Formulary Updates

DEFINITIONS

Formulary	These drugs are included in Mass General Brigham's covered drug list.
Non-Formulary	These drugs are not included in Mass General Brigham's formulary. The plan would only cover formulary alternatives. Providers can request Non-Formulary drugs as an exception, and the plan would require trial of all appropriate formulary alternatives prior to approving coverage of a Non-Formulary drug. If a Non-Formulary drug is approved, the member's cost sharing would be the highest tier.
Preferred	These drugs are on Mass General Brigham's formulary and offer a lower cost to members.
Non-Preferred	These drugs are on Mass General Brigham's formulary but offer a higher cost to members.
Excluded	Mass General Brigham does not cover these drugs. Members will receive a denial for all Excluded drug requests.

Updates for Commercial Members

Effective 07/01/2026
PHARMACY BENEFIT

The following changes are being made to the listed medications and classes on the pharmacy benefit:

Denosumab	• Enoby will be added to the formulary as a preferred Prolia biosimilar and will require prior authorization. Jubbonti and Stoboclo will continue to be preferred Prolia biosimilars and managed with prior authorization. • Xtrenbo will be added to the formulary as a preferred Xgeva biosimilar and will require prior authorization. Osenvelt and Wyost will continue to be preferred Xgeva biosimilars and managed with prior authorization. • Initial and reauthorization criteria for Prolia and nonpreferred biosimilars will require trial and failure with all of the following: Enoby AND Jubbonti AND Stoboclo. • Initial and reauthorization criteria for Xgeva and nonpreferred biosimilars will require trial and failure with all of the following: Osenvelt AND Wyost AND Xtrenbo.
Infliximab	• Avsola will be co-preferred with Inflectra. Criteria for Avsola will no longer require trial and failure with Inflectra and other diagnosis-specific biologic agents.

	• Initial and reauthorization criteria for Infliximab, Remicade and Renflexis will require trial and failure with both Avsola AND Inflectra. The diagnosis-specific biologic trial requirements in the initial and reauthorization criteria will remain the same.
Hysingla ER, Oxycontin	• Hysingla ER and Oxycontin will be moved to nonformulary status and will be removed from the Opioid Risk Management policy. Requests will be reviewed against the nonformulary criteria.
Crexont, Rytary	• Crexont and Rytary will be moved to nonformulary status. Requests will be reviewed against the nonformulary criteria. • The policy for Crexont and Rytary will be retired.
Forteo, Bonsity, Teriparatide, Tymlos	• Brand Forteo will be moved to nonformulary status. Prior authorization will be required to initiate or continue treatment with brand Forteo and requests will be reviewed against the nonformulary criteria. • Teriparatide (Alvogen manufacturer) will remain on the formulary on the nonpreferred specialty tier with prior authorization. All other generic teriparatide products will be moved to nonformulary status. Prior authorization will be required to initiate or continue treatment with generic teriparatide (non-Alvogen) and requests will be reviewed against the nonformulary criteria. • Any active authorizations for brand Forteo or generic teriparatide (non-Alvogen) will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy. • Bonsity and Tymlos will remain on the formulary on the nonpreferred specialty tier with prior authorization. • Initial criteria for teriparatide (Alvogen), Bonsity and Tymlos will require diagnosis (postmenopausal osteoporosis or osteopenia, or primary or hypogonadal osteoporosis or osteopenia), and either a) BMD T-score ≤ -2.5 and a history of fracture or trial and failure with one osteoporosis treatment, or b) BMD T-score between -1.0 and -2.5 and either i) history of fracture, or ii) trial and failure with osteoporosis treatment and FRAX 10-year probabilities of major osteoporotic fracture at of at least 20% or hip fracture of at least 3%, or iii) history of fragility fracture. • Reauthorization criteria for teriparatide (Alvogen), Bonsity and Tymlos will require that either the member has been treated for less than 24 months and has experienced clinical benefit without significant adverse effects, or that the member has been treated for more than 24 months and remains at high risk for fracture.
Tysabri	• Tysabri will be moved to the nonpreferred specialty tier. Prior authorization restrictions and criteria will remain the same.
Rezdiffra	• Initial and reauthorization criteria for metabolic dysfunction-associated steatohepatitis (MASH) are being updated to require submission of medical records (e.g., chart notes) to demonstrate criteria are met.

	• To meet initial criteria, in addition to having a diagnosis of MASH, members must meet all of the following: a) be at least 18 years of age, b) absence of cirrhosis, c) have fibrosis stage 2 or 3 confirmed either by i) FIB-4 score greater than or equal to 1.3 AND either ELF test or liver stiffness measurement (LSM) by vibration-controlled transient elastography (VCTE), or ii) one of the following: FibroScan aspartate aminotransferase (FAST), MRI aspartate aminotransferase (MAST), magnetic Resonance Elastography combined with fibrosis-4 index (MEFIB), liver biopsy within the past 12 months, d) use Rezdiffra as an adjunct to lifestyle modification (e.g., dietary or caloric restriction, exercise, behavioral support, community-based program), e) have at least one metabolic risk factor (e.g., type 2 diabetes, hypertension, obesity, reduced HDL cholesterol, raised cholesterol), f) Rezdiffra is prescribed by or in consultation with one of the following: gastroenterologist, hepatologist, endocrinologist, g) member has been counseled on alcohol consumption, h) member will not use Rezdiffra in combination with Wegovy for treatment of MASH. • To meet reauthorization criteria, all of the following must be met: a) positive clinical response to therapy, or ongoing stability (e.g., improvement in liver function tests (LFTs), fibrosis stage improvement, improvement from baseline on MASH-specific imaging [VCTE ≥ 25%, MRE ≥ 20%, etc.], etc.), b) Rezdiffra will continue to be used as an adjunct to lifestyle modification (e.g. dietary or caloric restriction, exercise, behavioral support, community-based program), c) member has not progressed to cirrhosis, d) requested medication is not being co-administered with Wegovy (semaglutide) for the treatment of MASH, e) prescribed by or in consultation with one of the following: gastroenterologist, hepatologist, endocrinologist. • A quantity limit of 1 tablet per day will apply.
Tryngolza	• Updating initial criteria to include diagnostic criteria for FCS and require trial and failure with standard of care triglyceride-lowering therapy. • Updating initial and reauthorization criteria to require that Tryngolza will not be used in combination with Redemplo.
Palsonify	• Updating initial criteria to remove Sandostatin LAR and Mycapssa as previous trial options.
Acne and Rosacea Medications	• Removing the following medications from the policy, as they are moving to nonformulary status: clindamycin 1% gel (once daily), sulfacetamide-sulfur 10%-5%, dapsone 5% gel, dapsone 7.5% gel, tretinoin microsphere 0.04% gel, tretinoin microsphere 0.1% gel. Prior authorization will be required to initiate or continue treatment with these agents and requests will be reviewed against the nonformulary criteria. Any active authorizations for these agents will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy. • These agents will be removed from the acne/rosacea step therapy program.
Attention Deficit Hyperactivity	• Removing methylphenidate transdermal patch (generic Daytrana) from the policy, as it is moving to nonformulary status. Prior authorization will be

