P&T Committee Meeting Minutes
Medicaid
January 13, 2026

Present (via Teams):	**Absent:**
Bret Yarczower, MD, MBA – Chair	Amir Antonious, Pharm.D.
Leslie Astleford, Pharm.D.	Kristen Bender, Pharm.D.
Emily Bednarz, Pharm.D.	Alyssa Cilia, RPh
Jeremy Bennett, MD	Bhargavi Degapudi, MD
Angela Bolesta, Pharm.D.	Keri Donaldson, MD, MSCE
Kim Castelnovo, RPh	Michael Dubartell, MD
Kimberly Clark, Pharm.D.	Michael Evans, RPh
Kelly Faust, Pharm.D.	Nichole Hossler, MD
Tricia Heitzman, Pharm.D.	Jason Howay, Pharm.D.
Keith Hunsicker, Pharm.D.	Kerry Ann Kilkenny, MD
Kelli Hunsicker, Pharm.D.	Philip Krebs, R.EEG T
Emily Jacobson, Pharm.D.	Perry Meadows, MD
Dennis Janosczyk, Pharm.D.	Jonas Pearson, RPh
Alexandra Kempf-Malys, MSW, BSc	Michael Shepherd, MD
Briana LeBeau, Pharm.D.	Luke Sullivan, DO
Ted Marines, Pharm.D.	Amanda Taylor, MD
Lisa Mazonkey, RPh	
Tyreese McCrea, Pharm.D.	
Jamie Miller, RPh	
Mark Mowery, Pharm.D.	
Andrei Nemoianu, MD	
Austin Paisley, Pharm.D.	
Lauren Pheasant, Pharm.D.	
Kimberly Reichard, Pharm.D.	
Melissa Sartori, Pharm.D.	
Kristen Scheib, Pharm.D.	
Kirsten Smith, Pharm.D.	
Aubrielle Smith-Masri, Pharm.D.	
Michael Spishock, RPh	
Todd Sponenberg, Pharm.D.	
Jill Stone, Pharm.D.	
Kevin Szczecina, RPh	
Ariana Wendoloski, Pharm.D.	
Brandon Whiteash, Pharm.D.	
Margaret Whiteash, Pharm.D.	
Benjamin Andrick, Pharm.D. (non-voting participant)	
Jeremy Garris, Pharm.D. (non-voting participant)	
Tiffany O'Hagan, Pharm.D., MBA (non-voting participant)	

Call to Order: Dr. Bret Yarczower called the meeting to order at 1:02 p.m., Tuesday January 13, 2026.

Review and Approval of Minutes, Reviews, Fast Facts, and Updates: Dr. Bret Yarczower asked for a motion or approval to accept the November 11, 2025 minutes as written. Minutes approved unanimously. None were opposed.

DRUG REVIEWS

Blenrep (belantamab mafodotin-blmf)

Review: Blenrep is a B-cell maturation antigen (BCMA)-directed antibody indicated in combination with bortezomib and dexamethasone for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least two prior lines of therapy, including a proteasome inhibitor and an immunomodulatory agent.

Clinical Discussion: The committee unanimously voted to accept the recommendations.

Financial Discussion: The committee unanimously voted to accept the recommendations.

Outcome: Blenrep is a medical benefit that will be managed by GHP. It will require to ensure appropriate utilization. The following prior authorization criteria should apply:

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that Blenrep is prescribed by a hematologist or oncologist AND
- Medical record documentation the Blenrep will be given in combination with bortezomib and dexamethasone for the first 8 cycles then continued as a single agent AND
- Medical record documentation of relapsed or refractory multiple myeloma AND
- Medical record documentation that member has received at least two prior lines of therapy, including a proteasome inhibitor and an immunomodulatory agent.

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease

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RPH Signoff Required: Yes

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Keytruda Qlex (pembrolizumab/berahyaluronidase alfa-pmph)

Review: Keytruda Qlex is a new subcutaneous formulation of Keytruda

Clinical Discussion: The committee unanimously voted to accept the recommendations.

Financial Discussion: The committee unanimously voted to accept the recommendations.

Outcome: Keytruda Qlex is a medical benefit that will be managed by GHP. The following prior authorization criteria should apply

1. **Melanoma**

- Prescription written by a hematologist/oncologist AND
- Medical record documentation of one of the following:

Unresectable or metastatic melanoma:

- Medical record documentation that patient is ≥ 18 years of age AND
- A diagnosis of unresectable or metastatic melanoma AND
- Keytruda Qlex is not being used in combination with any other agents for the treatment of unresectable or metastatic melanoma.

OR

Adjuvant treatment of completely resected melanoma

- Medical record documentation that patient is ≥ 12 years of age AND
- A diagnosis of Stage IIB, IIC, or III melanoma, which has been completely resected AND
- Keytruda Qlex is being used in the adjuvant setting (following complete resection) AND
- Keytruda Qlex is being used as a single agent.

2. Neoadjuvant or Adjuvant Treatment of Non-Small Cell Lung Cancer (NSCLC)

- Prescription written by a hematologist/oncologist AND
- Medical record documentation that patient is ≥ 18 years of age AND
- Medical record documentation of one of the following:
    - Medical record documentation of Stage IB (T2a ≥ 4 cm), II, or IIIa non-small cell lung cancer (NSCLC) **AND**
    - Keytruda Qlex is being used in the adjuvant setting following resection and platinum-based chemotherapy **AND**
    - Keytruda Qlex is being used as a single agent

OR

    - Medical record documentation of resectable (Tumors ≥ 4 cm or Node Positive) non-small cell lung cancer (NSCLC) AND
    - Keytruda Qlex is being used in the neoadjuvant setting in combination with platinum containing chemotherapy then continued as a single agent in the adjuvant setting following resection

