



The following changes will be effective on **June 1, 2026**, 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	Formulary Status	Policy Name
Finerenone (Kerendia) Tablet	Commercial: Down-tier to Tier 3	Kerendia
Nebivolol HCl Tablet	Add to Medicaid formulary	N/A
Nivolumab-hyaluronidase-nvhy (Opdivo Qvantig) Vial	Make non-preferred product <ul style="list-style-type: none"> Commercial/Medicaid: Medical Benefit, Prior Authorization 	Anti-Cancer Medications - Medical Benefit Criteria for Opdivo Qvantig: failure of therapy with Opdivo IV
Palopegteriparatide (Yorvipath) Pen Injctr	Remove from Medicaid formulary. Drug managed by Oregon Health Authority	N/A
<ul style="list-style-type: none"> Somatropin (Genotropin) Cartridge; Disp Syrin Somatropin (Norditropin Nordiflex) Pen Injctr 	Remove from Medicaid formulary Effective: 07/01/2026	Human Growth Hormones
Somatropin (Omnitrope) Cartridge; Vial	Add to Medicaid formulary	Human Growth Hormones
Tolvaptan	Add quantity limit: <ul style="list-style-type: none"> 15 and 30 mg tablets: Four (4) tablets per day Titration/weekly sleeve packs: Two (2) tablets per day 	

Tyvaso (treprostinil) nebulizer	Remove from Commercial and Medicaid formularies Effective: 07/01/2026	Pulmonary Hypertension
SGLT-2 and DPP-4 Changes		
<ul style="list-style-type: none"> Ertugliflozin/sitagliptin (Steglujan) Tablet Dapagliflozin/sitagliptin (Qtern) tablet 	Remove from Commercial formulary	N/A
<ul style="list-style-type: none"> Linagliptin/metformin (Jentadueto) Tablet Linagliptin/empagliflozin (Glyxambi) Tablet Linagliptin/empagliflozin/metformin (Trijardy XR) Tab BP 24h 	Remove from Commercial formulary	N/A
<ul style="list-style-type: none"> Sitagliptin/metformin (Janumet XR) Tablet 24hr Linagliptin (Tradjenta) tablet Linagliptin/metformin (Jentadueto XR) Tablet 	Remove from Commercial and Medicaid formularies	N/A
<ul style="list-style-type: none"> Saxagliptin/metformin TBMP 24hr Saxagliptin Tablet 	Commercial Dynamic: Down tier to Tier 2	N/A
<ul style="list-style-type: none"> Invokana (canagliflozin) Invokamet/Invokamet XR (canagliflozin/metformin) 	Remove from Medicaid formulary Effective 7/1/2026	N/A
Synjardy/Synjardy XR (empagliflozin/metformin)	Remove from Commercial and Medicaid formularies Effective 7/1/2026	N/A

Medical Policy Changes

Coverage Criteria Changes

Policy Name	Plans Affected	Summary of Change
Anti-Cancer Medications - Medical Benefit	<input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Added Rybrevant Faspro and Keytruda Qlex to policy. Added step criteria for Keytruda Qlex to step through Keytruda. Added step criteria for Opdivo Qvantig to step through Opdivo.
Anti-Cancer Medications – Self-Administered	<input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Added step therapy for Medicaid for the following agents when clinically appropriate: 1) Talzenna - step through Lynparza, 2) nilotinib (Tasigna), nilotinib (Danziten), nilotinib d-tartrate, bosutinib (Bosulif), or dasatinib (Sprycel) – step through imatinib, and 3) Xtandi – step through generic abiraterone 250 mg tab
Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists - Medicaid	<input type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Updated criteria to required failure of OnabotulinumtoxinA prior to CGRP approval for chronic migraine. Added Emgality as a preferred therapy.
Continuous Glucose Monitors for Personal Use	<input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Updated replacement criteria, expanded coverage for type 2 diabetes to all patients utilizing diabetes medications to align with new 2026 American Diabetes Association Standards of Care.
Crysvita	<input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Added age restrictions.
Fertility and Related Medications	<input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Updated criteria to allow for menstrual suppression when other fertility preservation methods are not appropriate or patient requires emergent oncologic therapy.
Formulary and Quantity Limit Exceptions	<input checked="" type="checkbox"/> Commercial <input type="checkbox"/> Medicaid	Updated language to clarify that requests for brand-name drugs applies to all drugs with generic availability. Updated quantity exception language to allow for compendia or guideline supported dosing.
GLP-1 Receptor Agonists and Related Medications for Diabetes - Commercial	<input checked="" type="checkbox"/> Commercial <input type="checkbox"/> Medicaid	Reduced quantity limit for exenatide 5 mcg to 1.2 mL per 30 days
GLP-1 Receptor Agonists and Related Medications for Diabetes - Medicaid	<input type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	The preferred GLP-1 agent was updated to liraglutide. Updated criteria to require failure of maximally tolerated oral therapies prior to use of GLP-1 therapy (specifically metformin and