Disorder (ADHD) Stimulants	required to initiate or continue treatment with methylphenidate transdermal patch and requests will be reviewed against the nonformulary criteria. Any active authorizations for methylphenidate transdermal patch will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy. • Methylphenidate transdermal patch will be removed from the ADHD stimulants step therapy program.
Antifungal Topical Agents	• The policy titled "Antifungal Topical Agents" will be retired, as Ecoza is moving to nonformulary status and all other second-line agents have been discontinued. Prior authorization will be required to initiate or continue treatment with Ecoza and requests will be reviewed against the nonformulary criteria. Any active authorizations for Ecoza will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy.
Retired policies for drugs moving to nonformulary status	• The following agents will be moving to nonformulary status and their respective policies will be retired: ○ Blujepa ○ Camzyos ○ Cardura XL ○ Cinryze ○ Deflazacort ○ Dojolvi ○ Droxidopa ○ Ferriprox ○ Glycerol phenylbutyrate (generic Ravicti) ○ Isturisa ○ Mupirocin ○ Nujo (topical immunomodulators ○ Olpruva ○ Palinzyq ○ Recorlev ○ Rezurock ○ Tarpeyo ○ Tascenso ○ Vivjoa ○ Zelapar ODT ○ Zileuton ER (leukotriene modifiers) • Prior authorization will be required to initiate or continue treatment with the agents listed above and requests will be reviewed against the nonformulary criteria. Any active authorizations for the medications listed above will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy.

Injectable CGRP Inhibitors	• Removing criteria for Ajovy from the policy as the agent is moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with Ajovy and requests will be reviewed against the nonformulary criteria. Any active authorizations for Ajovy will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy.
Glaucoma Step Therapy	• Removing Iyuzeh from the policy, as agent is moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with Iyuzeh and requests will be reviewed against the nonformulary criteria. Any active authorizations for Iyuzeh will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy. • Iyuzeh will be removed from the glaucoma step therapy program.
Growth Hormone	• Removing Humatrope from the policy as the agent is moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with Humatrope and requests will be reviewed against the nonformulary criteria. Any active authorizations for Humatrope will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy.
Hyaluronic Acid Derivative (HAD) for Joint Fluid Replacement	• Removing Gel-One, Monovisc, Synvisc and Synvisc One from the policy, as these agents are moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with these agents and requests will be reviewed against the nonformulary criteria. Any active authorizations for these agents will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy.
Imiquimod Agents	• Removing Zyclara 2.5% from the policy, as agent is moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with Zylcara 2.5% and requests will be reviewed against the nonformulary criteria. Any active authorizations for Zyclara 2.5% will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy.
Leuprolide Products	• Removing Camcevi from the policy, as agent is moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with Camcevi and requests will be reviewed against the nonformulary criteria. Any active authorizations for Camcevi will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy.
Long-Acting Granulocyte Colony Stimulating Factor Agents	• Removing Rolvedon from the policy, as agent is moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with Rolvedon and requests will be reviewed against the nonformulary criteria. Any active authorizations for Rolvedon will be terminated after June 30, 2026,

	and new prior authorization requests will need to be submitted to continue therapy. • Neulasta/Neulasta Onpro and Fulphila will continue to be the preferred long-acting GCSF agents and will continue to require prior authorization. Initial and reauthorization criteria for nonpreferred agents in the long-acting GCSF policy will continue to require trial and failure with Neulasta/Neulasta Onpro AND Fulphila.
Short-Acting Granulocyte Colony Stimulating Factor Agents	• Removing Nypozi from the policy, as agent is moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with Nypozi and requests will be reviewed against the nonformulary criteria. Any active authorizations for Nypozi will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy. • Zarxio will continue to be the preferred short-acting GCSF and will continue to require prior authorization. Initial and reauthorization criteria for nonpreferred agents in the short-acting GCSF policy will continue to require trial and failure with Zarxio.
Octreotide Products	• Removing Mycapssa and octreotide 10 mg, 20 mg, and 30 mg kit (Sandostatin LAR) from the policy, as these agents are moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with these agents and requests will be reviewed against the nonformulary criteria. Any active authorizations for these agents will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy.
Ophthalmic NSAIDs	• Removing Acuvail and Ilevro from the policy, as these agents are moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with these agents and requests will be reviewed against the nonformulary criteria. Any active authorizations for these agents will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy. • Acuvail and Ilevro will be removed from the ophthalmic NSAIDs step therapy program.
Ophthalmic Steroids	• Removing Lotemax 0.5% ophthalmic ointment and loteprednol 0.5% ophthalmic suspension from the policy, as both agents are moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with these agents and requests will be reviewed against the nonformulary criteria. Any active authorizations for these agents will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy. • Lotemax 0.5% ophthalmic ointment and loteprednol 0.5% ophthalmic suspension will be removed from the ophthalmic steroids step therapy program.

