P&T Committee Meeting Minutes
Medicaid
November 11, 2025

Present (via Teams):	**Absent:**
Bret Yarczower, MD, MBA – Chair	Leslie Astleford, Pharm.D
Amir Antonious, Pharm.D.	Emily Bednarz, Pharm.D.
Kristen Bender, 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.	Jonas Pearson, RPh
Kelli Hunsicker, Pharm.D.	Angela Scarantino
Emily Jacobson, Pharm.D.	Luke Sullivan, DO
Dennis Janosczyk, Pharm.D.	
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.	
Perry Meadows, MD	
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.	
Michael Shepherd, MD	
Kirsten Smith, Pharm.D.	
Aubrielle Smith-Masri, Pharm.D.	
Michael Spishock, RPh	
Todd Sponenberg, Pharm.D.	
Jill Stone, Pharm.D.	
Kevin Szczecina, RPh	
Amanda Taylor, MD	
Ariana Wendoloski, Pharm.D.	
Brandon Whiteash, Pharm.D.	
Margaret Whiteash, Pharm.D.	
Jeremy Garris, Pharm.D. (non-voting participant)	

Tiffany O'Hagan, Pharm.D., MBA (non-voting participant) Abigail Chua Lacey Blauser – Pharmacy resident (non-voting)	

Call to Order: Dr. Bret Yarczower called the meeting to order at 1:02 p.m., Tuesday November 11, 2025.

Review and Approval of Minutes, Reviews, Fast Facts, and Updates: Dr. Bret Yarczower asked for a motion or approval to accept the September 9, 2025 minutes as written. Minutes approved unanimously. None were opposed.

DRUG REVIEWS

Unloxcyt (cosibelimab-ipdl)

Review: Unloxcyt is a programmed death ligand-1 (PD-L1) blocking antibody indicated for the treatment of adults with metastatic cutaneous squamous cell carcinoma (mCSCC) or locally advanced CSCC (laCSCC) who are not candidates for curative surgery or curative radiation. Unloxcyt binds PD-L1 and blocks the interaction between PD-L1 and its receptors PD-1 and B7.1. This interaction in turn stops the inhibitory effects of PD-L1 on the anti-tumor immune response.

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

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

Outcome: Unloxcyt is a medical benefit that will be managed by GHP and will require a prior authorization.

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of a diagnosis of metastatic cutaneous squamous cell carcinoma (mCSCC) or locally advanced CSCC (laCSCC) 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.

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.

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.

Crenessity (crinecerfont)

Review: Crenessity is a corticotropin-releasing factor type 1 (CRF1) receptor antagonist indicated as adjunctive treatment to glucocorticoid (GC) replacement therapy for controlling androgens in adults and pediatric patients aged 4 years and older with classic congenital adrenal hyperplasia (CAH).

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

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

Outcome: Crenessity will be a pharmacy benefit and should be added to the GHP Family Formulary at the Brand tier. The additional following prior authorization criteria should apply:

- Medical record documentation of a confirmed diagnosis of classic congenital adrenal hyperplasia (CAH) due to 21-hydroxylase deficiency (21-OHD) **AND**
- Medical record documentation that member is 4 years of age or greater **AND**
- Medical record documentation that Crenessity is being prescribed by or in consultation with an endocrinologist or specialist experienced in CAH **AND**
- Medical record documentation that Crenessity will be used as an adjunctive treatment to glucocorticoid replacement (e.g., dexamethasone, hydrocortisone, methylprednisolone, prednisone, prednisolone) **AND**
- Medical record documentation that member has been receiving a stable regimen of glucocorticoid treatment for at least 4 weeks **AND**
- Medical record documentation of <u>one</u> of the following:
    - Documentation that member requires a supraphysiologic glucocorticoid dose to control their disease **OR**
    - Documentation that androgen levels remain uncontrolled despite maximum tolerated glucocorticoid dosing **AND**
- Medical record documentation that member has NOT had a history of bilateral adrenalectomy, hypopituitarism, or other condition requiring chronic glucocorticoid therapy **AND**
- Medical record documentation of appropriate weight-based dosing **AND**
- <u>If the request is for oral solution in patients weighing ≥55 kg OR in patients with a CYP3A4 dose adjustment weighing ≥20 kg</u>: Medical record documentation that patient is unable to swallow capsules or reason why capsule formulation couldn't be used.

