the age restriction for ≥ 2 years old based on the age group included in the analysis of the International Collaborative Gaucher Group Gaucher Registry which led to the FDA approval of Cerezyme for GD3 but which also included patients with GD1; updated initial approval duration from 6 months to 12 months; references reviewed and updated. RT4: updated the FDA Approved Indications section to reflect the recently FDA-approved status of the GD3 indication.
6/1/2026	CP.PHAR.155	Cysteamine oral (Cystagon, Procysbi)	2Q 2026 annual review: no significant changes; for initial therapy revised approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.156	Idursulfase (Elaprase)	2Q 2026 annual review: no significant changes; updated initial approval duration from 6 months to 12 months; for Continued Therapy added examples of positive treatment response that were already outlined in Appendix D and previously referred to within the criteria; references reviewed and updated.
6/1/2026	CP.PHAR.157	Taliglucerase Alfa (Elelyso)	2Q 2026 annual review: no significant changes; updated initial approval duration from 6 months to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.158	Agalsidase Beta (Fabrazyme)	2Q 2026 annual review: no significant changes; updated initial approval duration from 6 months to 12 months; for Continued Therapy added examples of positive treatment response that were already outlined in Appendix D and previously referred to within the criteria; references reviewed and updated.
6/1/2026	CP.PHAR.159	Sebelipase Alfa (Kanuma)	2Q 2026 annual review: no significant changes; updated initial approval duration from 6 months to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.16	Palivizumab (Synagis)	2Q 2026 annual review: no significant changes; added statement that Sobi, the manufacturer of Synagis, has discontinued Synagis as of 12/31/25 and it will no longer be available; references reviewed and updated.
6/1/2026	CP.PHAR.161	Galsulfase (Naglazyme)	2Q 2026 annual review: no significant changes; updated initial approval duration from 6 months to 12 months; for Continued Therapy added examples of positive treatment response that were already outlined in Appendix D and previously referred to within the criteria; references reviewed and updated.
6/1/2026	CP.PHAR.162	Elosulfase Alfa (Vimizim)	2Q 2026 annual review: no significant changes; updated initial approval duration from 6 months to 12 months; for Continued Therapy added examples of positive treatment response that were already outlined in Appendix D and previously referred to within the criteria; references reviewed and updated.
6/1/2026	CP.PHAR.163	Velaglucerase Alfa (VPRIV)	2Q 2026 annual review: no significant changes; updated initial approval duration from 6 months to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.164	Miglustat (Zavesca)	2Q 2026 annual review: no significant changes; updated initial approval duration from 6 months to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.172	Histrelin Acetate (Vantas, Supprelin LA)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PHAR.174	Nafarelin Acetate (Synarel)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PHAR.176	Paclitaxel, Protein-Bound (Abraxane)	2Q 2026 annual review: clarified off-label NCCN supported indications for Kaposi sarcoma, cervical cancer, endometrial carcinoma, cutaneous melanoma, and vaginal cancer, that Abraxane is prescribed as second-line or subsequent therapy per NCCN; for Kaposi sarcoma, removed requirement of HIV related and added member is paclitaxel intolerant per NCCN; clarified endometrial carcinoma as recurrent disease and melanoma as metastatic or unresectable disease per NCCN; for all indications for Medicaid and HIM, extended initial approval duration from 6 to 12 months; added ICD-10 code: C43.9 (correction made to be consistent with revision log entry in 11/11/22); references reviewed and updated.
6/1/2026	CP.PHAR.227	Pertuzumab (Perjeta), Pertuzumab-dpzb (Poherdy)	2Q 2026 annual review: for breast cancer, added option to be prescribed in combination with Enhertu and added option for use of aromatase inhibitor with trastuzumab for postmenopausal or premenopausal receiving ovarian ablation or suppression; added off-label indication for brain metastases in breast cancer; small bowel adenocarcinoma, appendiceal neoplasms and cancers per NCCN; for all indications for Medicaid and HIM, extended initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.228	Trastuzumab/Biosimilars, Trastuzumab-Hyaluronidase	2Q 2026 annual review: for gastric, esophageal and esophagogastric junction cancer, added option for use in members who are not surgical candidates per NCCN; for endometrial carcinoma, added option for carcinosarcoma histology; added off-label indication for brain metastasis due to breast cancer; appendiceal neoplasms and small bowel adenocarcinoma per NCCN; for all indications for Medicaid and HIM, extended initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.229	Ado-Trastuzumab Emtansine (Kadcyla)	2Q 2026 annual review: added off-label indication for brain metastases in HER2 positive breast cancer per NCCN; for NSCLC, added criteria prescribed as subsequent therapy per NCCN; for all indications for Medicaid and HIM, extended initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.230	AbobotulinumtoxinA (Dysport)	2Q 2026 annual review: no significant changes; references reviewed and updated.

6/1/2026	CP.PHAR.231	IncobotulinumtoxinA (Xeomin)	2Q 2026 annual review: extended Medicaid and HIM approval durations to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.232	OnabotulinumtoxinA (Botox)	2Q 2026 annual review: for primary axillary hyperhidrosis, removed step therapy bypass for IL HIM disclaimer for class alignment; references reviewed and updated. Per March SDC for chronic migraine, simplified criteria for concurrent use with CGRP to member has had a reduction in the overall migraine headache days per month with CGRP monotherapy and provider attestation of a significant number of migraine headache days despite CGRP monotherapy.
6/1/2026	CP.PHAR.233	RimabotulinumtoxinB (Myobloc)	2Q 2026 annual review: extended Medicaid and HIM approval durations to 12 months; references reviewed and updated.
9/1/2026	CP.PHAR.236	Darbepoetin Alfa (Aranesp)	2Q 2026 annual review: for continuation of therapy request for anemia associated with CKD, modified current hemoglobin requirement from ≤ 12 g/dL to ≤ 11.5 g/dL; for anemia associated with CKD, added requirement that requested product is not prescribed concurrently with a hypoxia-inducible factor prolyl hydroxylase (HIF PH) inhibitor; references reviewed and updated.
9/1/2026	CP.PHAR.237	Epoetin Alfa (Epogen, Procrit), Epoetin Alfa-epbx (Retacrit)	2Q 2026 annual review: for continuation of therapy request for anemia associated with CKD, modified current hemoglobin requirement from ≤ 12 g/dL to ≤ 11.5 g/dL; for anemia associated with CKD, added requirement that requested product is not prescribed concurrently with a hypoxia-inducible factor prolyl hydroxylase (HIF PH) inhibitor; references reviewed and updated.
9/1/2026	CP.PHAR.238	Methoxy Polyethylene Glycol-Epoetin Beta (Mircera)	2Q 2026 annual review: for continuation of therapy request modified current hemoglobin requirement from ≤ 12 g/dL to ≤ 11.5 g/dL; added requirement that requested product is not prescribed concurrently with a hypoxia-inducible factor prolyl hydroxylase (HIF PH) inhibitor; references reviewed and updated.
