P&T Committee Meeting Minutes
Medicaid
March 10, 2026

Present (via Teams):	**Absent:**
Bret Yarczower, MD, MBA – Chair	Jeremy Bennett, MD
Amir Antonious, Pharm.D.	Alyssa Cilia, RPh
Leslie Astleford, Pharm.D.	Bhargavi Degapudi, MD
Emily Bednarz, Pharm.D.	Keri Donaldson, MD, MSCE
Kristen Bender, Pharm.D.	Michael Dubartell, MD
Angela Bolesta, Pharm.D.	Michael Evans, RPh
Kim Castelnovo, RPh	Nichole Hossler, MD
Kimberly Clark, Pharm.D.	Jason Howay, Pharm.D.
Kelly Faust, Pharm.D.	Perry Meadows, MD
Tricia Heitzman, Pharm.D.	Jonas Pearson, RPh
Keith Hunsicker, Pharm.D.	Michael Shepherd, MD
Kelli Hunsicker, Pharm.D.	Todd Sponenberg, Pharm.D.
Emily Jacobson, Pharm.D.	Luke Sullivan, DO
Dennis Janosczyk, Pharm.D.	Amanda Taylor, MD
Alexandra Kempf-Malys, MSW, BSc	
Kerry Ann Kilkenny, MD	
Philip Krebs, R.EEG T	
Briana LeBeau, Pharm.D.	
Ted Marines, Pharm.D.	
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	
Jill Stone, Pharm.D.	
Kevin Szczecina, RPh	
Ariana Wendoloski, Pharm.D.	
Brandon Whiteash, Pharm.D.	
Margaret Whiteash, Pharm.D.	
Jeremy Garris, Pharm.D. (non-voting participant)	

Call to Order: Dr. Bret Yarczower called the meeting to order at 1:03 p.m., Tuesday March 10, 2026.

Review and Approval of Minutes, Reviews, Fast Facts, and Updates: Dr. Bret Yarczower asked for a motion or approval to accept the January 13, 2026 minutes as written. Minutes approved unanimously. None were opposed.

DRUG REVIEWS

Palsonfy (palusotine)

Review: Palsonify, an orphan drug, is a somatostatin receptor nonpeptide agonist that is FDA approved for the treatment of acromegaly in adults who had an inadequate response to surgery and/or for whom surgery is not an option. Its' mechanism of action is to act like our natural hormone, somatostatin. It works to suppress growth hormone (GH) and insulin-like growth factor-1 (IGF-1). It has selective agonism for the somatostatin receptor2 (SSTR2) and little to no affinity for any other SST receptor.

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

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

Outcome: Palsonify is a pharmacy benefit that will not be managed by the PDL. It is recommended to not be added to the Medicaid formulary. It will require prior authorization.

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation that the medication is prescribed by or in consultation with an endocrinologist and/or acromegaly specialist **AND**
- Medical record documentation of a diagnosis of acromegaly **AND**
- One of the following:
    - Medical record documentation that the patient has an insufficient response to surgery and/or radiotherapy **OR**
    - Medical record documentation that the patient is not a candidate for surgery and/or radiotherapy

AND

- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Octreotide Solution Injection.

GPI Level: GPI-12
Authorization Duration:

- **Initial Authorization Duration:** 12 months
- **Reauthorization Duration:** 12 months

Quantity Limit: N/A
Reauthorization Criteria: Medical record documentation or attestation 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.
Formulary Alternatives: Octreotide Acetate Solution (50mcg/mL, 100mcg/mL, 200mcg/mL, 500mcg/mL, 1000mcg/mL)
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.

Rhapsido (remibrutinib)

Review: Rhapsido is an oral Bruton's tyrosine kinase (BTK) inhibitor indicated for the treatment of chronic spontaneous urticaria (CSU) in adult patients who continue to experience symptoms while on H1 antihistamine treatment.

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

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

Outcome: Rhapsido is a pharmacy benefit and should not be added to the Geisinger Family Formulary. The following prior authorization criteria should apply:

- Medical record documentation that Rhapsido is prescribed by an allergist, immunologist, or dermatologist AND
- Medical record documentation of a diagnosis of moderate to severe chronic spontaneous urticaria AND
- Medical record documentation of at least 6 weeks history of symptoms (e.g., hives associated with itching, angioedema) AND
- Medical record documentation of age 18 years or older AND
- Medical record documentation of contraindication to, therapeutic failure on, or intolerance to a four-week trial of ALL of the following treatment options:
    - At least two different high dose antihistamines AND
    - Maximum dose antihistamine(s) used in combination with a leukotriene receptor antagonist (e.g. montelukast) AND
    - High dose antihistamine used in combination with H2 receptor antagonist (e.g. ranitidine) AND
    - Dose advancement of potent antihistamine (e.g., doxepin or hydroxyzine) AND
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least 2 formulary medications approved for CSU

Formulary Alternatives: per Statewide PDL
GPI Level: GPI-12
Quantity Limits: 30-day supply per fill
Authorization Duration: Initial approval will be for 12 months
Reauthorization Criteria: Subsequent approvals will be for an additional 12 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.
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.

