Commissioner for the Department for Medicaid Services Selections for Preferred Products

The following tables provide a summary of the final Preferred Drug List (PDL) selections made by the Commissioner for the Department for Medicaid Services (DMS) based on the Drug Review and Options for Consideration document prepared for the Pharmacy and Therapeutics (P&T) Advisory Committee's review on **April 18, 2024**, and the resulting official recommendations.

NEW PRODUCTS TO MARKET

Voquezna®

Proton Pump Inhibitors: Non-Preferred (NPD)

Approval Duration: ***8 weeks initial approval, 6 months for renewal***

- *Vonoprazan works by suppressing basal and stimulated gastric acid secretion at the secretory surface of the gastric parietal cell through inhibition of the H^+, K^+-ATPase enzyme system in a potassium competitive manner.*

Initial Approval Criteria:

- Diagnosis of diagnostically confirmed erosive esophagitis; **AND**
- Prescribed by, or in consultation with, a gastroenterologist or other specialist in the diagnosis and treatment of erosive esophagitis; **AND**
- Patient has had a ≥ 2-week trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to 2 preferred agents in this PDL class.

Renewal Criteria:

- Diagnosis of diagnostically confirmed erosive esophagitis; **AND**
- Prescribed by, or in consultation with, a gastroenterologist or other specialist in the diagnosis and treatment of erosive esophagitis; **AND**
- Patient has experienced symptom improvement or control during initial treatment course.

Age Limit: ≥ 18 years of age

Quantity Limit: 1 tablet per day

Drug Class	Preferred Agents	Non-Preferred Agents
Proton Pump Inhibitors	*esomeprazole capsule* QL	*Aciphex tablet* QL
	lansoprazole capsule QL	*Dexilant capsule* QL
	Nexium suspension QL	*dexlansoprazole DR capsule* QL
	omeprazole capsule QL	*esomeprazole suspension* QL
	pantoprazole tablets QL	*Konvomep suspension* QL
		lansoprazole ODT QL
		Nexium Capsule QL
		omeprazole/sodium bicarbonate capsule QL
		omeprazole/sodium bicarbonate packet QL
		pantoprazole suspension QL
		Prevacid capsule QL

Drug Class	Preferred Agents	Non-Preferred Agents
		Prevacid tablet QL
		Prilosec suspension QL
		Protonix suspension QL
		Protonix tablet QL
		rabeprazole tablet QL
		Voquezna AE, CC, QL
		Zegerid capsule QL
		Zegerid packet QL

Voquezna Dual Pak® and Voquezna Triple Pak®

H. Pylori Treatment: Non-Preferred (NPD)

Approval Duration: *30 days*

- *Vonoprazan works by suppressing basal and stimulated gastric acid secretion at the secretory surface of the gastric parietal cell through inhibition of the H^+, K^+-ATPase enzyme system in a potassium competitive manner. Amoxicillin and clarithromycin are antimicrobial agents that work by various mechanisms to treat bacterial infections.*

Initial Approval Criteria:

- Diagnosis of diagnostically confirmed *H. pylori* infection; **AND**
- Prescribed by, or in consultation with, a gastroenterologist or other specialist in the diagnosis and treatment of *H. pylori*; **AND**
- Patient has had a ≥ 2-week trial and failure, allergy, contraindication (including potential drug-drug interactions with other medications) or intolerance to Pylera.

Age Limit: ≥ 18 years of age

Quantity Limit: Voquezna Dual Pak: 1 carton of 28 tablets and 84 capsules per 14-day supply
Voquezna Triple Pak: 1 carton of 56 tablets and 56 capsules per 14-day supply

Drug Class	Preferred Agents	Non-Preferred Agents
H. Pylori Treatments	*Pylera capsule* QL	*bismuth subcitrate potassium/metronidazole/ tetracycline capsule* QL
		lansoprazole/amoxicillin/clarithromycin pack QL
		Omeclamox-Pak QL
		Talicia capsule
		Voquezna Dual Pak AE, CC, QL
		Voquezna Triple Pak AE, CC, QL

Fabhalta®

Non-PDL

Approval Duration: ***4 months for initial, 1 year for renewal***

- *Iptacopan inhibits Factor B, which acts proximally in the alternative pathway of the complement cascade to control C3B-mediated intravascular and extravascular hemolysis.*

Initial Approval Criteria:

- Diagnosis of paroxysmal nocturnal hemoglobinuria (PNH) confirmed by flow cytometry results demonstrating both of the following:
  - The absence or deficiency of glycosylphosphatidylinositol (GPI)-anchored proteins (e.g., CD55, CD59) on at least two cell lineages; **AND**
  - PNH granulocyte clone size ≥ 10%; **AND**
- Prescribed by, or in consultation with, a hematologist or other appropriate specialist in the treatment of paroxysmal nocturnal hemoglobinuria (PNH); **AND**
- Patient will not be using a C5 complement inhibitor (e.g., Soliris, Ultomiris) or a C3 complement inhibitor (e.g., Empaveli) while taking Fabhalta.