6/1/2026	CP.PHAR.239	Dabrafenib (Tafinlar)	2Q 2026 annual review: for BRAF V600E mutation-positive solid tumor per NCCN, removed "as subsequent treatment" from ampullary adenocarcinoma to allow first-line treatment and clarified requirement that disease is not amenable to radioactive iodine therapy for follicular and papillary thyroid carcinoma only; for off-label NCCN compendium indications, added pediatric LCH and pediatric LCH-associated abnormal CNS imaging/neurodegeneration; for all indications, extended Medicaid and HIM initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.240	Trametinib (Mekinist)	2Q 2026 annual review: for BRAF V600E mutation-positive solid tumor per NCCN, removed "as subsequent treatment" from ampullary adenocarcinoma to allow first-line treatment, clarified small bowel adenocarcinoma is advanced or metastatic, added option for use as a single agent in adult circumscribed glioma, clarified requirement that disease is not amenable to radioactive therapy for follicular and papillary thyroid carcinoma only; for off-label NCCN compendium indications, added criteria for pediatric LCH and pediatric LCH-associated abnormal CNS imaging/neurodegeneration, added criteria for epithelioid hemangioendothelioma; extended Medicaid and HIM initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.243	Alemtuzumab (Lemtrada)	2Q 2026 annual review: no significant changes; incorporated existing treatment course limitation from approval duration into criteria; added CIS to section III to align with MS agents with similar labeled limitations of use; references reviewed and updated.
6/1/2026	CP.PHAR.246	Canakinumab (Ilaris)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PHAR.248	Dalfampridine (Ampyra)	2Q 2026 annual review: no significant changes; for Medicaid and HIM, extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.249	Dimethyl Fumarate (Tecfidera), Diroximel Fumarate (Vumerity), Monomethyl Fumarate (Bafiertam)	2Q 2026 annual review: no significant changes; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.251	Fingolimod (Gilenya, Tascenso ODT)	2Q 2026 annual review: no significant changes; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.252	Glatiramer Acetate (Copaxone, Glatopa)	2Q 2026 annual review: no significant changes; for Medicaid and HIM, extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.255	Interferon Beta-1a (Avonex, Rebif)	2Q 2026 annual review: no significant changes; for Medicaid and HIM, extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated
6/1/2026	CP.PHAR.258	Mitoxantrone	2Q 2026 annual review: for pediatric BCR::ABL1-negative B-ALL, added requirement for use as a component of UKALL R3 or COG AALL 1331 per NCCN; removed B-cell lymphomas as coverable diagnoses as NCCN no longer recommends these uses; for Medicaid and HIM for all indications, extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated
6/1/2026	CP.PHAR.259	Natalizumab (Tysabri), Natalizumab-sztn (Tyruko)	2Q 2026 annual review: no significant changes; for MS, extended initial approval duration for Medicaid and HIM from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.260	Rituximab (Rituxan), Rituximab-arrx (Riabni), Rituximab-pvvr (Ruxience), Rituximab-abbs (Truxima), Rituximab/Hyaluronidase (Rituxan Hycela)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PHAR.266	Rilonacept (Arcalyst)	2Q 2026 annual review: Extended initial approval durations to 12 months for Medicaid and HIM; references reviewed and updated.
6/1/2026	CP.PHAR.271	Peginterferon Beta-1a (Plegridy)	2Q 2026 annual review: no significant changes; for Medicaid and HIM, extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.272	Sonidegib (Odomzo)	2Q 2026 annual review: extended Medicaid and HIM initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.273	Vismodegib (Erivedge)	2Q 2026 annual review: clarified metastatic BCC does not require additional requirement of disease recurrence following surgery/radiation or that member is not a candidate for surgery or radiation; extended Medicaid and HIM initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.294	Osimertinib (Tagrisso)	2Q 2026 annual review: per NCCN: added requirement for single agent therapy, added options for previous adjuvant chemoradiation and previous neoadjuvant Tagrisso, and removed "completely" as a qualifier for "resected"; revised initial approval duration for Medicaid/HIM to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.298	Afatinib (Gilotrif)	2Q 2026 annual review: no significant changes; revised initial approval duration for Medicaid/HIM to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.306	Ofatumumab (Arzerra, Kesimpta)	2Q 2026 annual review: no significant changes; for CLL, clarified that maximum dose also applies to duration as noted in section V; for Medicaid and HIM, extended initial approval durations from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
9/1/2026	CP.PHAR.316	Cabazitaxel (Jevtana)	2Q 2026 annual review: per NCCN compendium for off-label use in small cell/neuroendocrine prostate cancer clarified that Jevtana is prescribed in combination with carboplatin with concurrent steroid; revised initial approval duration for Medicaid/HIM from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.319	Ipilimumab (Yervoy)	2Q 2026 annual review: for melanoma, NSCLC, malignant pleural mesothelioma, ESCC, and off-label NCCN compendium indications, extended Medicaid and HIM initial approval durations from 6 months to 12 months for this maintenance medication for a chronic condition, extended Commercial initial approval duration is "6 months or to the member's renewal data, whichever is longer"; for NSCLC, malignant pleural mesothelioma, and ESSC continued therapy, added criterion for maximum duration of therapy limit of 2 years and extended Commercial approval duration is "6 months or to the member's renewal data, whichever is longer"; for ESCC, added option to be prescribed as induction therapy; for off-label NCCN compendium indications, removed use as a single agent for soft tissue sarcoma, added off-label indications for appendiceal neoplasms and cancers, small bowel adenocarcinoma with POLE/POLD mutation, cervical cancer, neuroendocrine and adrenal tumors, uterine neoplasms, vaginal cancer, and vulvar cancer, extended Commercial continued therapy approval duration is "6 months or to the member's renewal data, whichever is longer"; references reviewed and updated.
6/1/2026	CP.PHAR.327	Nusinersen (Spinraza)	2Q 2026 annual review: no significant changes; clarified "at least" 6 months of trial prior to treatment change per 2025 AAN SMA update; added Itvisma, a newly approved one-time intrathecal version of Zolgensma, as another example for no concurrent use; added HFMSE as an alternative option for demonstrating prior treatment response; references reviewed and updated.
6/1/2026	CP.PHAR.335	Ocrelizumab (Ocrevus), Ocrelizumab/Hyaluronidase-ocsq (Ocrevus Zunovo)	2Q 2026 annual review: no significant changes; for Medicaid and HIM, extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
9/1/2026	CP.PHAR.337	Telotristat Ethyl (Xermelo)	2Q 2026 annual review: added failure of an SSA for IL HIM requests per prescribing information; in continued therapy, clarified examples of positive therapy; extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.

