Providence Health Plan

Providence Health Assurance

Healthcare Services: Medical, Pharmacy, Reimbursement, and Coding Policy Alerts

Number 111

October 1, 2025

This is the October 1, 2025 issue of the Providence Health Plans, Providence Health Assurance and Providence Plan Partners, Policy Alert to our providers. The focus of this update is to communicate to providers' new or revised Medical, Pharmacy, Reimbursement, and Coding policy changes. The Health Plan has a standard process to review all policies annually. Policies will be available for review on ProvLink and via the PHP website at: https://healthplans.providence.org/providers/provider-support/medical-policy-pharmacy-policy-and-provider-information/

The Provider Alert, Prior Authorization Requirements, and subsequent policies are all available on ProvLink and through the link above.

NOTE: For Oregon Medicaid requests, services which do not require prior authorization will process against the Prioritized List. To determine which services require prior-authorization, please see the current PHP prior authorization list here.

****EXTERNAL PROVIDER REVIEW OPPORTUNITY****

PHP Medical Policy Committee is seeking feedback from providers to serve as clinical subject matter experts (SMEs) through the policy development and annual review processes. This review process allows providers to offer their expertise and discuss relevant research in their field that will be used to support how these policy decisions are made. This will allow providers an opportunity to offer valuable insight that will help shape policies that affect provider reimbursement and patient care.

If interested, please email us at PHPmedicalpolicyinquiry@providence.org with your name, specialty, and preferred email address.

Providence Health Plan

Providence Health Assurance

MEDICAL POLICY COMMITTEE

MEDICAL

COMPANY POLICIES

Effective 11/1/2025

Spinal Epidural Injections
 	
MP14
	Policy Updates:
	• *Criteria*
	  ○ Allow moderate-to-severe disability for thoracic/lumbar ESIs (currently requires "severe" disability); in line with requirement for cervical ESIs.
	• Policy Guidelines
	  ○ Added language allowing a qualified provider (e.g., Physician, Physician's Assistant, Nurse Practitioner) to perform the initial evaluation and submit a request for the injection.
	  ○ Added language clarifying that the provider performing the injection must review clinical findings and confirm the procedure's appropriateness before performing the injection.
	Codes/PA: No changes to codes or PA.

Serum Iron Studies **MP321**	**Policy Updates:** No recommended changes to criteria. **Codes/PA:** Updated pair to pay configuration based on Medicare Lab Manual.
Wireless Capsule Endoscopy **MP134**	**Policy Updates:** Added criteria allowing small-bowel wireless capsule endoscopy as medically necessary for re-evaluation of patients with biopsy-confirmed celiac disease who remain symptomatic despite adherence to a gluten-free diet, when conventional evaluation (e.g., repeat endoscopy, serology) is inconclusive or not feasible. **Codes/PA:** No changes to codes or PA.

Effective 12/1/2025

Small Joint Surgery
 	
MP438
	Policy Updates:
	• Added note to top of policy about emergent procedures
	• Added criterion for sesamoidectomy (criterion XV.).
	• In Policy Guidelines, added the following to the imaging requirements:
	  ○ "If discrepancies should arise in the interpretation of the imaging, the radiologist's report will supersede"
	  ○ "Imaging completed within the past 12 months"
	• In Policy Guidelines, specified in the conservative management definition that debridement of corns and calluses is specific to metatarsal pain/indications.
	Codes/PA: No changes to codes or PA

Shoulder Arthroscopy and Open Procedures
 	
MP436
	Policy Updates:
	• Criterion VI: Moved definition out of criteria and instead added it as a note below
	• Updated conservative care definition to include MD/DO supervised physical therapy
	• Added note to top of policy about emergent procedures
	• In imaging requirements in policy guidelines:
	  • "If discrepancies should arise in the interpretation of the imaging, the radiologist's report will supersede"
	  • "Imaging completed within the past 12 months"
	Codes/PA: No changes to codes or PA

Knee Arthroscopy and Open Procedures
 	
MP434
	Policy Updates:
	• Added note to top of policy about emergent procedures
	• In Policy Guidelines, added to imaging requirements:
	  ○ "If discrepancies should arise in the interpretation of the imaging, the radiologist's report will supersede"
	  ○ "imaging completed within the past 12 months"
	Codes/PA: Removed code 29870 from draft table, has no code configuration as of 11/1/2025

Total Knee Arthroplasty **MP418**	**Policy Updates:** In Policy Guidelines, added to imaging requirements: • "If discrepancies should arise in the interpretation of the imaging, the radiologist's report will supersede" • "Imaging completed within the past 12 months" **Codes/PA:** No changes to codes or PA

Total Hip Arthroplasty **MP130**	**Policy Updates:** In Policy Guidelines, added to imaging requirements: • "If discrepancies should arise in the interpretation of the imaging, the radiologist's report will supersede" • "Imaging completed within the past 12 months" **Codes/PA:** No changes to codes or PA
Total Shoulder Arthroplasty **MP430**	**Policy Updates:** In Policy Guidelines, added to imaging requirements: • "If discrepancies should arise in the interpretation of the imaging, the radiologist's report will supersede" • "Imaging completed within the past 12 months" **Codes/PA:** No changes to codes or PA

ARCHIVE

Effective 11/1/2025

Radiofrequency Ablation and Cryoablation for Plantar Fasciitis **MP165**	**Policy Updates:** Archived policy due to low utilization. **Codes/PA:** Removed existing configuration from all codes.

MEDICARE POLICIES

Effective 11/1/2025

Genicular Nerve Blocks and Nerve Ablation for Knee Pain **MP354**	**Policy Updates:** No change to criteria. Continue to apply either Medicare coverage criteria or Company criteria, depending on the procedure in question. Removed reference to RFA/cryo for plantar fasciitis policy, since that policy is being archived. **Codes/PA:** No change to codes or configuration.

