



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 **January 18, 2024**, and the resulting official recommendations.

# NEW PRODUCTS TO MARKET

# Vowst<sup>™</sup>

# Antibiotics, Gastrointestinal: Non-Preferred (NPD)

# Approval Duration: 30 days (Limit to 1 fill per approval)

• Vowst (fecal microbiota spores, live-brpk) is a bacterial spore suspension in capsules indicated for the prevention of recurrent Clostridioides difficile infection (CDI) following antibacterial treatment for recurrent CDI (rCDI).

# Initial Approval Criteria:

- Diagnosis of recurrent Clostridioides difficile infection (CDI); AND
- Prescribed by, or in consultation with, a gastroenterologist or infectious disease specialist; AND
- Patient has completed at least 3 full courses of antibiotic treatment with two or more of the following guideline recommended agents:
  - Vancomycin oral
  - o Dificid
  - Metronidazole oral; AND
- Treatment with Vowst will be initiated between 48 and 96 hours of completion of the most recent course of antibiotics; **AND**
- At least 8 hours prior to the first dose of Vowst, the patient will receive an appropriate bowel cleansing regimen (e.g., magnesium citrate or polyethylene glycol)

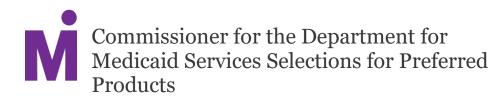
# **Renewal Criteria:**

- Diagnosis of recurrent Clostridioides difficile infection (CDI); AND
- Prescribed by, or in consultation with, a gastroenterologist or infectious disease specialist; AND
- Patient had treatment failure defined as the presence of CDI diarrhea within 8 weeks of the first dose of Vowst AND a positive stool test for *C. difficile*; **AND**
- Patient has not previously received more than 1 treatment course of Vowst; AND
- Previous course of Vowst was at least 12 days ago but no more than 8 weeks ago.

# Age Limit: ≥ 18 years of age

Quantity Limit: 12 capsules over 3 days







Drug Class	Preferred Agents	Non-Preferred Agents
Antibiotics,	Firvanq <sup>cc</sup>	Aemcolo
Gastrointestinal	Metronidazole tablet	Dificid <sup>CC, QL</sup>
	Neomycin	Flagyl
	Tinidazole	Likmez
	Vancomycin capsule <sup>CC</sup>	Metronidazole capsule
	Xifaxan <sup>CC, QL</sup>	Nitazoxamide
		Paromomycin
		Solosec AE, CC, QL
		Vancocin
		Vancomycin solution Vowst <sup>AE, CC, QL</sup>
		Vowst <sup>AE, CC, QL</sup>

# **Bimzelx**®

# Cytokine and CAM Antagonists: Non-Preferred (NPD)

#### Approval Duration: 6 months initial; 1 year renewal

• Bimekizumab-bkzx is a humanized immunoglobulin IgG1/kappa monoclonal antibody indicated for the treatment of moderate to severe plaque psoriasis.

#### Initial Approval Criteria:

- Diagnosis of moderate to severe plaque psoriasis; AND
- Prescribed by or in consultation with a dermatologist, rheumatologist, or other specialist in the treatment of psoriasis; **AND**
- Symptoms persistent for  $\geq$  6 months with at least 1 of the following:
  - Involvement of at least 3% of body surface area (BSA); OR
  - Psoriasis Area and Severity Index (PASI) score of 10 or greater; **OR**
  - Incapacitation due to plaque location (e.g., head and neck, palms, soles, or genitalia);
    AND
- Trial and failure (at least 3 months) of  $\geq$  1 conventional therapy, such as:
  - o Disease-modifying anti-rheumatic drug (DMARD), such as methotrexate
  - Immunosuppressant (e.g., cyclosporine)
  - Oral retinoid (e.g., acitretin); AND
- NOT used in combination with any other biologic agent; AND
- 3-month trial and failure of, contraindication, or intolerance to ≥ 1 preferred cytokine or CAM antagonist indicated for the treatment of this condition.





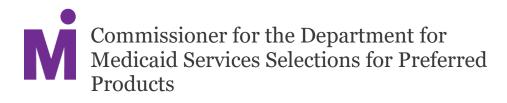
# **Renewal Criteria:**

• Documentation (e.g., progress note) of response to therapy compared to baseline, such as redness, thickness, scaliness, amount of surface area involvement, and/or PASI score.