6/1/2026	CP.PHAR.339	Durvalumab (Imfinzi)	2Q 2026 annual review: per NCCN, revised the following – for NSCLC, added option for use after completion of adjuvant chemoradiation; for SCLC, added option for use in combination with etoposide and carboplatin or cisplatin as subsequent treatment for progression or relapse if member had prolonged disease free time; for BTC, added option for use in combination with carboplatin if cisplatin ineligible; for HCC, added option for use as subsequent-line therapy and added requirement for use as a single agent or in combination with Imjudo; for endometrial cancer, added option for use in pMMR disease in combination with Lynparza; for GC/GEJC, removed requirement for PD-L1 combined positive score or tumor area positivity; added off-label criteria for small bowel adenocarcinoma; references reviewed and updated.
6/1/2026	CP.PHAR.340	Valbenazine (Ingrezza, Ingrezza Sprinkle)	2Q 2026 annual review: no significant changes; added step therapy bypass for IL HIM per IL HB 5395; revised initial approval durations from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.342	Brigatinib (Alunbrig)	2Q 2026 annual review: no significant changes; revised initial approval durations for Medicaid/HIM to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.343	Edaravone (Radicava, Radivaca ORS)	2Q 2026 annual review: no significant changes; revised approval durations for Medicaid/HIM to 12 months and for Commercial to "6 months or to the member's renewal date, whichever is longer;" references reviewed and updated.
6/1/2026	CP.PHAR.344	Midostaurin (Rydapt)	2Q 2026 annual review: for systemic mastocytosis, added off-label use in WDSM per NCCN; for Medicaid and HIM, extended initial approval durations from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.349	Ceritinib (Zykadia)	2Q 2026 annual review: no significant changes; revised initial approval durations for Medicaid/HIM to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.369	Alectinib (Alecensa)	2Q 2026 annual review: for resected NSCLC, revised cancer staging to include IB per NCCN and removed corresponding tumor and lymph node staging; for anaplastic large cell lymphoma, added option for subsequent therapy for progressive disease per NCCN; revised initial and continued approval durations for Medicaid/HIM to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.374	Vestronidase Alfa-vjbk (Mepsevii)	2Q 2026 annual review: no significant changes; updated initial and continued approval durations from 6 months to 12 months; for Continued Therapy added examples of positive treatment response that were already outlined in Appendix D and previously referred to within the criteria; references reviewed and updated.
6/1/2026	CP.PHAR.378	Ibalizumab-uiyk (Trogarzo)	2Q 2026 annual review: extended Medicaid and HIM initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; for initial and continued therapy, extended Commercial approval duration from 6 months to "6 months or to the member's renewal date, whichever is longer"; references reviewed and updated.
6/1/2026	CP.PHAR.380	Cobimetinib (Cotellic)	2Q 2026 annual review: for histiocytic neoplasms, added option for use in disease that is positive for MAP kinase pathway mutation, has no detectable mutation, or testing is not available; extended Medicaid and HIM initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.394	Migalastat (Galafold)	2Q 2026 annual review: no significant changes; updated initial approval duration from 6 months to 12 months; for Continued Therapy added examples of positive treatment response that were already outlined in Appendix F and previously referred to within the criteria; references reviewed and updated.
6/1/2026	CP.PHAR.395	Patisiran (Onpattro)	2Q 2026 annual review: no significant changes; removed Tegsedi from criteria as agent is discontinued; for Medicaid/HIM revised initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.405	Inotersen (Tegsedi)	2Q 2026 annual review: no significant changes; for Medicaid/HIM revised initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.406	Lorlatinib (Lorbrena)	2Q 2026 annual review: for ROS1 positive NSCLC, added Ibtrozi as a failure option and clarified that failure is required for one of the listed agents with the addition of "or" per NCCN; added maximum dose option of 125 mg per day if receiving a moderate CYP3A4 inducer and removed tablet quantity limit to accommodate dose adjustments; for anaplastic large cell lymphoma, added clarification that Lorbrena is subsequent therapy for relapsed, or refractory, or progressive disease and added palliative treatment as an option per NCCN; revised initial approval durations for Medicaid/HIM to 12 months; references reviewed and updated.
9/1/2026	CP.PHAR.416	Caplacizumab-yhdp (Cablivi)	2Q 2026 annual review: for continued criteria for new treatment cycle requests, added diagnostic requirement for confirmation of relapse; references reviewed and updated.
6/1/2026	CP.PHAR.417	Brexanolone (Zulresso)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PHAR.418	Dexrazoxane (Totect)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PHAR.419	Elapegademase-lvlr (Revcovi)	2Q 2026 annual review: no significant changes; moved examples of positive response to therapy from Appendix D into Continued Therapy criteria section; revised initial approval duration for Medicaid/HIM to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.421	Onasemnogene Abeparvovec (Zolgensma)	2Q 2026 annual review: revised prior treatment response monitoring duration from 3 to 6 months to at least 6 months per the 2025 AAN update; added C9399, J3590 for Itvisma; references reviewed and updated.
6/1/2026	CP.PHAR.422	Cladribine (Mavenclad)	2Q 2026 annual review: no significant changes; incorporated existing treatment course limitations from approval duration into criteria; added primary progressive MS to section III to align with other MS agents; references reviewed and updated
6/1/2026	CP.PHAR.427	Siponimod (Mayzent)	2Q 2026 annual review: no significant changes; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; added primary progressive MS to section III to align with other MS agents; references reviewed and updated.
6/1/2026	CP.PHAR.43	Sapropterin Dihydrochloride (Kuvan, Javygtor)	2Q 2026 annual review: no significant changes; added requirement for a redirection from Zelvysia (another branded generic) to unbranded generic sapropterin; added endocrinologist as a possible specialist to align with the Palynziq and Sephience criteria; added adherence to Phe-restricted diet per plan feedback and align with Sephience criteria; references reviewed and updated.
6/1/2026	CP.PHAR.447	Mercaptopurine (Purixan)	2Q 2026 annual review: added criteria set for NCCN compendium supported off-label use in histiocytic neoplasms; revised initial approval duration for Medicaid/HIM from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.461	Nadofaragene firadenovec-vncg (Adstiladrin)	Removed lifetime dose requirement, clarified frequency does not exceed every 3 months, removed specification of "a single dose."
6/1/2026	CP.PHAR.462	Ozanimod (Zeposia)	2Q 2026 annual review: no significant changes; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.468	Aducanumab-avwa (Aduhelm)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PHAR.471	Fosdenopterin (Nulibry)	2Q 2026 annual review: no significant changes; for initial approval duration for genetically confirmed diagnosis, revised Medicaid/HIM to 12 months; for all approval durations for Commercial, revised to "6 months or to the member's renewal date, whichever is longer;" references reviewed and updated.
6/1/2026	CP.PHAR.474	Remestemcel-L-rknd (Ryoncil)	2Q 2026 annual review: moved total number of doses allowed from approval duration into criteria; references reviewed and updated.