Gene Expression Profile Testing for Melanoma **MP253**	**Policy Updates:** No changes to criteria. Continue to apply Medicare coverage criteria relevant to the test requested. **Codes/PA:** • Removed PA from 81529. All PAs received in relation to this policy are for this single code, and all have been approved. • No changes to other codes or configuration.
Sleep Disorder Surgery **MP244**	**Policy Updates:** No changes to criteria. Continue to apply either Medicare coverage criteria or Company criteria, depending on the procedure in question. **Codes/PA:** Added CPT 64568 to the policy as a relevant code for hypoglossal nerve stimulation, continue PA (Noridian has added this code retroactively as an applicable CPT, so the Plan is following suit). No changes to other codes in the policy, or their configuration.

Effective 12/1/2025

Ablative Procedures to Treat Back and Neck Pain **MP13**	**Policy Updates:** It was discovered the policy included several Medicare references, but didn't include any criteria for non-facet joint interventions. Added non-facet joint pain intervention procedures to the criteria. Since there are no fully established Medicare coverage policies for these services, criteria will direct the user to our internal Company policy criteria. **Codes/PA:** No change to codes or configuration.

ARCHIVE

Effective 11/1/2025

Radiofrequency Ablation and Cryoablation for Plantar Fasciitis **MP364**	**Policy Updates:** Archived. **Codes/PA:** Configuration changes include the following: • 0441T: Removed **only some** DX codes from configuration list. This code continues to have utilization related to another medical policy, and that configuration will remain in place. • No changes to other codes, other than term relationship to this archived medical policy. CPT 64640 continues to have utilization related to another medical policy based on a Noridian LCA, and that configuration will remain in place.

REIMBURSEMENT POLICIES

Effective 12/1/25

Anesthesia Services **RP 26**	This new policy will be effective December 1, 2025 to align with the archival of Coding Policy 09.0 Anesthesia. These are the notable updates: • Qualifying circumstances for anesthesia are not recognized and therefore are not eligible for reimbursement. Effective December 1, 2025, PHP will deny qualifying circumstances (codes 99100, 99116, 99135, and 99140) for all lines of business. This denial is consistent with existing Coding Policy 13.0 (Bundled or Adjunct Services) which states codes listed as bundled services on the Medicare Physician Fee Schedule (Status B) are considered "bundled" services. • According to current coding policy standards, **all** anesthesia time is to be reported by adding the minutes of anesthesia time to the "units" column on the claim form. In addition to this, current coding policy states that obstetric epidural anesthesia (01967) is to be reported **only** for time units involving insertion, management of adverse events, delivery, and removal – in other words, only for the time when the anesthesiologist is in attendance, furnishing continuous anesthesia care to a patient **and** is physically present with the patient. ASA code 01967 will be limited to 480 units, or 8 hours of anesthesia personal attendance time.
Emergency Department Evaluation & Management Services **RP 11**	Effective December 1, 2025, this reimbursement policy will be updated to include several Z ICD-10 diagnosis codes which do not qualify for reimbursement of higher-level Evaluation and Management CPT code (99284 or 99285), that do not substantiate the need for level 4 or level 5 Emergency Department Evaluation and Management visits. When a high-level emergency department evaluation and management (E&M) code is billed with a low acuity non emergent (LANE) diagnosis code, it denies as not reimbursable. In order to be considered for reimbursement, a provider consideration request must be submitted with documentation that supports the higher-level Evaluation and Management code.

CODING POLICIES

Effective 11/1/25

Coding Policy 04.0 (Procedure-Specific Policies) **(REPEAT ARTICLE from May 2025)**	During surgery, any assessment of vascular patency, tissue viability, perfusion, or organ identification is considered integral to the primary procedure and is not eligible for separate reimbursement. Providers are encouraged to consult the National Correct Coding Initiative Policy Manual published by CMS for guidance on incidental procedures. Intraoperative angiography (e.g. SPY, firefly, pinpoint endoscopic fluorescence imaging, etc.) used for these assessments should not be billed separately. These techniques are considered incidental to the associated surgical procedure. Effective November 1, 2026, Providence Health Plan (PHP) will deny reimbursement for CPT code 15860 (Intravenous Injection of agent [eg, fluorescein] to test vascular flow in flap or graft) when it is billed with other surgical codes on the same date of service. This code may be eligible for separate reimbursement if it is the sole service performed on a particular date of service, or upon appeal if documentation shows it is clinically unrelated to the other surgical services reported on the same date.

Effective 1/1/26

Coding Policy 85.0 – Rehabilitation Therapy Services (Physical, Speech, and Occupational Therapy Services)	Two modifiers are used to identify outpatient therapy services furnished in whole or in part by a therapist assistant. These modifiers are required to be used, when applicable, on the claim line of the service, along with the respective GP or GO therapy modifier: • CQ Modifier: Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant (PTA) • CO Modifier: Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant (OTA) Effective January 1, 2026, services reported with modifiers CO or CQ will be reimbursed at 85% of the applicable allowed amount. This payment reduction aligns with the Balanced Budget Act of 2018, which establishes lower reimbursement for services provided by assistants compared to those provided by a licensed physical therapist or occupational therapist.
Coding Policy 57.0 – Modifiers -52 and -53: Reduced or Discontinued Procedures (Professional Charges)	Due to extenuating circumstances or those that threaten the wellbeing of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. Modifier 53 may be added to the procedure code when a procedure is terminated after the induction of anesthesia (e.g. local, regional block(s), or general anesthesia), or after the procedure was started (incision made, intubation started, scope inserted). Effective January 1, 2026, reimbursement for procedures appended with modifier 53 will be adjusted to reflect 25% of the provider's applicable fee schedule allowed amount. Where there is a published RVU on the Medicare Physician Fee schedule for the procedure code with modifier 53 appended, the published RVU will be used for pricing.
Coding Policy 27.0 – Unlisted Procedure Codes	In effort to streamline review and improve accuracy, Providence Health Plan (PHP) will require a concise procedure description (maximum of 70 characters) on all claims billing unlisted codes to be reported in:

	• Box 19 (Additional Claim Information) for professional claims or • Field 80 (Remarks) for facility claims. Effective January 1, 2026, charges for unlisted codes that are missing the name or brief description of the procedure in the appropriate claim form field will be denied. This update to Coding Policy 27.0 (Unlisted Procedure Codes) changing the previous recommendation to a mandatory requirement will be posted on ProvLink on or before the effective date.

