Providence Health Plan Providence Health Assurance

The following changes will be effective on January 1, 2027, unless otherwise specified and apply to the following plans:

Individual and Family, Large/Small Groups (Commercial)
Health Share of Oregon/Providence (Medicaid)

Formulary Changes

Drug Name	Recommendation	Policy Name
Budesonide/glycopyr/formoterol (Breztri Aerosphere) HFA AER AD	Commercial: Add to Formulary, Tier 3 Effective 11/1/2026	N/A
Insulin aspart/b3/pump cart (Fiasp Pumpcart) Cartridge	Commercial: add in parity with other Fiasp products, Formulary, Tier 3 Effective 11/1/2026	N/A
Isotretinoin 10 mg; 20 mg; 40 mg Capsules	• Commercial: Add to Formulary, Tier 2 • Medicaid: Add generic to Formulary, Prior Authorization (age ≥21 years)	• Commercial: N/A • Medicaid: Acne Medications
Isotretinoin 30 mg Capsule	• Commercial Dynamic: Move from Tier 4 to Tier 2	N/A
Chlorzoxazone Tablet	• Commercial: Add to Formulary, Tier 2 • Medicaid: Add to Formulary	N/A
• **Ustekinumab-hmny (Starjemza) 45mg/0.5mL Vial** • **Ustekinumab-hmny (Starjemza) 90mg/mL Syringe**	Add as preferred ustekinumab biosimilar • Commercial: Add to Formulary, Tier 5, Prior Authorization, Quantity Limit (one injection per 84 days) • Medicaid: Add to Formulary, Prior Authorization, Quantity Limit (one injection per 84 days)	Therapeutic Immunomodulators (TIMS)
Eplontersen sodium (Wainua) 45mg/0.8mL Auto Injct	Commercial: Add to Formulary, Tier 6	Transthyretin (TTR) Lowering Agents

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Drug Name	Recommendation	Policy Name
Omalizumab (Xolair) 75mg/0.5ml; 150 mg/mL Auto Injct/Syringe	Add to Medicaid formulary	Therapeutic Immunomodulators (TIMS)
• **Elafibranor (Iqirvo) Tablet** • **Seladelpar lysine (Livdelzi) Capsule**	Commercial: Add to Formulary, Tier 5 Effective: 9/1/2026	Primary Biliary Cholangitis Agents
Tepmetko (tepotinib) tablet	Commercial: Move to Tier 5 from Tier 6	Anti-Cancer Agents – Self-Administered
• **Clindamycin phosphate 1 % Lotion** • **Clindamycin/benzoyl peroxide 1%-5% Gel/Gel w/Pump** • **Clindamycin/benzoyl peroxide 1.2%-2.5% Gel w/Pump** • **Crofelemer (Mytesi) Tablet DR** • **Diphenoxylate/atropine Liquid** • **Fluorometholone (FML Forte) Drops Susp** • **Griseofulvin Oral Susp and Tablet** • **Guaifenesin/dextromethorphan/phenylephrine Liquid** • **Hydrocodone/homatropine Tablet** • **Ketorolac tromethamine Drops** • **Loperamide Capsule** • **Opium Tincture** • **Prednisolone acetate (Pred Mild) Drops Susp** • **Promethazine/codeine Syrup** • **Promethazine/dextromethorphan Solution** • **Promethazine-phenylephrine Syrup** • **Tretinoin 0.025% Gel (Gram)**	Remove from Medicaid formulary	N/A
• **Aluminum chloride 20% Solution** • **Azelaic Acid 15% Gel (Gram)**	Add to Medicaid formulary	N/A

Drug Name	Recommendation	Policy Name
• **Ciclopirox 0.77% Cream** • **Ciclopirox 8% Topical Solution** • **Cromolyn Sodium 4% Eye Drops** • **Levocetirizine dihydrochloride Tablet** • **Metronidazole 0.75% Gel w/Appl; Gel; and Cream**		
Cyclosporine 0.05 % Droperette	Add to Medicaid formulary	Medications for Dry Eye Disease
Nitisinone (Nityr) Tablet	Remove from Commercial and Medicaid formularies	N/A

Medical Policy Changes

Coverage Criteria Changes:

MAJOR CHANGES		
Policy Name	**Plans Affected**	**Policy Change Summary**
Acne Medications - Medicaid	☐ Commercial ☒ Medicaid	• Added coverage criteria for treatment of hidradenitis suppurativa (previously unfunded condition). • For acne, updated preferred product options: 1) require failure of topical clindamycin prior to coverage of topical erythromycin and 2) require failure of adapalene prior to coverage of tretinoin. • Removed the following drugs from the formulary: clindamycin/benzoyl peroxide 1-5%, tretinoin 0.025% gel, clindamycin 1% lotion, and sulfacetamide suspension.
Anti-Cancer Medications - Self-Administered	☒ Commercial ☒ Medicaid	Update policy to require trial of nilotinib (generic Tasigna) in addition to imatinib for non-preferred products (such as Cavhanza, Danziten, nilotinib d-tartrate, bosutinib, Phyrago, and dasatinib)

MAJOR CHANGES		
Policy Name	**Plans Affected**	**Policy Change Summary**
Antifungal Medications - Medicaid	☐ Commercial ☒ Medicaid	Split out policy specific to Medicaid. Criteria will align with Oregon Health Authority criteria that defines medically necessary systemic fungal infections. Flucytosine was added to this policy to ensure appropriate use. In addition, the policy establishes preferred therapies, as indicated, as itraconazole tablet/solution, fluconazole tablet/suspension, and terbinafine tablet.
Complement Inhibitors	☒ Commercial ☒ Medicaid	Added criteria for primary immunoglobulin A nephropathy (IgAN) that patients must have stable on a sodium-glucose cotransporter 2 (SGLT2) inhibitor for at least three months.
Constipation Agents – Medicaid	☐ Commercial ☒ Medicaid	• Removed references to the Oregon Health Authority (OHA) prioritized list funding line, as the funding line will be retired for 2027. Constipation will be coverable with meeting medical necessity criteria. • For less cost-effective therapies (Trulance, Relistor), added prerequisite therapy requirements.
Continuous Glucose Monitors for Personal Use	☒ Commercial ☒ Medicaid	Updated criteria for post-bariatric hypoglycemia. Clarified preferred products are Dexcom and Freestyle Libre.
FcRn Antagonists	☒ Commercial ☒ Medicaid	For chronic inflammatory demyelinating polyneuropathy (CIDP): removed “current active disease” wording from criterion for CIDP Disease Activity Status, as a score of 2 indicates remission.
Formulary and Quantity Limit Exceptions - Medicaid	☐ Commercial ☒ Medicaid	Removed references to the Oregon Health Authority (OHA) prioritized list funding line, as the funding line will be retired for 2027.
Gene Therapy for Hemophilia	☒ Commercial ☒ Medicaid	Removed Beqvez and Roctavian from policy as they have been removed from the market. No clinical changes to policy.
Hyperhidrosis Agents	☒ Commercial ☒ Medicaid	Removed references to the Oregon Health Authority (OHA) prioritized list funding line, as the funding line will be retired for 2027. Primary axillary hyperhidrosis is no longer considered unfunded and medical necessity criteria will apply for Medicaid. Coverage criteria reviewed without significant changes.
Infusion Therapy Site of Care	☒ Commercial ☐ Medicaid	Removed Radicava from list.

MAJOR CHANGES		
Policy Name	**Plans Affected**	**Policy Change Summary**
Insomnia Agents - Medicaid	☐ Commercial ☒ Medicaid	• Removed references to the Oregon Health Authority (OHA) prioritized list funding line, as the funding line will be retired for 2027. Insomnia will be coverable with meeting medical necessity criteria. • Updated criterion regarding cognitive behavioral therapy (CBT) to require current CBT or brief behavioral treatment or documented failure to multiple interventions. • Added criteria outlining coverage requires either 1) exclusion evaluation for chronic insomnia disorder or 2) documented sleep-wake disorder and request is for melatonin agonist.
Interleukin-1 Inhibitors	☐ Commercial ☒ Medicaid	Added prescriber restriction for Medicaid.
Intranasal Allergy Medications – Medicaid	☐ Commercial ☒ Medicaid	• Removed references to the Oregon Health Authority (OHA)) prioritized list funding line, as the funding line will be retired for 2027. • Consolidated criteria for all patients (removed separate criteria for EPSDT eligible patients).
Lynkuet, Veozah	☒ Commercial ☒ Medicaid	Updated trial and failure criteria for Medicaid to align with Oregon Health Authority.
Medical Nutrition Policy - Medicaid	☐ Commercial ☒ Medicaid	• Removed references to the Oregon Health Authority (OHA) prioritized list funding line, as the funding line will be retired for 2027. • Updated criteria to align with OHA criteria and Oregon Administrative Rules (OAR) language.
Medically Infused Therapeutic Immunomodulators - Commercial	☒ Commercial ☐ Medicaid	• Updated coverage duration for initial authorization to six months and one year for reauthorization (for all indications). • For asthma: 1) updated criteria for defining uncontrolled asthma, 2) added trial of Cinqair (reslizumab) for Exdensur (depemokinab), 3) removed specific criteria defining positive response to therapy.
Medications for Dry Eye Disease	☐ Commercial ☒ Medicaid	New prior authorization policy to align with Oregon Health Authority (OHA) utilization management criteria for dry eye disease medications. Products are newly covered as prioritized list and funding line eliminated for 2027. Medications include