Lynkuet (elinzanetant)

Review: Lynkuet (elinzanetant) is an oral neurokinin 1 (NK1) and neurokinin 3 (NK3) receptor antagonist indicated for the treatment of moderate to severe vasomotor symptoms (VMS) or hot flashes due to menopause. Lynkuet blocks Substance P and Neurokinin B (NKB) by binding on the kisspeptin/NKB/dynorphin (KNDy) neurons, thus modulating neuronal activity in the thermoregulatory center associated with hot flashes.

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

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

Outcome: Lynkuet is a pharmacy benefit managed by GHP and should not be added to the GHP Family formulary. It should be added to **Policy 1574.0F Veozah**. No changes need to be made to the prior authorization criteria.

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

Tecentriq Hybreza (atezolizumab and hyalurinidase-tqjs)

Review: Tecentriq Hybreza is a new subcutaneous formulation of Tecentriq.

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

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

Outcome: Tecentriq Hybreza will be a medical benefit managed by GHP. The following prior authorization criteria should apply:

1. Non-Small Cell Lung Cancer:

- Prescription written by an oncologist **AND**
- Medical record documentation of a diagnosis of non-small cell lung cancer meeting <u>one</u> of the following situations:
    - Medical record documentation of disease progression during or following platinum-containing chemotherapy

OR

    - Medical record documentation of disease progression on at least one FDA-approved therapy targeting EGFR or ALK if the patient has EGFR or ALK genomic tumor aberrations (e.g. mutation, deletion, insertion, etc.)

OR

    - Medical record documentation of a non-squamous histologic subtype **AND**
    - Medical record documentation that Tecentriq Hybreza will be given as first-line treatment for metastatic disease **AND**
    - Medical record documentation that Tecentriq Hybreza will be given in combination with bevacizumab, paclitaxel, AND carboplatin **OR** paclitaxel protein-bound AND carboplatin **AND**
    - Medical record documentation that the patient does not have an EGFR or ALK genomic tumor aberration.

OR

    - Medical record documentation that Tecentriq Hybreza will be given as first-line treatment for metastatic disease **AND**

- Medical record documentation that tumors have high PD-L1 expression (PD-L1 stained ≥ 50% of tumor cells [TC ≥ 50%] or PD-L1 stained tumor-infiltrating immune cells [IC] covering ≥ 10% of the tumor area [IC ≥ 10%]) as determined by an FDA-approved test **AND**
- Medical record documentation that the patient does not have an EGFR or ALK genomic tumor aberration.

OR

- Medical record documentation of stage II to IIIA disease **AND**
- Medical record documentation of use as adjuvant treatment following resection and platinum-based therapy **AND**
- Medical record documentation that tumors have PD-L1 expression on ≥1% of tumor cells as determined by an FDA-approved test **AND**
- Medical record documentation that Tecentriq Hybreza is being given as a single agent.

2. Small Cell Lung Cancer (SCLC):

- Prescription written by an oncologist **AND**
- Medical record documentation of a diagnosis of extensive-stage small cell lung cancer (ES-SCLC) **AND**
- Medical record documentation that Tecentriq Hybreza will be used in combination with carboplatin and etoposide **AND**
- Medical record documentation of use as first-line treatment of extensive-stage disease

OR

- Prescription written by an oncologist **AND**
- Medical record documentation of a diagnosis of extensive stage small cell lung cancer (ES-SCLC) **AND**
- Medical record documentation that Tecentriq Hybreza will be used in combination with lurbinectedin for maintenance treatment **AND**
- Medical record documentation that the disease has not progressed after first-line induction therapy with Tecentriq or Tecentriq Hybreza, carboplatin and etoposide

3. Unresectable or Metastatic Hepatocellular Carcinoma (HCC)

- Prescription written by an oncologist **AND**
- Medical record documentation of diagnosis of unresectable or metastatic hepatocellular carcinoma (HCC) **AND**
- Medical record documentation that Tecentriq Hybreza will be given in combination with bevacizumab **AND**
- Medical record documentation that patient has not received prior systemic treatment for hepatocellular carcinoma