ARCHIVE

Effective 12/1/2025

Coding Policy 09.0 – Anesthesia	Qualifying circumstances for anesthesia are not recognized and therefore are not eligible for reimbursement. Effective December 1, 2025, PHP will deny qualifying circumstances (codes 99100, 99116, 99135, and 99140) for all lines of business. This denial is consistent with existing Coding Policy 13.0 (Bundled or Adjunct Services) which states codes listed as bundled services on the Medicare Physician Fee Schedule (Status B) are considered "bundled" services. Coding Policy 09.0 (Anesthesia) will be retired and replaced by Reimbursement Policy 26 (Anesthesia Services) which also details this change on or before the effective date.

GENERAL CODING UPDATES

Rehabilitation Therapy Services - Plan of Care Therapy Modifiers	Plan of care therapy modifiers GP, GO, and GN must be added to therapy codes as appropriate. Report only one plan of care therapy modifier per claim line. These modifiers do not identify distinct procedural services and thus do not preclude the need for modifier -59 when separate services are provided. • GP: Services delivered under an outpatient physical therapy plan of care • GO: Services delivered under an outpatient occupational therapy plan of care • GN: Services delivered under an outpatient speech language pathology plan of care

	Facility claims containing revenue codes 042X, 043X, or 044X must include the appropriate plan of care therapy modifier. Claims containing lines with revenue codes and modifiers that do not match or lines that contain more than one therapy modifier will not be considered.
Correct Diagnosis Coding for Radiation Therapy Encounters	PHP has observed an increase in claims for Intensity-Modulated Radiation Therapy (IMRT) that list only diagnosis code Z51.0 (Encounter for antineoplastic radiation therapy). While Z51.0 is appropriate as the primary diagnosis for encounters chiefly for radiation therapy, it is not sufficient on its own. According to the ICD-10-CM Official Guidelines for Coding and Reporting (Chapter 2, Sections a and e.2), when a patient is admitted or seen primarily for chemotherapy, immunotherapy, or external beam radiation therapy: • The appropriate Z51.-- code (e.g., Z51.0 for radiation therapy) should be assigned as the first-listed or principal diagnosis. • The underlying malignancy for which the therapy is being administered must be reported as a secondary diagnosis. Additionally, Z51.0 includes a "code also" instruction, reinforcing the need to report both the therapy encounter and the condition being treated. For IMRT claims, ensure that Z51.0 is paired with the appropriate cancer diagnosis to fully describe the clinical scenario and support accurate coding and reimbursement.

VENDOR UPDATES

Effective 11/15/25

Carelon

Interim Update

The following codes will require prior authorization through Carelon starting 11/15/25:

RADIOLOGY:

CPT Code	Description	Modality	Procedure
95965	Magnetoencephalography (MEG), recording and analysis; for spontaneous brain magnetic activity (e.g., epileptic cerebral cortex localization)	MEG	Magnetic Encephalography
95966	Magnetoencephalography (MEG), recording and analysis; for evoked magnetic fields, single modality (e.g., sensory, motor, language, or visual cortex localization)	MEG	Magnetic Encephalography

CARDIOLOGY:

CPT Code	Description	Modality	Procedure
C7562	Catheter placement in coronary artery(s) for coronary angiography, including intraprocedural injection(s) for coronary angiography, imaging supervision and interpretation; with right and left heart catheterization including intraprocedural injection(s) for left ventriculography, when performed with intraprocedural coronary fractional flow reserve (ffr) with 3d functional mapping of color-coded ffr values for the coronary tree, derived from coronary angiogram data, for real-time review and interpretation of possible atherosclerotic stenosis(es) intervention	Coronary Angiography	Coronary Angiography with 3- D FFR mapping
0238T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; iliac artery, each vessel	Iliac artery revascularization	Iliac atherectomy

Here's what's new from the following policy committees:

Providence Health Plan

Providence Health Assurance

Table of Contents:

New Drugs and Combinations:

1. **Avutometinib capsules; defactinib tablets (Avmapki Fakzynja Co-Pack®)**
    a. **Indication**: For the treatment of adult patients with KRAS-mutated recurrent low-grade serous ovarian cancer (LGSOC) who have received prior systemic therapy.
    b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Formulary	Formulary	Part D: Formulary Part B: N/A
Tier**	Tier 6 - Non-Preferred Specialty	N/A	Specialty
Affordable Care Act Eligible	N/A; Non-Formulary	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	Prior Authorization
Quantity Limit	1 pack (66 tablets)/28 days	1 pack (66 tablets)/28 days	1 pack (66 tablets)/28 days
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: N/A			

    a. **Prior Authorization Criteria for Commercial/Medicaid**: Add drug to "Anti-Cancer Medications-Self-Administered" Policy
    b. **Prior Authorization Criteria for Medicare Part D**: Add drug to "Anti-Cancer Agents" Policy

2. **Ensartinib capsule (Ensacove®)**
    a. **Indication**: For the treatment of adult patients with anaplastic lymphoma kinase (ALK)-positive locally advanced or metastatic non-small cell lung cancer (NSCLC) who have not previously received an ALK-inhibitor.

b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Formulary	Formulary	Part D: Formulary Part B: N/A
Tier**	Tier 6 - Non-Preferred Specialty	N/A	Specialty
Affordable Care Act Eligible	No	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	Prior Authorization
Quantity Limit	100 mg: 2/day; 25 mg: 1/day	100 mg: 2/day; 25 mg: 1/day	100 mg: 2/day; 25 mg: 1/day
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: cizotinib (Xalkori®), alectinib (Alecensa®), lorlatinib (Lorbrena®), brigatinib (Alunbrig®)			

c. **Prior Authorization Criteria for Commercial/Medicaid**: Add drug to "Anti-Cancer Medications-Self-Administered" Policy
d. **Prior Authorization Criteria for Medicare Part D**: Add drug to "Anti-Cancer Agents" Policy