3. Metastatic Non-Small Cell Lung Cancer (NSCLC)

- Prescription written by a hematologist/oncologist AND
- Medical record documentation that patient is ≥ 18 years of age AND
- Medical record documentation of a diagnosis of metastatic NSCLC meeting one of the following situations:
    - Medical record documentation of stage III NSCLC, metastatic NSCLC, OR that the member is not a candidate for surgical resection or definitive chemoradiation **AND**
    - Medical record documentation that Keytruda Qlex is being used as first-line treatment AND
    - Medical record documentation that Keytruda Qlex is being given as monotherapy AND
    - Medical record documentation that tumors express PD-L1 (TPS) ≥1% as determined by an FDA-approved test AND
    - Medical record documentation that tumors do not have EGFR or ALK genomic tumor aberrations

OR

- Medical record documentation that Keytruda Qlex is being given as monotherapy AND Medical record documentation that tumors express PD-L1 (TPS) ≥1% as determined by an FDA-approved test **AND**
- Medical record documentation of disease progression on or after platinum-containing chemotherapy **AND**
- For patients with EGFR or ALK genomic tumor aberrations:
  - medical record documentation of disease progression on FDA-approved therapy for these aberrations prior to receiving Keytruda Qlex

OR

- Medical record documentation of metastatic nonsquamous NSCLC **AND**
- Medical record documentation that Keytruda Qlex will be given in combination with pemetrexed AND either carboplatin or cisplatin **AND**
- Medical record documentation that tumors do not have EGFR or ALK genomic tumor aberrations

OR

- Medical record documentation of metastatic squamous NSCLC AND
- Medical record documentation that Keytruda Qlex will be given in combination with carboplatin AND either paclitaxel or nab-paclitaxel AND
- Medical record documentation that Keytruda Qlex, carboplatin, and paclitaxel (or nab-paclitaxel) are being used as first-line treatment AND
- Medical record documentation that tumors do not have EGFR or ALK genomic tumor aberrations

4. Head and Neck Squamous Cell Carcinoma

- Prescription written by a hematologist/oncologist AND
- Medical record documentation that patient is ≥ 18 years of age AND
- Medical record documentation of one of the following:
  - A diagnosis of Head and Neck Squamous Cell Carcinoma that is recurrent or metastatic **AND**
  - Disease progression on or after platinum-containing chemotherapy **AND**
  - Keytruda Qlex is being used as a single agent.

OR

- A diagnosis of metastatic or unresectable, recurrent Head and Neck Squamous Cell Carcinoma AND
- Keytruda Qlex is being used as a first-line treatment AND
- Keytruda Qlex is being used as a single agent AND
- Tumors express PD-L1 [Combined Positive Score (CPS) ≥ 1] as determined by an FDA-approved test

OR

- A diagnosis of metastatic or unresectable, recurrent Head and Neck Squamous Cell Carcinoma AND
- Keytruda Qlex is being used as a first-line treatment AND

- Keytruda Qlex is being administered in combination with platinum chemotherapy and fluorouracil (FU)

OR

- A diagnosis of resectable locally advanced Head and Neck Squamous Cell Carcinoma AND
- Tumors express PD-L1 [Combined Positive Score (CPS) ≥ 1] as determined by an FDA-approved test AND
- Keytruda Qlex is being used as a single agent for neoadjuvant treatment, followed by adjuvant treatment in combination with radiotherapy (RT) with or without cisplatin and then as a single agent

5. Microsatellite Instability-High Cancer

- Prescription written by a hematologist/oncologist AND
- Medical record documentation of unresectable or metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) solid tumors OR colorectal cancer

AND

- For solid tumors:
  - Medical record documentation of progression following prior treatment(s) AND
  - Medical record documentation of no satisfactory alternative treatment options

6. Urothelial Carcinoma

- Prescription written by a hematologist/oncologist AND
- Medical record documentation that patient is ≥ 18 years of age AND
- Medical record documentation of locally advanced or metastatic urothelial carcinoma AND
- Medical record documentation of one of the following:
  - Disease progression during or following platinum-containing chemotherapy OR
  - Disease progression within 12 months of neoadjuvant or adjuvant treatment with platinum-containing chemotherapy OR
  - Patient is not eligible for any platinum-containing chemotherapy

OR

- Patient has high-risk, non-muscle invasive bladder cancer (NMIBC)** AND
- Patient's disease is unresponsive to an adequate trial of Bacillus Calmette-Guerin (BCG) therapy** AND
- Patient is ineligible for or has elected not to undergo cystectomy

OR

- Keytruda Qlex is being used in combination with Padcev

**Note:

- BCG-unresponsive high-risk NMIBC is defined as persistent disease despite adequate BCG therapy, disease recurrence after an initial tumor-free state following adequate BCG therapy, or T1 disease following a single induction course of BCG.
- Adequate BCG therapy was defined as administration of at least five of six doses of an initial induction course plus either of: at least two of three doses of maintenance therapy or at least two of six doses of a second induction course.

7. Gastric Cancer

- Prescription written by a hematologist/oncologist AND
- Medical record documentation that Keytruda will be used as first-line treatment AND
- Medical record documentation of one of the following:
    - Medical record documentation of a diagnosis of locally advanced unresectable or metastatic HER-2 positive gastric or gastroesophageal junction adenocarcinoma AND
    - Medical record documentation that tumors express PD-L1 (CPS≥1) as approved by an FDA approved test AND
    - Medical record documentation that Keytruda Qlex will be used in combination with trastuzumab, fluoropyrimidine- and platinum-containing chemotherapy

OR

    - Medical record documentation of locally advanced unresectable or metastatic HER-2 negative gastric or gastroesophageal junction (GEJ) adenocarcinoma AND
    - Medical record documentation that tumors express PD-L1 (CPS≥1) as approved by an FDA approved test AND
    - Medical record documentation that Keytruda Qlex will be used in combination with fluoropyrimidine- and platinum-containing chemotherapy

8. Cervical Cancer

- Prescription written by a hematologist/oncologist AND
- One of the following:
    - Medical record documentation of recurrent or metastatic cervical cancer AND
    - Medical record documentation that tumors express PD-L1 (CPS≥1) **AND**
    - Medical record documentation of disease progression after receiving at least one prior line of therapy

OR

    - Medical record documentation of persistent, recurrent or metastatic cervical cancer AND
    - Medical record documentation that tumors express PD-L1 (CPS≥1) AND
    - Medical record documentation that Keytruda Qlex will be used in combination with chemotherapy (paclitaxel, cisplatin or carboplatin), with or without bevacizumab

OR

- Medical record documentation of FIGO 2014 Stage III-IVA cervical cancer AND
- Medical record documentation that Keytruda Qlex will be used in combination with chemoradiotherapy (cisplatin and external beam radiation therapy [EBRT] followed by brachytherapy [BT])

*Note: FIGO 2014 Stage III-IVA includes patients with tumor involvement of the lower vagina with or without extension onto pelvic sidewall or hydronephrosis/non-functioning kidney or has spread to adjacent pelvic organs.