4. Melanoma

- Medical record documentation of unresectable or metastatic melanoma **AND**
- Medical record documentation of BRAF V600 mutation as determined by an FDA-approved test **AND**
- Medical record documentation that Tecentriq Hybreza will be given in combination with Cotelliq (cobimetinib) and Zelboraf (vemurafenib)

5. Alveolar Soft Part Sarcoma (ASPS)

- Prescription written by an oncologist **AND**
- Medical record documentation of age greater than or equal to 12 years **AND**
- Medical record documentation of a weight of 40 kg or greater AND
- Medical record documentation of diagnosis of unresectable or metastatic alveolar soft part sarcoma (ASPS)

AUTHORIZATION DURATION:
For adjuvant treatment of stage II to IIIA non-small cell lung cancer (NSCLC) following resection and platinum-based chemotherapy: One approval will be given for 12 months or less if the reviewing provider feels it is medically appropriate. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Authorization of Tecentriq Hybreza for adjuvant treatment of stage II to IIIA non-small cell lung cancer (NSCLC) following resection and platinum-based chemotherapy should not exceed the FDA-approved treatment duration of 1 year (12 months) in patients. For requests exceeding the above limit, 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 12 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.

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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NexoBrid (anacaulase-bcdb)

Review: Nexobrid is a topical enzymatic debridement agent containing proteolytic enzymes enriched in bromelain from pineapple stems for selective eschar removal in deep partial-thickness (DPT) and full-thickness (FT) thermal burns.

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

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

Outcome: *NexoBrid* is a Medical Benefit that will not be covered as its manufacturer, Vericel, is a non-rebateable manufacturer. If the manufacturer becomes rebateable, NexoBrid will be managed by the PDL.

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

FAST FACTS

Enhertu

Updated Indication: Enhertu is now indicated in combination with pertuzumab as first-line treatment of adult patients with unresectable or metastatic HER2-positive (IHC 3+ or ISH+) breast cancer, as determined by an FDA-approved test.

Discussion: The committee unanimously voted to accept the recommendations.

Outcome: No changes are recommended for the formulary placement. The following changes are recommended to the Medical Benefit Policy 208.0 to incorporate the new indication:

Breast Cancer

- Prescription written by a hematologist or oncologist **AND**
- Medical record documentation of patient age greater than or equal to 18 years **AND**
- Medical record documentation of unresectable or metastatic HER2-positive (IHC 3+ or ISH positive) breast cancer **AND**
- Medical record documentation of one of the following:
    - Documentation of a prior anti-HER2 based therapy in the metastatic setting **OR**
    - Documentation of a prior anti-HER2 based therapy in the neoadjuvant or adjuvant setting AND documentation of disease recurrence during or within 6 months of completing therapy **OR**
    - Documentation of first line treatment in combination with pertuzumab

OR

- Prescription written by a hematologist or oncologist **AND**
- Medical record documentation of patient age greater than or equal to 18 years **AND**
- Medical record documentation of unresectable or metastatic hormone-receptor (HR)-positive breast cancer **AND**
- Medical record documentation of one of the following:
    - Documentation that the tumor is HER2-low (IHC 1+ or IHC 2+/ISH-) as determined by an FDA-approved test **OR**
    - Documentation that the tumor is HER2-ultralow (IHC 0 with membrane staining) as determined by an FDA-approved test

AND

- Medical record documentation that the patient has progressed on one or more endocrine therapies in the metastatic setting

OR

- Prescription written by a hematologist or oncologist **AND**
- Medical record documentation of patient age greater than or equal to 18 years **AND**
- Medical record documentation of unresectable or metastatic HER2-low (IHC 1+ or IHC 2+/ISH-) breast cancer, as detected by an Food and Drug Administration (FDA)-approved test **AND**
- Medical record documentation that Enhertu will be used as a single agent **AND**
- Medical record documentation of one of the following:
    - Documentation of a prior chemotherapy in the metastatic setting **OR**
    - Documentation of disease recurrence during or within 6 months of completing adjuvant chemotherapy

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

UPDATES

2026 GHP Family Formulary

Recommendations: The 2026 GHP Family formulary was presented to the Committee for review. The recommendation was to approve the formulary as presented.

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

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February ELECTRONIC VOTE

An electronic vote was held from February 5, 2026, to February 12, 2026. Responses were received from 31 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.