6/1/2026	CP.PHAR.475	Sacituzumab Govitecan-hziy (Trodelvy)	2Q 2026 annual review: for TNBC, added option to be prescribed as first-line therapy per NCCN; for all indications for Medicaid and HIM, extended initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.477	Risdiplam (Evrysdi)	2Q 2026 annual review: no significant changes; clarified "at least" 6 months of trial prior to treatment change per 2025 AAN SMA update; added Itvisma, a newly approved one-time intrathecal version of Zolgensma, as another example for no concurrent use; added HFMSE as an alternative option for demonstrating prior treatment response; references reviewed and updated.2Q 2026 annual review:
6/1/2026	CP.PHAR.478	Selpercatinib (Retevmo)	2Q 2026 annual review: added tablet/capsule quantity limit bypass for documentation supporting inability to swallow oral capsules/tablets; revised initial approval durations for Medicaid/HIM to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.479	Decitabine/Cedazuridine (Inqovi)	2Q 2026 annual review: extended Medicaid and HIM initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; updated Appendix D with revised language and exception for Tennessee; references reviewed and updated.
6/1/2026	CP.PHAR.480	Ferric Derisomaltose (Monoferric)	2Q 2026 annual review: no significant changes; revised approval durations for anemia associated with CKD and cancer/chemotherapy for Medicaid/HIM to 12 months and for Commercial to "6 months or to the member's renewal date, whichever is longer;" references reviewed and updated.
6/1/2026	CP.PHAR.481	Idecabtagene Vicleucel (Abecma)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PHAR.482	Isatuximab-irfc (Sarclisa)	2Q 2026 annual review: extended Medicaid and HIM initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; extended Commercial approval duration from 6 months to "6 months or to the member's renewal date, whichever is longer"; added off-label indication for primary therapy in combination with lenalidomide and dexamethasone per NCCN; references reviewed and updated.
6/1/2026	CP.PHAR.483	Lisocabtagene Maraleucel (Breyanzi)	2Q 2026 annual review: no significant changes; RT4: for FL in FDA approved indications removed reference to footnote designating approval under accelerated approval per updated prescribing information; references reviewed and updated.
6/1/2026	CP.PHAR.486	Bimatoprost Implant (Durysta)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PHAR.50	Binimetinib (Mektovi)	2Q 2026 annual review: for histiocytic neoplasms, removed age requirement to allow use in pediatric population per NCCN; for all indications, extended Medicaid and HIM initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.503	Sutimlimab-jome (Enjaymo)	2Q 2026 annual review: no significant changes; references reviewed and updated.

6/1/2026	CP.PHAR.504	Voclosporin (Lupkynis)	2Q 2026 annual review: no significant changes; revised initial approval duration from 6 to 12 months; added Gazyva as an example of a biologic that is excluded for concurrent use; references reviewed and updated.
6/1/2026	CP.PHAR.512	Pegunigalsidase Alfa-iwxj (Elfabrio)	2Q 2026 annual review: no significant changes; updated initial approval duration from 6 months to 12 months for Medicaid/HIM and added the standard auth duration language for Commercial; for Continued Therapy added examples of positive treatment response that were already outlined in Appendix D and previously referred to within the criteria; references reviewed and updated.
6/1/2026	CP.PHAR.516	Fostemsavir (Rukobia)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PHAR.526	Fibrinogen Concentrate [Human] (Fibryga, RiaSTAP)	2Q 2026 annual review: no significant changes; RT4: added new Fibryga 2 gm/100 mL dosage strength; references reviewed and updated.
6/1/2026	CP.PHAR.527	Narsoplimab (Yartemlea)	2Q 2026 annual review: no significant changes; in initial therapy, added criterion that maximum duration of therapy doesn't exceed 16 weeks for review of new members already started on Yartemlea therapy; added HCPCS code C9399; references reviewed and updated.
6/1/2026	CP.PHAR.528	Odevixibat (Bylvay)	2Q 2026 annual review: no significant changes; revised initial approval durations for both PFIC and ALGS to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.529	Relugolix (Orgovyx), Relugolix/Estradiol/Norethinedrone (Myfembree)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PHAR.530	Tepotinib (Tepmetko)	2Q 2026 annual review: no significant changes; revised initial approval duration for Medicaid/HIM to 12 months; references reviewed and updated.
9/1/2026	CP.PHAR.533	Ciltacabtagene Autoleucel (Carvykti)	2Q 2026 annual review: per NCCN added additional approval pathway after ≥ 3 prior lines of therapy that also includes one anti-CD38 antibody; references reviewed and updated.
6/1/2026	CP.PHAR.534	Insulin Delivery Systems (V-Go, Omnipod, InPen)	2Q 2026 annual review: revised insulin administration method criterion to require duration only for multiple daily insulin injections; for V-Go and Omnipod Pods, revised initial approval duration for Medicaid and HIM from 6 to 12 months; added exception to prescriber requirement for Oregon requests per health plan request due to endocrinologist shortage; references reviewed and updated. Per March SDC, reduced duration requirement for insulin administration method for multiple daily insulin injections from 6 months to 3 months, reduced duration requirement for blood glucose monitoring from 6 months to 2 months.
6/1/2026	CP.PHAR.536	Ophthalmic Riboflavin (Photrexa, Photrexa Viscous)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PHAR.537	Ponesimod (Ponvory)	2Q 2026 annual review: no significant changes; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.538	Tivozanib (Fotivda)	2Q 2026 annual review: revised "at least 2 prior systemic therapies" to "prior systemic therapy" per NCCN; for Medicaid and HIM, extended initial approval duration from 6 to 12 months; references reviewed and updated.
9/1/2026	CP.PHAR.550	Vutrisiran (Amvuttra)	2Q 2026 annual review: for diagnosis by cardiac uptake, specified radionucleotide scan should be SPECT (Single Photon Emission Computed Exercise Tomography) per updated 2025 ACC Clinical Guidance; removed Tegsedi from criteria as agent is discontinued; for Medicaid/HIM revised initial approval duration from 6 to 12 months; references reviewed and updated.
9/1/2026	CP.PHAR.558	Mitapivat (Pyrukynd, Aqvesme)	Per March SDC: for beta thalassemia and Hemoglobin E/beta thalassemia, added redirection to Reblozyl for members that received ≥ 6 RBC units in the last 6 months
9/1/2026	CP.PHAR.573	Cabotegravir, Cabotegravir-Rilpivirine (Apretude, Cabenuva)	2Q 2026 annual review: for PrEP, added requirement that Apretude is not prescribed concurrently with any other antiretroviral medications for PrEP; references reviewed and updated.
6/1/2026	CP.PHAR.575	Tebentafusp-tebn (Kimmtrak)	2Q 2026 annual review: extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; extended Commercial approval duration from 6 months to "6 months or to the member's renewal date, whichever is longer"; references reviewed and updated.