Age Limit: ≥ 18 years of age

Quantity Limit: 2 injections per 28 days

Drug Class	Preferred Agents	Non-Preferred Agents
Cytokine and CAM	Cosentyx <sup>CC, QL</sup>	Abrilada <sup>CC, QL</sup>
Antagonists	Enbrel <sup>CC, QL</sup>	Actemra <sup>CC, QL</sup>
	Humira <sup>CC, QL</sup>	Adalimumab-aacf <sup>CC, QL</sup>
	Otezla <sup>CC, QL</sup>	Adalimumab-adaz <sup>CC, QL</sup>
	Xeljanz <sup>CC, QL</sup>	Adalimumab-adbm <sup>CC, QL</sup>
		Adalimumab-fjkp <sup>CC, QL</sup>
		Amjevita <sup>CC, QL</sup>
		Bimzelx AE, CC, QL
		Cibinqo <sup>CC, QL</sup>
		Cimzia <sup>CC, QL</sup>
		Cyltezo <sup>CC, QL</sup>
		Enspryng <sup>AE, CC, QL</sup>
		Hadlima <sup>CC, QL</sup>
		Hulio <sup>CC, QL</sup>
		Hyrimoz <sup>CC, QL</sup>
		Idacio <sup>CC, QL</sup>
		Ilaris <sup>CC, QL</sup>
		llumya <sup>AE, CC, QL</sup>
		Kevzara <sup>AE, CC, QL</sup>
		Kineret <sup>CC, QL</sup>
		Olumiant AE, CC, QL
		Omvoh <sup>AE, CC, QL</sup>
		Orencia <sup>CC, QL</sup>
		Rinvoq <sup>AE, CC, QL</sup>
		Siliq <sup>AE, CC, QL</sup>
		Simponi <sup>CC, QL</sup>
		Skyrizi <sup>AE, CC, QL</sup>
		Sotyktu <sup>AE, CC, QL</sup>
		Stelara <sup>CC, QL</sup>
		Taltz <sup>CC, QL</sup>
		Tremfya <sup>AE</sup> , <sup>CC, QL</sup>
		Velsipity <sup>AE</sup> , <sup>CC, QL</sup>
		Xeljanz XR <sup>CC, QL</sup>
		Yuflyma <sup>CC, QL</sup>
		Yusimry <sup>CC, QL</sup>





# Velsipity<sup>™</sup>

# Cytokine and CAM Antagonists: Non-Preferred (NPD)

# Approval Duration: 6 months initial; 1 year renewal

• Etrasimod is a sphingosine 1-phosphate (S1P) receptor modulator that binds with high affinity to S1P receptors 1, 4, and 5 indicated for the treatment of moderate to severe ulcerative colitis (UC).

# Initial Approval Criteria:

- Diagnosis of moderate to severe ulcerative colitis (UC); AND
- Prescribed by, or in consultation with, a gastroenterologist or other specialist in the treatment of UC; AND
- Patient has had a trial and failure of  $\geq$  1 of the following conventional therapies:
  - Oral/rectal 5-aminosalicylic acid agents (e.g., Apriso, balsalazide, Lialda, mesalamine, sulfasalazine)
  - Oral/rectal steroids (e.g., budesonide, hydrocortisone, prednisone)
  - Immunosuppressant (e.g., azathioprine, mercaptopurine); **OR**
- Patient is deemed high-risk for intestinal complications or post-operative recurrence; AND
- NOT used in combination with any other biologic agent; AND
- Patient has had a 3-month trial and failure of, or contraindication or intolerance to, ≥ 1 preferred cytokine or CAM antagonist indicated for the treatment of UC; **AND**
- Patient meets the minimum age recommended by the package insert for use in UC.

#### **Renewal Criteria:**

• Documentation (e.g., progress notes) of response to therapy compared to baseline.

# Age Limit: ≥ 18 years of age

Quantity Limit: 1 tablet per day

Drug Class	Preferred Agents	Non-Preferred Agents
Cytokine and CAM	Cosentyx <sup>CC, QL</sup>	Abrilada <sup>CC, QL</sup>
Antagonists	Enbrel <sup>CC, QL</sup>	Actemra <sup>CC, QL</sup>
	Humira <sup>CC, QL</sup>	Adalimumab-aacf <sup>CC, QL</sup>
	Otezla <sup>CC, QL</sup>	Adalimumab-adaz <sup>CC, QL</sup>
	Xeljanz <sup>CC, QL</sup>	Adalimumab-adbm <sup>CC, QL</sup>
		Adalimumab-fjkp <sup>CC, QL</sup>
		Amjevita <sup>CC, QL</sup>
		Bimzelx AE, CC, QL
		Cibingo <sup>CC, QL</sup>
		Cimzia <sup>CC, QL</sup>
		Cyltezo <sup>CC, QL</sup>
		Enspryng <sup>AE, CC, QL</sup>
		Hadlima <sup>CC, QL</sup>