9. Hepatocellular Carcinoma (HCC)

- Prescription written by a hematologist/oncologist AND
- Medical record documentation that patient is ≥ 18 years of age AND
- Medical record documentation of a diagnosis of hepatocellular carcinoma secondary to Hepatitis B AND
- Medical record documentation of at least one (1) prior systemic therapy other than a PD-1 and PD-L1 containing regimen

10. Merkel Cell Carcinoma (MCC)

- Prescription written by a hematologist/oncologist AND
- Medical record documentation of a diagnosis of Merkel Cell Carcinoma AND
- Medical record documentation of metastatic and/or recurrent disease

11. Renal Cell Carcinoma (RCC)

- Prescription written by a hematologist/oncologist AND
- Medical record documentation that patient is ≥ 18 years of age AND
- Medical record documentation of one of the following:

Advanced Renal Cell Carcinoma

- Medical record documentation of a diagnosis of advanced renal cell carcinoma **AND**
- Medical record documentation that Keytruda Qlex is being used in combination with axitinib (Inlyta) OR lenvatinib (Lenvima) AND
- Medical record documentation that Keytruda Qlex in combination with axitinib (Inlyta) OR lenvatinib (Lenvima) is being used as first-line treatment for advanced disease

Note: In clinical trials, advanced disease included newly diagnosed or recurrent Stage IV renal cell carcinoma

OR

Adjuvant treatment of Renal Cell Carcinoma

- A diagnosis of renal cell carcinoma AND
- Documentation of intermediate-high or high risk of recurrence following nephrectomy, or following nephrectomy and resection of metastatic lesions AND
- Keytruda Qlex is being used in the adjuvant setting AND
- Keytruda Qlex is being used as a single agent

Note: In clinical trials, intermediate-high risk category included: pT2 with Grade 4 or sarcomatoid features; pT3, any Grade without nodal involvement (N0) or distant metastases (M0); and high risk included: pT4, any Grade N0 and M0; any pT, any Grade with nodal involvement and M0. The M1 no evidence of disease (NED) category includes patients with metastatic disease who had undergone complete resection of primary and metastatic lesions.

12. Esophageal Cancer

- Prescription written by a hematologist/oncologist AND
- Medical record documentation that patient is ≥ 18 years of age AND
- One of the following:
    - Medical record documentation of a diagnosis of locally advanced or metastatic squamous cell carcinoma of the esophagus or gastroesophageal junction (GEJ) AND
    - Medical record documentation that tumors express PD-L1 (CPS ≥10) as determined by an FDA-approved test AND
    - Medical record documentation of disease progression after one or more prior lines of systemic therapy for advanced disease.

OR

    - Medical record documentation of a diagnosis of locally advanced or metastatic esophageal or gastroesophageal junction (GEJ) carcinoma not amenable to surgical resection or definitive chemoradiation AND
    - Medical record documentation of use in combination with platinum (oxaliplatin or cisplatin) and fluoropyrimidine-based (fluorouracil or capecitabine) chemotherapy

13. Endometrial Carcinoma

- Prescription written by a hematologist/oncologist AND
- Medical record documentation of one of the following:
    - Medical record documentation of a diagnosis of primary advanced or recurrent endometrial carcinoma AND
    - Medical record documentation that Keytruda will be used in combination with carboplatin and paclitaxel followed by Keytruda Qlex as a single agent

OR

    - Medical record documentation of a diagnosis of advanced endometrial carcinoma AND
    - Medical record documentation of disease progression following at least one prior systemic therapy AND
    - Medical record documentation that patient is not a candidate for curative surgery or radiation AND
    - Medical record documentation of one of the following:
    - Medical record documentation that tumors are not microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) AND
    - Medical record documentation that Keytruda Qlex will be given in combination with lenvatinib (Lenvima)

OR

- Medical record documentation that Keytruda Qlex will be used as a single agent for treatment of tumors that are microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR)

14. Tumor Mutational Burden – High (TMB-H) Solid Tumors

- Prescription written by a hematologist/oncologist AND
- Medical record documentation of unresectable or metastatic solid tumors AND
- Medical record documentation that tumors are tumor mutational burden-high (TMB-H), defined as greater than or equal to 10 mutations per megabase (≥10 mut/Mb), determined by an FDA-approved test AND
- Medical record documentation of progression following prior treatment(s) AND
- Medical record documentation of no satisfactory alternative treatment options

15. Cutaneous Squamous Cell Carcinoma (cSCC)

- Prescription written by a hematologist/oncologist AND
- Medical record documentation of locally advanced, recurrent, OR metastatic cutaneous squamous cell carcinoma AND
- Medical record documentation that the patient's disease is not curable by surgery AND
- Medical record documentation that the patient's disease is not curable by radiation.

16. Triple Negative Breast Cancer

- Prescription written by a hematologist/oncologist AND
- Medical record documentation of age greater than or equal to 18 years AND
- Medical record documentation of one of the following:
    - Medical record documentation of locally recurrent unresectable or metastatic triple-negative breast cancer (TNBC) AND both of the following:
        - Medical record documentation that tumors express PD-L1 [Combined Positive Score (CPS) greater than or equal to 10] as determined by an FDA approved test **AND**
        - Medical record documentation that Keytruda Qlex will be given in combination with chemotherapy (paclitaxel, paclitaxel protein-bound, or gemcitabine and carboplatin).