Darzalex Faspro

Updated Indication: Darzalex Faspro is indicated for multiple myeloma in combination with bortezomib, lenalidomide, and dexamethasone in newly diagnosed patients who are ineligible for autologous stem cell transplant. Darzalex Faspro is also indicated in high-risk smoldering multiple myeloma as monotherapy. The accelerated approval disclaimer contained within the light chain amyloidosis indication has been removed

Recommendation: It is recommended to change the prior authorization criteria and authorization duration for MBP 230.0

Multiple Myeloma

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation a diagnosis of multiple myeloma **AND**

If newly diagnosed multiple myeloma (transplant **ineligible**):

- Medical record documentation that the member is not eligible for stem-cell transplantation (e.g. coexisting conditions, age greater than 65, etc.) **AND**
- Medical record documentation that Darzalex Faspro will be given in combination with one of the following options:
    - Bortezomib (Velcade)*, lenalidomide (Revlimid)*, and dexamethasone **OR**
    - Bortezomib (Velcade)*, melphalan (Alkeran, Evomela), and prednisone [VMP] **OR**
    - Lenalidomide (Revlimid)* and dexamethasone

AND

- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

OR

If newly diagnosed multiple myeloma (transplant **eligible**):

- Medical record documentation that the member is eligible for stem-cell transplantation **AND**
- Medical record documentation that Darzalex Faspro will be given in combination with one of the following options:
    - Bortezomib (Velcade)*, lenalidomide (Revlimid)*, and dexamethasone **OR**
    - Bortezomib (Velcade)*, thalidomide (Thalomid)*, and dexamethasone (DVTd) **OR**
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

If relapsed/refractory multiple myeloma:

- One of the following:
    - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least three prior lines of therapy including a proteasome inhibitor [including but not limited to bortezomib (Velcade)*, carfilzomib (Kyprolis)*, or ixazomib (Ninlaro)*] and an immunomodulatory agent [including but not limited to pomalidomide (Pomalyst)*, lenalidomide (Revlimid)*, thalidomide (Thalomid)*] **OR**
    - Medical record documentation that the patient is double-refractory to a proteasome inhibitor [including but not limited to bortezomib (Velcade)*, carfilzomib (Kyprolis)*, or ixazomib (Ninlaro)*] and an immunomodulatory agent [including but not limited to pomalidomide (Pomalyst)*, lenalidomide (Revlimid)*, thalidomide (Thalomid)*] **OR**
    - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least one prior line of therapy including lenalidomide (Revlimid) and a proteasome inhibitor [including but not limited to bortezomib (Velcade)*, carfilzomib (Kyprolis)*, or ixazomib (Ninlaro)*] AND Darzalex Faspro will be prescribed in combination with pomalidomide (Pomalyst)* and dexamethasone **OR**
    - Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least one prior therapy including a proteasome inhibitor [including but not limited to bortezomib (Velcade)*, carfilzomib (Kyprolis)*, or ixazomib (Ninlaro)*] or an immunomodulatory agent [including but not limited to pomalidomide (Pomalyst)*, lenalidomide (Revlimid)*, thalidomide (Thalomid)*] AND one of the following:
        - Medical record documentation that Darzalex Faspro will be prescribed in combination with lenalidomide (Revlimid)* and dexamethasone **OR**
        - Medical record documentation that Darzalex Faspro will be prescribed in combination with bortezomib (Velcade)* and dexamethasone **OR**
        - Medical record documentation that Darzalex Faspro will be prescribed in combination with carfilzomib (Kyprolis)* and dexamethasone

    AND

- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

High-risk smoldering multiple myeloma

- Prescription written by or in consultation with and hematologist/oncologist **AND**
- Medical record documentation of a diagnosis of high-risk smoldering multiple myeloma **AND**
- Medical record documentation that Darzalex Faspro will be used as monotherapy **AND**
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

Light-chain (AL) amyloidosis

- Prescription written by or in consultation with and hematologist/oncologist **AND**
- Medical record documentation of a diagnosis of light-chain (AL) amyloidosis **AND**
- Medical Record documentation that the patient does NOT have New York Heart Association (NYHA) Class IIIB (defined by marked limitation of physical activity, comfortable at rest, less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain, symptomatic with recent history of dyspnea at rest) or Class IV heart failure, or mayo cardiac stage IIIB **AND**
- Medical record documentation that Darzalex Faspro will be used in combination with bortezomib (Velcade)*, cyclophosphamide and dexamethasone **AND**
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

Note: Mayo Cardiac Stage IIIB defined as NT-proBNP > 8500 ng/L

*Prior authorization may be required

AUTHORIZATION DURATION ~~(all diagnoses except light-chain (AL) amyloidosis)~~:

Multiple Myeloma

Initial approval will be for 3 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 the following:

- Continued disease improvement or lack of disease progression **AND**
- An FDA approved dose and dosing interval

The medication will no longer be covered if patient experiences toxicity or worsening of disease or a non-FDA approved dose or dosing interval.