NOTE TO REVIEWER: In the CAHtalyst trials, supraphysiologic GC dose was defined as ≥ 12 mg/m²/day hydrocortisone equivalent in pediatrics or ≥ 13 mg/m²/day in adults.

AUTHORIZATION DURATION :

Approval will be given for an initial duration of **6 months**, requiring:

- Medical record documentation that a reduction in daily glucocorticoid dose was able to be achieved **AND**
- Medical record documentation that Crenessity will continue to be used as an adjunctive treatment to glucocorticoid replacement **AND**
- Medical record documentation of appropriate weight-based dosing **AND**

- If the request is for oral solution in patients weighing ≥55 kg OR in patients with a CYP3A4 dose adjustment weighing ≥20 kg: Medical record documentation that patient is unable to swallow capsules or reason why capsule formulation couldn't be used.

Subsequent approvals will be for a duration of **12 months**, requiring:

- Medical record documentation that a reduction in daily glucocorticoid dose was able to be maintained **AND**
- Medical record documentation that Crenessity will continue to be used as an adjunctive treatment to glucocorticoid replacement **AND**
- Medical record documentation of appropriate weight-based dosing **AND**
- If the request is for oral solution in patients weighing ≥55 kg OR in patients with a CYP3A4 dose adjustment weighing ≥20 kg: Medical record documentation that patient is unable to swallow capsules or reason why capsule formulation couldn't be used.

GPI Level: GPI-12
Quantity Limits: 30-day supply
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.

Zelsuvmi (berdazimer)

Review: Zelsuvmi (berdazimer topical gel 10.3%) was approved in 2024 and is the first and only FDA approved at home prescription treatment indicated for the topical treatment of molluscum contagiosum (MC) in adults and pediatric patients aged ≥1 year.

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

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

Outcome: Zelsuvmi (berdazimer) is a pharmacy benefit and is recommended NOT to be added to the Medicaid formularies and will require prior authorization. The following prior authorization criteria should apply:

- Medical record documentation of patient age ≥ 1 year AND
- Medical record documentation of diagnosis of Molluscum Contagiosum AND
- Lesions have not resolved on their own within 6 months OR
- One of the following:
    - Lesions located in a sensitive area (face, eye genital region)
    - Members have atopic dermatitis.
    - Members have a weakened immune system (HIV/AIDS, immunosuppressive therapy, primary immunodeficiency)
- Medical record documentation of treating new lesions that have not been previously treated with Zelsuvmi for ≥ 12 weeks
- No other treatments for MC are being used concurrently.

- If age ≥ 10 years, medical documentation of intolerance to, or contraindication to, or therapeutic failure trial of Podofilox

GPI Level: 12
Authorization Duration: 12 weeks
Quantity Limit: 30 days
Reauthorization Info: None
Formulary Alternatives: Podofilox
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.

FAST FACTS

Adcetris

Updated Indication: Adcetris is a CD30-directed antibody and microtubule inhibitor conjugate now indicated in combination with lenalidomide and a rituximab product, for the treatment of adult patients with relapsed or refractory large B-cell lymphoma (LBCL), including diffuse large B-cell lymphoma (DLBCL) not otherwise specified (NOS), DLBCL arising from indolent lymphoma, or high-grade B-cell lymphoma (HGBL), after two or more lines of systemic therapy who are not eligible for auto-Hematopoietic stem cell transplantation (HSCT) or chimeric antigen receptor (CAR) T-cell therapy

Discussion: The committee unanimously voted to accept the recommendations.

Outcome: There are no changes recommended to the formulary placement of Adcetris. It is recommended to change the prior authorization criteria and authorization duration for MBP 166.0. Adcetris (brentuximab vedotin) will be considered medically necessary for all lines of business when ALL of the following criteria are met:

Relapsed or Refractory Large B-Cell Lymphoma (LBCL)

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation that patient is at least 18 years of age **AND**
- Medical record documentation of a diagnosis of relapsed or refractory Large B-Cell Lymphoma (LBCL), including diffuse large B-cell lymphoma (DLBCL) Not Otherwise Specified (NOS), DLBCL arising from indolent lymphoma, or high-grade B-cell lymphoma (HGBL) **AND**
- Medical record documentation that Adcetris will be used in combination with lenalidomide and a rituximab product **AND**
- Medical record documentation of two (2) or more prior lines of systemic therapy **AND**
- Medical record documentation that patient is not eligible for auto-HSCT or chimeric antigen receptor (CAR) T-cell therapy.