3. **Pivmecillinam tablet (Pivya®)**
   a. **Indication**: For the treatment of female patients 18 years of age and older with uncomplicated urinary tract infections (uUTI) caused by susceptible isolates of *Escherichia coli (E. Coli)*, *Proteus mirabilis*, and *Staphylococcus saprophyticus*.
   b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Formulary	Formulary	Part D: Formulary Part B: N/A
Tier**	Tier 4	N/A	Non-preferred Drug
Affordable Care Act Eligible	No	N/A	N/A
Utilization Management Edits	Step Therapy	Step Therapy	Step Therapy
Quantity Limit	3 tablets per day	3 tablets per day	3 tablets per day

* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).
Formulary Alternatives: nitrofurantoin, fosfomycin, trimethoprim/sulfamethoxazole

c. **Step Therapy Criteria for Commercial/Medicaid**:

STEP THERAPY CRITERIA	Pivmecillinam (Pivya)
MEDICATION NAME	Pivmecillinam (Pivya)
PA INDICATION INDICATOR	1 - All FDA-Approved Indications
EXCLUSION CRITERIA	N/A
REQUIRED MEDICAL INFORMATION	A trial, contraindication, or intolerance to the use of formulary fosfomycin, sulfamethoxazole-trimethoprim, or nitrofurantoin
AGE RESTRICTIONS	N/A
PRESCRIBER RESTRICTIONS	N/A
COVERAGE DURATION	Authorization will be approved until no longer eligible with the plan, subject to formulary and/or benefit changes

d. **Step Therapy Criteria for Medicare Part D:**

STEP THERAPY CRITERIA	Pivmecillinam (Pivya)
MEDICATION NAME	Pivmecillinam (Pivya)
CRITERIA	One of the following: 1) History of paid claim or documented trial of one of the following formulary medications: fosfomycin, sulfamethoxazole-trimethoprim, nitrofurantoin, OR 2. Documented intolerance/contraindication to all the following formulary medications: fosfomycin, sulfamethoxazole-trimethoprim, nitrofurantoin.

4. **Atrasentan tablet (Vanrafia®)**
   a. **Indication**: To reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression, generally a urine protein-to-creatinine ratio (UPCR) of at least 1.5 g/g.
   b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Non-formulary	Non-formulary	Part D: Non-formulary Part B: N/A

Tier**	N/A	N/A	N/A
Affordable Care Act Eligible	N/A; Non-Formulary	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	N/A
Quantity Limit	One tablet per day	One tablet per day	N/A
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: Filspari, Tarpeyo, Fabhalta			

c. **Prior Authorization Criteria for Commercial/Medicaid**:

PA PROGRAM NAME	Filspari
MEDICATION NAME	Vanrafia
EXCLUSION CRITERIA	For sparsentan only: Concurrent therapy with angiotensin receptor blockers, endothelin receptor antagonists, or aliskiren
REQUIRED MEDICAL INFORMATION	For initial authorization, all the following criteria must be met: 1. Diagnosis of primary immunoglobulin A nephropathy (IgAN), confirmed by biopsy 2. Patient has been receiving a stable dose of an angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blockers (ARB), at a maximally tolerated dose, with statement that ACE or ARB will be discontinued before sparsentan therapy is initiated (discontinuation is not required for atrasentan) 3. Patient is at high risk of disease progression, defined as meeting one of the following criteria (a or b): a. Proteinuria of more than 1.0 g/day; OR b. Urine protein-to-creatinine ratio of 1.5 g/g or more 4. eGFR greater than or equal to 30 mL/min1.73m^2 Reauthorization: Documentation of positive response to therapy defined as improvement in proteinuria.

5. **Nipocalimab solution (Imaavy®)**

a. **Indication**: For the treatment of generalized myasthenia gravis (gMG) in adult and pediatric patients 12 years of age and older who are anti-acetylcholine receptor (AChR) or anti-muscle-specific tyrosine kinase (MuSK) antibody positive

b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Medical	Medical	Part D: Non-formulary

			Part B: Medical
Tier**	N/A	N/A	Specialty
Affordable Care Act Eligible	No	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	Prior Authorization
Quantity Limit	N/A	N/A	N/A
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: Medically administered: Vyvgart (efgartigimod alfa) and Rystiggo (rozanolixizumab-noli)			

c. **Prior Authorization Criteria for Commercial/Medicaid/Medicare Part B**:

PA PROGRAM NAME	FcRn Antagonists
MEDICATION NAME	Nipocalimab (Imaavy)
PA INDICATION INDICATOR	1 - All FDA-Approved Indications
EXCLUSION CRITERIA	Use in combination with other immunomodulatory biologic therapies, such as rituximab, eculizumab (Soliris®), ravulizumab (Ultomiris®), efgartigimod (Vyvgart®/Vyvgart Hytrulo®), rozanolixizumab (Rystiggo®), zilucoplan (Zilbrysq®)
REQUIRED MEDICAL INFORMATION	REQUIRED MEDICAL INFORMATION: For initial authorization, must meet all the indication-specific criteria below: Generalized Myasthenia Gravis (gMG): 1. Anti-acetylcholine receptor (anti-AChR) antibody positive OR anti-muscle-specific tyrosine kinase (MuSK) antibody positive (Rystiggo® and Imaavy only) 2. One of the following: a. For Vyvgart/Vyvgart Hytrulo i. Myasthenia Gravis Foundation of America (MGFA) Clinical Classification Class II to IV ii. Myasthenia Gravis - Activities of Daily Living (MG-ADL) total score of five or greater b. For Rystiggo: i. Myasthenia Gravis Foundation of America (MGFA) Clinical Classification Class II to Iva ii. Myasthenia Gravis - Activities of Daily Living (MG-ADL) total score of three or greater (with 3 or greater points from non-ocular symptoms) c. For Imaavy:

	i. MGFA Clinical Classification of Class II to IV ii. MG-ADL total score of six or greater 3. Failure with treatment of one of the following over the course of at least 12 months, unless intolerance or contraindication to all therapies: a. At least TWO immunosuppressive agents (such as azathioprine, methotrexate, cyclosporine, mycophenolate, corticosteroids, tacrolimus, cyclophosphamide, or rituximab) b. ONE immunosuppressive therapy and required at least four infusions/year of either intravenous immunoglobulin (IVIG), or plasmapheresis/plasma exchange (PLEX) 4. Dose and frequency are in accordance with FDA-approved labeling
AGE RESTRICTIONS	Age must be appropriate based on FDA-approved indication
PRESCRIBER RESTRICTIONS	Must be prescribed by, or in consultation with, a neurologist or rheumatologist
COVERAGE DURATION	Initial authorization will be approved for six months. Reauthorization will be approved for one year.

6. **Efbemalenograstim alfa-vuxw injection (Ryzneuta®)**
   a. **Indication**: To decrease the incidence of infection, as manifested by febrile neutropenia, in adult patients with non-myeloid malignancies receiving myelosuppressive anti-cancer drugs associated with a clinically significant incidence of febrile neutropenia.
   b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Medical	Medical	Part D: Non-formulary Part B: Medical
Tier**	N/A	N/A	N/A
Affordable Care Act Eligible	N/A; Non-Formulary	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	Prior Authorization
Quantity Limit	N/A	N/A	N/A
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: Neulasta, Neupogen, biosimilar filgrastim, biosimilar pegfilgrastim			

c. **Prior Authorization Criteria for Commercial/Medicaid/Medicare Part B**: Added to "Granulocyte Colony Stimulating Factors (G-CSF)" policy as a non-preferred product

7. **Telisotuzumab vedotin-tllv injection (Emrelis®)**
   a. **Indication**: For the treatment of adult patients with locally advanced or metastatic nonsquamous (NSQ) non-small cell lung cancer (NSCLC) with high c-Met protein overexpression (OE) [at least 50% of tumor cells with strong (3+) staining], as determined by an FDA-approved test, who have received a prior systemic therapy
   b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Medical	Medical	Part D: Non-formulary Part B: Medical
Tier**	N/A	N/A	N/A
Affordable Care Act Eligible	N/A; Non-Formulary	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	Prior Authorization
Quantity Limit	N/A	N/A	N/A
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: None			

   c. **Prior Authorization Criteria for Commercial/Medicaid**: Added to "Anti-Cancer Medications – Medical benefit" Policy
   d. **Prior Authorization Criteria for Medicare Part B**: Added to "Anti-Cancer Medications Prior Authorization and Step Therapy Policy - Medicare Part B"

8. **Deuruxolitinib tablet (Leqselvi®)**
   a. **Indication**: For the treatment of severe alopecia areata.
   b. **Decision**:

	Commercial	Medicaid	Medicare
Formulary Status*	Non-formulary	Non-formulary	Part D: Non-formulary Part B: N/A
Tier**	N/A	N/A	N/A

Affordable Care Act Eligible	N/A; Non-Formulary	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	N/A
Quantity Limit	Two tablets per day	Two tablets per day	N/A
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: Olumiant, Litfulo (Non-formulary as alopecia areata is a benefit exclusion for most groups)			

c. **Prior Authorization Criteria for Commercial/Medicaid**: Added to "Therapeutic Immunomodulators" Policy.

9. **Prademagene zamikeracel cellular sheet (Zevaskyn®)**
   a. **Indication**: For the treatment of wounds in adult and pediatric patients with recessive dystrophic epidermolysis bullosa (RDEB).
   b. **Decision**:

	Commercial	**Medicaid**	**Medicare**
Formulary Status*	Medical	Medical	Part D: Non-formulary Part B: Medical
Tier**	N/A	N/A	N/A
Affordable Care Act Eligible	N/A; Non-Formulary	N/A	N/A
Utilization Management Edits	Prior Authorization	Prior Authorization	Prior Authorization
Quantity Limit	N/A	N/A	N/A
* Recommendations for placement may differ between lines of business due to regulatory requirements. ** Medications will be placed on recommended tier above for the base formulary; tier placement for custom formulary(ies) will be based on designation above. For example, Commercial Tier 6 designation above means that the medication will be placed on the highest cost-sharing tier on the respective formulary(ies).			
Formulary Alternatives: None			

   c. **Prior Authorization Criteria for Commercial/Medicaid/Medicare Part B**:

PA PROGRAM NAME	Medications for Rare Indications

MEDICATION NAME	Prademagene zamikeracel (Zevaskyn)
PA INDICATION INDICATOR	1 - All FDA-Approved Indications
EXCLUSION CRITERIA	Concomitant use with Vyjuvek or Filsuvez
REQUIRED MEDICAL INFORMATION	For initial authorization: 1. Diagnosis of recessive dystrophic epidermolysis bullosa (RDEB) with genetic confirmation of mutations in both COL7A1 genes 2. Treatment will be used on partial-thickness RDEB wounds open chronically for at least six months For reauthorization: Must meet initial criteria
AGE RESTRICTIONS	Age must be appropriate based on FDA-approved indication
PRESCRIBER RESTRICTIONS	Must be prescribed by, or in consultation with a specialist in the respective disease state.
COVERAGE DURATION	Initial and reauthorization is limited to one treatment course. Approval duration will be for 12 weeks.