For requests exceeding United States Food and Drug Administration (FDA) labeling, National Comprehensive Cancer Network® (NCCN), or indication specific peer-reviewed literature, 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

High-Risk Smoldering Multiple Myeloma

Initial approval will be for 3 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 the following:

- Continued disease improvement or lack of disease progression **AND**
- An FDA approved dose and dosing interval

The medication will no longer be covered if patient experiences toxicity or worsening of disease or a non-FDA approved dose or dosing interval.

Authorization of Darzalex Faspro for light-chain (AL) amyloidosis should not exceed the FDA-approved treatment duration of 3 years (36 months). For requests exceeding the above limit, 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

Light Chain (AL) Amyloidosis

Initial approval will be for 3 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 the following:

- Continued disease improvement or lack of disease progression **AND**
- An FDA approved dose and dosing interval.

The medication will no longer be covered if patient experiences toxicity, worsening of disease, or a non-FDA approved dose or dosing interval.

Authorization of Darzalex Faspro for light-chain (AL) amyloidosis should not exceed the FDA-approved treatment duration of 2 years (24 months). For requests exceeding the above limit, 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

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

Epkinly

Updated Indication: The FDA approved epcoritamab-bysp (Epkinly) with lenalidomide and rituximab for relapsed or refractory follicular lymphoma (FL).

Recommendation: Make the following updates:
Follicular Lymphoma

- Medical record documentation of age greater than or equal to 18 years AND
- Medical record documentation that epcoritamab-bysp is written by a hematologist or oncologist AND
- Medical record documentation of a diagnosis of relapsed or refractory follicular lymphoma (FL) AND
- Medical record documentation of prior therapy with at least two lines of systemic therapy OR
- Medical record documentation that epcoritamab-bysp is being used in combination with lenalidomide and rituximab

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 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.

For the treatment of FL in combination with lenalidomide and rituximab: 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 Epkinly for the treatment of FL in combination with lenalidomide and rituximab should not exceed the FDA-approved treatment duration of 1 year (12 months).

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

Gazyva

Updated Indication: Gazyva gained FDA approval for treatment of adult patients with active lupus nephritis (LN) who are receiving standard therapy on 10/20/2025, expanding its indications outside of oncology..

Recommendation: It is recommended to change the prior authorization criteria and authorization duration for MBP 113.0

Active Lupus Nephritis

- Medical record documentation of age greater than or equal to 18 years **AND**
- Physician provided documentation of a diagnosis of active lupus nephritis, Class III, IV, V alone or in combination, confirmed by a kidney biopsy **AND**
- Gazyva will be prescribed in combination with standard therapy (e.g. mycophenolate mofetil (MMF), corticosteroids, cyclophosphamide, azathioprine) **AND**
- Prescription written by or in consultation with a rheumatologist or nephrologist **AND**
- Medical record documentation of a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

AUTHORIZATION DURATION:

Initial approval will be for 12 months. Subsequent approvals will be for 12 months. Re-authorization will require the following:

- Medical record documentation of a positive clinical response to Gazyva (e.g. improvement/stabilization in UPCR, eGFR, renal-related events) **AND**
- Medical record documentation that Gazyva will be prescribed in combination with standard therapy (e.g. mycophenolate mofetil (MMF), corticosteroids, cyclophosphamide, azathioprine) **AND**
- Medical record documentation of a dose and duration of therapy that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

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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Imfinzi

Updated Indication: Imfinzi is now indicated for use in combination with fluorouracil, leucovorin, oxaliplatin, and docetaxel (FLOT) chemotherapy as neoadjuvant and adjuvant treatment, followed by single agent IMFINZI, for the treatment of adult patients with resectable gastric or gastroesophageal junction adenocarcinoma (GC/GEJC).

Recommendation: recommend adding the following prior authorization criteria to MBP policy 156.0 for the new indication of use in combination with fluorouracil, leucovorin, oxaliplatin, and docetaxel (FLOT) chemotherapy as neoadjuvant and adjuvant treatment, followed by single agent IMFINZI, for the treatment of adult patients with resectable gastric or gastroesophageal junction adenocarcinoma (GC/GEJC).