Authorization Duration:

Indication	Initial Authorization	Subsequent Authorizations
Previously Untreated Stage III or IV cHL	Initial approval will be limited to 12 doses (6 months) or less if the reviewing provider feels it is medically appropriate.	Subsequent approval for treatment past the initial 12 doses will require documentation of well-controlled, peer-reviewed literature with evidence to support this request.
Previously Untreated high risk cHL in pediatric patients	Initial approval will be limited to 5 doses (15 weeks) or less if the reviewing provider feels it is medically appropriate	Subsequent approval for treatment past the initial 5 doses will require documentation of well-controlled, peer-reviewed literature with evidence to support this request.
cHL Consolidation	Initial approval will be limited to 6 months or less if the reviewing provider feels it is medically appropriate.	Subsequent approval will be for one additional 6-month authorization to allow for a total of 16 cycles of treatment. Subsequent approval for treatment past 16 cycles will require documentation of well-controlled, peer-reviewed literature with evidence to support this request.
Relapsed pcALCL or CD30-expressing MF		
Previously Untreated sALCL or Other CD30-expressing PTCLs	Initial approval will be limited to 8 doses (6 months) or less if the reviewing provider feels it is medically appropriate.	Subsequent approval for treatment past the initial 8 doses will require documentation of well-controlled, peer-reviewed literature with evidence to support this request.
Relapsed cHL	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. Adcetris will no longer be covered if the member experiences unacceptable toxicity or worsening of disease.
Relapsed sALCL		
Relapsed or refractory LBCL	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. Adcetris 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

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Libtayo

Updated Indication: Libtayo is a programmed death receptor-1 (PD-1) blocking antibody now indicated for the adjuvant treatment of adult patients with cutaneous squamous cell carcinoma (CSCC) at high risk of recurrence after surgery and radiation.

Discussion: The committee unanimously voted to accept the recommendations.

Outcome: There are no changes recommended to the formulary placement of Libtayo. It is recommended to change the prior authorization criteria and authorization duration for MBP 186.0. Libtayo (cemiplimab-rwlc) will be considered medically necessary for all lines of business when ALL of the following criteria are met:

Cutaneous Squamous Cell Carcinoma (cSCC)

- Prescription written by a hematologist or oncologist **AND**
- Documentation that the patient is 18 years of age or older **AND**
- One of the following:
    - Medical record documentation of a diagnosis of metastatic cutaneous squamous cell carcinoma (cSCC) or locally advanced cSCC **AND**
    - Medical record documentation that the patient is not a candidate for curative surgery or curative radiation

OR

    - Medical record documentation of adjuvant treatment for cutaneous squamous cell carcinoma (cSCC) **AND**
    - Medical record documentation that the patient is at high risk of recurrence after surgery and radiation.

Basal Cell Carcinoma

- Prescription written by a hematologist or oncologist **AND**
- Medical record documentation that the patient is 18 years of age or older **AND**
- Medical record documentation of a diagnosis of one of the following:
    - Documentation of a diagnosis of locally advanced BCC (laBCC) **OR**
    - Documentation of a diagnosis of metastatic BCC (mBCC)

AND

- Medical record documentation of previous treatment with a hedgehog pathway inhibitor or documentation that a hedgehog pathway inhibitor is not appropriate

Non-Small Cell Lung Cancer (NSCLC)

- Prescription written by a hematologist or oncologist **AND**
- Medical record documentation that the patient is 18 years of age or older **AND**
- Medical record documentation of non-small cell lung cancer (NSCLC) **AND** medical record documentation of one of the following:
    - Documentation of locally advanced disease AND the patient is not a candidate for surgical resection or definitive chemoradiation **OR**