OR

    - Medical record documentation of high-risk, early-stage triple-negative breast cancer (TNBC) AND
    - Medical record documentation that Keytruda Qlex will be given in combination with chemotherapy as neoadjuvant treatment, and then continued as a single agent as adjuvant treatment after surgery

LIMITATIONS: The treatment of patients with multiple myeloma with a PD-1 or PD-L1 blocking antibody in combination with a thalidomide analogue plus dexamethasone is not recommended outside of controlled clinical trials.

17. Biliary Tract Cancer

- Prescription written by a hematologist/oncologist AND

- Medical record documentation of locally advanced unresectable or metastatic biliary tract cancer AND
- Medical record documentation that Keytruda Qlex will be used in combination with gemcitabine and cisplatin

18. Malignant Pleural Mesothelioma (MPM)

- Prescription written by a hematologist/oncologist AND
- Medical record documentation that patient is ≥ 18 years of age AND
- Medical record documentation of unresectable advanced or metastatic malignant pleural mesothelioma (MPM) AND
- Medical record documentation that Keytruda Qlex is being used as first-line treatment in combination with pemetrexed and platinum chemotherapy.

AUTHORIZATION DURATION:

For adjuvant treatment of metastatic melanoma (completely resected melanoma), neoadjuvant/adjuvant treatment of early-stage triple negative breast cancer, neoadjuvant/adjuvant treatment of non-small cell lung cancer, and adjuvant treatment of renal cell carcinoma:

Initial approval will be for 6 months. One subsequent approval will be for an additional 6 months and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

- Authorization of Keytruda for the adjuvant treatment of metastatic melanoma, of non-small cell lung cancer, and of renal cell carcinoma should not exceed the FDA-approved treatment duration of 1 year (12 months).
- Authorization of Keytruda for the treatment of early-stage triple negative breast cancer should not exceed the approved treatment duration of 24 weeks for neoadjuvant therapy and 27 weeks for adjuvant therapy.
- Authorization for the treatment of neoadjuvant/adjuvant treatment of non-small cell lung cancer should not exceed the approved treatment duration of 12 weeks of neoadjuvant treatment and 39 weeks of adjuvant therapy.

For requests exceeding the above limits, medical record documentation of the following is required:

- Peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration

For neoadjuvant/adjuvant treatment of head and neck squamous cell carcinoma:

Initial approval will be for 6 months. Additional approval will be for up to an additional 12 months or less if determined medically appropriate by the reviewing provider and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

- Authorization for the treatment of neoadjuvant/adjuvant treatment of head and neck squamous cell carcinoma should not exceed the approved treatment duration of 6 weeks of neoadjuvant treatment and 12 months of adjuvant treatment.

For requests exceeding the above limits, medical record documentation of the following is required:

- Peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by dosing beyond the FDA-approved treatment duration

For all other indications:
Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Require RPH Sign off: Yes. Rph signoff will be required to ensure appropriate utilization.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Tepylute (thiotepa)

Review: Tepylute is indicated for the treatment of adenocarcinoma of the breast or ovary. Tepylute is a new formulation of thiotepa (an alkylating drug related to nitrogen mustard) that is supplied as a ready to dilute solution for intravenous administration (no reconstitution needed).

Clinical Discussion: The committee unanimously voted to accept the recommendations.

Financial Discussion: The committee unanimously voted to accept the recommendations.

Outcome: Tepylute is a medical benefit that will be manage by GHP. The following prior authorization criteria should apply:

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that Tepylute is prescribed by a hematologist and/or oncologist **AND**
- Medical record documentation of a diagnosis of adenocarcinoma of the breast or ovary **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to thiotepa

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Penmenvy (meningococcal groups A, B, C, W, and Y vaccine)

Review: Penmenvy is a vaccine indicated for active immunization to prevent invasive disease caused by *Neisseria meningitidis* serogroups A, B, C, W, and Y in individuals 10 through 25 years of age.

Clinical Discussion: The committee unanimously voted to accept the recommendations.

Financial Discussion: The committee unanimously voted to accept the recommendations.

Outcome:

- Penmenvy will be a medical or pharmacy benefit and should be added to the Brand Tier of the GHP Family formulary. Penmenvy will not require a prior authorization for members 19 through 25 years of age but will have the following limits:
    - **Age Limit**: 19 years to 25 years
    - **Quantity Limit**: 1 mL / 999 days
- For members under 19 years of age and greater than 25 years of age, the following prior authorization criteria will apply:
    - Peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improved by administering to an individual with an age under the FDA-approved age
        - **Quantity Limit:** 1 mL / 999 days
- For members under 19 years of age, Penmenvy will not be covered as these members are required to receive the vaccine from their MD through the VFC program

GPI Level: GPI-12
Require Rph Sign Off: No

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee

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Sephience (sepiapterin)

Review: Sephience is a phenylalanine hydroxylase (PAH) activator indicated for the treatment of hyperphenylalaninemia (HPA) in adult and pediatric patients 1 month of age and older with sepiapterin-responsive phenylketonuria (PKU). It is to be used in conjunction with a phenylalanine (Phe)-restricted diet. Sephience will compete with Kuvan (sapropterin), another PAH activator, and Palzyniq, a Phe metabolizing enzyme.

Clinical Discussion: The committee unanimously voted to accept the recommendations.

Financial Discussion: The committee unanimously voted to accept the recommendations.