Policy Name	Plans Affected	Summary of Change
		sodium-glucose cotransporter-2 inhibitors), unless clinically inappropriate. Effective 5/1/2026
Hepatitis C - Direct Acting Antivirals	<input checked="" type="checkbox"/> Commercial <input type="checkbox"/> Medicaid	Updated criteria to allow coverage in both acute and chronic Hepatitis C infection (HCV). Mavyret is approved in both acute and chronic HCV and treatment is recommended by American Association for the Study of Liver Diseases (AASLD).
Human Growth Hormones - Medicaid	<input type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Changed preferred products from Norditropin/Genotropin to Omnitrope.
Immune Gamma Globulin (IgG)	<input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Added IVIG preferred product strategy criteria to reflect new preferred IVIG and SCIG products. The preferred products are: Gammagard Liquid, Gammaked, Gamunex-C, Hizentra, Octagam, and Privigen
Kerendia	<input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Updated policy criteria to require a trial of a sodium-glucose cotransporter 2 (SGLT2) inhibitor for heart failure to align with clinical guidelines, including American College of Cardiology/American Heart Association.
Korlym	<input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Added criteria to require generic mifepristone for Brand Korlym requests.
Lantidra	<input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Updated duration of diagnosis from over five years to at least five years.
Medical Hormone Therapy Policy	<input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Updated Medicaid information, added testosterone 30 mg pump as a trial and failure option for topical products and for 'all other requests', added testosterone cypionate as a trial and failure option for delayed puberty. Added quantity limits for most drugs on policy.
Osteoanabolic Agents	<input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Extend coverage duration of Evenity to allow for 12 fills. Added language that all product dosing must follow FDA approved or compendia-supported guidelines.

Policy Name	Plans Affected	Summary of Change
Pituitary Disorder Therapies	<input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Policy criteria updated for acromegaly to include trial and failure of surgical resection and/or radiation; reauthorization criteria updated for oncological diagnoses.
Rezdiffra	<input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Updated criteria for diagnosis, specified maximum quantity of alcohol consumption allowed, removed requirement for pharmacotherapy for other conditions (such as diabetes, cardiovascular disease), and added requirement of trial of Wegovy (excluding combination therapy).
Self-Administered Drugs (SAD) Policy	<input checked="" type="checkbox"/> Commercial <input type="checkbox"/> Medicaid	<ul style="list-style-type: none"> • Several drugs were added to this policy as "pharmacy benefit only" including, calcitonin salmon (J0630), cortotrophin gel (J0802), Lasix ONYU (J3490/C9399), Imcivree (J3490), Sogroya (J3590), and Egrifta (J3590). • Several drugs were added with "medical transition allowed" including apomorphine (J0364), Rivfloza (J3490), Palynziq (J3590), Arcalyst (J2793). • Additionally, all formulations of Orencia, Benlysta, and tocilizumab will be required to transition to self-administration.
Strensiq	<input type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Added clarification that this medication is now part of the Oregon Health Authority (OHA) high-cost drug carve-out (HCDC) list and will be managed by OHA.
Tarpeyo	<input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Updated policy criteria to align with 2025 KDIGO guidelines: add required trial and failure of a sodium-glucose cotransporter-2 inhibitor (SGLT2i) and update high risk of disease progression to include fifty percent (50%) or more decline in eGFR.
Therapeutic Immunomodulators – Medicaid	<input type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid	Added specific criteria for the coverage of the following indications with criteria: Behcet's disease, bullous pemphigoid, enthesitis related arthritis, giant cell arteritis, polymyalgia rheumatica, systematic juvenile idiopathic arthritis, systemic-sclerosis associated interstitial lung disease, uveitis, and other FDA approved/compendia supported.

Policy Name	Plans Affected	Summary of Change
		<p>Added prescriber restrictions; updated coverage duration to six months for initial authorization and one year for reauthorization; updated preferred and non-preferred agents; added conventional therapy requirements; specified/clarified diagnostic requirements</p> <p>Effective 5/1/2026</p>
<p>Total Parenteral Nutrition (TPN) Policy</p>	<p><input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid</p>	<p>Updated TPN criteria to require evidence of failure of oral nutrition or non-functioning GI tract. Added criteria for initiation of intradialytic parenteral nutrition (IDPN) based on ASPEN/KDOQI guidelines. Added policy exclusion for intraperitoneal nutrition (IPN) or intraperitoneal amino acid (IPAA) administration due to lack of evidence of medical necessity.</p>
<p>Tzield</p>	<p><input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid</p>	<p>Updated policy criteria to expand the definition of abnormal glucose.</p>
<p>Vaginal Progesterone Formulations</p>	<p><input checked="" type="checkbox"/> Commercial <input type="checkbox"/> Medicaid</p>	<p>Clarified that crinone 8% is only strength covered for Assisted Reproductive Technology.</p>
<p>Viojoice</p>	<p><input type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid</p>	<p>Added clarification that this medication is now part of the Oregon Health Authority (OHA) high-cost drug carve-out (HCDC) list and will be managed by OHA.</p>
<ul style="list-style-type: none"> • Weight Management Medications Policy (Policy A) • Weight Management Medications Policy - Medicaid 	<p><input checked="" type="checkbox"/> Commercial <input checked="" type="checkbox"/> Medicaid</p>	<p>Changed names to “GLP-1 receptor agonists and related medications for non-diabetes Indications” and updated policy to include only GLP-1 related medications (removed Qsymia and phentermine references). Removed BMI requirement and updated diagnostic requirements for metabolic dysfunction-associated steatohepatitis (MASH). Added exclusion for combination with Rezdiffra.</p>
<p>Yorvipath Policy</p>	<p><input checked="" type="checkbox"/> Commercial <input type="checkbox"/> Medicaid</p>	<p>Added clarification that this medication is now part of the Oregon Health Authority (OHA) high-cost drug carve-out (HCDC) list and will be managed by OHA.</p>