MAJOR CHANGES		
Policy Name	**Plans Affected**	**Policy Change Summary**
		cyclosporine 0.005% eye emulsion droperette (preferred therapy), Cequa, Eysuvis, Miebo, Restasis Multidose, Tryptyr, Tyrvaya, Verkazia, Vevye, Xiidra
New Medications and Formulations without Established Benefit	☒ Commercial ☒ Medicaid	• Removed obsolete medications. • Removed chlorzoxazone 365 mg and 750 mg from policy and added to formulary without restriction. • Removed Seysara (sarecycline) from policy but will remain non-formulary. • Removed Absorica from policy and added to Commercial formulary without restriction. Abosrica will be managed through Acne medication policy for Medicaid.
Primary Biliary Cholangitis Agents	☒ Commercial ☒ Medicaid	Removed reference to "documentation" to be compliant with cost-positioning contract requirements
Saphnelo	☒ Commercial ☒ Medicaid	Added criteria requiring use of self-administered formulation instead of intravenous formulation.
Second and Third Generation Antihistamines - Medicaid	☐ Commercial ☒ Medicaid	• Removed references to the Oregon Health Authority (OHA) prioritized list funding line, as the funding line will be retired for 2027. • Consolidated criteria for all patients (removed separate criteria for EPSDT eligible patients). • Added levocetirizine tablet as a preferred drug.
Therapeutic Immunomodulators - Commercial	☒ Commercial ☐ Medicaid	• Added tocilizumab products as co-preferred with adalimumab products. • Defined "established on therapy" as within 90 days. • Updated coverage duration for initial authorization to six months and one year for reauthorization (for all indications). • Added criteria for coverage of ustekinumab every four-week dosing. • Updated prescriber restrictions for several indications. • For asthma/COPD: updated criteria defining uncontrolled disease. • Added/updated diagnostic and/or trial criteria for allergic fungal rhinosinusitis, Behcet's disease, bullous pemphigoid, hidradenitis suppurativa, non-radiographic axial spondyloarthritis, polyarticular juvenile arthritis, psoriatic arthritis, rheumatoid arthritis, and uveitis.

MAJOR CHANGES		
Policy Name	**Plans Affected**	**Policy Change Summary**
		• Added specific criteria for other diagnoses not already listed in the policy.
Therapeutic Immunomodulators - Medicaid	☐ Commercial ☒ Medicaid	• Removed references to the Oregon Health Authority (OHA) prioritized list funding line, as the funding line will be retired for 2027. • Added Avtozma (tocilizumab-anoh) as co-preferred biosimilar (with Tyenne). • Added criteria for coverage of ustekinumab every four week dosing. • Defined "established on therapy" as within 90 days. • For asthma: updated criteria defining uncontrolled disease. • Updated prescriber restrictions for several indications. Added/updated diagnostic and/or trial criteria for allergic fungal rhinosinusitis, bullous pemphigoid, eosinophilic esophagitis, hidradenitis suppurativa, polyarticular juvenile idiopathic arthritis, and rheumatoid arthritis.
Therapies for Duchenne Muscular Dystrophy	☒ Commercial ☒ Medicaid	Updated policy to note that medication is managed directly by the Oregon Health Authority for Medicaid due to being on the High Cost Drug Carve Out List
Topical Agents for Skin Conditions – Medicaid	☐ Commercial ☒ Medicaid	• Removed references to the Oregon Health Authority (OHA) prioritized list funding line, as the funding line will be retired for 2027. • Removed criteria specific to the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. • For atopic dermatitis: require failure to both steroid (2 weeks) and calcineurin inhibitor (4 weeks) and added additional trial of Eucrisa (crisaborole) and Zoryve (roflumilast) for less cost-effective agents, Vtama (tapinarof) and Opzelura (ruxolitinib). • For chronic hand eczema, added requirement of confirmation of moderate to severe condition. • For vitiligo, added requirement that condition affects 10% or less of body surface area and requirment for trial of phototherapy. • For plaque psoriasis: updated required prerequisite therapies to include topical vitamins D analogues, tazarotenem and topcial calcineurin inhibitors (in addition to steroids); added requirement for coverage of less cost-effective therapies (Enstilar, Wynzora, or Vtama) to fail Zoryve.