Outcome: Sephience will be managed by GHP and should not be added to the Geisinger Gold formulary, The following additional prior authorization criteria should apply:

- Medical record documentation that Sephience is prescribed by a metabolic specialist AND
- Medical record documentation of a diagnosis of hyperphenylalaninemia (baseline blood Phe level greater than or equal to 360 μmol/L) AND
- Medical record documentation of baseline Phe level AND
- Medical record documentation that the member is on and compliant with a Phe-restricted diet AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to sapropterin*

MEDISPAN AUTHORIZATION LEVEL: GPI-12

AUTHORIZATION DURATION: Approval for new starts will be given for an initial authorization duration of eight (8) weeks. For continuation of coverage, the following criteria is required:

- Medical record documentation of a response to Sephience defined by a reduction in blood Phe levels from baseline OR
- Medical record documentation of an increase in Phe tolerance (addition of Phe in diet with stable Phe level)

After the initial 8 week approval, subsequent approvals will be for a duration of one (1) year. Reevaluation of coverage will be every one (1) year requiring the following:

- Medical record documentation of a sustained reduction in blood Phe levels OR
- Medical record documentation of improvement in neuropsychiatric symptoms or an increase in Phe tolerance

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Papzimeos (zopapogene imadenovec-drba)

Review: Papzimeos (zopapogene imadenovec-drba) is a gene therapy for the treatment of recurrent respiratory papillomatosis (RRP). RRP is a rare disease caused by the human papilloma virus (HPV), with HPV strains 6 and 11 noted to cause up to 90% of RRP cases in the United States. RRP is characterized by the growth of benign papillomas within the respiratory tract. Most commonly, papillomas affect the larynx, but can occur in any portion of the respiratory tract, including the trachea and lungs. RRP can develop at any age in children (juvenile-onset before age 13) or adults after exposure to HPV, which generally occurs during vaginal delivery at birth or sexual intercourse. In the United States, RRP is estimated to affect 20,000 adults and can cause symptoms such as hoarseness, difficulty breathing, or need for tracheostomy, depending on the location and size of the papillomas

Clinical Discussion: The committee unanimously voted to accept the recommendations.

Financial Discussion: The committee unanimously voted to accept the recommendations.

Outcome: Papzimeos should be added to medical benefit and should not be added to pharmacy benefit. It is recommended that Papzimeos be added to medical benefit with prior authorization and quantity limit for Medicaid

- Medical record documentation that member is 18 years of age or older **AND**
- Medical record documentation that member has a confirmed diagnosis of recurrent respiratory papillomatosis (RRP) with laryngopharyngeal papillomas **AND**
- Medical record documentation that member has confirmed HPV serotypes 6 or 11 **AND**
- Medical record documentation that member has histologic confirmation of RRP from a CLIA-certified laboratory **AND**
- Medical record documentation that Papzimeos is prescribed by or in consultation with a pulmonologist, otolaryngologist, or oncologist **AND**

- Medical record documentation that member has had an inadequate response or contraindication to intralesional cidofovir or systemic bevacizumab **AND**
- Medical record documentation that member has required three or more surgeries (i.e., debulking procedures) for RRP within the past 12 months **AND**
- If member is 9 years of age to 45 years of age: Medical record documentation that member has received vaccination with HPV-9 vaccine (Gardasil-9), unless contraindicated, and continues to require surgical interventions **AND**
- Medical record documentation that provider will evaluate and/or perform surgical procedures (i.e., debulking procedures) prior to the first, third and fourth doses (at weeks 0, 6, and 12) of Papzimeos **AND**
- Medical record documentation of a prescribed dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

Authorization Duration: 6 months
Quantity Limit: 4 mL (4 vials) per lifetime
Reauthorization Info: No reauthorization permitted.
Require RPH Sign off: Yes

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Vanrafia (atrasentan)

Review: Vanrafia is an endothelin receptor antagonist indicated to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) ≥ 1.5 g/g. This indication is approved under accelerated approval based on a reduction of proteinuria. It has not been established whether Vanrafia slows kidney function decline in patients with IgAN. Continued approval for this indication may be contingent upon verification and description of clinical benefit in a confirmatory clinical trial. Endothelin (ET)-1 is thought to contribute to the pathogenesis of IgAN via the ET_AR and Vanrafia is a selective ET_A receptor antagonist.

Clinical Discussion: The committee unanimously voted to accept the recommendations.

Financial Discussion: The committee unanimously voted to accept the recommendations.

Outcome: Vanrafia is a pharmacy benefit that will be managed by GHP. It should not be added to the GHP Family formulary. The following prior authorization criteria should apply:

- Medical record documentation of age greater than or equal to 18 years AND
- Medical record documentation of primary immunoglobulin A nephropathy (IgAN) verified by biopsy AND
- Medical record documentation that Vanrafia is prescribed by or in consultation with a nephrologist AND
- Medical record documentation that patient is at risk of disease progression, defined as proteinuria greater than 1 gram/day AND
- Medical record documentation of estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min/1.73 m2 AND
- Medical record documentation that member has received a stable dose of a renin-angiotensin system (RAS) Inhibitor (ACE inhibitor or ARB) at a maximally tolerated dose for greater than or equal to 90 days AND

- Medical record documentation that a renin-angiotensin system (RAS) inhibitor (ACE inhibitor or ARB) will be used in combination with Vanrafia AND
- Medical record documentation that member has received greater than or equal to 90 days of optimized supportive care, including blood pressure management, lifestyle modification, and cardiovascular risk modification

Medispan Authorization Level: GPI-12
AUTHORIZATION DURATION FOR IgAN: Initial approval will be for 9 months. Subsequent authorizations will be for 12 months and will require:

- Medical record documentation of continued disease improvement or lack of disease progression according to prescriber (i.e., decreased levels of proteinuria from baseline or decreased urine protein-to-creatinine ratio (UPCR) from baseline)

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Brinsupri (brensocatib)

Review: Brinsupri (brensocatib) was approved in August 2025 for the treatment of non-cystic fibrosis bronchiectasis (NCFB) in adults and adolescents aged 12 years and older. Brensocatib is a competitive, reversible inhibitor of dipeptidyl peptidase 1 (DPP1), which reduces activation of neutrophil serine proteases (NSPs) during neutrophil maturation

Clinical Discussion: The committee unanimously voted to accept the recommendations.

Financial Discussion: The committee unanimously voted to accept the recommendations.