Commissioner for the Department for Medicaid Services Selections for Preferred Products



Drug Class	Preferred Agents	Non-Preferred Agents
		Hulio <sup>CC, QL</sup>
		Hyrimoz <sup>CC, QL</sup>
		Idacio <sup>CC, QL</sup>
		Ilaris <sup>CC, QL</sup>
		llumya <sup>AE, CC, QL</sup>
		Kevzara <sup>AE, CC, QL</sup>
		Kineret <sup>CC, QL</sup>
		Olumiant AE, CC, QL
		Omvoh <sup>AE, CC, QL</sup>
		Orencia <sup>CC, QL</sup>
		Rinvoq <sup>AE, CC, QL</sup>
		Siliq <sup>AE, CC, QL</sup>
		Simponi <sup>CC, QL</sup>
		Skyrizi <sup>AE, CC, QL</sup>
		Sotyktu <sup>AE, CC, QL</sup>
		Stelara <sup>CC, QL</sup>
		Taltz <sup>CC, QL</sup>
		Tremfya <sup>AE</sup> , <sup>CC, QL</sup>
		Velsipity <sup>AE</sup> , <sup>CC, QL</sup>
		Xeljanz XR <sup>CC, QL</sup>
		Yuflyma <sup>CC, QL</sup>
		Yusimry <sup>CC, QL</sup>

# Omvoh<sup>™</sup>

# Cytokine and CAM Antagonists: Non-Preferred (NPD)

# Approval Duration: 6 months initial; 1 year renewal

• Mirkizumab-mrkz is a humanized IgG4 monoclonal antibody indicated for the treatment of moderate to severe ulcerative colitis (UC).

# Initial Approval Criteria:

- Diagnosis of moderate to severe ulcerative colitis (UC); AND
- Prescribed by, or in consultation with, a gastroenterologist or other specialist in the treatment of UC; AND
- Patient has had a trial and failure of  $\geq 1$  of the following conventional therapies:
  - Oral/rectal 5-aminosalicylic acid agents (e.g., Apriso, balsalazide, Lialda, mesalamine, sulfasalazine)
  - Oral/rectal steroids (e.g., budesonide, hydrocortisone, prednisone)
  - Immunosuppressant (e.g., azathioprine, mercaptopurine); **OR**
- Patient is deemed high-risk for intestinal complications or post-operative recurrence; AND





- NOT used in combination with any other biologic agent; AND
- Patient has had a 3-month trial and failure of, or contraindication or intolerance to, ≥ 1 preferred cytokine or CAM antagonist indicated for the treatment of UC; **AND**
- Patient meets the minimum age recommended by the package insert for use in UC.

## **Renewal Criteria:**

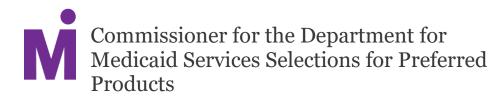
• Documentation (e.g., progress notes) of response to therapy compared to baseline.

# **Age Limit:** ≥ 18 years of age

Quantity Limit: 2 mL per 28 days

Drug Class	Preferred Agents	Non-Preferred Agents
Cytokine and CAM	Cosentyx <sup>CC, QL</sup>	Abrilada <sup>CC, QL</sup>
Antagonists	Enbrel <sup>CC, QL</sup>	Actemra <sup>CC, QL</sup>
	Humira <sup>CC, QL</sup>	Adalimumab-aacf <sup>CC, QL</sup>
	Otezla <sup>CC, QL</sup>	Adalimumab-adaz <sup>CC, QL</sup>
	Xeljanz <sup>CC, QL</sup>	Adalimumab-adbm <sup>CC, QL</sup>
		Adalimumab-fjkp <sup>CC, QL</sup>
		Amjevita <sup>ČC, QL</sup> Bimzelx <sup>AE, CC, QL</sup>
		Cibingo <sup>CC, QL</sup>
		Cimzia <sup>CC, QL</sup>
		Cyltezo <sup>CC, QL</sup>
		Enspryng <sup>AE, CC, QL</sup>
		Hadlima <sup>CC, QL</sup>
		Hulio <sup>CC, QL</sup>
		Hyrimoz <sup>CC, QL</sup>
		Idacio <sup>CC, QL</sup>
		<i>llaris</i> <sup>CC, QL</sup>
		Ilumya <sup>AE, CC, QL</sup>
		Kevzara <sup>AE, CC, QL</sup>
		Kineret <sup>CC, QL</sup>
		Olumiant AE, CC, QL
		Omvoh <sup>AE, CC, QL</sup>
		Orencia <sup>CC, QL</sup>
		Rinvoq <sup>AE, CC, QL</sup>
		Siliq <sup>AE, CC, QL</sup>
		Simponi <sup>CC, QL</sup>
		Skyrizi <sup>AE, CC, QL</sup>
		Sotyktu <sup>AE, CC, QL</sup>
		Stelara <sup>CC, QL</sup>
		Taltz <sup>CC, QL</sup>
		Tremfya <sup>AE</sup> , <sup>CC, QL</sup>