MAJOR CHANGES		
Policy Name	**Plans Affected**	**Policy Change Summary**
		• Added coverage criteria for seborrheic dermatitis (require trial of topical antifungal with either steroid or calcineurin inhibitor).
Transthyretin Lowering Agents	☒ Commercial ☒ Medicaid	• Updated exclusions to reflect contraindications per package insert. • Added criteria for Polyneuropathy of Hereditary Transthyretin-mediated Amyloidosis to confirm that peripheral neuropathy is not caused by scondary condition.
Xiaflex	☐ Commercial ☒ Medicaid	• Removed references to the Oregon Health Authority (OHA) prioritized list funding line, as the funding line will be retired for 2027. Peyronie's disease is no longer considered unfunded and medical necessity criteria will apply for Medicaid. • Coverage criteria reviewed without significant changes

Retired Medical Policies:

- **None**

New Drugs:

Drug Name	Recommendations	Policy Name
Atacicept-vymj (Trutakna) Auto Injct	Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (4 mL per 28 days)	Filspari, Vanrafia, Voyxact, Trutakna
Insulin icodec-abae (Awiqli FlexTouch) Insulin Pen	Commercial/Medicaid: Non-Formulary	N/A
Allogeneic regulatory T cell immunotherapy with HSPC and T cells-vldq (Tregzi) Plast. Bag	Commercial/Medicaid: Medical, Prior Authorization, Quantity Limit (one treatment per lifetime)	T-Cell Therapy

Enlicitide decanoate (Lipfendra) Tablet	• Commercial: Non-Formulary, Prior Authorization, Quantity Limit (1 tablet per day) • Medicaid: Formulary, Prior Authorization, Quantity Limit (1 tablet per day)	PCSK-9 Inhibitors
Etuvetidigene autotemcel (Waskyra) Plast. Bag	Commercial: Medical, Prior Authorization	Medications for Rare Indications
Finafloxacin (Xtoro) Drops Susp	Commercial/Medicaid: Non-Formulary	N/A
Influenza vaccine, mRNA injection, suspension (mFLUSIVA 2026-2027) Syringe (Informational)	Vaccine is covered in full for patients age ≥50 years per Federal rules and requirements for all lines of business	N/A
Gedatolisib (Revtorpyk) Vial	Commercial/Medicaid: Medical, Prior Authorization	Anti-Cancer Medications - Medical Benefit
Iberdomide hcl (Zenbexus) Capsule	• Commercial: Formulary, Tier 6, Prior Authorization, Quantity Limit (21 capsules per 28 days) • Medicaid: Formulary, Prior Authorization, Quantity Limit (21 capsules per 28 days)	Anti-Cancer Medications - Self-Administered
Linerixibat (Lynavoy) Tablet	Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (2 tablets per day)	Primary Biliary Cholangitis Agents
Veligrotug-vvze (Lumvoa) Vial	Commercial/Medicaid: Medical, Prior Authorization, Quantity Limit (5 total infusions per lifetime)	Lumvoa, Tepezza
Zidesamtinib (Jideytro) Tablet	• Commercial: Formulary, Tier 6, Prior Authorization, Quantity Limit (25 mg: 3 tablets per day; 100 mg: 1 tablet per day) • Medicaid: Formulary, Prior Authorization, Quantity Limit (25 mg:	Anti-Cancer Medications - Self-Administered