Renewal Criteria:

- Physician attestation of clinical benefit, such as reduction in number of blood transfusions needed, improvement or stabilization of hemoglobin levels, reduction in hemolysis.

Age Limit: ≥ 18 years of age

Quantity Limit: 2 capsules per day

Jesduvroq®

Erythropoiesis Stimulating Proteins: Non-Preferred (NPD)

Approval Duration: *6 months*

- *Jesduvroq works by increasing transcription of the HIF-responsive genes, including erythropoietin.*

Initial Approval Criteria:

- Diagnosis of chronic kidney disease (N18.9); **AND**
- Pretreatment hemoglobin level ≤ 11g/dl; **AND**
- Patient has been receiving dialysis for at least 4 months; **AND**
- Patient is not receiving treatment with any other erythropoiesis stimulating agents.

Renewal Criteria:

- Documentation (e.g., progress note, laboratory report) demonstrating a positive response to therapy.

Quantity Limit: 1mg one daily

2mg one daily

4mg one daily

6mg two daily

8mg three daily

Drug Class	Preferred Agents	Non-Preferred Agents
Erythropoiesis Stimulating Proteins	*Aranesp* [CC]	***Jesduvroq*** [CC, QL]
	Epogen [CC]	*Procrit*
	Mircera	*Reblozyl* [AE, CC]
	Retacrit [CC] *(Pfizer)*	*Retacrit* [CC] *(Vifor)*

Wainua™

Non-PDL

Approval Duration: ***1 year***

- *Eplontersen is a ligand-conjugated antisense oligonucleotide that degrades transthyretin (TTR) mRNA, thereby decreasing TTR protein and thus amyloid deposits in the liver.*

Initial Approval Criteria:

- Patient has a definitive diagnosis of hereditary transthyretin-mediated (hATTR) amyloidosis/FAP (familial amyloidotic polyneuropathy) as documented by:
  - Amyloid deposition on tissue biopsy; **OR**
  - Identification of a pathogenic TTR variant using molecular genetic testing; **AND**
- Patient has polyneuropathy attributed to hATTR/FAP; **AND**
- Patient has NOT received an orthotopic liver transplant (OLT); **AND**
- Patient will not be using Wainua in combination with other TTR-reducing agents (e.g., inotersen [Tegsedi], patisiran [Onpattro], tafamidis [Vyndamax, Vyndaqel], vutrisiran [Amvuttra]).

Renewal Criteria:

- Prescriber attestation of clinically significant improvement or stabilization in clinical signs and symptoms, such as improvement in ambulation, neurologic symptoms, or activities of daily living.

Age Limit: ≥ 18 years of age

Quantity Limit: 1 auto-injector per 28 days

Agamree®

Steroids, Oral: Non-Preferred (NPD)

Approval Duration: ***1 year***

- *Vamorolone is a corticosteroid that acts through the glucocorticoid receptor to exert anti-inflammatory and immunosuppressive effects. The precise mechanism by which vamorolone exerts its effect in patients with Duchenne Muscular Dystrophy is unknown.*

Initial Approval Criteria:

- Diagnosis of Duchenne Muscular Dystrophy (DMD); **AND**
- Patient is currently receiving, or planning to receive, physical therapy; **AND**
- Patient has tried prednisone or prednisolone for at least 6 months; **OR**
- Patient has experienced 1 of the following adverse reactions directly attributable to previous therapy with prednisone or prednisolone:
  - Significant behavioral changes negatively impacting function at school, home, day care, etc.; **OR**
  - Significant weight gain (e.g., crossing 2 percentiles and/or reaching 98th percentile for age and sex).

Renewal Criteria:

- Patient continues to receive physical therapy; **AND**
- Patient has received benefit from therapy (i.e. stability, improvement or slowing of decline) in one or more of the following areas of assessment:
  - Motor function (North Star Ambulatory Assessment (NSAA)
  - Cardiology
  - Endocrinology
  - Orthopedics (e.g., scoliosis)
  - Pulmonary function.

