Michigan Pharmacy and Therapeutics Committee
Tuesday, December 2, 2025
Minutes - Final

Committee Members Present: Andrew Adair (Oakland County), Katie Axford (Kent County), Kassen Elhelou (Oakland County), Kaitlin Liroff (Oakland County), Ijeoma Opara (Wayne County), Nora Orow (Macomb County), Patricia Railling (Kalamazoo County), Brad Uren (Livingston County)

Committee Members Absent: None

MDHHS/Prime Therapeutics Present: Glenda England (MDHHS), Grace Gere (MDHHS), Jed Miller (MDHHS), Danielle Waggoner (MDHHS), Mark England (MDHHS), Hannah Silaphath (Prime Therapeutics), Sandy Pranger (Prime Therapeutics)

The MDHHS Pharmacy and Therapeutics (P&T) Committee was held via Microsoft Teams web conference with teleconference only option of participation also.

The meeting was called to order at 6:00 pm by Brad Uren (chair) with roll call of the members present. The members provided the location from which they were attending. Committee quorum was established.

Committee Business

Committee members present at the meeting reported no conflicts of interest.

The agenda was reviewed and approved. The minutes of the September 2, 2025, meeting were reviewed and approved.

Katie Axford was elected to Vice-chairperson.

MDHHS Updates

Trish Bouck presented the MDHHS department updates. She reported that the FY2026 Budget was finalized via Public Act 22 of 2025. She noted that the department will revise existing pharmacy coverage policies to limit the authorization of anti-obesity GLP-1 receptor agonists exclusively to individuals classified as morbidly obese. These changes will take effect 1/1/2026. MDHHS is finalizing a notice to affected beneficiaries as well as a provider letter for pharmacies and prescribers. In addition, a web announcement is being developed this week with additional details to assist providers as they plan for the 1/1/2026 changes posted at https://mi.primetherapeutics.com/ > Providers >. Existing prior authorizations for GLP-1 anti-obesity medications approved prior to 1/1/2026 will be honored for the remainder of the 6-month authorization.

Ms. Bouck shared that SPA 25-0011, excluding copayments for HIV PrEP and PEP drugs, was approved on November 14, 2025, effective November 1, 2025. Additionally, the end date for Medication Assisted Treatment (MAT) coverage was removed, making MAT a permanent Medicaid benefit under Section 201 of the Consolidated Appropriations Act of 2024 for individuals meeting medical necessity criteria. Final Policy MMP 25-44, which removes pharmacy copayments for HIV prevention drugs (PrEP and PEP), was issued on September 30, 2025.

Ms. Bouck presented a list of Provider L-Letters and links: 1. L 25-50: Electronic Funds Transfer (EFT) Enrollment Requirement for Pharmacy Payments, 2. L 25-54: Permanent Continuation of Medication Assisted Treatment (MAT) Coverage State Plan Amendment (SPA) Request, 3. L 25-68: 340B Rebate Model Pilot Program - Claims Submission Requirements • Questions can be directed to: MDHHSPharmacy340B@michigan.gov and a final link to all letters at 2025 Medicaid Provider L Letters.

Ms. Bouck noted that the current Single PDL and Brand over Generics, effective 12/1/2025 are posted on the website at https://mi.primetherapeutics.com > Providers > Documents. Quarterly, the MCO Common Formulary workgroup provides input and recommendations on Single PDL coverage for P&T Workgroup consideration before each full P&T Committee meeting. The P&T Committee makes clinical recommendations for both the Michigan Pharmaceutical Product List (MPPL) and the subset of drugs on the Single PDL. Ms. Bouck stated that a quarterly Summary of PDL changes update is available following the P&T Committee meetings at https://mi.primetherapeutics.com > Providers > Recent Changes - MI Single Preferred Drug List (Single PDL). The next quarterly update will list the changes effective 2/1/2026.

MDHHS received CMS approval in October 2018 to pursue Outcomes/Value-Based Purchasing Agreements with drug manufacturers to address high-cost drugs. MDHHS currently has six active Outcomes/Value-Based Contract Agreements with others also under review. Agreements that allow MDHHS staff to track outcomes instead of by a third-party data aggregator are preferred. MDHHS also prefers contracts where the outcomes can be easily tracked using claims data such as orphan drugs where the eligible patient population is

small or for drugs where the eligible patient population is large, and outcomes are based on volume and adherence. Contact Rita Subhedar (SubhedarR1@michigan.gov) or MDHHS-MSAIndustryRequests@michigan.gov to start discussions (See Procedure).

Lastly, Ms. Bouck provided website links to additional resources such as MDHHS policy bulletins, web announcements, DUR Board and P&T Committee.