	3 tablets per day; 100 mg: 1 tablet per day)	
Ranibizumab-leyk (Nufymco) Vial	New biosimilar; non-preferred • Commercial/Medicaid: Medical Prior Authorization •	Ophthalmic Vascular Endothelial Growth Factor (VEGF) Inhibitors
Nilotinib (Cavhanza) Tab Rapdis	New dosage form (tab rapdis); non-preferred • Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (4 tablets per day)	Self-Administered Anti-Cancer Medication Policy
Fulvestrant (Cligavyx) Syringe	New branded fulvestrant product; • Commercial/Medicaid: Medical, Prior Authorization	Anti-Cancer Medications - Medical Benefit • Added as non-preferred product behind fulvestrant (J9393, J9394, J9395)
Fosaprepitant dimeglumine (Navitrux) Vial	New brand fosaprepitant; • Commercial/Medicaid: Medical Prior Authorization	Anti-Cancer Medications - Medical Benefit • Added as non-preferred product behind fosaprepitant (J1453)
Revtorpyk Vial	New entity; • Commercial/Medicaid: Medical Prior Authorization	Anti-Cancer Medications - Medical Benefit
Clotrimazole (Clotic) Droperette	New formulation; • Commercial/Medicaid: Non-Formulary	N/A
Duloxetine HCl Capsule DR	New strengths (80 mg; 90 mg; 120 mg); • Commercial/Medicaid: Non-Formulary	N/A
Omalizumab-igec (Omlyclo) Syringe	New biosimilar for Xolair; • Commercial: Non-Formulary, Prior Authorization, Quantity Limit (one injection per 28 days)	Therapeutic Immunomodulators

	• Medicaid: Formulary, Prior Authorization, Quantity Limit (one injection per 28 days)	
Isatuximab-irfc (Sarclisa Escena) Vial	New subQ version; • Commercial/Medicaid: Medical, Prior Authorization	Anti-Cancer Medications - Medical Benefit
Aflibercept-jbvf (Yesafili) Syringe	New biosimilar for Eylea. • Commercial/Medicaid: Medical Prior Authorization	Ophthalmic Vascular Endothelial Growth Factor (VEGF) Inhibitors • Added as non-preferred biosimilar
Doxycycline hyclate Capsule	New strength (75 mg). • Commercial/Medicaid: Non-Formulary	N/A
Furosemide (Furoscix Readyflow) Auto Injct	New dosage form (auto injc). • Commercial/Medicaid: Non-Formulary	N/A
Norelgestromin/ethin.estradiol (Gwyn Lo) Patch TDWK	New formulation. • Commercial: Preventive • Medicaid: Formular	N/A
Tapentadol hcl Solution	New strength (20 mg/mL) and dosage form (solution). • Commercial/Medicaid: Non-Formulary, Quantity Limit (30 mL per day	N/A
Thiotepa (Tepadina) Plast. Bag	New strength (400 mg). • Commercial/Medicaid: Medical benefit	N/A
Ursodiol (Ursolign) Capsule	New strength (150 mg). • Commercial/Medicaid: Non-Formulary	N/A
Lecanemab-irmb (Leqembi Iqlik) Auto Injct	New strength (500 MG/2.5). ; • Commercial/Medicaid: Non-Formulary, Prior Authorization,	Anti-Amyloid Monoclonal Antibodies
Fluorouracil (Favlyxa) Vial	New strength (2.5g/100mL). • Commercial/Medicaid: Medical benefit, Prior Authorization	Anti-Cancer Medications - Medical Benefit

Tislelizumab-jsgr (Tevimbra) Vial	New strength (150mg/15mL). • Commercial/Medicaid: Medical benefit, Prior Authorization	Anti-Cancer Medications - Medical Benefit
Ropeginterferon alfa-2b-njft (Besremi Pen) Pen Injctr	New dosage form (pen inctr). • Commercial: Formulary, Tier 6, Prior Authorization, Quantity Limit (1 ml per 28 days) • Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (1 ml per 28 days)	Anti-Cancer Medications - Self-Administered
Axatilimab-csfr (Niktimvo) Vial	New strength (22 mg/2.2mL). • Commercial/Medicaid: Medical benefit, Prior Authorization	Medications For Graft-versus-Host-Disease
Buspirone hcl (Bucapsol) Capsule	New strength (5 mg). • Commercial: Non-Formulary, Prior Authorization • Medicaid: Non-Formulary	• Commercial: New Medications and Formulations without Established Benefit • Medicaid: N/A
Selexipag (Uptravi) Tablet	New strengths (100 mcg and 150 mcg). • Commercial: Formulary, Tier 5, Prior Authorization, Quantity Limit (2 tablets per day) • Medicaid: Formulary, Prior Authorization, Quantity Limit (2 tablets per day), Specialty	Pulmonary Hypertension
Olezarsen sodium (Tryngolza) Auto Injct	New strength (50 mg/0.8 ml). • Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (0.8 mL per 28 days), Specialty	Redemplo, Tryngolza
Ustekinumab-aauz (Otulfi) Vial	New formulation (single dose vial).	Therapeutic Immunomodulators (TIMS)

	• Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (0.5 mL per 84 days)	