9/1/2026	CP.PHAR.582	Lutetium Lu 177 vipivotide tetraxetan (Pluvicto)	2Q 2026 annual review: added Erleada and Nubeqa as additional examples of androgen receptor pathway inhibitors that would qualify to satisfy prior therapy requirements; for continuation of therapy added requirement that member continues to use a GnRH analog concurrently or has had a bilateral orchiectomy; references reviewed and updated.
6/1/2026	CP.PHAR.583	Pacritinib (Vonjo)	2Q 2026 annual review: for NCCN compendium indications per NCCN 2A recommendation, added criteria for myeloid/lymphoid neoplasms with eosinophilia and JAK2 rearrangement, added criteria for MPN; for all indications, extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.584	Sodium Phenylbutyrate/Taurursodiol (Relyvrio)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PHAR.590	Omaveloxolone (Skyclarys)	2Q 2026 annual review: extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.592	Beremagene Geperpavec (Vyjuvek)	For initial approval criteria and continued therapy, added "on the same target wound" to clarify Vyjuvek is not used concurrently on the same wound as Filsuvez and Zevaskyn.
6/1/2026	CP.PHAR.594	Donanemab-azbt (Kisunla)	Removed the requirement for follow-up MRIs in the Continued Therapy section; added Leqembi Iqlik as a recently FDA-approved alternative formulation of Leqembi that should not be used concomitantly with Kisunla; extended initial and continued approval durations to 6 and 12 months, respectively for Medicaid/HIM, with 6 months or renewal date for Commercial reauthorizations.
6/1/2026	CP.PHAR.596	Lecanemab-irmb (Leqembi)	Removed the requirement for follow-up MRIs in the Continued Therapy section; added Leqembi Iqlik as a recently FDA-approved alternative formulation of Leqembi that should not be used concomitantly with Kisunla; extended initial and continued approval durations to 6 and 12 months, respectively for Medicaid/HIM, with 6 months or renewal date for Commercial reauthorizations.
9/1/2026	CP.PHAR.60	Capecitabine (Xeloda)	2Q 2026 annual review: updated boxed warnings for patients with complete DPD deficiency and added criterion to confirm that a homozygous or compound heterozygous DPYD variant is not present, unless immediate treatment is necessary per updated PI; for off-label indications, added appendiceal neoplasms and cancers and subtypes of head and neck cancer (nasopharynx and occult primary tumor) and removed endometrial carcinoma per NCCN; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.600	Trofinetide (Daybue)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PHAR.601	Velmanase Alfa-tycv (Lamzede)	2Q 2026 annual review: no significant changes; updated initial and continued approval durations from 6 months to 12 months for Medicaid/HIM and added the standard auth duration language for Commercial; for Initial Approval added examples of CNS manifestations of AM that were already outlined in Appendix D and previously referred to within the criteria; for Continued Therapy added examples of positive treatment response that were already outlined in Appendix D and previously referred to within the criteria; references reviewed and updated.
6/1/2026	CP.PHAR.606	Spesolimab-sbzo (Spevigo)	2Q 2026 annual review: no significant changes; extended initial approval duration from 6 to 12 months for HIM/Medicaid; references reviewed and updated.
6/1/2026	CP.PHAR.609	Prademagene Zamikeracel (Zevaskyn)	Added criteria "on the same target wound" to clarify Zevaskyn is not used concurrently on the same wound as Vyjuvek and Filsuvez.
9/1/2026	CP.PHAR.616	Zilucoplan (Zilbrysq)	Per March SDC, added redirection to Ultomiris.
6/1/2026	CP.PHAR.620	Pirtobrutinib (Jaypirca)	2Q 2026 annual review: for MZL, clarified prior therapy requirement with a covalent BTK inhibitor; references reviewed and updated.
6/1/2026	CP.PHAR.621	Ublituximab-xiiy (Briumvi)	2Q 2026 annual review: no significant changes; for Medicaid and HIM, extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; added primary progressive MS to section III to align with other MS agents; references reviewed and updated.
6/1/2026	CP.PHAR.622	Lenacapavir (Sunlenca, Yeztugo)	2Q 2026 annual review: for HIV-1 infection, extended initial approval duration from 7 months to 12 months for this maintenance medication for a chronic condition and extended Commercial approval duration from 6 months to "6 months or to the member's renewal date, whichever is longer"; references reviewed and updated.
6/1/2026	CP.PHAR.623	Elacestrant (Orserdu)	2Q 2026 annual review: added step therapy bypass for IL HIM per IL HB 5395; extended Medicaid and HIM initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.625	Concizumab-mtci (Alhemo)	2Q 2026 annual review: removed requirements for documentation and provider attestations of Concizumab ELISA; for hemophilia A or B without inhibitors, added clarification that hemophilia severity associated with factor level is taken at baseline prior to use of factor products for routine prophylaxis; modified initial approval durations for Medicaid/HIM to 12 months and for Commercial to "6 months or to the member's renewal date, whichever is longer" as this is a maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.626	Pozelimab-bbfg (Veopoz)	2Q 2026 annual review: extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.629	Retifanlimab-dlwr (Zynyz)	2Q 2026 annual review: added off-label criteria for appendiceal neoplasms and cancers per NCCN; simplified NCCN off-label uses under section "NCCN Recommended Uses (off-label)"; references reviewed and updated.
6/1/2026	CP.PHAR.631	Sparsentan (Filspari)	2Q 2026 annual review: revised criterion for proteinuria ≥ 0.5 g/day per updated KDIGO 2025 guidance; references reviewed and updated.
6/1/2026	CP.PHAR.633	Eplontersen (Wainua)	2Q 2026 annual review: no significant changes; for Medicaid/HIM revised initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.639_PEPP	Troriluzole (BHV-4157)_PEPP	2Q 2026 annual review: no significant changes as the drug is not yet FDA-approved; revised brand name "BHV-4157" to "Vyglxia" per manufacturer press release; references reviewed and updated.

6/1/2026	CP.PHAR.64	Topotecan (Hycamtin)	2Q 2026 annual review: for all indications, extended Medicaid and HIM initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; for off-label NCCN recommendations, revised neuroblastoma to include non-induction therapy; references reviewed and updated.
6/1/2026	CP.PHAR.65	Imatinib (Gleevec, Imkeldi)	2Q 2026 annual review: no significant changes; for Imkeldi, added step therapy bypass for IL HIM per IL HB 5395; revised initial approval durations for HIM/Medicaid from 6 months to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.650	Zuranolone (Zurzuvae)	2Q 2026 annual review: no significant changes; references reviewed and updated.
9/1/2026	CP.PHAR.669	Birch Triterpenes (Filsuvez)	For initial approval criteria and continued therapy, added “on the same target wound” to clarify Filsuvez is not used concurrently on the same wound as Zevaskyn and Vyjuvek; added no concurrent use with Zevaskyn.