New Indications: Deferred to October P&T

Drug Safety Monitoring: Deferred to October P&T

Other Formulary Changes:

Drug Name	Recommendation	Policy Name
Acetaminophen/codeine oral solution	Remove from Commercial formulary	
Aztreonam/avibactam sodium (Emblaveo) Vial	New combination; • Commercial/Medicaid/Medicare Part B: Medical Benefit • Medicare Part D: Non-Formulary	N/A
Bisoprolol fumarate Tablet	New strength (2.5 mg); • Non-formulary for all lines of business	N/A
Buprenorphine hcl/naloxone hcl (Zubsolv) Tab Subl	• I Medicaid: Add all strengths to Formulary with Quantity Limits as follows: ○ 11.4-2.9 mg: 1 tablet per day ○ 8.6-2.1 mg: 2 tablets per day (no change) ○ All other strengths: 3 tablets per day	N/A

Drug Name	Recommendation	Policy Name
Buspirone hcl	New dosage form (capsule); • Commercial: Non-Formulary, Prior Authorization • Medicaid/Medicare Part D: Non-Formulary	• Commercial: New Medications and Formulations without Established Benefit • Medicaid/Medicare Part D: N/A
Clesrovimab-cfor (Enflonsia) Syringe	New RSV Vaccine. Line extend with other RSV vaccines • Medical Benefit for all lines of business	
Diazoxide choline (Vykat XR) Tab ER 24h	Correction from June 2025 P&T: • Commercial/Medicaid: Non-Formulary with Prior Authorization	Medications For Rare Indications
Diflunisal (Dolobid) Tablet	New strength (375 mg); • Non-formulary for all lines of business	N/A
Eculizumab-aagh (Epysli) Vial	New BLA; New non-preferred biosimilar for Soliris. • Commercial/Medicaid/Medicare Part B: Medical Benefit, Prior Authorization • Medicare Part D: Non-Formulary	Complement Inhibitors
Eculizumab-aeeb (Bkemv) Vial	New BLA; New preferred biosimilar for Soliris. • Commercial/Medicaid/Medicare Part B: Medical Benefit, Prior Authorization • Medicare Part D: Non-Formulary	Complement Inhibitors
Emgality (galcanezumab-gnlm) syringe and pen injector	Remove from Medicaid formulary to align with Oregon Health Authority preferred drug list	Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists
Eszopiclone tablet	Remove from Medicaid formulary to align with Oregon Health Authority preferred drug list	Insomnia Agents- Medicaid
Fentanyl citrate products (lozenge, effervescent tablets, nasal spray, etc.)	Remove from Commercial/Medicaid formularies, as products are now obsolete	Fentanyl citrate (policy to be retired)
Hemiclor (chlorthalidone) 12.5 mg tablet	New Strength. Non-formulary for all lines of business	N/A
Ibuprofen/acetaminophen (Combogesic) Tablet	New strength; • Non-formulary for all lines of business	N/A
Jubbonti (denosumab-bbdz) syringe	New preferred biosimilar for Prolia. Medical benefit for all lines of business	N/A
Losartan potassium (Arbli) Oral Susp	New formulation;	N/A

Drug Name	Recommendation	Policy Name
	• Non-formulary for all lines of business	
Melatonin tablets and 1 mg/mL liquid	Require PA for adults 19 years and above	Insomnia Agents- Medicaid
Merilog (insulin aspart-szjj)	New biosimilar for Novolog. Non-formulary for all lines of business	N/A
Rilpivirine hcl (Edurant Ped) Tab Susp	New dosage form; • Commercial: Formulary, Tier 4, Quantity Limit (6 tablets per day) • Medicaid: Formulary, Quantity Limit (6 tablets per day) • Medicare Part D: Formulary, Tier 5	N/A
Sunosi (solreiamfetol)	Change tier for Commercial: Formulary, Tier 5 (from Tier 4), Prior Authorization, Quantity Limit (one tablet per day)	Narcolepsy Agents
Teriparatide (Bonsity) Pen Injctr	New MedID; New brand-name product. Non-formulary for all lines of business	Osteoanabolic Agents
Ustekinumab-aekn syringe	New biosimilar for Selarsdi. Non-preferred. • Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (one injection per 84 days) • Medicare: Non-Formulary	Therapeutic Immunomodulators
Wakix (pitolisant)	Remove from Commercial formularies	Narcolepsy Agents
Wyost (denosumab-bbdz) vial	New preferred biosimilar for Xgeva. Medical benefit for all lines of business	N/A
Xyrem (sodium oxybates)	Remove brand-name formulation from the Commercial formulary. Move generic formulation to Tier 6 (from Tier 5)	Narcolepsy Agents

The formulary status for the following drugs was line extended in accordance with Providence Health Plan Pharmacy Operational Policy ORPTCOPS062

INFORMATIONAL ONLY

NEW DRUGS / COMBINATIONS / STRENGTHS / DOSAGE FORMS		
Drug Name	**Action Taken**	**Policy Name**
Dapsone Gel (Gram)	New Strength. Line extend with existing strengths; • Commercial Standard: Formulary, Tier 2	N/A

	• Commercial Dynamic: Formulary, Tier 4 • Medicaid: Non-Formulary • Medicare Part D: Non-Formulary	
Nirmatrelvir/ritonavir (Paxlovid) Tab DS PK	New strength (150-100 mg). Line extend with Paxlovid; • Commercial/Medicare Part D: Formulary, Tier 3 • Medicaid: Formulary	N/A
Thiotepa (Tepylute) Vial	New strength (15 mg/1.5ml; 100 mg/10 ml). Line extend with thiotepa; • Medical Benefit, Prior Authorization for all lines of business	Anti-Cancer Medications - Medical Benefit
Zolbetuximab-clzb (Vyloy) Vial	New strength (300 mg). Line extend with Vyloy 100mg vial; • Medical Benefit, Prior Authorization for all lines of business	Anti-Cancer Medications - Medical Benefit
Maralixibat chloride (Livmarli) Tablet	New dosage form (tablet). Line extend with Livmarli solution; • Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (2 tablets per day) • Medicare Part D: Non-Formulary, FDA Max (2 tablets per day)	Cholestatic Pruritus Agents