Outcome: Brinsupri is a pharmacy benefit and should not be added to the GHP Family formulary. The following prior authorization criteria should apply:

- Medical record documentation of age ≥ 12 years AND
- Medical record Brinsupri was prescribed by or in consultation with a pulmonologist AND
- Medical record documentation of a diagnosis of bronchiectasis confirmed by chest computed tomography (CT) scan AND
- Medical record documentation of a diagnosis of a clinical history consistent with bronchiectasis (chronic cough, chronic sputum production, and/or recurrent respiratory tract infections) AND
- Medical record documentation that member does not have bronchiectasis due to cystic fibrosis AND
- Medical record documentation of at least 2 pulmonary exacerbations (1 for patients 12-17 years of age) in the past 12 months requiring an antibiotic prescription, urgent care or emergency room visit, or hospitalization.

GPI Level: GPI-12
Quantity Limits: 30 days
Authorization Duration: 1 year
Reauthorization info: Medical record documentation of clinical benefit of the use of Brinsupri including a decrease in the frequency, severity, or duration of pulmonary exacerbations and medical record of appropriate clinical follow-up from specialist**.**
Require RPH Sign off: Ye**s**

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

FAST FACTS

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UPDATES

Tecartus Update

Recommendations: It is recommended to update the authorization duration of MBP 224.0 to define a specific duration for the approval to allow time for the administration while simultaneously ensuring an unlimited lifetime authorization is not entered (to match MBP 335.0 Aucatzyl duration).

MBP 224.0 Tecartus
AUTHORIZATION DURATION: One-time six (6) month authorization for one administration of Tecartus

Outcome: The committee unanimously voted to accept the recommendation.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee

01.2026 DUR Update

The January 2026 DUR Update was presented to the Committee for review.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee

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December ELECTRONIC VOTE
An electronic vote was held from December 13, 2025, to December 19, 2025. Responses were received from 33 members (out of 49 members) and all voted to approve. Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Imaavy (nipocalimab-aahu)

Review: Imaavy is indicated for the treatment of generalized myasthenia gravis (gMG) in adult and pediatric patients 12 years of age and older who are anti-acetylcholine receptor (AChR) or anti-muscle specific tyrosine kinase (MuSK) antibody positive. Imaavy is a human IgG1 monoclonal antibody that binds the neonatal Fc receptor (FcRn), resulting in the reduction of circulating IgG levels. Imaavy is the first FcRn blocker approved for the treatment of pediatric patients with gMG. It will compete with Vyvgart/Vyvgart Hytrulo and Rystiggo which are only approved for treatment of adult patients.

Recommendation: Imaavy is a medical benefit that will be managed by GHP and will require a prior authorization. The following prior authorization criteria should apply:

- Medical record documentation of age 12 years or older AND
- Medical record documentation that Imaavy is prescribed by or in consultation with a neurologist **AND**
- Medical record documentation of a diagnosis of generalized myasthenia gravis (gMG) that is anti-acetylcholine receptor (AChR) positive OR anti-muscle-specific tyrosine kinase (MuSK) antibody positive **AND**
- Medical record documentation of Myasthenia Gravis Foundation of America Clinical Classification (MGFA) Class II to IVa **AND**
- Medical record documentation of a baseline Myasthenia Gravis-Activities of Daily Living (MG-ADL) score greater than or equal to 6 **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to corticosteroids AND
- Medical record documentation of therapeutic failure on intolerance to, or contraindication to at least two (2) non-steroidal immunosuppressive therapies OR has failed at least one (1) immunosuppressive therapy and required chronic plasmapheresis or plasma exchange (PE) **AND**
- Medical record documentation of failure on, intolerance to, or contraindication to intravenous immunoglobulin (IVIG).

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months and will require:

- Medical record documentation of continued disease improvement or lack of disease progression **AND**
- Medical record documentation that the member is responding positively to therapy as evidenced by an improvement of Myasthenia Gravis-Activities of Daily Living (MG-ADL) total score from baseline.

The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Empaveli

Updated Indication: Empaveli is a complement inhibitor that is now indicated for the treatment of adult and pediatric patients aged 12 years and older with C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN), to reduce proteinuria.

Recommendation: Make the following updates:

- Medical record documentation of a diagnosis of paroxysmal nocturnal hemoglobinuria (PNH)
- Medical record documentation of flow cytometry confirming diagnosis AND
- Medical record documentation that Empaveli is prescribed by a hematologist AND
- Medical record documentation that member has received vaccinations against encapsulated bacteria, including *Streptococcus pneumoniae, Neisseria meningitidis,* and *Haemophilus influenzae type B* AND
- Medical record documentation of one of the following:
    - member is transfusion-dependent (i.e., has at least 1 transfusion in the 24 months prior to initiation of pegcetacoplan due to documented hemoglobin less than 7 g/dL in persons without anemic

symptoms or less than 9 g/dL in persons with symptoms from anemia) prior to initiation of pegcetacoplan treatment; or
    - there is a significant adverse impact on the insured individual's health such as end organ damage or thrombosis without other cause.
- **OR**
- Medical record documentation of a diagnosis of C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN) AND
- Medical record documentation that Empaveli is being used to reduce proteinuria AND
- Medical documentation of age 12 years old or older AND
- Medical record documentation that Empaveli is prescribed by a hematologist or nephrologist AND
- Medical record documentation that member has received vaccinations against encapsulated bacteria, including Streptococcus pneumoniae, Neisseria meningitidis, and Haemophilus influenzae type B. AND
- Medical record documentation of eGFR ≥30 mL/min/1.73 m2, proteinuria ≥1 g/day, and urine protein-to-creatinine ratio (UPCR) ≥1 g/g AND
- Medical record documentation of optimized doses of angiotensin-converting enzyme inhibitors, angiotensin receptor blockers and/or sodium-glucose cotransporter-2 (SGLT2) inhibitors or Immunosuppressant medications AND
- Medical record documentation of a prescribed dose that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature.

AUTHORIZATION DURATION: Initial approval will be for 6 months. Subsequent approvals will be for an additional 6 months and will require the following:

FOR C3G or IC-MPGN

Provider assessment of response to therapy or documentation of a decrease or maintenance in proteinuria compared to baseline.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the committee.

