Department of Medicaid

30 Day Change Notice
Effective Date: April 1, 2025

NEW PREFERRED DRUGS	
THERAPEUTIC CLASS	**NO PA REQUIRED PREFERRED**
Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY	VIGAFYDE
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY	desvenlafaxine succ ER (gen of PRISTIQ)
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	ONYDA XR SUSP
Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY	emtricitabine

NEW CLINICAL PA REQUIRED PREFERRED DRUGS	
THERAPEUTIC CLASS	**CLINICAL CRITERIA REQUIRED PREFERRED**
Immunomodulator Agents: Systemic Inflammatory Disease	adalimumab-adaz (gen of HYRIMOZ) EBGLYSS TREMFYA

NEW NON-PREFERRED DRUGS	
THERAPEUTIC CLASS	**PA REQUIRED NON-PREFERRED**
Cardiovascular Agents: Angina, Hypertension and Heart Failure	TRYVIO
Central Nervous System (CNS) Agents: Antidepressants* LEGACY CATEGORY	desvenlafaxine ER (gen of KHEDEZLA)
Central Nervous System (CNS) Agents: Atypical Antipsychotics* LEGACY CATEGORY	COBENFY
Central Nervous System (CNS) Agents: Parkinson's Agents	CREXONT
Central Nervous System (CNS) Agents: Skeletal Muscle Relaxants, Non-Benzodiazepine	TANLOR
Immunomodulator Agents: Systemic Inflammatory Disease	HYRIMOZ (Bio of HUMIRA)
Infectious Disease Agents: Antivirals – HIV* LEGACY CATEGORY	EMTRIVA
Topical Agents: Corticosteroids	diflorasone diacetate
Topical Agents: Immunomodulators	ZORYVE CREAM, FOAM

THERAPEUTIC CATEGORIES WITH CHANGES IN CRITERIA
Analgesic Agents: Opioids
Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants
Cardiovascular Agents: Angina, Hypertension and Heart Failure
Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY
Central Nervous System (CNS) Agents: Anticonvulsants Rescue

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Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents
Endocrine Agents: Endometriosis
Respiratory Agents: Inhaled Agents
Topical Agents: Antifungals
Topical Agents: Immunomodulators

REVISED THERAPEUTIC CATEGORY CRITERIA	
THERAPEUTIC CLASS	**SUMMARY OF CHANGE**
Analgesic Agents: Opioids	**MORPHINE SULFATE ER (~~KADIAN,~~ MS CONTIN) ~~& TAPENTADOL ER (NUCYNTA)~~ CRITERIA:** • Unless receiving for cancer pain, palliative care, or end-of-life/hospice care, must provide documentation of an inadequate clinical response with at least one opioid formulation taken for at least 30 of the last 60 days • Must also meet LONG-ACTING OPIOID CRITERIA
Blood Formation, Coagulation, and Thrombosis Agents: Oral Anticoagulants	**AR** – PRADAXA PELLET PAK, XARELTO SUSP: a PA is required for patients ~~older than~~ 12 years ~~old~~ and older
Cardiovascular Agents: Angina, Hypertension and Heart Failure	**ADDITIONAL APROCITENTAN (TRYVIO) CRITERIA:** • Must have had an inadequate clinical response of at least 30 days of at least four different classes of antihypertensive medications concurrently without adequate blood pressure control
Central Nervous System (CNS) Agents: Anticonvulsants* LEGACY CATEGORY	**AR** – BRIVIACT SOLUTION: a PA is required for patients 12 years and older **AR** – EPRONTIA SOLUTION: a PA is required for patients 12 years and older **AR** – vigabatrin powder: a PA is required for patients ~~3~~ 2 years and older **AR** – VIGAFYDE SOLUTION: a PA is required for patients 2 years and older
Central Nervous System (CNS) Agents: Anticonvulsants Rescue	**AR** – LIBERVANT: a PA is required for patients older than 5 years old and older
Central Nervous System (CNS) Agents: Attention Deficit Hyperactivity Disorder Agents	**AR** – ONYDA XR SUSP: a PA is required for patients 12 years and older
Endocrine Agents: Endometriosis	**ADDITIONAL INFORMATION:** • A total lifetime duration of therapy of 730 days between ~~Oriahnn~~ ORILISSA and MYFEMBREE or 365 days for LUPRON DEPOT will be authorized

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Respiratory Agents: Inhaled Agents	**ADDITIONAL BUDESONIDE/ALBUTEROL (AIRSUPRA) CRITERIA:** • Must have had an inadequate clinical response of at least 14 days with either DULERA or SYMBICORT
Topical Agents: Antifungals	~~**ADDITIONAL INFORMATION**~~ • ~~Requests may be authorized if:~~ ○ ~~The infection is caused by an organism resistant to preferred antifungal drugs (note diagnosis and any culture/sensitivity results)~~
Topical Agents: Immunomodulators	**ADDITIONAL ROFLUMILAST (ZORYVE) CRITERIA:** • **0.15% CREAM:** Must have had an inadequate clinical response of at least 30 days with at least one preferred topical corticosteroid OR topical calcineurin inhibitor • **0.3% CREAM:** Must have had an inadequate clinical response of at least 30 days with at least one preferred topical corticosteroid OR topical calcipotriene • **FOAM:** Must have had an inadequate clinical response of at least 30 days with at least one preferred agent indicated for Seborrheic Dermatitis (such as a topical antifungal, topical calcineurin inhibitor, or topical corticosteroid)