Neoadjunctive/Adjunctive Resectable Gastric/Gastroesophageal Junction Adenocarcinoma (GC/GEJC)
• Medical record documentation that Imfinzi is prescribed by a hematologist or oncologist AND
• Medical record documentation of age greater than or equal to 18 years AND
• Medical record documentation of resectable gastric or gastroesophageal adenocarcinoma (GC/GEJC) AND
• Medical record documentation that Imfinzi is being used in the neoadjuvant setting in combination with fluorouracil, leucovorin, oxaliplatin, and docetaxel (FLOT) chemotherapy for 2 cycles prior to and 2 cycles after surgery, then Imfinzi is being continued as a single agent in the adjuvant setting for up to 10 cycles.

AUTHORIZATION DURATION: Neoadjunctive/Adjunctive Resectable Gastric/Gastroesophageal Junction Adenocarcinoma (GC/GEJC): One approval for 18 months or less if the reviewing provider feels it is medically appropriate. The medication will no longer be covered if patient experiences toxicity or worsening of disease. Authorization of Imfinzi for the neoadjuvant treatment of GC/GEJC should not exceed the FDA-approved maximum treatment duration of 14 cycles (2 cycles of neoadjuvant treatment prior to surgery and 12 cycles as adjuvant treatment after surgery). For requests exceeding the above limit, 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.

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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Keytruda and Keytruda Qlex

Updated Indication: Keytruda (pembrolizumab) and Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) are now indicated in combination with Padcev (enfortumab vedotin), as neoadjuvant treatment, and then continued after cystectomy as adjuvant treatment of adult patients with muscle invasive bladder cancer (MIBC) who are ineligible for cisplatin-containing chemotherapy.

Recommendation: For Keytruda, the following additional criteria is recommended for the "urothelial carcinoma" portion of MBP 119.0.For Keytruda Qlex, the same additional criteria recommended for the "urothelial carcinoma" portion of MBP 119.0 will be recommended for the Keytruda Qlex medical benefit policy 375.0.

MBP 119.0

Urothelial 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:
  - 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 is being used in combination with Padcev

OR

- Medical record documentation of muscle invasive bladder cancer (MIBC) **AND**
- Medical record documentation that Keytruda will be prescribed in combination with Padcev **AND**
- Medical record documentation of use in the neoadjuvant setting and then continued after cystectomy as adjuvant treatment **AND**
- Medical record documentation that member is ineligible for cisplatin-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

**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.

MBP 357.0

Urothelial 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:
  - 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
    - Keytruda is being used in combination with Padcev

OR

- Medical record documentation of muscle invasive bladder cancer (MIBC) **AND**
- Medical record documentation that Keytruda will be prescribed in combination with Padcev **AND**
- Medical record documentation of use in the neoadjuvant setting and then continued after cystectomy as adjuvant treatment **AND**
- Medical record documentation that member is ineligible for cisplatin-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

**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.

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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Tecentriq

Updated Indication: Tecentriq is now FDA approved in combination with lurbinectedin (Zepzelca) 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 Tecentriq or atezolizumab and hyalurinidase-tqjs (Tecentriq Hybreza), carboplatin and etoposide. This new indication is the second approved for ES-SCLC.

Recommendation: It is recommended that the medical benefit policy (MBP 144.0) for Tecentriq be updated to account for the new indication.

Small Cell Lung Cancer (SCLC):

- Prescription written by an oncologist **AND**

- Medical record documentation of a diagnosis of extensive stage small cell lung cancer (ES-SCLC) **AND**
- Medical record documentation that Tecentriq will be used in combination with carboplatin and etoposide AND
- Medical record documentation of use as first-line treatment of extensive-stage disease

OR

- Prescription written by an oncologist **AND**

- Medical record documentation of a diagnosis of extensive stage small cell lung cancer (ES-SCLC) **AND**
- Medical record documentation that Tecentriq will be used in combination with lurbinectedin **AND**
- Medical record documentation that the disease has not progressed after first-line induction therapy with Tecentriq or atezolizumab and hyaluronidase-tqjs, carboplatin and etoposide

AUTHORIZATION DURATION:
For adjuvant treatment of stage II to IIIA non-small cell lung cancer (NSCLC) following resection and platinum-based chemotherapy: One approval will be given for 12 months or less if the reviewing provider feels it is medically appropriate. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

Authorization of Tecentriq for adjuvant treatment of stage II to IIIA non-small cell lung cancer (NSCLC) following resection and platinum-based chemotherapy should not exceed the FDA-approved treatment duration of 1 year (12 months) in patients. For requests exceeding the above limit, 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 12 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.