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Drug Class	Preferred Agents	Non-Preferred Agents
		Velsipity <sup>AE</sup> , <sup>CC, QL</sup>
		Xeljanz XR <sup>CC, QL</sup>
		Yuflyma <sup>CC, QL</sup>
		Yusimry <sup>CC, QL</sup>

Zurzuvae™

Antidepressants, Other: Non-Preferred (NPD)

Approval Duration: Six months with limit of 2 courses of treatment (28 days)

• Zuranolone is a neuroactive steroid gama-aminobutyric acid (GABA)<sub>A</sub> receptor positive modulator indicated for the treatment of postpartum depression (PPD) in adults.

Initial Approval Criteria:

- Diagnosis of Postpartum Depression (PPD) in adults
- Within one year of giving birth

Quantity Limit: maximum 14 day supply per fill, maximum 2 fills per 180 days

Drug Class	Preferred Agents	Non-Preferred Agents
Antidepressants, Other	Bupropion	Aplenzin ER tablet
	Bupropion SR tablet	Auvelity tablet AE, CC, QL
	Bupropion XL 150 mg, 300 mg tablet	Bupropion XL 450 mg tablet
	Mirtazapine ODT	Forfivo XL tablet
	Mirtazapine tablet	Nefazodone tablet
	Trazodone tablet	Remeron Soltab
		Remeron tablet
		Spravato spray AE, CC, QL
		Trintellix tablet
		Viibryd tablet dose pack
		Viibryd tablet
		Vilazodone tablet
		Wellbutrin SR tablet
		Wellbutrin XL tablet
		Zurzuvae <sup>cc, qL</sup>





# Xphozah<sup>®</sup>

# Blood Modifiers, Phosphate Binders: Non-Preferred (NPD)

# Approval Duration: 1 year

• Tenapanor is a sodium/hydrogen exchanger 3 (NHE3) inhibitor used reduce serum phosphorus in adults with chronic kidney disease (CKD) on dialysis.

# Initial Approval Criteria:

- Diagnosis of chronic kidney disease; AND
- Diagnosis of elevated serum phosphorous; AND
- Patient is on dialysis; AND
- Patient has had a trial and failure, contraindication to, intolerance, or inadequate response to at least 2 preferred phosphate binders.

# Age Limit: ≥ 18 years of age

# Quantity Limit: 2 tablets daily

Drug Class	Preferred Agents	Non-Preferred Agents
Electrolyte Depleters	Calcium Acetate capsule	Auryxia
	Calcium Acetate tablet	Fosrenol chewable tablet
	Renvela powder packet	Fosrenol powder packet
	Renvela tablet	Lanthanum Carbonate chewable tablet
		Renagel
		Sevelamer Carbonate powder packet
		Sevelamer tablet
		Velphoro
		Xphozah <sup>AE, CC, QL</sup>

# **FULL CLASS REVIEWS**

# **Cephalosporins and Related Antibiotics**

- DMS to select preferred agent(s) based on economic evaluation; however, at least 3 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 *Cephalosporins and Related Antibiotics* class, require PA until reviewed by the P&T Committee.





Drug Class	Preferred Agents	Non-Preferred Agents
Cephalosporins and Related	Cefaclor Capsule	Cefaclor ER Tablet
Antibiotics	Cefadroxil Capsule	Cefaclor Suspension
	Cefadroxil Suspension	Cefadroxil Tablet
	Cefdinir Capsule	Cefixime Capsule
	Cefdinir Suspension	Cefixime Suspension
	Cefprozil Suspension	Cefpodoxime Suspension
	Cefprozil Tablet	Cefpodoxime Tablet
	Cefuroxime Tablet	Cephalexin Tablet
	Cephalexin Capsule	Suprax Capsule
	Cephalexin Suspension	Suprax Suspension
		Suprax Chewable Tablet

# **Glucocorticoids**, Inhaled

# **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 *Glucocorticoids, Inhaled* class, require PA until reviewed by the P&T Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Glucocorticoids, Inhaled	Asmanex Twisthaler QL	Alvesco <sup>QL</sup>
	Budesonide Inhalation Suspension <sup>AE, QL</sup>	Armonair Digihaler <sup>QL</sup>
	Flovent HFA QL	Arnuity Ellipta <sup>QL</sup>
	Fluticasone Propionate HFA <sup>QL</sup>	Asmanex HFA QL
		Flovent Diskus <sup>QL</sup>
		Fluticasone Propionate Diskus <sup>QL</sup>
		Pulmicort Respules QL
		Pulmicort Flexhaler QL
		Qvar RediHaler

# **Hepatitis C Agents**

- 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 *Hepatitis C Agents* class, require PA until reviewed by the P&T Committee.