Fabhalta

Updated Indication: Fabhalta is now indicated for the treatment of adults with complement 3 glomerulopathy (C3G) to reduce proteinuria. C3G is a rare kidney disease, which is characterized by alternative pathway dysregulation that can lead to kidney failure within 10 years of diagnosis. Fabhalta is the first therapeutic agent indicated in the treatment of C3G. It is a selective inhibitor of factor B which is a key component in the alternative pathway.

Recommendation: There are no changes recommended for the formulary placement or quantity limits of Fabhalta. The following prior authorization criteria and authorization durations are recommended to incorporate the new indication.:

- Medical record documentation of a diagnosis of native kidney complement 3 glomerulopathy (C3G) confirmed by biopsy **AND**

- Medical record documentation that Fabhalta will be used for reduction of proteinuria in members with a urine protein-to-creatinine ratio (UPCR) of greater than or equal to 1 g/g **AND**
- Medical record documentation that Fabhalta is prescribed by a nephrologist **AND**
- Medical record documentation that member has received vaccinations against encapsulated bacteria, including *Streptococcus pneumoniae, Neisseria meningitidis,* and *Haemophilus influenzae type B* **AND**
- Medical record documentation of estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min/1.73 m2 **AND**
- Medical record documentation that member has received a stable dose of a RAS inhibitor (ACE inhibitor or ARB) at a maximally tolerated dose for greater than or equal to 90 days **AND**

AUTHORIZATION DURATION FOR C3G: Initial approval will be for 6 months. Subsequent authorizations will be for 6 months and will require:

- Medical record documentation of continued disease improvement or lack of disease progression according to prescriber (i.e., decreased levels of proteinuria from baseline or decreased urine protein-to-creatinine ratio (UPCR) from baseline)

MEDISPAN AUTHORIZATION LEVEL: GPI-12

QUANTITY LIMIT: 30-day supply per fill

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the Committee

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Gamifant

Updated Indication: Gamifant is an interferon gamma (IFNγ) neutralizing antibody now indicated for the treatment of: adult and pediatric (newborn and older) patients with hemophagocytic lymphohistiocytosis (HLH)/macrophage activation syndrome (MAS) in known or suspected Still's disease, including systemic Juvenile Idiopathic Arthritis (sJIA), with an inadequate response or intolerance to glucocorticoids, or with recurrent MAS

Recommendation: It is recommended to update medical benefit policy 198.0 to include the new FDA approved indication.

Primary Hemophagocytic Lymphohistiocytosis (HLH)

- Prescription written by or in consultation with a hematologist or oncologist **AND**
- Medical record documentation of a diagnosis of primary hemophagocytic lymphohistiocytosis (HLH) based on one of the following:
    - A molecular diagnosis (HLH gene mutations) **OR**
    - A family history consistent with primary HLH (X-linked lymphoproliferative syndrome) **OR**
    - 5 out of the following 8 criteria fulfilled:
        - Fever ≥ 38.5ºC

- Splenomegaly
- Cytopenias affecting 2 of 3 lineages in the peripheral blood; hemoglobin <9 g/dL (<10 g/dL for infants aged less than 4 weeks old), platelets <100 x 10^9/L, neutrophils <1 x 10^9/L
- Hypertriglyceridemia (fasting triglycerides > 3 mmol/L or ≥ 265 mg/dL) and/or hypofibrinogenemia (≤1.5 g/L)
- Hemophagocytosis in bone marrow, spleen, or lymph nodes with no evidence of malignancy
- Low or absent NK-cell activity
- Ferritin ≥ 500 mcg/L
- Soluble CD25 level (i.e. soluble IL-2 receptor) of ≥ 2,400 U/mL or two standard deviations above age-adjusted laboratory-specific norms

AND

- Medical record documentation of refractory, recurrent or progressive disease or intolerance with conventional HLH therapy (e.g. etoposide, dexamethasone, cyclosporine A, intrathecal methotrexate

Authorization Duration (for members **without** a confirmed molecular diagnosis): Initial approval will be for 4 weeks or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of a diagnosis of primary hemophagocytic lymphohistiocytosis based on molecular diagnosis (HLH gene mutations). Subsequent approvals will be for an additional 6 months of less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement (e.g. improvement in hemoglobin/lymphocyte/platelet counts, afebrile, normalization of inflammatory factors/markers) or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or received a hematopoietic stem cell transplantation.

Authorization Duration (for members **with** a confirmed molecular diagnosis): Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement (e.g. improvement in hemoglobin/lymphocyte/platelet counts, afebrile, normalization of inflammatory factors/markers) or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or received a hematopoietic stem cell transplantation.

Note: For Medicaid (GHP Family), any requests for services that do not meet criteria set in the PARP will be evaluated on a case-by-case basis.

HLH/MAS Associated with Still's Disease (Systemic Juvenile Idiopathic Arthritis or Adult-Onset Still's Disease)

- Prescription written by or in consultation with a hematologist or oncologist **AND**
- Medical record documentation of a diagnosis of Still's disease (sJIA or AOSD)

AND

- Medical record documentation of active macrophage activation syndrome (MAS), defined by:
  - Ferritin ≥ 684 ng/mL

    AND
  - 2 of the following 4 laboratory criteria fulfilled:
    - Platelets ≤ 181 × 10^9/L
    - AST > 48 U/L
    - Triglycerides > 156 mg/dL
    - Fibrinogen ≤ 360 mg/dL

AND

- Medical record documentation of one of the following:
  - inadequate response, intolerance, or contraindication to glucocorticoid therapy **OR**
  - refractory or recurrent MAS

Authorization Duration: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals for up to 6 months with documentation of continued clinical improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or received a hematopoietic stem cell transplantation.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the Committee

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Opdivo Qvantig

Updated Indication: Opdivo Qvantig has expanded the current melanoma and unresectable or metastatic microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) colorectal cancer indications in product labeling to allow for use in pediatric patients 12 years of age and older. Previously Opdivo Qvantig was only indicated for adult patients

Recommendation: Update age for Melanoma and Colorectal Cancer criteria to 12 years old

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the Committee

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TNKase

Updated Indication: Updated Indication: TNKase is now indicated for the treatment of acute ischemic stroke in adults. Previously, it was approved to reduce the risk of death associated with acute ST elevation myocardial infarction (STEMI) in adults.