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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Vyjuvek

Updated Indication: Vyjuvek (beremagene geperpavec-svdt) is a herpes-simplex virus type 1 (HSV-1) vector-based gene therapy indicated for the treatment of wounds in adult and pediatric patients with dystrophic epidermolysis bullosa with mutation(s) in the collagen type VII alpha 1 chain (COL7A1) gene. Vyjuvek was previously approved only in patients 6 months of age and older.

Recommendation: Vyjuvek is a medical or pharmacy benefit managed by GHP. Vyjuvek should not be added to the GHP Family formulary.

- Medical record documentation that Vyjuvek is prescribed by or in consultation with a dermatologist who specializes in epidermolysis bullosa (EB) management AND
- ~~Medical record documentation of age greater than or equal to 6 months AND~~
- Medical record documentation of diagnosis of dystrophic epidermolysis bullosa (DEB) AND
- Medical record documentation of genetic testing confirming mutation(s) in the COL7A1 gene AND
- Medical record documentation of at least one open dystrophic epidermolysis bullosa (DEB) wound AND
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

GPI Level: GPI-12
Authorization Duration: 6 months
Quantity Limit: 28 day supply per fill
Reauthorization Info: Subsequent approvals will be for an additional 6 months and will require medical record documentation of clinical response to prior dystrophic epidermolysis bullosa (DEB) wounds treated with Vyjuvek therapy and lack of toxicity.
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.

Padcev

Updated Indication: Padcev (enfortumab vedotin) received approval for use in combination with Keytruda (pembrolizumab) or Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph), as neoadjuvant treatment and then continued after cystectomy as adjuvant treatment, for the treatment of adult patients with muscle invasive bladder cancer (MIBC) who are ineligible for cisplatin-containing chemotherapy.

Recommendation: The following changes are recommended to Medical Benefit Policy 209.0..

MBP 209.0

- Medical record documentation that prescription is written by a hematologist or 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 advanced or metastatic urothelial cancer **AND**
  - Medical record documentation of one of the following:
    - Medical record documentation that member has received a programmed death receptor-1 (PD-1) or programmed death-ligand 1 (PD-L1) inhibitor and platinum-containing chemotherapy **OR**
    - Medical record documentation that member has received at least one prior line of therapy and is ineligible for cisplatin-containing chemotherapy* **OR**
    - Medical record documentation that Padcev will be prescribed in combination with Keytruda or Keytruda Qlex

  OR

  - Medical record documentation of muscle invasive bladder cancer (MIBC) **AND**
  - Medical record documentation that Padcev will be prescribed in combination with Keytruda or Keytruda Qlex **AND**
  - Medical record documentation of use in the neoadjuvant setting and then continued after cystectomy as adjuvant treatment **AND**
  - Medical record documentation that member is ineligible for cisplatin-containing chemotherapy

*Note to reviewer: In clinical trials, patients who were not considered cisplatin-eligible had one or more of the following characteristics: baseline creatinine clearance of 30 – 59 mL/min, ECOG performance status of 2, or Grade 2 or greater hearing loss.

AUTHORIZATION DURATION: Initial approval will be for 12 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.

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

Rituximab Update

Recommendations: It is recommended to update the prior authorization criteria of MBP 48.0 Rituxan (rituximab), Truxima (rituximab-abbs), Ruxience (rituximab-pvvr), and Riabni (rituximab-arrx) to have an all-inclusive range of diagnosis codes for MS.

MBP 48.0 Rituxan (rituximab), Truxima (rituximab-abbs), Ruxience (rituximab-pvvr), and Riabni (rituximab-arrx)

8. For Multiple Sclerosis (MS)

Note: Prior authorization is not required for Ruxience, Riabni or Truxima for diagnosis code G35.A-35.D. In the event of a request for the rituximab reference product (i.e. Rituxan), OR in the event a requestor would like a medical necessity review completed, the following criteria would apply:

Imaavy Update

Discussion: Based on PARP review, the below updates were made to the reauthorization criteria of Imaavy. The initial reauthorization verifies initial benefit from treatment. Subsequent reauthorizations verify either continued improvement or sustained initial benefit.

MBP 354.0 Imaavy (nipocalimab-aahu)

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

- 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.

Subsequent reauthorizations will be for an additional 6 months and will require:

- Medical record documentation of continued disease improvement or lack of disease progression **OR**
- 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.

Opdivo and Opdivo Qvantig Update

Recommendations: It is recommended to update the prior authorization criteria of MBP 126.0 Opdivo (nivolumab) and MBP 342.0 Opdivo Qvantig (nivolumab-hyaluronidase-nvhy) to include changes recommended by PARP

review.