Drug Class	Preferred Agents	Non-Preferred Agents
Hepatitis C Agents	Mavyret <sup>AE, CC, QL</sup>	Epclusa AE, CC, QL
	Sofosbuvir/velpatasvir AE, CC, QL	Harvoni <sup>AE, CC, QL</sup>
		Ledipasvir/sofosbuvir <sup>AE, CC, QL</sup>
		Sovaldi AE, CC, QL
		Viekira Pak AE, CC, QL
		Vosevi <sup>AE, CC, QL</sup>
		Zepatier AE, CC, QL

# Macrolides/Ketolides

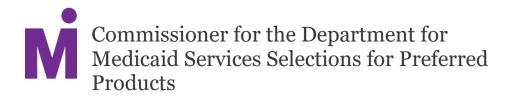
#### **Class Selection & Guidelines**

- 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 *Macolides/Ketolides* class, require PA until reviewed by the P&T Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Macrolides/Ketolides	Azithromycin Packet	Clarithromycin ER Tablet
	Azithromycin Suspension	E.E.S. 400 Tablet
	Azithromycin Tablet	Eryped Suspension
	Clarithromycin Suspension	Ery-Tab DR Tablet
	Clarithromycin Tablet	Erythrocin Stearate Tablet
	E.E.S. Granules	Erythromycin Ethylsuccinate Suspension
	Erythromycin DR Capsule	Erythromycin Ethylsuccinate Tablet
	Ery-Tab DR Tablet	Erythromycin Tablet
		Erythromycin DR Tablet
		Zithromax Powder Packet
		Zithromax Suspension
		Zithromax Tablet
		Zithromax Tri-Pak

# Oxazolidinones

- DMS to select preferred agent(s) based on economic evaluation; however, at least 1 unique chemical entity should be preferred.
- Agents not selected as preferred will be considered non-preferred and will require PA.





• For any new chemical entity in the *Oxazolidinones* class, require PA until reviewed by the P&T Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Oxazolidinones	Linezolid suspension <sup>QL, MD</sup>	Linezolid suspension QL, MD
	Linezolid tablet <sup>CC, QL, MD</sup>	Sivextro QL
		Zyvox suspension <sup>QL, MD</sup>
		Zyvox tablet QL, MD

# **Tetracyclines**

- 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 *Tetracyclines* class, require PA until reviewed by the P&T Committee.

Drug Class	Preferred Agents	Non-Preferred Agents
Tetracyclines	Demeclocycline Tablet	Doryx MPC DR Tablet
	Doxycycline Hyclate Capsule	Doryx DR Tablet
	Doxycycline Hyclate Tablet	Doxycycline Hyclate DR Tablet
	Doxycycline Monohydrate 50, 100 mg Capsule	Doxycycline IR-DR Capsule
	Doxycycline Monohydrate	Doxycycline Monohydrate 40, 75,
	Suspension	150 mg Capsule
	Doxycycline Monohydrate Tablet	LymePak
	Minocycline Capsule	Minocycline ER Tablet
	Tetracycline Capsule	Minocycline Tablet
		Minolira ER Tablet
		Morgidox Capsule
		Morgidox Kit
		Nuzyra Tablet
		Solodyn ER Tablet
		Vibramycin Capsule





# **CONSENT AGENDA REVIEWS**

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

#### **Therapeutic Classes**

- Antibiotics, Gastrointestinal
- Antibiotics, Inhaled
- Antibiotics, Vaginal
- Antifungals, Oral
- Antihistamines, Minimally Sedating
- Antiretrovirals, HIV/AIDS
- Bronchodilators, Beta Agonist
- Chronic Obstructive Pulmonary Disease (COPD) Agents
- Epinephrine, Self-Injectable
- Hepatitis B Agents
- Intranasal Rhinitis Agents
- Leukotriene Modifiers
- Oral Antivirals, Herpes
- Oral Antivirals, Influenza
- Penicillins
- Pleuromutulins
- Quinolones
- Sulfonamides, Folate Antagonist