6/1/2026	CP.PHAR.673	Garadacimab-gxii (Andembry)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PHAR.676	Aprocitentan (Tryvio)	2Q 2026 annual review: for initial approval criteria, revised BP threshold from ≥ 140/90 mmHg to ≥ 130/80 mmHg per 2025 ACC/AHA guideline, added pathway for use in BP < 130/80 mmHg if adherent to and prescribed concurrently with four or more antihypertensive drug classes; extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
9/1/2026	CP.PHAR.677	Vadadustat (Vafseo)	2Q 2026 annual review: for continuation of therapy request modified current hemoglobin requirement from ≤ 12 g/dL to ≤ 11.5 g/dL; added requirement that Vafseo should not be prescribed concurrently with ESAs; references reviewed and updated.
6/1/2026	CP.PHAR.679	Mavorixafor (Xolremdi)	2Q 2026 annual review: no significant changes; added dermatologist as an additional prescriber specialty; references reviewed and updated.
6/1/2026	CP.PHAR.68	Gefitinib (Iressa)	2Q 2026 annual review: no significant changes; revised initial approval duration for Medicaid/HIM to 12 months; references reviewed and updated.
9/1/2026	CP.PHAR.689	Olezarsen (Tryngolza)	2Q 2026 annual review: added option to be prescribed by gastroenterologist or pancreatologist; added requirement that Tryngola is not prescribed concurrently with Redemplo to prevent duplicative therapy; references reviewed and updated.
6/1/2026	CP.PHAR.69	Sorafenib (Nexavar)	2Q 2026 annual review: for DTC, modified requirement for radioactive iodine-refractory disease to apply only to papillary and follicular carcinomas per NCCN; for GIST, added disease qualifiers along with requirement that disease is imatinib-sensitive KIT or PDGFRA mutant per NCCN; for Medicaid and HIM, extended initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.708	Sepiapterin (Sephience)	2Q 2026 annual review: bringing forward to align with the annual review cycle for Kuvan and Palynziq; references reviewed and updated.
6/1/2026	CP.PHAR.71	Lenalidomide (Revlimid)	2Q 2026 annual review: revised the following per NCCN – for MM, added options for use for treatment of MIDD, MGRS, and CNS system disease, and simplified use for treatment of POEMS; for MZL, added option for use for extranodal MZL; for FL, added option for use in combination with rituximab and Epkinly; for off-label uses, added option for use for primary vitreoretinal lymphoma/PCNSL ocular variant, Rosai-Dorfman disease, KICS, and mycosis fungoides/Sezary syndrome; for all indications for Medicaid and HIM, extended initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.714	Copper Histidinate (Zycubo)	Drug is now FDA-approved – criteria updated per FDA labeling; added upper age limit of 17 years; added requirement for documentation of baseline (within the last 30 days) serum copper and ceruloplasmin levels; added requirement that member does not have occipital horn syndrome; for continued therapy positive response, added serum levels or neurologic symptom parameters.
6/1/2026	CP.PHAR.714_PEPP	Copper Histidinate (CUTX-101)_PEPP	Retire drugs is now FDA approved.
6/1/2026	CP.PHAR.715	Datopotamab Deruxtecan-dlnk (Datroway)	2Q 2026 annual review: added criteria for TNBC per NCCN; for all indications for Medicaid and HIM, extended initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.716_PEPP	Deramiocel (CAP-1002)_PEPP	2Q 2026 annual review: no significant changes as drug is not yet FDA-approved; references reviewed and updated.
6/1/2026	CP.PHAR.717	Donidalorsen (Dawnzera)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PHAR.718	Mirdametinib(Gomekli)	2Q 2026 annual review: no significant changes; for Medicaid/HIM, extended initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.719_PEPP	Mozafancogene Autotemcel (RP-L102)_PEPP	2Q 2026 annual review: no significant changes as the drug is not yet FDA-approved; updated language under Policy/Criteria to effectively redirect prior authorization reviews to Precision Drug Action Committee (PDAC) Utilization Management Review; references reviewed and updated.
6/1/2026	CP.PHAR.72	Dasatinib (Sprycel, Phyrago)	2Q 2026 annual review: added NCCN compendium supported use in Grade 4 CRS that is refractory to high-dose corticosteroids and anti-IL-6 therapy; generic dasatinib is now available, so clarified generic redirection by removing ‘if available’; for Medicaid/HIM revised initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.720	Nipocalimab-aahu (Imaavy)	2Q 2026 annual review: clarified that the required immunosuppressive therapy should be non-steroidal; modified initial approval duration from 6 months to 12 months for MED/HIM and 6 months or to the member’s renewal date for COM as gMG is a chronic condition; references reviewed and updated.
9/1/2026	CP.PHAR.721	Plozasiran (Redemplo)	2Q 2026 annual review: added option to be prescribed by gastroenterologist or pancreatologist; in continued therapy, added Redemplo is not prescribed concurrently with Tryngolza; references reviewed and updated.
6/1/2026	CP.PHAR.722_PEPP	Rebisufligene Etisparvovec (UX111)_PEPP	2Q 2026 annual review: no significant changes as drug is not yet FDA-approved; updated language under Policy/Criteria to effectively redirect prior authorization reviews to Precision Drug Action Committee (PDAC) Utilization Management Review; references reviewed and updated.
6/1/2026	CP.PHAR.723	Sebetralstat (Ekterly)	2Q 2026 annual review: extended initial approval duration from 6 months to 12 months for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.724_PEPP	Sodium Dichloroacetate (SL-1009)_PEPP	2Q 2026 annual review: no significant changes as drug is not yet FDA-approved; references reviewed and updated.
9/1/2026	CP.PHAR.725	Tiopronin Delayed-Release (Thiola EC)	2Q 2026 annual review: no significant changes; added Venxxiva as another brand formulation of Thiola EC that would require redirection to a non-brand generic equivalent; for Continued Therapy added the same requirement for concomitant use with conventional therapies as exists in the Initial Approval section and as stated in the FDA-labeled indication; references reviewed and updated.
6/1/2026	CP.PHAR.726	Vimseltinib (Romvimza)	2Q 2026 annual review: no significant changes; revised initial approval duration to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.727	Atrasentan (Vanrafia)	2Q 2026 annual review: revised proteinuria criterion from 1 g/day to 0.5 g/day per updated 2025 KDIGO guidelines; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.728_PEPP	Rexlemestrocel-L (Revascor)_PEPP	2Q 2026 annual review: no significant changes as the drug is not yet FDA-approved; updated language under Policy/Criteria to effectively redirect prior authorization reviews to Precision Drug Action Committee (PDAC) Utilization Management Review; references reviewed and updated.