Topical Corticosteroids	• Removing triamcinolone aerosol solution, desoximetasone 0.05% ointment, desoximetasone 0.05% cream, and pramosone 2.5% lotion from the policy as these agents are moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with these agents and requests will be reviewed against the nonformulary criteria. Any active authorizations for these agents will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy. • These agents will be removed from the topical corticosteroids step therapy program.
Overactive Bladder Medications	• Removing fesoterodine ER from the policy, as the agent is moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with fesoterodine ER and requests will be reviewed against the nonformulary criteria. Any active authorizations for fesoterodine ER will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy. • Fesoterodine ER will be removed from the overactive bladder medications step therapy program.
Proton Pump Inhibitors	• Removing the following second-line step therapy agents, as they are moving to nonformulary status: omeprazole/sodium bicarbonate packets, rabeprazole sprinkle capsules, dexlansoprazole capsules, Prilosec packets for suspension, pantoprazole packets for suspension, lansoprazole ODT. • The third-line step therapy agent Konvomep will be removed from the policy, as it is moving to nonformulary status. • The following PPIs will continue to be covered without prior authorization or step therapy restrictions and will be considered first-line: omeprazole capsules (Rx only), pantoprazole tablets, lansoprazole 15 mg and 30 mg capsules (Rx only), esomeprazole capsules and tablets (Rx and OTC), rabeprazole tablets. • Esomeprazole packets for suspension will continue to be a second-line step-therapy agent, requiring trial and failure with at least two first-line agents. • For all PPIs moving to nonformulary status, prior authorization will be required to initiate or continue treatment with these agents and requests will be reviewed against the nonformulary criteria. Any active authorizations for these agents will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy.
Relistor	• Removing Relistor tablet from the policy, as it is moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with Relistor tablet and requests will be reviewed against the nonformulary criteria. Any active authorizations for Relistor tablet will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy. • Relistor injection will remain on the formulary and will continue to require prior authorization.

Sevenfact	• Removing Sevenfact from the NovoSevenRT/Sevenfact policy, as Sevenfact is moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with Sevenfact and requests will be reviewed against the nonformulary criteria. Any active authorizations for Sevenfact will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy.
Tasimelteon	• Removing Hetlioz LQ from policy, as agent is moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with Hetlioz LQ and requests will be reviewed against the nonformulary criteria. Any active authorizations for Hetlioz LQ will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy. • Updating reauthorization criteria for tasimelteon capsule (generic Hetlioz) to require submission of medical records (e.g., chart notes) documenting member has had a positive response to therapy.
Testosterone Products	• Removing Tlando and testosterone topical 1.62% (20.25 MG/1.25GM) transdermal gel from the policy, as these agents are moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with these agents and requests will be reviewed against the nonformulary criteria. • For Tlando and testosterone topical 1.62% (20.25 MG/1.25GM) transdermal gel, any active authorizations will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy. • Removing Androderm patch from the policy due to product discontinuation.
Vitamin D Analogues	• Removing brand and generic Sorilux from the policy, as the agents are moving to nonformulary status. Prior authorization will be required to initiate or continue treatment with brand and generic Sorilux and requests will be reviewed against the nonformulary criteria. Any active authorizations for these agents will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy.
Xadago	• Xadago is being removed from the policy shared with Inbrija and Nourianz, as it is being moved to nonformulary status. Prior authorization will be required to initiate or continue treatment with Xadago and requests will be reviewed against the nonformulary criteria. Any active authorizations for Xadago will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy.
Skeletal Muscle Relaxants	• Removing metaxalone 800 mg tablet as a first-line step therapy agent, as it is moving to nonformulary status. • Updating policy to indicate that cyclobenzaprine tablet 5 mg and 10 mg will be first-line step therapy agents. Cyclobenzaprine 7.5 mg tablet is moving to nonformulary status.

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- Updating policy to indicate that tizanidine capsule 6 mg will be a first-line step therapy agent, as will tizanidine tablet 2 mg and 4 mg. Tizanidine 2 mg, 4 mg, and 8 mg capsules are moving to nonformulary status.
- For all skeletal muscle relaxants moving to nonformulary status, prior authorization will be required to initiate or continue treatment with these agents and requests will be reviewed against the nonformulary criteria. Any active authorizations will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy. These agents will also be removed from the skeletal muscle relaxant step therapy program.

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<tr><td>Drugs Moving to Nonformulary Status</td><td>

- The drugs listed in the tablet below are moving to nonformulary status and will be removed from the pharmacy formulary. Prior authorization will be required to initiate or continue treatment and requests will be reviewed against criteria for nonformulary drugs. Any active authorizations for these agents will be terminated after June 30, 2026, and new prior authorization requests will need to be submitted to continue therapy.