MBP 126.0 Opdivo (nivolumab)

3. *Renal Cell Carcinoma*

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation that patient is ≥ 18 years of age **AND**
  - Medical record documentation of use as a single agent for ~~relapse or for surgically unresectable~~ advanced ~~or metastatic~~ renal cell carcinoma **AND**
  - Medical record documentation of a therapeutic failure on or intolerance to prior anti-angiogenic therapy, including, but not limited to, Sutent (sunitinib), Votrient (pazopanib), Inlyta (axitinib), Nexavar (sorafenib), Avastin (bevacizumab), Afinitor (everolimus), or Torisel (temsirolimus).

MBP 342.0 Opdivo Qvantig (nivolumab-hyaluronidase-nvhy)

1. ***Melanoma***
   - Prescription written by a hematologist/oncologist **AND**
   - Medical record documentation that patient is ≥ ~~18 years~~ 12 years of age **AND**
   - Medical record documentation of one of the following:
     - A diagnosis of unresectable or metastatic melanoma **AND**
     - Opdivo Qvantig is being used as a single agent ~~following combination treatment with intravenous nivolumab and ipilimumab~~

     OR

     - A diagnosis of completely resected (no evidence of disease) Stage IIB, Stage IIC, Stage III, or Stage IV melanoma **AND**
     - Opdivo Qvantig is being used in the adjuvant setting **AND**

Opdivo Qvantig is being used as a single agent

2. ***Renal Cell Carcinoma***
   - Prescription written by a hematologist/oncologist **AND**
   - Medical record documentation that patient is ≥ 18 years of age **AND**
   - Medical record documentation of use as a single agent ~~for relapse or for surgically unresectable~~ advanced ~~or metastatic~~ renal cell carcinoma **AND**
   - Medical record documentation of a therapeutic failure on or intolerance to prior anti-angiogenic therapy, including, but not limited to, Sutent (sunitinib), Votrient (pazopanib), Inlyta (axitinib), Nexavar (sorafenib), Avastin (bevacizumab), Afinitor (everolimus), or Torisel (temsirolimus).

3. ***Colorectal Cancer***
   - Prescription written by a hematologist/oncologist **AND**
   - Medical record documentation that patient is ≥ ~~18 years~~ 12 years of age **AND**
   - Medical record documentation of a diagnosis of metastatic colorectal cancer **AND**
   - Medical record documentation of microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease **AND**
   - One of the following:
     - Medical record documentation of progression following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan ~~**AND**~~ as a single agent **OR**

- Medical record documentation that Opdivo Qvantig is being used ~~as a single agent or~~ as a single agent following combination treatment with intravenous nivolumab and ipilimumab (Yervoy).

4. ***Hepatocellular Carcinoma (HCC)***
   - Prescription written by a hematologist/oncologist **AND**
   - Medical record documentation of a diagnosis of unresectable or metastatic hepatocellular carcinoma **AND**
   - One of the following:
     - Medical record documentation of a therapeutic failure on or intolerance to sorafenib (Nexavar) **AND**
     - Medical record documentation that Opdivo Qvantig will be used as a single-agent following combination treatment with intravenous nivolumab and ipilimumab (Yervoy).

     OR

     - Medical record documentation that Opdivo Qvantig is being used as a single-agent in the first-line setting following combination treatment with intravenous nivolumab and ipilimumab (Yervoy).

Retired Policies Update

Discussion: Per an FDA safety communication released on 12/18/25, postmarketing safety data on Andexxa has led to the conclusion that the risks of the product outweigh the benefits. AstraZeneca submitted a request to voluntarily withdraw the BLA and sales in the United States ended on 12/22/25. As of February 2025, Pfzier announced they are discontinuing Beqvez, ceasing global development and commercialization of the product. As of December 2025, Merck announced they are discontinuing Zinplava, effective 1/31/25.

Recommendations: It is recommended to retire the medical benefit policies listed in the following table for all lines of business. Beqvez will remain on the prior authorization list at this time to indicate a prior authorization is required if the medication is being requested.

Medical Benefit Policy	Recommendation
MBP 332.0 Beqvez (fidanacogene elaparvovec-dzkt)	Retire
MBP 183.0 Andexxa (andexanet alfa)	Retire

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_____
_____

Meeting adjourned at 4:02 PM

Future Scheduled Meetings
The next bi-monthly scheduled meeting will be held May 12, 2026.

Meetings will be held virtually via phone/Microsoft Teams