6/1/2026	CP.PHAR.729_PEPP	Vatiquinone (PTC743)_PEPP	2Q 2026 annual review: no significant changes as drug is not yet FDA-approved; references reviewed and updated.
6/1/2026	CP.PHAR.73	Sunitinib (Sutent)	2Q 2026 annual review: per NCCN, revised the following – for GIST, added requirement that disease is imatinib-sensitive KIT or PDGFRA mutant, added additional disease qualifier of gross residual (R2 resection) for combination therapy, and replaced requirement for use of Sprycel with Sutent prior to Sutent+everolimus combination therapy; for chordoma, thymic carcinoma, and soft tissue sarcoma, specified use a single agent; for differentiated thyroid carcinoma, modified requirement for radioactive iodine-refractory disease to apply only to papillary and follicular carcinomas; added off-label uses of meningioma and dedifferentiated chondrosarcoma; for Medicaid and HIM, extended initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.74	Erlotinib (Tarceva)	2Q 2026 annual review: for kidney cancer, removed single-agent therapy option per NCCN; revised initial approval durations for Medicaid/HIM to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.75	Bexarotene (Targretin Capsules, Gel)	2Q 2026 annual review: no significant changes; modified Medicaid/HIM initial approval duration from 6 to 12 months per standard oncology approach; references reviewed and updated.
9/1/2026	CP.PHAR.759	Nerandomilast (Jascayd)	Per March SDC, for IPF added redirection through both generic pirfenidone and Ofev; for PPF added redirection through Ofev
9/1/2026	CP.PHAR.76	Nilotinib (Tasigna, Danziten)	2Q 2026 annual review: added new branded product Nilceya to criteria;, generic nilotinib is now available, so clarified generic redirection by removing ‘if available’ and for Danziten and Nilceya added step therapy bypass for IL HIM per IL HB 5395; for Medicaid/HIM revised initial approval duration from 6 to 12 months; extended off-label use to other nilotinib formulations; references reviewed and updated.
6/1/2026	CP.PHAR.77	Temozolomide (Temodar)	2Q 2026 annual review: for off-label NCCN Compendium, added criteria for metastatic Ewing sarcoma, neuroblastoma in combination with irinotecan, naxitamab-gqgk, and sargramostim, borderline/malignant phyllodes tumor of the breast, epithelioid hemangioendothelioma, mucosal melanoma, adult high-grade glioma, and leptomeningeal metastases; for all indications, extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PHAR.771_PEPP	Dalnacogene Ponparvovec (BBM-H901)_PEPP	Policy created pre-emptively.
6/1/2026	CP.PHAR.772_PEPP	Doruxapapogene Ralaplasmid (INO-3107)_PEPP	Policy created pre-emptively.

6/1/2026	CP.PHAR.773_PEPP	Veligrotug (VRDN-001)_PEPP	Policy created pre-emptively.
6/1/2026	CP.PHAR.774_PEPP	Vusolimogene Oderparepvec (RP1)_PEPP	Policy created pre-emptively.
6/1/2026	CP.PHAR.775	Sibeprenlimab-szsi (Voyxact)	Policy created
6/1/2026	P.PHAR.776_PEP	Gefurulimab (ALXN1720)_PEPP	Policy created pre-emptively
9/1/2026	CP.PHAR.78	Thalidomide (Thalomid)	2Q 2026 annual review: for MCD, removed option as use in active idiopathic MCD without organ failure per NCCN; for MM, ENL and off-label NCCN compendium indications, extended initial approval durations from 6 months to 12 months for this maintenance medication for a chronic condition; revised continued therapy duration for aphthous stomatitis or ulcers to 6 months; references reviewed and updated.
6/1/2026	CP.PHAR.88	Belimumab (Benlysta)	2Q 2026 annual review: no significant changes; added Gazyva as an example of a biologic that is excluded for concurrent use; references reviewed and updated.
6/1/2026	CP.PHAR.90	Crizotinib (Xalkori)	2Q 2026 annual review: no significant changes; revised initial approval durations for Medicaid/HIM to 12 months; references reviewed and updated.
6/1/2026	CP.PHAR.92	Tetrabenazine (Xenazine)	2Q 2026 annual review: no significant changes; added Ingrezza Sprinkle to the concurrent use exclusion; revised initial approval durations from 6 to 12 months for Medicaid/HIM; references reviewed and updated.
6/1/2026	CP.PMN.110	Crisaborole (Eucrisa)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PMN.117	Naproxen/Esomeprazole (Vimovo)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PMN.119	Ozenoxacin (Xepi)	2Q 2026 annual review: clarified maximum dose in initial and continued therapy; references reviewed and updated.
6/1/2026	CP.PMN.120	Ibuprofen/Famotidine (Duexis)	2Q 2026 annual review: extended initial approval duration from 6 to 12 months; references reviewed and updated.
6/1/2026	CP.PMN.124	Itraconazole (Sporanox, Tolsura)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PMN.125	Milnacipran (Savella)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PMN.127	Fentanyl IR (Actiq, Fentora, Lazanda, Subsys)	Retire. products discontinued
6/1/2026	CP.PMN.128	Dutasteride (Avodart), Dutasteride/Tamsulosin (Jalyn)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PMN.130	Cysteamine Ophthalmic (Cystaran, Cystadrops)	2Q 2026 annual review: extended initial approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PMN.136	Mecamylamine (Vecamyl)	2Q 2026 annual review: extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PMN.138	Age Limit Override (Codeine, Tramadol, Hydrocodone)	2Q 2026 annual review: updated Appendix D with revised language and exception for Tennessee; references reviewed and updated.
6/1/2026	CP.PMN.154	Isavuconazonium (Cresemba)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PMN.192	Brimonidine Tartrate (Mirvaso)	2Q 2026 annual review: no significant changes; standardized approval duration language for Commercial to align with Medicaid/HIM; added that plan-approved quantity limit may apply; references reviewed and updated.
9/1/2026	CP.PMN.193	Hydroxyurea (Siklos, Xromi)	2Q 2026 annual review: for oncology off-label indications, added specialist requirement for an oncologist or hematologist; references reviewed and updated.
6/1/2026	CP.PMN.196	Rifamycin (Aemcolo)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PMN.198	Overactive Bladder Agents	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PMN.199	Esketamine (Spravato)	2Q 2026 annual review: no significant changes; revised TRD initial approval duration to 3 months and up to 48 nasal spray devices; references reviewed and updated.
9/1/2026	CP.PMN.209	Solriamfetol (Sunosi)	2Q 2026 annual review: added requirement for OSA that Sunosi is prescribed concurrently with continued use of positive airway pressure therapy; revised CPAP requirement to allow any positive airway pressure therapy (e.g., BiPAP); for continued therapy added improvement in reported daytime wakefulness as an example of positive response to therapy; references reviewed and updated.