<table>
<tr><th colspan="3">Drugs Moving to Nonformulary Status</th></tr>
<tr><td>ABIRATERONE TABLET 500MG</td><td>JAYTHARI TABLET</td><td>PRILOSEC POWDER FOR ORAL SUSPENSION</td></tr>
<tr><td>ACTIVNUTRIENTS CHEW TAB</td><td>JENLIVA CAPSULE</td><td>PRIMIDONE TABLET 125MG</td></tr>
<tr><td>ACUVAIL OPHTHALMIC SOLUTION</td><td>K/NA CITRATE CITRIC ACID SOLUTION</td><td>PROCORT CREAM</td></tr>
<tr><td>AJOVY AUTOINJECTOR, PREFILLED SYRINGE</td><td>KARBINAL ER SUSPENSION</td><td>PROCYSBI CAPSULE</td></tr>
<tr><td>ALAVERT D-12 TABLET</td><td>KETOPROFEN ER CAPSULE 200MG</td><td>PROCYSBI GRANULES PACKET</td></tr>
<tr><td>ALTITUSS LIQUID</td><td>KETOROLAC TROMETHAMINE INJ 30MG/ML</td><td>PROFOLA TABLET</td></tr>
<tr><td>AMOXICILLIN CAPSULE/ CLARITHROMYCIN TABLET/ LANSOPRAZOLE DR CAPSULE</td><td>KEYFOLIC TABLET</td><td>PROLATE TABLET</td></tr>
<tr><td>ANALPRAM HC LOTION</td><td>KEYLOSA TABLET</td><td>PROMETHAZINE HYDROCHLORIDE/PHENYLEPHRINE HYDROCHLORIDE ORAL SOLUTION</td></tr>
<tr><td>ANUCORT-HC SUPPOSITORY</td><td>KLARITY-A DROPS</td><td>PROMETHAZINE VC SYRUP</td></tr>
<tr><td>APOKYN INJECTION*</td><td>KLARITY-C OPTHALMIC EMULSION</td><td>PROXIVOL GEL 2%</td></tr>
<tr><td>BAXDELA TABLET</td><td>KLOR-CON/EF TABLET</td><td>PYQUVI ORAL SUSPENSION</td></tr>
<tr><td>BELLADONNA/OPIUM SUPPOSITORY</td><td>KONVOMEP SUSPENSION</td><td>QDOLO ORAL SOLUTION</td></tr>
<tr><td>BENSAL HP OINTMENT</td><td>K-PHOS NO 2 TAB</td><td>QUFLORA PED CHEWABLE TABLET</td></tr>
<tr><td>BESIFLOXACIN OPHTHALMIC SUSPENSION</td><td>KYMBEE TABLET</td><td>RABEPRAZOLE DR CAP 10MG</td></tr>
<tr><td>BIOCOTRON ORAL LIQUID</td><td>LANSOPRAZOLE ODT</td><td>RAYAVIT TABLET</td></tr>
<tr><td>BLUJEPA TABLET</td><td>LANTHANUM CHEW TAB</td><td>RECORLEV TABLET</td></tr>
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BP (SULFACETAMIDE SODIUM W/ SULFUR) EMULSION 10-1%)	LEVOCETIRIZINE ORAL SOLUTION	RELEVIA TABLET 27-1MG
BUDESONIDE ER TABLET	LEVORPHANOL TABLET	RELISTOR TABLET
BUTALBITAL/APAP/CAFFEINE 50 MG/325 MG/40 MG CAPSULE	LIDOCAINE TOPICAL SOLUTION 4%	REZUROCK TABLET
BUTALBITAL-ACETAMINOPHEN-CAFFEINE W/ CODEINE CAP 50MG-300MG-40MG-30 MG	LIQREV SUSPENSION	RIVASTIGMINE TRANSDERMAL PATCH
BUTRANS TRANSDERMAL PATCH*	LOTEMAX OPHTHALMIC OINTMENT 0.5%	ROLVEDON INJECTION
CALCIPOTRIENE AEROSOL FOAM	LOTEPREDNOL OPHTHALMIC SUSPENSION 0.5%	ROXICODONE TABLET 15 MG, 30 MG*
CAMCEVI INJECTION	LUTRATE DEPOT INJECTION	SAFETUSSIN DM LIQUID
CAMZYOS CAPSULE	MATRONEX TABLET	SALICYLIC ACID AEROSOL FOAM
CANDESARTAN TABLET	MATZIM LA TABLET	SALICYLIC ACID ER TOPICAL SOLUTION 28.5%
CANDESARTAN/HCTZ TABLET	MAXTUSSIN DM LIQUID	SALICYLIC ACID OINTMENT
CARBAMAZEPINE CHEWABLE TABLET 200MG	MECLOFENAMATE SODIUM CAPSULE	SALICYLIC ACID SHAMPOO
CARBINOXAMINE ER SUSPENSION 4MG/5ML	MESALAMINE DR TABLET 800MG	SALSALATE TABLET
CARDURA XL TABLET	METAXALONE TABLET 800MG	SELECT-OB CHEWABLE TABLET
CARVEDILOL ER CAPSULE	METHENAMINE MANDELATE TABLET	SELECT-OB+DHA PAK
CAYSTON	METHYLENE BLUE INJECTION	SELENIUM SULFIDE SHAMPOO 2.25%
CEM-UREA SOLUTION 45%	METHYLPHENIDATE TRANSDERMAL PATCH	SEVENFACT INJECTION
CHENODAL TABLET	METHYLTESTOSTERONE CAPSULE	SILVER NITRATE TOPICAL SOLUTION
CHLORDIAZEPOXIDE/CLIDINIUM CAPSULE	METOPIRONE CAPSULE	SODIUM SULFACETAMIDE GEL 10%
CHROMAGEN CAPSULE	METRONIDAZOLE CAP 375MG	SODIUM SULFACETAMIDE LIQUID WASH 10%
CINRYZE INJECTION	MICOTRIN AC CREAM	SODIUM SULFACETAMIDE SHAMPOO
CITRANATAL 90 DHA	MICOTRIN AL LIQUID	SODIUM SULFACETAMIDE SHAMPOO 9.8%
CITRANATAL ASSURE	MONOVISC INJECTION	SODIUM SULFACETAMIDE/ SULFUR LIQUID 9-4.5%
CITRANATAL B-CALM	MORPHINE SULFATE SUPPOSITORY	SODIUM SULFACETAMIDE/SULFUR CREAM 10-2%
CITRANATAL HARMONY	MS CONTIN TABLET*	SODIUM SULFACETAMIDE/SULFUR CREAM 9.8-4.8%
CLARINEX-D 12-HOUR TABLET	MUCOLYTE-DM LIQUID	SODIUM SULFACETAMIDE/SULFUR EMULSION 10-1%
CLINDAMYCIN GEL 1% ONCE-DAILY	MULTIPRO CAPSULE	SODIUM SULFACETAMIDE/SULFUR LIQUID 10-2%

CLOBETASOL AEROSOL 0.05% FOAM	MULTITAM TABLET	SODIUM SULFACETAMIDE/SULFUR LIQUID 10-5%
CLONIDINE TRANSDERMAL PATCH	MULTITOL-M TABLET	SODIUM SULFACETAMIDE/SULFUR LIQUID 9.8-4.8%
CONZIP CAPSULE	MUPIROCIN CREAM 2%	SODIUM SULFACETAMIDE/SULFUR LOTION 10-5%
COREVIA TABLET	MYCAPSSA CAPSULE	SODIUM SULFACETAMIDE/SULFUR SUSPENSION 8-4%
CORPHENA ORAL SOLUTION	NAFTIFINE CREAM 1%	SODIUM SULFACETAMIDE/SULFUR TOPICAL LOTION 9.8-4.8%
CORTANE-B LOTION	NAFTIFINE GEL 2%	SORBUGEN NR LIQUID
COVARYX TABLET	NALOCET TABLET	SORILUX AEROSOL FOAM
COVARYX HS TABLET	NAPROXEN SUSPENSION	SSS 10-5 AEROSOL 10-5% FOAM
CYCLOBENZAPRINE TAB 7.5MG	NAPROXEN DR TAB 375MG	STROVITE ONE TABLET
CYTRA K CRYSTALS	NEEVO DHA CAPSULE	SULFACETAMIDE SODIUM W/ SULFUR LIQUID WASH 9-4%
DAPSONE GEL	NEONATAL COMPLETE TABLET	SULFACLEANSE SUSPENSION 8-4%
DAYAVITE TABLET	NEONATAL PLUS TABLET	SULFAMEZ EMULSION 10-1%
DEFERIPRONE TABLET	NESTABS TAB	SULFAMYLON CREAM
DEFLAZACORT SUSPENSION	NESTABS DHA PAK	SYNTHROID TABLET*
DEFLAZACORT TABLET	NIACIN TABLET 500MG	SYNVISC INJECTION
DERMACINRX RIBOTIN-E TABLET	NIACOR TABLET 500MG	SYNVISC ONE INJECTION
DESLORATADINE TABLET	NICADAN TABLET	TALIVA CAPSULE
DESMOPRESSIN SOLUTION 1.5MG/ML	NICARDIPINE CAPSULE	TARPEYO CAPSULE
DESOXIMETASONE CREAM 0.05%	NICAZEL TABLET	TASCENSO ODT
DESOXIMETASONE OINTMENT 0.05%	NICAZEL FORTE TABLET	TELMISARTAN/HCTZ TABLET
DEXLANSOPRAZOLE DR CAPSULE	NISOLDIPINE ER TABLET	TESTOSTERONE GEL 1.62%
DIABETIC TUSSIN LIQUID COUGH DM	NITRO-DUR TRANSDERMAL PATCH	TETRACAINE INJECTION
DIABETIC TUSSIN LIQUID DM	NITRO-TIME ER CAPSULE	TIMOLOL MALEATE OPHTHALMIC GEL SOLUTION 0.5%
DIATROL TABLET	NORGESIC TABLET	TIMOLOL MALEATE OPHTHALMIC SOLUTION 0.25%
DICLOFENAC SODIUM/ MISOPROSTOL TABLET	NUCYNTA ER TABLET	TIMOLOL MALEATE OPHTHALMIC SOLUTION 0.5%
DILAUDID TABLET*	NUJO SOLUTION	TIMOLOL OPHTHALMIC GEL FORMING SOLUTION 0.25%
DILTIAZEM CD CAPSULE 360MG	NULEV TABLET	TIZANIDINE CAPSULE 2 MG, 4 MG, 8 MG
DILTIAZEM ER CAPSULE 120MG	NUTRALYN TABLET	TLANDO CAPSULE
DILTIAZEM ER TABLET 120 MG, 180 MG, 240MG, 300 MG, 360 MG, 420 MG	NUVESSA GEL	TOLNAFI-AL LIQUID
DILTIAZEM ER CAPSULE 360MG	NYPOZI	TOVET AEROSOL FOAM
DOJOLVI LIQUID	OB COMPLETE TABLET	TRAMADOL HCL CAPSULE ER