Recommendation: No changes recommended.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the Committee

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Zepzelca

Updated Indication: Zepzelca is now FDA approved in combination with atezolizumab or atezolizumab and hyaluronidase-tqjs, for the maintenance treatment of adult patients with extensive-stage small cell lung cancer (ES-SCLC) whose disease has not progressed after first-line induction therapy with atezolizumab or atezolizumab and hyaluronidase-tqjs, carboplatin and etoposide.

Recommendation: It is recommended that the medical benefit policy (MBP) 222 Zepzelca be updated to account for the new indication. See below for the recommended highlighted changes.

For metastatic small cell lung cancer (SCLC):

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that Zepzelca is written by a hematologist or oncologist **AND**
- Medical record documentation of metastatic small cell lung cancer (SCLC) **AND**
- Medical record documentation of disease progression on or after platinum-based chemotherapy

For extensive-stage small cell lung cancer (ES-SCLC):

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that Zepzelca is written by a hematologist or oncologist **AND**
- Medical record documentation of extensive-stage small cell lung cancer (ES-SCLC) **AND**
- Medical record documentation that Zepzelca will be used as maintenance treatment in combination with atezolizumab or atezolizumab and hyaluronidase-tqjs **AND**
- Medical record documentation of disease that has NOT progressed after first-line induction therapy with atezolizumab or atezolizumab and hyaluronidasetqjs, carboplatin and etoposide.

AUTHORIZATION DURATION: Initial approval will be for 6 months. Subsequent approvals will be for an additional 6 months and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if the member experiences unacceptable toxicity or worsening of disease.

Additional evidence of the criteria used to make this decision can be found in the drug review presented to the Committee.

Medical Benefit Policy Update

Bendamustine Update
MBP 349.0 Bendamustine (Belrapzo, Bendeka, Treanda, or Vivimusta)

Bendamustine products for Medicaid line of business	
Preferred Agents	**Non-Preferred Agents**
Bendamustine (generic Treanda)	Treanda* (bendamustine)
	Bendamustine* (generic Belrapzo)
	Belrapzo* (bendamustine)
	Bendeka* (bendamustine)
	Vivimusta* (bendamustine)
*clinical prior authorization required	

Generic Treanda will not require prior authorization Medicaid. Brand Treanda, Belrapzo (and its generics), Bendeka, and Vivimusta, will be considered medically necessary for the Medicaid line of business when ALL of the following criteria are met.

~~**For Treanda requests:**~~

- ~~Medical record documentation of a therapeutic failure on, or intolerance to the generic formulary agent(s)~~ ~~**OR**~~
- ~~Medical record documentation of a therapeutic failure on, intolerance to, or contraindication to the inactive ingredients of the generic formulary agent(s)~~

~~**For Belrapzo (or its generics) and Bendeka requests:**~~

- ~~Medical record documentation of a therapeutic failure of, intolerance to, or contraindication to generic Treanda*~~

~~**For Vivimusta requests:**~~

- ~~Medical record documentation of a therapeutic failure of, intolerance to, or contraindication to generic Treanda*~~ ~~**AND**~~
- ~~Medical record documentation of a therapeutic failure of, intolerance to, or contraindication to both of the following: Belrapzo (or its generics)* AND Bendeka*~~

~~*prior authorization required (note: generic Treanda is preferred and does not require prior authorization)~~

For Treanda, generic Belrapzo, Belrapzo, Bendeka requests:

- Medical record documentation of a therapeutic failure of, intolerance to, or contraindication to the preferred

agent

For Vivimusta requests:

- Medical record documentation of a therapeutic failure of, intolerance to, or contraindication to the preferred agent **AND**
- Medical record documentation of a therapeutic failure of, intolerance to, or contraindication to Bendeka* AND Belrapzo (brand or generic)*

*prior authorization required

Somatuline Depot Update

Recommendations: It is recommended to update the prior authorization criteria for MBP 348.0 Somatuline Depot (lanreotide) per DHS recommendation.

MBP 348.0 Somatuline Depot (lanreotide)

Gastroenteropancreatic Neuroendocrine Tumors (GEP-NETs)

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of well- or moderately- differentiated, unresectable locally advanced or metastatic gastroenteropancreatic neuroendocrine tumor (GEP-NET) **AND**
- All of the following:
  - ~~Medical record documentation that the tumor is unresectable **AND**~~
  - Medical record documentation that the tumor is non-functioning **AND**
  - Medical record documentation that the tumor is without hormone-related symptoms

AND

- Medical record documentation that the medication is being used to improve progression-free survival

Arexvy Update

Recommendations: It is recommended to update the prior authorization criteria for MBP 329.0 Arexvy (Respiratory Syncytial Virus Vaccine (Adjuvanted) Injection) per DHS recommendation.

MBP 329.0 Arexvy (Respiratory Syncytial Virus Vaccine (Adjuvanted) Injection)

For the Medicaid line of business, Arexvy (Respiratory Syncytial Virus Vaccine (Adjuvanted) Injection) will not require prior authorization for patients greater than or equal to 60 years of age. Arexvy is provided by Vaccines for Children (VFC) Program and is not eligible for reimbursement for patients less than 19 years of age. Arexvy will be considered medically necessary for patients greater than or equal to 50 years of age to less than 60 years of age when ALL of the following criteria are met:

- Medical record documentation that the member is 50 to 59 years of age **AND**
- Medical record documentation of a diagnosis of chronic pulmonary disease, chronic cardiovascular disease, diabetes, chronic kidney disease, or chronic liver disease ~~**AND**~~
- ~~Medical record documentation that the member is at an increased risk of lower respiratory tract disease (LRTD) caused by respiratory syncytial virus (RSV)~~

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Meeting adjourned at 3:07 PM

Future Scheduled Meetings
The next bi-monthly scheduled meeting will be held March 10, 2026.

Meetings will be held virtually via phone/Microsoft Teams