6/1/2026	CP.PMN.221	Pitolisant (Wakix)	2Q 2026 annual review: RT4: for narcolepsy with cataplexy, revised age and dosing to allow use in patients 6 years of age and older per updated prescribing information; references reviewed and updated.
6/1/2026	CP.PMN.235	Emtricitabine/Tenofovir Alafenamide (Descovy)	2Q 2026 annual review: for PrEP, added requirement that Descovy is not prescribed concurrently with any other antiretroviral medications for PrEP; references reviewed and updated.
6/1/2026	CP.PMN.262	Quinine Sulfate (Qualaquin)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PMN.264	Viloxazine (Qelbree)	2Q 2026 annual review: no significant changes; revised initial approval duration from 6 months to 12 months; references reviewed and updated.
6/1/2026	CP.PMN.275	Levoketoconazole (Recorlev)	2Q 2026 annual review: no significant changes; extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PMN.277	Ulcer Therapy Products	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PMN.278	Ganaxolone (Ztalmy)	2Q 2026 annual review: extended initial approval duration from 6 to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PMN.287	Nabumetone Double-Strength (Relafen DS)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	CP.PMN.293	Berdazimer (Zelsuvmi)	2Q 2026 annual review: no significant changes; incorporated existing approval duration into criteria by adding requirement that requested duration of treatment does not exceed 12 weeks; references reviewed and updated.
6/1/2026	CP.PMN.294	Budesonide (Eohilia, Uceris)	2Q 2026 annual review: no significant changes; for EoE, revised quantity limit from 20 mL to 2 packets to better reflect product availability and incorporated existing approval duration into criteria by adding requirement that requested duration of treatment does not exceed 12 weeks; references reviewed and updated.
6/1/2026	CP.PMN.295	Semaglutide (Wegovy)	2Q 2026 annual review: modified preferred liraglutide product to state 'liraglutide (generic Victoza)'; references reviewed and updated.
6/1/2026	CP.PMN.298	Tirzepatide (Zepbound)	2Q 2026 annual review: revised language for members with concurrent T2DM language from "failure" to "member has received optimal diabetic standard of care therapy as evidenced by a trial" to align with drug class; modified preferred liraglutide product to state 'liraglutide (generic Victoza);' for OSA continued therapy, clarified "physician directed" weight loss program; RT4: added new multi-dose vial dosage form and new KwikPen dosage form; references reviewed and updated.
6/1/2026	CP.PMN.301	Suzetrigine (Journavx)	2Q 2026 annual review: no significant changes; RT4: updated FDA approved indication to include postoperative pain per PI; references reviewed and updated.
6/1/2026	CP.PMN.305	GLP-1 RA Weight Management Benefit for Pediatric Members	2Q 2026 annual review: no significant changes; updated MDRP table in Appendix D with IL-specific policies to use for IL Meridian and Youthcare Medicaid per health plan request; references reviewed and updated.
6/1/2026	CP.PMN.307	Tradipitant (Nereus)	Policy created.
6/1/2026	CP.PMN.33	Pregabalin (Lyrica*, Lyrica CR)	2Q 2026 annual review: no significant changes; references reviewed and updated.
9/1/2026	CP.PMN.35	Armodafinil (Nuvigil)	2Q 2026 annual review: added requirement for OSA that armodafinil (Nuvigil) is prescribed concurrently with continued use of positive airway pressure therapy; revised CPAP requirement to allow any positive airway pressure therapy (e.g., BiPAP); references reviewed and updated.
9/1/2026	CP.PMN.39	Modafinil (Provigil)	2Q 2026 annual review: added requirement for OSA that modafinil (Provigil) is prescribed concurrently with continued use of positive airway pressure therapy; revised CPAP requirement to allow any positive airway pressure therapy (e.g., BiPAP); references reviewed and updated.
9/1/2026	CP.PMN.42	Sodium Oxybate (Xyrem, Lumryz) and Calcium, Magnesium, Potassium, and Sodium Oxybate (Xywav)	2Q 2026 annual review: for continued therapy added requirement for brand Xyrem requests, member must use sodium oxybate (generic Xyrem); references reviewed and updated.
6/1/2026	CP.PMN.48	Cyclosporine (Cequa, Restasis, Verkazia, Vevye, Klarity-C)	2Q 2026 annual review: for all indications, extended initial and continued therapy approval duration from 6 months to 12 months for this maintenance medication for a chronic condition; references reviewed and updated.
6/1/2026	CP.PMN.79	Doxycycline Hyclate (Acticlate, Doryx), Doxycycline (Oracea)	2Q 2026 annual review: no significant changes; added references to doxycycline hyclate (generic Acticlate); references reviewed and updated.

6/1/2026	CP.PMN.80	Minocycline ER (Emrosi, Solodyn, Ximino, Minolira), Microspheres (Arestin), Foam (Zilxi)	2Q 2026 annual review: no significant changes; removed references to Ximino as product is discontinued; references reviewed and updated.
6/1/2026	CP.PMN.86	Oxymetazoline (Rhofade, Upneeq)	2Q 2026 annual review: no significant changes; standardized approval duration language for Commercial to align with Medicaid/HIM; added that plan-approved quantity limit may apply; references reviewed and updated.
6/1/2026	HIM.PA.08	Entecavir (Baraclude)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	HIM.PA.100	Non-Formulary and Formulary Contraceptives	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	HIM.PA.109	Step Therapy	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	HIM.PA.139	Opioid Analgesics*	2Q 2026 annual review: removed disclaimers directing to CP.PMN.127 for fentanyl IR products due to policy retirement; updated Appendix D with revised language and exception for Tennessee; references reviewed and updated.
6/1/2026	HIM.PA.168	Repository Corticotropin Injection (Acthar Gel, Purified Cortrophin Gel)	2Q 2026 annual review: no significant changes; references reviewed and updated.
6/1/2026	HIM.PA.178	Immune Globulins	2Q 2026 annual review: for CAR-T cell-related toxicities, added use for AIDP-type picture or bilateral facial palsy per NCCN; added off-label indications for immune checkpoint inhibitor-related toxicities, LCHI/ND, HIT, and pediatric ALL per NCCN; added HCPCS code [J1553]; references reviewed and updated.
6/1/2026	HIM.PA.46	Butorphanol Nasal Spray	2Q 2026 annual review: updated Appendix D with revised language and exception for Tennessee; references reviewed and updated.
6/1/2026	HIM.PA.SP60	Biologic and Non-biologic DMARDs	2Q 2026 annual review: RT4: added newly approved autoinjector formulation for Pyzchiva; RT4: added newly approved single-dose vial for SC injection for Selarsdi; RT4: applied Idacio's pediatric age extensions for HS and UV; no other significant changes; references reviewed and updated.
6/1/2026	HIM.PA.SP69	Dupilumab (Dupixent)	RT4: added new indication for AFRS per updated prescribing information.