DONNATAL ELIXIR GRAPE	OB COMPLETE DHA CAP	TRAMADOL HCL TABLET 25MG, 75 MG
DONNATAL ELIXIR MINT	OB COMPLETE ONE CAP	TRAMADOL ORAL SOLUTION 5MG/ML
DOXERCALCIFEROL CAPSULE	OB COMPLETE PETITE CAPSULE	TRETINOIN MICROSPHERE GEL 0.04%
DOXYCYCLINE CAPSULE 40MG	OB COMPLETE PREMIER TABLET	TRETINOIN MICROSPHERE GEL 0.1%
DOXYCYCLINE MONOHYDRATE CAP 150MG	OCTREOTIDE KIT 10MG, 20 MG, 30 MG	TRETINOIN MICROSPHERE GEL 0.1% PUMP
DROXIDOPA CAPSULE	OLOPATADINE NASAL SPRAY	TRETINOIN MICROSPHERE PUMP GEL 0.04% PUMP
EC-NAPROXEN TABLET 375MG	OLPRUVA PAK	TRIAMCINOLONE ACETONIDE AEROSOL SPRAY
ECOZA AEROSOL FOAM	OMEPRAZOLE/SODIUM BICARBONATE CAPSULE	TRIAMTERENE CAPSULE
EEMT (ESTERIFIED ESTROGENS & METHYLTESTOSTERONE) TABLET	OMEPRAZOLE/SODIUM BICARBONATE POWDER FOR ORAL SUSPENSION	TRICITRATES SOLUTION
EEMT HS (ESTERIFIED ESTROGENS & METHYLTESTOSTERONE) TABLET	ONDANSETRON 16MG ODT	TRISTART DHA CAP
ENALAPRIL ORAL SOLUTION	ONEVITE TABLET	TRITONACIDE SOLUTION
EPINEPHRINE NASAL SOLUTION	OPIUM TINCTURE ORAL SOLUTION	UREA CREAM 39%
EPINEPHRINE SOLUTION PREFILLED SYRINGE 0.3MG (NOT generic EpiPen)	ORACIT SOLUTION	UREA CREAM 45%
ESGIC CAPSULE	ORPHENADRINE/ASPIRIN/ CAFFEINE TAB	UREA CREAM 47%
ESTERIFIED ESTROGENS/METHYLTESTOSTERONE HS TABLET	OXYCODONE AND ACETAMINOPHEN TABLET 7.5MG-300MG	UREA LOTION 40%
ESTERIFIED ESTROGENS/ METHYLTESTOSTERONE TABLET	OXYCODONE HCL TAB ABUSE DETER 15 MG	UREDEB CREAM 39%
ESTRATEST FS TABLET	OXYCODONE/APAP TABLET 10MG-300MG	VALSARTAN ORAL SOLUTION 20MG/5ML
ESTRATEST HS TABLET	OXYCODONE/APAP TABLET 2.5MG-300MG	VARDENAFIL ODT
EVERVITA TABLET	OXYCODONE/APAP TABLET 5MG-300MG	VEMLIDY TABLET
FEM PH GEL	PALYNZIQ INJECTION	VENEXA TABLET
FENOFIBRATE CAPSULE 130MG	PANTOPRAZOLE SODIUM DR SUSPENSION PACKET	VENEXA FE TABLET
FENOFIBRIC ACID TABLET 35MG, 105 MG	PAPAVERINE INJECTION	VENLAFAXINE ER TABLET 37.5MG, 75MG, 150 MG
FERRIPROX TWICE-A-DAY TABLET	PENICILLAMINE CAPSULE	VENTRIXYL TABLET
FESOTERODINE ER TABLET	PERCOCET TABLET*	VENTRIXYL FE TABLET
FINAZOL TABLET	PHENOBARBITAL/ HYOSCYAMINE SULFATE/ ATROPINE SULFATE/ SCOPOLAMINE ELIXIR	VEREGEN OINTMENT