NEW GENERICS		
Drug Name	**Action Taken**	**Policy Name**
Emtricita/rilpivirine/tenof df (Complera) Tablet	First generic drug (Complera). Line extend as generic; • Commercial Standard: Formulary, Tier 2 • Commercial Dynamic: Formulary, Tier 3 • Medicaid: Formulary • Medicare Part D: Formulary, Tier 5, Quantity Limit (1 tablet per day)	N/A
Flutamide (Eulexin) Capsule	Return of generic. Line extend as generic; • Commercial: Formulary, Tier 4 • Medicaid: Formulary	Medicare Part D: Anti-Cancer Agents

NEW GENERICS		
Drug Name	**Action Taken**	**Policy Name**
	• Medicare Part D: Formulary, Tier 5, Prior Authorization, Quantity Limit (1 tablet per day)	
Gadoteridol Vial	First generic drug (Prohance). Line extend as generic; • Medical Benefit for all lines of business	N/A
Thyroid, Pork (Renthyroid) Tablet	New generic pork thyroid. Line extend with other generic pork thyroids; • Commercial: Formulary, Tier 2 • Medicaid: Formulary • Medicare Part D: Formulary, Tier 4	N/A
Sitagliptin-Metformin ER TBMP 24hr	First generic drug (Zituvimet XR). Line extend as generic; • Non-formulary for all lines of business	N/A
Ticagrelor Tablet	First Generic Drug (Brilinta). Line extend as generic; • Commercial Standard: Formulary, Tier 2 • Commercial Dynamic: Formulary, Tier 3 • Medicaid: Formulary • Medicare Part D: Formulary, Tier 3	N/A
Eslicarbazepine Acetate Tablet	First generic drug (Aptiom). Line extend as generic; • Commercial Standard: Formulary, Tier 2, Step Therapy, Quantity Limit (2 tablets per day) • Commercial Dynamic: Formulary, Tier 4, Step Therapy, Quantity Limit (2 tablets per day) • Medicaid: Step Therapy, Quantity Limit (2 tablets per day) • Medicare Part D: Formulary, Tier 5, Step Therapy, Quantity Limit (2 tablets per day)	Antiepileptic Medications Step Therapy Policy
Exenatide Pen Injctr	First generic drug (Byetta). Line extend as generic;	GIP and GLP-1 Receptor Agonists

NEW GENERICS		
Drug Name	**Action Taken**	**Policy Name**
	• Commercial: Non-Formulary, Prior Authorization, Quantity Limit (2.4 mL/30) • Medicaid: Formulary, Prior Authorization, Quantity Limit (2.4 mL/30) • Medicare Part D: Non-Formulary	
Umeclidinium-Vilanterol Blst w/Dev	First generic drug (Anoro Ellipta). Line extend as Non-Formulary for Commercial/Medicare Part D • Medicaid: Formulary	N/A
Pilocarpine hcl (Vuity) Drops	First generic drug (Vuity). Line extend as generic; • Commercial/Medicaid: Non-Formulary, Prior Authorization • Medicare Part D: Formulary, Tier 4	• Commercial/Medicaid: Qlosi, Vuity • Medicare Part D: N/A
• **Ustekinumab 45 mg/0.5 mL Vial** • **Ustekinumab 45 mg/0.5 mL Syringe** • **Ustekinumab 90 mg/mL**	New generic (Stelara); Line extend as generic; • Commercial/Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (0.5 mL per 84 days) • Medicare Part D: Non-Formulary, Quantity Limit (3 mL per 84 days)	• Commercial/Medicaid: Therapeutic Immunomodulators (TIMS) • Medicare Part D: N/A
Ustekinumab 130 mg/26 ml Vial	New generic (Stelara); Line extend as generic; • Commercial/Medicaid: Medical Benefit, Prior Authorization • Medicare Part D: Non-Formulary • Medicare Part B: Medical Benefit, Prior Authorization	• Commercial: Medically Infused Therapeutic Immunomodulators (Tims) – Comm • Medicaid: Therapeutic Immunomodulators (TIMS) – Medicaid • Medicare Part D: Medically Infused Therapeutic Immunomodulators (TIMs) Prior Authorization and Step Therapy Policy - Medicare Part B
Eltrombopag Olamine 12.5mg & 25mg Tablets	First generic drug (Promacta). Line extend as generic;	Thrombocytopenia Medications

NEW GENERICS		
Drug Name	**Action Taken**	**Policy Name**
	• Commercial: Formulary, Tier 6, Prior Authorization, Quantity Limit (1 tablet per day) • Medicaid: Formulary, Prior Authorization, Quantity Limit (1 tablet per day) • Medicare Part D: Formulary, Tier 5, Prior Authorization, Quantity Limit (1 tablet per day)	
Eltrombopag Olamine 50mg & 75mg Tablets	First generic drug (Promacta). Line extend as generic; • Commercial: Formulary, Tier 6, Prior Authorization, Quantity Limit (2 tablets per day) • Medicaid: Formulary, Prior Authorization, Quantity Limit (2 tablets per day) • Medicare Part D: Formulary, Tier 5, Prior Authorization, Quantity Limit (2 tablets per day)	Thrombocytopenia Medications
Eltrombopag Olamine 12.5mg & 25mg Powd Pack	First generic drug (Promacta). Line extend as generic; • Commercial: Formulary, Tier 6, Prior Authorization, Quantity Limit (12.5 mg 1 packet per day; 25 mg 6 packets per day) • Medicaid: Formulary, Prior Authorization, Quantity Limit (12.5 mg 1 packet per day; 25 mg 6 packets per day) • Medicare Part D: Formulary, Tier 5, Prior Authorization, Quantity Limit (12.5 mg 1 packet per day; 25 mg 6 packets per day)	Thrombocytopenia Medications
Tolvaptan Tablet SEQ	First generic drug (Jynarque). Line extend as generic; • Commercial: Formulary, Tier 6, Prior Authorization	• Commercial/Medicaid: Tolvaptan • Medicare Part D: N/A