Age Limit: ≥ 2 years of age

Quantity Limit: 7.5 mL per day

Drug Class	Preferred Agents	Non-Preferred Agents
Steroids, Oral	*budesonide DR capsule* QL	***Agamree*** AE, CC, QL
	budesonide EC capsule QL	*Alkindi Sprinkle capsule*
	dexamethasone elixir, solution, tablet	*Cortef tablet*
	hydrocortisone tablet	*cortisone acetate tablet*
	methylprednisolone dose pack, 4 mg, 32 mg tablet	*deflazacort tablet* AE, CC, QL
	prednisolone solution	*dexamethasone dose pack, Intensol drop*
	prednisolone sodium phosphate solution 5 mg/5 mL, 15 mg/5 mL, 25 mg/5 mL	*Emflaza* AE, CC, QL
	prednisone dose pack, solution, tablet	*Hemady tablet*

Drug Class	Preferred Agents	Non-Preferred Agents
		Medrol dose pack, tablet
		methylprednisolone 8 mg, 16 mg tablet
		Millipred dose pack, tablet
		prednisolone tablet
		prednisolone sodium phosphate ODT, solution 10 mg/5 mL, 20 mg/5 mL
		prednisone Intensol oral concentrate
		Rayos DR tablet
		TaperDex dose pack
		Tarpeyo DR capsule

Zilbrysq®

Non-PDL

Approval Duration: ***Initial 3 months; Renewal 1 year***

- *Zilucoplan is a complement inhibitor indicated for the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.*

Initial Approval Criteria:

- Diagnosis of generalized myasthenia gravis (MGFA Clinical Classification Class II to IV) with positive serologic test for anti-acetylcholine receptor (AChR) antibodies; **AND**
- Member has a baseline MG-Activities of Daily Living (MG-ADL) total score ≥ 6; **AND**
- Patient has tried and failed at least two immunosuppressive therapies (one corticosteroid and one non-steroid immunosuppressive therapy, e.g., azathioprine, cyclosporine, mycophenolate); **AND**
- Patient does not have unresolved Neisseria meningitidis infection.

Renewal Criteria:

- For initial renewal: Patient has disease improvement as evidenced by:
  - At least 2-point reduction in MG-ADL total score from baseline; **OR**
  - Improvement in signs or symptoms that impact daily function; **OR**
- For subsequent renewal after an initial beneficial response:
  - Patient is stable on therapy; **OR**
  - Patient requires continuous treatment due to new or worsening disease activity.

Age Limit: ≥ 18 years of age

Quantity Limit: 1 syringe per day

FULL CLASS REVIEWS

Non-Steroid Anti-Inflammatory Drugs (NSAIDs)

Class Selection & Guidelines

- DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) class, require PA until reviewed by the P&T Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Non-Steroid Anti-Inflammatory Drugs (NSAIDs)	*celecoxib* [QL]	*Arthrotec*
	diclofenac sodium topical gel (1%)	*Celebrex* [QL]
	diclofenac sodium DR/EC tablets	*Daypro*
	Ibu tablet	*diclofenac epolamine patch* [CC]
	Ibuprofen tablet	*diclofenac potassium capsule*
	indomethacin capsule	*diclofenac potassium powder pack*
	indomethacin ER capsule	*diclofenac potassium tablet*
	ketorolac tablet	*diclofenac topical solution* [CC]
	meloxicam tablet	*diclofenac sodium SR/ER tablet*
	nabumetone tablet	*diclofenac 2% solution pump* [CC]
	naproxen sodium tablet	*diclofenac sodium/misoprostol*
	naproxen tablet	*diflunisal tablet*
	piroxicam capsule	*Duexis tablet* [CC]
	sulindac tablet	*EC-Naprosyn tablet*
		EC-Naproxen tablet
		Elyxyb solution [CC, AE, QL]
		etodolac capsule
		etodolac tablet
		etodolac ER tablet
		Feldene capsule
		fenoprofen capsule
		fenoprofen tablet
		Flector patch [CC]
		flurbiprofen tablet
		ibuprofen/famotidine tablet
		indomethacin suppository
		indomethacin suspension [QL]
		ketoprofen ER capsule
		ketoprofen capsule
		ketorolac nasal spray [CC]
		Kiprofen capsule
		Licart patch [CC]
		Lofena tablet
		meclofenamate capsule
		mefenamic acid capsule
		meloxicam capsule [CC, QL]

Drug Class	Preferred Agents	Non-Preferred Agents
		nabumetone tablet
		Nalfon capsule
		Nalfon tablet
		Naprelan CR tablet
		Naprosyn
		naproxen DR tablet
		naproxen suspension
		naproxen sodium CR/ER tablet
		naproxen/esomeprazole DR tablet CC, QL
		oxaprozin tablet
		Pennsaid CC
		piroxicam capsule
		Relafen tablet
		Relafen DS tablet
		tolmetin capsule
		tolmetin tablet
		Vimovo CC, QL