FLUOXETINE TABLET 20MG	PHENOBARBITAL/ HYOSCYAMINE SULFATE/ ATROPINE SULFATE/ SCOPOLAMINE TABLET	VINATE DHA CAP 27-1.13MG
FOLAMAX TABLET	PHENOHYTRO ELIXIR	VITAFOL ULTRA CAP
FOLAPRIME TABLET	PHENOHYTRO TABLET	VITAFOL-NANO TAB
FOLATEN TABLET	PHENTERMINE TABLET 8MG	VITAFOL-OB TAB 65-1MG
FOLIFLEX TABLET	PHOSPHA 250 NEUTRAL TABLET	VITAFOL-OB+DHA PAK
FOLITIN-Z TABLET	PHOSPHOLINE OPHTHALMIC SOLUTION	VITAFOL-ONE CAPSULE
FOLIXIA TABLET	PLEXION NS SHAMPOO 9.8%	VITAMEDMD ONE RX/QUATREFOLIC CAP
FORTEO INJECTION	PONVORY TABLET	VITAMEZ CAPSULE
GEL-ONE INJECTION	PONVORY TABLET STARTER PACK	VITAPEARL CAPSULE
GLIPIZIDE TABLET 2.5MG	POTASSIUM CHLORIDE POWDER 40MEQ	VITATHELY TABLET
GLYCEROL PHENYLBUTYRATE LIQUID	POTASSIUM IODIDE ORAL SOLUTION	VITRAMYN TABLET
HC PRAMOXINE CREAM 2.5-1%	PRAMIPEXOLE ER TABLET	VITRANOL TABLET
HC PRAMOXINE RECTAL CREAM 2.5-1%	PRAMIPEXOLE ER TABLET	VITRANOL FE TABLET
HEMMOREX-HC SUPPOSITORY	PRAMOSONE CREAM 1-1%	VITREXATE TABLET
HETLIOZ LQ SUSPENSION	PRAMOSONE LOTION 2.5%	VITREXATE FE TABLET
HOVYN SOLUTION	PRAMOSONE OINTMENT 1%	VITREXYL TABLET
HUMATROPE	PRAMOSONE OINTMENT 2.5%	VITREXYL IRON TABLET
HYDROCORTISONE ACETATE SUPPOSITORY	PRAMOXINE-HC LOTION	VIVJOA CAPSULE
HYDROMORPHONE SUPPOSITORY	PREDNISOLONE TABLET	WELLFOLA TABLET
HYLAZINC TABLET	PREDNISONE INTENSOL CONCENTRAL ORAL SOLUTION	WESNATE DHA CAPSULE
HYOSCYAMINE SULFATE ORAL DROPS 0.125/ML	PREMESISRX TABLET	WESTGEL DHA CAPSULE
HYOSYNE DROPS 0.125MG/ML	PRENA1 CHEWABLE TABLE	XADAGO TABLET
ILEVRO OPHTHLAMIC DROPS	PRENA1 PEARL CAPSULE	XUREA CREAM 39%
IMBRUVICA TABLET 140MG, 280 MG	PRENAISSANCE CAPSULE	XYVONA TABLET
INDOMETHACIN SUSPENSION	PRENATAL PLUS TABLET	YONSA TABLET
IROSPAN 24/6	PRENATE AM TABLET	ZELAPAR ODT
ISOSORBIDE DINITRATE TABLET 40MG	PRENATE CHEWABLE TABLET 0.6-0.4MG	ZILEUTON ER TABLET
ISTURISA TABLET	PRENATE ENHANCE CAP	ZINTREXYL-C TABLET
IYUZEH OPHTHALMIC DROPS	PRENATE MINI CAPSULE	ZITHRANOL SHAMPOO
JAVYGTOR PAK*	PRENATE RESTORE CAPSULE	ZOMIG NASAL SPRAY 2.5 MG

	JAVYGTOR POWDER FOR ORAL SOLUTION*	PRENATRIX TABLET	ZYCLARA PUMP CREAM 2.5%
	JAVYGTOR TABLET*	PRENATRYL TABLET	
	JAYTHARI SUSPENSION	PREV-RX TABLET	
	*Coverage of generic not impacted		

Effective 07/01/2026
MEDICAL BENEFIT

The following changes are being made to the listed medications and classes on the medical benefit:

Denosumab	• Enoby will be added to the formulary as a preferred Prolia biosimilar and will required prior authorization. Jubbonti and Stoboclo will continue to be preferred Prolia biosimilars and managed with prior authorization. • Xtrenbo will be added to the formulary as a preferred Xgeva biosimilar and will require prior authorization. Osenvelt and Wyost will continue to be preferred Xgeva biosimilars and managed with prior authorization. • Initial and reauthorization criteria for Prolia and nonpreferred biosimilars will require trial and failure with a lof the following: Enoby AND Jubbonti AND Stoboclo. • Initial and reauthorization criteria for Xgevea and nonpreferred biosimilars will require trial and failure with all of the following: Osenvelt AND Wyost AND Xtrenbo. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Cosentyx IV	• Updating criteria for moderate-to-severe hidradenitis suppurativa, reducing minimum age to 12 years old. Also updating renewal criteria section and dosing table to reflect the addition of this new indication. • To review the criteria in full, refer to the following link: https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Nulibry	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods and to include number of days allowed. • Removing example of substrate replacement therapy from Universal Criteria. • To Billing Code/Availability section, removing discontinued HCPCS codes J3490 and C9399. • Adding Appendix A - Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Revcovi	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods and to include number of days allowed. • To ADA-SCID, adding option of likely pathogenic variants in the ADA gene for confirming diagnosis.

	• Adding Appendix A - Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Adzynma	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal period and to include number of days allowed for authorization durations. • Removing specific contraindications in criteria and replacing with general language indicating member does not have any FDA contraindications. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Akynzeo IV	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal period and to include number of days allowed for authorization durations. • Removing specific contraindications in criteria and replacing with general language indicating member does not have any FDA contraindications. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Aldurazyme	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods as well as include number of days allowed. • To MPS I, adding option of likely pathogenic variants in the IDUA gene for confirming diagnosis. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Bavencio	• Adding new indication for use in Colon Cancer, Rectal Cancer, and Small Bowel Adenocarcinoma with applicable criteria and dosing supported by NCCN. • To ICD 10 table adding the following per NCCN: C18.0, C18.2-C18.9, and C78.6 (related to Colon Cancer), C19, C20, C21.8 (related to rectal cancer), C78.00, C78.01, C78.02 and C78.7 (related to both Colon and Rectal Cancers) and C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, and Z85.068 (related to Small Bowel Adenocarcinoma). • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Brineura	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods and to include number of days allowed. • Removing specific contraindications in criteria and replacing with general language indicating member does not have any FDA contraindications. • Adding Appendix A - Non-Quantitative Treatment Limitations (NQTL) Factor Checklist.