- Documentation of metastatic disease

AND

- Medical record documentation of no EGFR, ALK, or ROS1 genomic tumor aberrations **AND**
- Medical record documentation that Libtayo is being used as first-line treatment **AND**
- Medical record documentation of one of the following situations being met:
  - Libtayo is being used as a single agent **AND**
  - High PD-L1 expression [Tumor Proportion Score (TPS) ≥ 50%] as determined by an FDA-approved test

OR

  - Libtayo is being used in combination with platinum-based chemotherapy

AUTHORIZATION DURATION:

For adjuvant treatment of Cutaneous Squamous Cell Carcinoma (cSCC):

One initial approval will be 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 Libtayo for the adjuvant treatment of Cutaneous Squamous Cell Carcinoma should not exceed the FDA-approved treatment duration of 48 weeks. 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

UPDATES

October ELECTRONIC VOTE

An electronic vote was held from October 10, 2025, to October 17, 2025. Responses were received from 27 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.

Elrexfio

Updated Dose: Elrexfio can now be administered every 4 weeks in those patients who maintained a response to Elrexfio after 24 weeks of receiving bi-weekly dosing

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.

Velkury

Updated Indication Veklury is a severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) nucleotide analog RNA polymerase inhibitor indicated for the treatment of coronavirus disease 2019 (COVID-19) in adults and pediatric patients (birth to less than 18 years of age weighing at least 1.5 kg) who are hospitalized or not hospitalized, and have mild-to-moderate COVID-19, and are at high risk for progression to severe COVID-19, including hospitalization or death. Veklury was previously indicated for pediatric patients (infants 28 days of age and older and weighing at least 3 kg) who have positive results of direct SARS-CoV-2 viral testing, who are hospitalized OR not hospitalized, but have mild to moderate COVID-19 and are at high risk for progression to severe COVID-19, including hospitalization or death.

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.

Vuity

Updated Dose: Vuity (pilocarpine ophthalmic solution, 1.25%) has received an update to its FDA-approved dosing for the treatment of presbyopia in adults. The new dosing option now allows for a second dose (1 additional drop in each eye) and now reads: instill one drop of Vuity in each eye once daily. A second dose (one additional drop in each eye) may be administered 3-6 hours after the first dose. Previously, the dosing instructions were to instill one drop of Vuity in each eye once daily. Additionally, on August 6, 2025, an AB-rated generic of Vuity was launched, pilocarpine 1.25% ophthalmic solution. A brand-generic swap is recommended for our current Vuity policies for the Medicare and Medicaid lines of business.

Recommendation: Update policy. Prior authorization of Vuity will be made for members who meet the following criteria:

- Prescription written by or in consultation with an optometrist or ophthalmologist AND
- Medical record documentation of a diagnosis of Presbyopia AND
- Medical record documentation of age greater than or equal to 40 years AND
- Medical record documentation of intolerance to, or contraindication to corrective lenses

MEDISPAN AUTHORIZATION LEVEL**:** GPI-14, generic only

Quantity Limit: 25-day supply

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

committee.

Specialty Update

Discussion: Navitus recommended updates to the specialty look up tool based on how the drug is administered and current utilization. The recommended updates were reviewed and the following formulary changes are recommended.

Recommendation: Update the following medications to non-formulary:

Drug Name	Current Status for Medicaid	Specialty Routing Tool Update	Recommendations to Medicaid formulary
Bendamustine	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Bleomycin	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Camptosar	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Cisplatin	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Dacarbazine	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Dactinomycin	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Dexrazoxane	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Floxuridine	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Fludarabine	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Hyperhep B	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Idarubicin	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Melphalan	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Mitomycin	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Mutamycin	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Nipent	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Oxaliplatin	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Paclitaxel	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Paraplatin	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Pemetrexed	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Pemfexy	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**

Pemrydi	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Vinorelbine	**Medical Specialty**	**Buy and Bill only**	**Non-formulary**
Elrexfio	**Pending tier**	**Buy and Bill only**	**Non-formulary**

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

Amvuttra

Discussion: update policy criteria to match other LOB

Recommendation: Amvuttra (vutrisiran) will be considered medically necessary for the Medicaid and Medicare lines of business when all of the following criteria are met:

- Prescription written by or in consultation with a neurologist, cardiologist, board-certified medical geneticist, or specialist with experience in the treatment of hereditary or wild-type transthyretin-mediated amyloidosis **AND**
- Medical record documentation of age greater than or equal to 18 years **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 **AND**
- Medical record documentation that Amvuttra will not be used in combination with other RNA interference treatment **AND**

<u>For hereditary transthyretin-mediated amyloidosis (hATTR):</u>

- Medical record documentation of diagnosis of hereditary transthyretin-mediated amyloidosis as confirmed by genetic testing to confirm a pathogenic mutation in TTR AND one of the following:
    - Biopsy of tissue/organ to confirm amyloid presence **OR**
    - A clinical manifestation typical of hATTR (Neuropathy and/or CHF) without a better alternative explanation **AND**
- One of the following:
    - Medical record documentation of Amvuttra being used to treat polyneuropathy **AND**
    - Medical record documentation of familial amyloid polyneuropathy (FAP) stage 1-2 and/or polyneuropathy disability score (PND) indicating the patient is not wheelchair bound or bedridden

OR

    - Medical record documentation of Amvuttra being used for cardiomyopathy to reduce cardiovascular mortality, cardiovascular hospitalizations and urgent heart failure visits

OR

<u>For wild-type transthyretin-mediated amyloidosis (wtATTR):</u>

- Medical record documentation of diagnosis of wild-type transthyretin-mediated amyloidosis as confirmed by genetic testing **AND**
- Medical record documentation Amvuttra is being used for cardiomyopathy to reduce cardiovascular mortality, cardiovascular hospitalizations and urgent heart failure visits

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

Beyfortus

Discussion: It is recommended to update the prior authorization criteria for Beyfortus to include Enflonsia as part of a therapeutic duplication review in the event one may be needed.

Recommendation: The following updated prior authorization criteria will apply.

- Medical record documentation that member has not received Synagis or Enflonsia during the current RSV season

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

GHP Family Update

DUR Survey: The CMS FFY 2024 Managed Care Organization (MCO) Drug Utilization Review (DUR) Survey was completed on June 12, 2025. A copy of the survey will be posted here at a later time: Drug Utilization Review Annual Report | Medicaid

Recommendation: approve the following updates based on feedback from DHS.
Arexvy – DHS noted that increased risk of RSV is defined as having one of the diagnoses listed in the 2rd bullet point and requested that we remove the 3rd bullet point.

- 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)~~

Journavx - DHS would not approve a policy that requires trial of a short-acting opioid prior to approval of Journavx. They asked that we consider revising to therapeutic failure or contraindication or intolerance to two formulary alternatives and list multiple formulary alternatives such as NSAIDs, acetaminophen, short-acting opioids, topical analgesics.

- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of moderate to severe acute pain **AND**
- Medical record documentation that Journavx will not be used in combination with opioid products **AND**
- Medical record documentation of a contraindication to, intolerance to, or therapeutic failure on two formulary alternatives

  Formulary alternatives: short-acting opioids and NSAIDs per Statewide PDL, acetaminophen, topical analgesics

Furoscix – DHS asked if the policy could be reorganized to accurately reflect the FDA approved indication ...treatment of edema in adult patients with chronic heart failure or chronic kidney disease, including the nephrotic syndrome. DHS noted that as written the policy gives the impression members would need to have CHF and fluid overload or CHF and CKD including the nephrotic syndrome.

- Medical record documentation that Furoscix is prescribed by or in consultation with a cardiologist **AND**
- Medical record documentation of age greater than or equal to 18 years **AND**
- Medical record documentation of edema in patient with chronic heart failure ~~**AND**~~ **OR**
- ~~Medical record documentation of congestion due to fluid overload **AND**~~
- Medical record documentation of edema in patients with chronic kidney disease (CKD), including the nephrotic syndrome **AND**
- Medical record documentation that member is stable on background loop diuretic therapy **AND**
- Medical record documentation of provider attestation that member will use Furoscix for short-term use only and will be transitioned to oral diuretics as soon as practical

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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Meeting adjourned at 3:13 PM

Future Scheduled Meetings
The next bi-monthly scheduled meeting will be held January 13, 2026.

Meetings will be held virtually via phone/Microsoft Teams