NEW GENERICS		
Drug Name	**Action Taken**	**Policy Name**
	• Medicaid: Formulary, Prior Authorization, Specialty • Medicare Part D: Non-Formulary	
Phentermine-Topiramate ER CPMP 24hr	First generic drug (Qsymia). Line extend as generic; • Commercial Standard: Formulary, Tier 2, Prior Authorization, Quantity Limit (1 capsule per day) • Commercial Dynamic: Non-Formulary, Prior Authorization, Quantity Limit (1 capsule per day) • Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (1 capsule per day) • Medicare Part D: Non-Formulary	• Commercial/Medicaid: Weight Management Medications • Medicare Part D: N/A
Perampanel tablet	First generic drug (Fycompa). Line extend as generic: • Commercial Standard: Formulary, Tier 2, Step Therapy, Quantity Limit (1 tablet per day) • Commercial Dynamic: Formulary, Tier 4, Step Therapy, Quantity Limit (1 tablet per day) • Medicaid: Formulary, Prior Authorization, Quantity Limit (1 tablet per day) • Medicare Part D: Formulary, Tier 5, Step Therapy, Quantity Limit (1 tablet per day)	Antiepileptic Medications Step Therapy

Clinical Policy Changes:

PHARMACY CLINICAL POLICIES – MAJOR CHANGES	
Policy Name	**Summary of Change**

Anti-Amyloid Monoclonal Antibodies - Medicaid	Updated criteria to align with Oregon Health Authority (OHA) policy, which excludes concurrent anti-coagulant or anti-platelet therapy (except aspirin 81 mg) and adds specific reauthorization requirements for Kisunla (donanemab).
Anti-Amyloid Monoclonal Antibodies Prior Authorization and Step Therapy Policy - Medicare Part B	Added Kisunla® (donanemab) and removed Aduhelm® (aducanumab) coverage per CMS National Coverage Determination (NCD).
Anti-Cancer Medications - Self-Administered	Scemblix® (asciminib) step criteria removed from policy.
Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists - Medicaid	For migraine prophylaxis: (1) updated trial and failure prerequisite drugs to align with OHA, (2) added wording to clarify appropriate dose required for prerequisite drugs, and (3) updated botulinum toxin language from two months to three months to capture all current users as botulinum toxinis dosed every 12 weeks. For cluster headaches: (1) updated trial and failure prerequisite drugs to align with OHA.
Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists - Commercial	Updated prerequisite drugs for migraine prophylaxis to align with current American Headache Society guidelines.
Calcitonin Gene-Related Peptide (CGRP) Receptor Antagonists Prior Authorization and Step Therapy Policy - Medicare Part B	Updated prerequisite drugs for migraine prophylaxis to align with current American Headache Society guidelines and removed Qulipta® (atogepant) as a preferred agent.
Elevidys	For Medicaid, added criteria for coverage to align with OHA. Continues to be considered not medically necessary for other lines of business.
Epidiolex	Added clobazam and felbamate as options to try for Lennox-Gastaut syndrome
Exon-Skipping Therapies for Duchenne Muscular Dystrophy	For Medicaid, added criteria for coverage to align with the OHA. Continues to be considered not medically necessary for other lines of business.
Fintepla	Added clobazam and felbamate as options to try for Lennox-Gastaut syndrome
Firdapse	Increase quantity limit to 10 tablets per day.
Gene Therapies for Hemoglobin Disorders	Requirement to use busulfan for pre-treatment conditioning added to support value-based agreement operationalization.
Hetlioz, Hetlioz LQ	Age updated to "must be appropriate based on FDA-approved indication"
Infusion Therapy Site of Care	Site of Care medication list expanded to include additional immunotherapy anti-cancer agents.
Insomnia Agents - Medicaid	Updated melatonin to not allow coverage for patients over 18 to align with OHA
Krystexxa	Allow radiographic damage to confirm diagnosis of symptomatic chronic gout and, require combination with methotrexate for reauthorization.
Long-Acting Opioids	Added nalmefene as another option for opioid reversal agent prescribing.
Maximum Allowable Opioid Dose	Removed quantity limit for morphine sulfate solution and hydromorphone tabs. Max morphine equivalent edit in claims processor will block excessive use.
Medications for Female Sexual Interest and Arousal Disorder	Removed exclusion criteria as duplicative with medical necessity criteria.

Narcolepsy Agents	Updated preferred agents and removed criteria for combination use of agents due to lack of evidence supporting combination therapy.
Pediatric Analgesics	Updated to require trial and failure of all formulary drugs, unless not indicated.
Qudexy XR	Removed requirements for coverage of brand-name formulation, as brand is no longer available.
Radicava, Radicava ORS	Policy updated to include Awaji-Shima criteria to establish amyotrophic lateral sclerosis diagnosis.
Spravato	Prescriber restrictions were updated to clarify that medication must be prescribed directly by a psychiatrist or psychiatric nurse practitioner.
Therapies for Spinal Muscular Atrophy	Add quantity limit of one tablet per day to Evrysdi tablets; Added allowance for therapies with worsening of disease after gene therapy administration.
Triptan Quantity Limit	Criteria combined for all headache types to require prophylactic therapy, rule-out medication overuse headache, and requiring medical rationale for all initial requests. Added requirement for prophylactic therapy for continuation of therapy.
VMAT2 Inhibitors	Updated quantity limits

DEFERRED POLICIES	
Policy Name	
Journavx	Non-Preferred Fumarate Products
Lemtrada	Tysabri
Lemtrada Prior Authorization and Step Therapy Policy - Medicare Part B	Tysabri Prior Authorization and Step Therapy Policy - Medicare Part B
Medically Administered Multiple Sclerosis Agents	Zeposia
Medically Administered Multiple Sclerosis Agents Prior Authorization and Step Therapy Policy – Medicare Part B	Zeposia - Medicaid
Multiple Sclerosis Agents	

RETIRED POLICIES	
Policy Name	**Summary Of Change**
Chenodal, Ctexli	Medications moved to Medications for Rare Indications policy
Fentanyl Citrate	Due to the drugs on the policy are obsolete