	• https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Elaprase	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods as well as include number of days allowed. • To MPS II, adding option of likely pathogenic variants in the IDS gene for confirming diagnosis. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Elelyso	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal period and to include number of days allowed for authorization durations. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Elfabrio	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods as well as include number of days allowed. • To Fabry Disease, adding option of likely pathogenic variants in the GLA gene for confirming diagnosis. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Fabrazyme	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods and to include number of days allowed. • To Fabry Disease, adding option of likely pathogenic variants in the GLA gene for confirming diagnosis. • Adding Appendix A - Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Imfinzi	• To Ampullary Adenocarcinoma, updating to include intermediate performance status (ECOG PS 2) per NCCN update. • To Esophageal/EGJ Cancers, updating criteria for use as neoadjuvant therapy in combination with tremelimumab to better align with NCCN and the Imjudo policy. • Adding new indications for use in Colon Cancer, Rectal Cancer, and Small Bowel Adenocarcinoma with applicable criteria and dosing supported by NCCN. • To the dosing table, for neoadjuvant treatment of Esophageal/Gastric indications, added “including induction therapy” in combination with FLOT to

	clarify that the dosing for induction therapy in combo with FLOT for relieving dysphagia falls under neoadjuvant therapy. • Updating the verbiage in the Length of Authorization section to mirror changes made to dosing table. • To ICD 10 table, adding the following per NCCN: C18.0, C18.2-C18.9, and C78.6 (related to Colon Cancer), C19, C20, C21.8 (related to rectal cancer), C78.00, C78.01, C78.02 and C78.7 (related to both Colon and Rectal Cancers), and C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, and Z85.068 (related to Small Bowel Adenocarcinoma). • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Imjudo	• Administrative changes made throughout the policy. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Jemperli	• To dMMR/MSI-H Cancer initial therapy for Esophageal, Esophagogastric Junction, and Gastric cancers, adding allowance for use in patients with either no prior checkpoint inhibitor therapy or no tumor progression while on checkpoint inhibitor therapy when used in the first-line setting. • To dMMR/MSI-H Cancer, adding use as neoadjuvant therapy for advanced or metastatic Small Bowel Adenocarcinoma per NCCN. • To Anal Carcinoma, adding option for use in combination with paclitaxel and carboplatin for treatment of inguinal node recurrence or as first-line treatment of metastatic disease per NCCN. • To Dosage/Administration table, adding dosing for combination therapy for Anal Carcinoma. Corresponding updates being made to Length of Authorization section. • To Appendix 1 - Covered Diagnosis Codes, adding ICD-10 codes C50.A0-C50.A2 (related to Breast Cancer) per NCCN. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Kanuma	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods and to include number of days allowed. • To LAL Deficiency, adding option of likely pathogenic variants in the LIPA gene for confirming diagnosis. Added Appendix A - Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Lamzede	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal period and to include number of days allowed for authorization durations. • To Alpha Mannosidosis, adding option of likely pathogenic variants in the MAN2B1 gene for confirming diagnosis. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates

Lenmeldy	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods. • To Initial criteria, updating language for the pre-lab work and vaccine requirement. • To Initial and Renewal criteria, updating 'coverage' to 'prior authorization validity'. • Removing inactive HCPCS code J3590 – Unclassified biologics and J9399 - Unclassified drugs or biologicals, per IPD Analytics. • Adding Appendix A - Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Libtayo	• To Anal Carcinoma, adding combination use with paclitaxel and carboplatin for use as treatment of inguinal node recurrence or as first line therapy for metastatic disease per updates in NCCN. • Updating Length of Authorization section and Dosing/Administration table to reflect this new addition. • To NSCLC as subsequent therapy in combination, adding use for members with ERBB2 (HER2) mutations per NCCN. • To Appendiceal Neoplasms and Carincoma, removing specific use in neoadjuvant therapy as per NCCN this use falls under recurrent or metastatic disease. • To Rectal Cancer, adding option for use in locally unresectable or medically inoperable disease per changes in NCCN. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Loqtozi	• To Anal Carcinoma, adding use in combination with paclitaxel and carboplatin for use as treatment of inguinal node recurrence or as first line therapy for metastatic disease. Corresponding updates being made to the dosing box and length of authorization section to align with NCCN recommendations for this indication. • To Rectal Cancer, adding option for use in locally unresectable or medically inoperable disease per changes in NCCN. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Lumizyme	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal period and to include number of days allowed for authorization durations. • To Pompe Disease, adding option of likely pathogenic variants in the GAA gene for confirming diagnosis. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Mepsevvi	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods as well as include number of days allowed.

	• To MPS VI, adding option of likely pathogenic variants in the GUSB gene for confirming diagnosis. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Naglazyme	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods as well as include number of days allowed. • To MPS VI, adding option of likely pathogenic variants in the ARSB gene for confirming diagnosis. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Nexviazyme	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods and to include number of days allowed. • To Pompe Disease, adding option of likely pathogenic variants in the GAA gene for confirming diagnosis. • Adding Appendix A - Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Penpulimab-kcqx	• To Head and Neck cancers, adding use for oligometastatic disease in combination with cisplatin or carboplatin and gemcitabine as subsequent therapy. • To Appendiceal Neoplasms and Carcinomas, removing specific use in neoadjuvant therapy as per NCCN this use falls under recurrent or metastatic disease. • Per NCCN updates, adding indications of Colon Cancer, Rectal Cancer, Anal Carcinoma, and Small Bowel Adenocarcinoma per 2A recommendations. Corresponding updates being made to Dosage/Administration table and Length of Authorization for the addition of the new indications. • To Appendix 1 – Covered Diagnosis Codes, adding C17.0-C17.3, C17.8, C17.9, and Z85.068 (related to Small Bowel Adenocarcinoma), C18.0, C18.2-C18.9, C78.00-C78.02, C78.6, C78.7 and C19, C20 (Colon/Rectal Cancer), C21.0-C21.2, and C21.8(related to Anal Carcinoma), C30.0, C31.0, and Z85.818(related to Very Advanced Head and Neck Cancer). • Removing ICD-10 code C79.89(related to Very Advanced Head and Neck Cancer). • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Pombiliti	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods as well as include number of days allowed.