Policy Name	Plans Affected	Summary of Change
		Updated reauthorization criteria to require monitoring of parathyroid hormone levels and shortened initial authorization from one year to six months.

Retired Medical Policies

- **DPP-4 Inhibitors Step Therapy Policy** - Due to low-cost generic availability.
- **Tolvaptan** - Due to low risk of inappropriate utilization and generic availability.

New Drugs:

Drug Name	Recommendation	Policy Name
Amivantamab-hyaluronidase-lpuj (Rybrevant Faspro) Vial	New biologic product for Rybrevant <ul style="list-style-type: none"> • Commercial/Medicaid: Medical Benefit, Prior Authorization 	Anti-Cancer Medications - Medical Benefit
Amlodipine besylate (Sdamlo) Powder Concentrate	New formulation; <ul style="list-style-type: none"> • Commercial/Medicaid: Non-Formulary 	N/A
Besifloxacin hcl Drops Susp	New generic; <ul style="list-style-type: none"> • Commercial: Formulary, Tier 4 • Medicaid: Non-Formulary 	N/A
Brivaracetam 10 mg Tablet	New generic for existing brand (Briviact); <ul style="list-style-type: none"> • Commercial: Formulary, Tier 2, Quantity Limit (4 tablets per day) • Medicaid: Formulary, Quantity Limit (4 per day) 	N/A
Brivaracetam 25, 50, 75, 100 mg Tablet	New generic for existing brand (Briviact); <ul style="list-style-type: none"> • Commercial: Formulary, Tier 2, Quantity Limit (2 tablets per day) 	N/A

	<ul style="list-style-type: none"> Medicaid: Formulary, Quantity Limit (2 per day) 	
Cefixime Tablet	<ul style="list-style-type: none"> New generic; Commercial/Medicaid: Non-Formulary 	N/A
Delgocitinib (Anzupgo) Cream	<ul style="list-style-type: none"> Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (30 grams per month) 	Topical Agents for Skin Conditions
Lunsumio Velo (mosunetuzumab-axgb) vial	<ul style="list-style-type: none"> New formulation; Commercial/Medicaid: Medical Benefit, Prior Authorization 	T-cell therapy
Metoprolol tartrate (Lopressor) Tablet	<ul style="list-style-type: none"> New strength (12.5 mg); Commercial/Medicaid: Non-Formulary 	N/A
Omidenepag isopropy (Omlonti) Drops	<ul style="list-style-type: none"> Commercial: Formulary, Tier 3, Step Therapy, Quantity Limit (25 mL per 25 days) Medicaid: Formulary, Step Therapy, Quantity Limit (25 mL per 25 days) 	Anti-Glaucoma Agents Step Therapy Policy
Onasemnogene abeparvovec-brve (Itvisma) Vial	<ul style="list-style-type: none"> New formulation; Commercial: Medical Benefit, Prior Authorization Medicaid: High-cost drug carve-out 	<ul style="list-style-type: none"> Commercial/Medicare Part B: Therapies For Spinal Muscular Atrophy Medicaid: N/A
Pembrolizum-berahyaluron-pmph (Keytruda Qlex) Vial	<ul style="list-style-type: none"> New formulation; Non-preferred product Commercial/Medicaid: Medical Benefit, Prior Authorization 	<ul style="list-style-type: none"> Commercial/Medicaid: Anti-Cancer Medications - Medical Benefit Criteria for Keytruda Qlex: failure of therapy with Keytruda IV
Sepiapterin (Sephience) Powder Pack	<ul style="list-style-type: none"> Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (250 mg packets: 3 packets per day) 	Phenylalanine-Lowering Therapies for Phenylketonuria
Sibeprenlimab-szsi (Voyxact) Syringe	<ul style="list-style-type: none"> Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (2 mL per 28 days) 	Filspari, Vanrafia, Voyxact



Tizanidine (Ontralfy) Solution	New formulation; • Commercial/Medicaid: Non-Formulary	N/A
Tobramycin-Loteprednol Eye Drops	New generic; • Commercial: Formulary, Tier 4 • Medicaid: Formulary	N/A