Antihyperuricemics

Class Selection & Guidelines

- DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Antihyperuricemics class, require PA until reviewed by the P&T Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Antihyperuricemics	*allopurinol tablet*	*colchicine capsule CC*
	colchicine tablet CC	***Colcrys tablet CC***
	febuxostat tablet QL	*Gloperba solution CC*
	probenecid tablet	*Mitigare capsule CC*
	probenecid/colchicine tablet	*Uloric tablet QL*
		Zyloprim tablet

Erythropoiesis Stimulating Proteins

Class Selection & Guidelines

- DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Erythropoiesis Stimulating Proteins class, require PA until reviewed by the P&T Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Erythropoiesis Stimulating Proteins	*Aranesp* [CC]	*Jesduvroq* [CC, QL]
	Epogen [CC]	*Procrit*
	Mircera	*Reblozyl* [AE, CC]
	Retacrit [CC] *(Pfizer)*	*Retacrit* [CC] *(Vifor)*

Steroids, Oral

Class Selection & Guidelines

- DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Steroids, Oral class, require PA until reviewed by the P&T Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Steroids, Oral	*budesonide DR capsule* [QL]	*Agamree* [AE, CC, QL]
	budesonide EC capsule [QL]	*Alkindi Sprinkle capsule*
	dexamethasone elixir*, solution, tablet*	*Cortef tablet*
	hydrocortisone tablet	*cortisone acetate tablet*
	methylprednisolone dose pack, 4 mg, 32 mg tablet	*deflazacort tablet* [AE, CC, QL]
	prednisolone solution	*dexamethasone dose pack, Intensol drop*
	prednisolone sodium phosphate solution 5 mg/5 mL, 15 mg/5 mL, 25 mg/5 mL	*Emflaza* [AE, CC, QL]
	prednisone dose pack, solution, tablet	*Hemady tablet*
		Medrol dose pack, tablet
		methylprednisolone 8 mg, 16 mg tablet
		Millipred dose pack, tablet
		prednisolone tablet
		prednisolone sodium phosphate ODT, solution 10 mg/5 mL, 20 mg/5 mL
		prednisone Intensol oral concentrate
		Rayos DR tablet
		TaperDex dose pack
		Tarpeyo DR capsule

Pancreatic Enzymes

Class Selection & Guidelines

- DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Pancreatic Enzymes class, require PA until reviewed by the P&T Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Pancreatic Enzymes	*Creon capsule*	*Pertzye capsule*
	Viokace tablet	
	Zenpep Capsule	

Colony Stimulating Factors

Class Selection & Guidelines

- DMS to select preferred agent(s) based on economic evaluation; however, at least 2 unique chemical entities should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.
- For any new chemical entity in the Colony Stimulating Factors class, require PA until reviewed by the P&T Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Colony Stimulating Factors	***Fylnetra*** *QL*	*Fulphila CC, QL*
	Neupogen CC, QL	*Granix QL*
		Leukine QL
		Neulasta CC, QL
		Neulasta Onpro CC, QL
		Nivestym QL
		Nyvepria CC, QL
		Releuko QL
		Rolvedon AE, CC, QL
		Stimufend QL
		Udenyca CC, QL
		Zarxio QL
		Ziextenzo CC, QL

CONSENT AGENDA REVIEWS

For the following therapeutic classes, there were no changes in PDL status:

Therapeutic Classes
• Narcotics, Long Acting • Narcotics, Short Acting • Narcotic Agonist/Antagonists • Narcotics, Fentanyl Buccal Products • Antimigraine Agents, Triptans • Antimigraine Agents, CGRP Inhibitors • Neuropathic Pain • Opiate Dependence Treatments • Skeletal Muscle Relaxants • Phosphate Binders • Sickle Cell Anemia Treatments • Thrombopoiesis Stimulating Proteins • Alpha-Glucosidase Inhibitors • Dipeptidyl Peptidase-4 (DPP-4) Inhibitors • Glucagon-Like Peptide (GLP-1) Receptor Agonists • Insulin & Related Agents • Meglitinides • Metformins • Sodium-Glucose Cotransporter-2 (SGLT2) Inhibitors • Sulfonylureas • Thiazolidinediones (TZDs) • Androgenic Agents • Bone Resorption Suppression & Related Agents • Glucagon Agents • Growth Hormones • Progestins for Cachexia • Uterine Disorder Treatments