	• Removing specific contraindications in criteria and replacing with general language indicating member does not have any FDA contraindications. • To Pompe Disease, adding option of likely pathogenic variants in the GAA gene for confirming diagnosis. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Poteligeo	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods and to include number of days allowed for authorization durations, and to Initial and Renewal criteria to update 'coverage' to 'prior authorization validity'. • Adding Non-Quantitative Treatment Limitations (NQTL) Factor Checklist to appendix section. • Updating Mycosis Fungoides/Sezary Syndrome indication heading to Cutaneous Lymphomas (Mycosis Fungoides/Sezary Syndrome) to align with NCCN. • To Adult T-Cell Leukemia/Lymphoma, adding use in combination with CHOP as first-line therapy, continued treatment, or additional therapy per NCCN. Corresponding updates being made to Length of Authorization, Max Units, and Dosage/Administration sections. • Moving single-agent use from Universal Criteria to under indication specific headings. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Reblozyl	• Updating the up-titration dosing rules for Anemia Due to Myelodysplastic Syndromes. Updating the dosing table and renewal criteria sections to reflect this update. • Updating dosing table for both Beta Thalassemia and Anemia Due to Myelodysplastic Syndromes to more closely align with the changes made to the package insert. • Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods and to include the number of days for approval and addition of Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist to the policy as a part of the global changes being made across all policies. • Updating Initial and Renewal criteria to update 'coverage' to 'prior authorization validity'. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Rituximab IV	• To oncology indications, adding statement to allow KSHV-Associated Inflammatory Cytokine Syndrome to be excluded from CD20 positive requirement. • To Adult B-Cell Lymphomas - PTLD and Pediatric Aggressive B-Cell Lymphomas PTLD, adding option for prevention of EBV PTLD when member has EBV reactivation, indication was also added to length of auth section.

	• To Unicentric Castleman Disease, adding alternate first-line therapy for unresectable or incompletely resected disease per NCCN update. • To Management of Immune Checkpoint Inhibitor Related Toxicities, updating criteria on myositis to align with NCCN. • Splitting GPA/MPA criteria to allow for approvals as induction therapy in combination with steroids and maintenance therapy allowable with or without steroids to reflect guideline support for combination with steroid to induce remission and allow tapering or discontinuation of steroids when receiving maintenance therapy. • To Multiple Sclerosis, removing tables required for definitive diagnosis for RRMS, SPMS, and CIS. • To SLE/LN, removing criteria requiring confirmation of FDA labeled or compendia supported indication for use since rituximab is compendia supported for this use. • To Dosing table, adding voluntary dose reduction and/or interval extension recommendations. • Adding ICD-10 codes D89.89, & D89.9 related to KSHV-associated inflammatory cytokine syndrome. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Rituximab SC	• To universal criteria adding statement to allow for KSHV-Associated Inflammatory Cytokine Syndrome to be excluded from CD20 positive requirement. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Tecentriq IV	• To Length of Authorization, streamlining duration of use for adjuvant treatment of Colon Cancer. • To NSCLC, streamlining options for use in the adjuvant setting to align with NCCN. • To Colon Cancer, removing requirement for stage III disease for use in the adjuvant setting and instead allowing for treatment of stage IIC, III or metastatic disease. Also adding option for use as a single agent for locally unresectable, medically inoperable, advanced or metastatic disease per updated NCCN guidelines, along with dosing. • Adding new indications of Small Bowel Adenocarcinoma and Rectal Cancer with corresponding criteria and dosing per NCCN. • Updating Length of Authorization to accommodate new SBA indication. • To Appendix 1, adding ICD-10 codes C43.10 (related to Cutaneous Melanoma), C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, Z85.068 (related to Small Bowel Adenocarcinoma), C78.6 (related to Colon Cancer), C19, C20, C21.8 (related to Rectal Cancer), C78.00-C78.02, C78.7 (related to Colon and Rectal Cancer). • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Tevimbra	• To Esophageal, Esophagogastric & Gastric cancers, removing symbol leading to notes box from the indication heading and adding allowance for use in patients with either no prior checkpoint inhibitor therapy or no tumor progression while on checkpoint inhibitor therapy when used in the first-line setting for

	gastric cancer or in the first or subsequent-line setting for esophageal/GEJ cancer. • To Anal Carcinoma, adding option for use in combination with paclitaxel and carboplatin as treatment of inguinal node recurrence or first-line treatment of metastatic disease. Updating the dosing table and Length of Authorization to accommodate this new regimen. • To Appendiceal Neoplasms and Cancers, streamlining criteria to mirror other PD1/PD-L1 policies. • To Rectal Cancer, adding option for use in locally unresectable or medically inoperable per changes in NCCN. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Unloxcyt	• Adding Colon Cancer, Rectal Cancer, and Small Bowel Adenocarcinoma indication headings and criteria to Initial Approval Criteria section per NCCN. • Updated Dosing table to indicate that the dosing pattern listed applies to all indications. • Adding additional active NDC to the Billing Code/Availability section, per DrugIQ review. • To ICD10 table, added C18.0, C18.2-C18.9, C78.6 (related to Colon Cancer), C19, C20, C21.8 (related to Rectal Cancer), C78.00-C78.02, and C78.7 (related to both Colon and Rectal Cancer), C17.0, C17.1, C17.2, C17.3, C17.8, C17.9, and Z85.068 (related to Small Bowel Adenocarcinoma). • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Vimizim	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal periods as well as include number of days allowed. • To MPS VI, adding option of likely pathogenic variants in the GALNS gene for confirming diagnosis. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
VPRIV	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal period and to include number of days allowed for authorization durations. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Xenpozyme	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal period and to include number of days allowed for authorization durations. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist.

	• Updating Length of Authorization section to delineate between authorization durations for initial and renewal period and to include number of days allowed for authorization durations. • To ASMD, adding option of likely pathogenic variants in the SMPD1 gene for confirming diagnosis. • To Renewal Criteria, adding option of skeletal maturation assessment to align with baseline measures in Initial Criteria. • Adding Appendix A – Non-Quantitative Treatment Limitations (NQTL) Factor Checklist. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates
Zynyz	• Updating section heading for Anal Carcinoma, editorial changes to use with paclitaxel and carboplatin to add use as treatment of inguinal node recurrence per updates in NCCN. Updating Length of Authorization section and Dosing/Administration table to reflect changes to this indication. • To Appendiceal Neoplasms and Cancers, removing specific use in neoadjuvant therapy as per NCCN this use falls under recurrent or metastatic disease. • To Rectal Cancer, adding option for use in locally unresectable or medically inoperable disease per changes in NCCN. • https://gatewaypa.com/policydisplay/57/mgb-upcoming-policy-updates