Public Comments:

1. **Lauren Oshman, MD, MPH, on behalf of herself, on prior authorization criteria for medications for obesity treatment.**
2. **Preety Gadhoke, PhD, MPH, Medical Outcomes & Science Liaison, on behalf of AbbVie Inc., on Atogepant (Qulipta).**
3. **Sean Bingham, Associate Director, Midwest Boehringer Value & Access (MI Medicaid contact), on behalf of Boehringer-Ingelheim, on Oncology Treatment, Hernexeos (NSCLC/HER2+/po).**
4. **Jasmine Inman, PharmD, Field Value Evidence and Outcomes, on behalf of Teva Pharmaceuticals, on Ajovy.**
5. **Erica Griffin, MD, Family and Obesity Medicine Physician, on behalf of the Upper Peninsula Health System, on GLP-1 Access for Obesity and other indications.**

New Drugs for Review

1. **Andembry (garadacimab-gxii) prefilled autoinjector and prefilled syringe** – an activated Factor XII (FXIIa) inhibitor (monoclonal antibody) indicated for prophylaxis to prevent attacks of hereditary angioedema (HAE) in adult and pediatric patients aged 12 years and older. **[Not a PDL class - Add to MPPL with PA]**
   (NOTE: To be added to the MHP pharmacy carve-out list)

   Proposed criteria:
   - Patient is 12 years of age or older; **AND**
   - Diagnosis of hereditary angioedema; **AND**
   - Attestation that diagnosis was confirmed by a C4 level below the lower limit of normal as defined by laboratory test and any of the following:
     - C1 inhibitor (C1-INH) antigenic level below the lower limit of normal as defined by the laboratory performing the test; **OR**
     - C1-INH functional level below the lower limit of normal as defined by the laboratory performing the test; **OR**
     - Presence of a known HAE-causing C1-INH mutation; **OR**
     - **Recurring angioedema attacks that are refractory to high-dose antihistamines; AND**
   - Patient has a history of ONE of the following criteria for long-term hereditary angioedema (HAE) prophylaxis:
     - History of two or more severe HAE attacks per month (i.e., airway swelling, debilitating cutaneous or gastrointestinal episodes); **OR**
     - Patient is disabled more than five days per month by HAE; **OR**
     - History of recurrent laryngeal attacks caused by HAE; **AND**
   - Prescribed by, or in consultation with, a specialist in allergy, immunology, hematology, pulmonology or medical genetics; **AND**
   - Patient is not using Andembry in combination with another FDA-approved product for long-term prophylaxis of HAE attacks (e.g., Cinryze, Haegarda, Orladeyo, Takhzyro,)
   - Length of approval: 1 year

2. **Blujepa (gepotidacin mesylate) -** is a triazaacenaphthylene bacterial type II topoisomerase inhibitor indicated for the treatment of female adult and pediatric patients 12 years of age and older weighing at least 40 kilograms (kg) with uncomplicated urinary tract infections (uUTI) caused by the following susceptible microorganisms: Escherichia coli, Klebsiella pneumoniae, Citrobacter freundii complex, Staphylococcus saprophyticus, and Enterococcus faecalis. To reduce the development of drug-resistant bacteria and maintain the effectiveness of Blujepa and other antibacterial drugs, Blujepa should be used only to treat infections that are proven or strongly suspected to be caused by susceptible bacteria. When culture and susceptibility information are available, they should be considered in selecting or modifying antibacterial therapy. In the absence of such data, local epidemiology and susceptibility patterns may contribute to the empiric selection of therapy. **[Not a PDL class - Add to MPPL with PA]**

   Proposed criteria:
   - Female patient is 12 years of age or older; **AND**
   - Weight ≥ 40 kg; **AND**
   - Diagnosis of uncomplicated urinary tract infection; **AND**
   - Patient has classic symptoms of cystitis (e.g., dysuria, urinary frequency, urinary urgency, and/or suprapubic pain, etc.); **AND**
   - Patient does not have any one of the following:
     - atypical symptoms with pyuria (e.g., fall, confusion, altered mentation, etc.)
     - signs or symptoms of upper urinary tract infection (e.g., fever, flank pain, etc.)
     - anatomical or functional urinary tract abnormalities (e.g., an indwelling bladder catheter, nephrostomy tube(s), urostomy stent(s), nephrolithiasis, neurogenic bladder, recent urinary system instrumentation, history of urinary system reconstruction, etc.); **AND**
   - Patient is not pregnant; **AND**
   - An uncomplicated urinary tract infection has been confirmed using an uncontaminated urine culture demonstrating at least 100,000 CFU/ml of one of the 5 following bacteria for which it is approved:
     - *Escherichia coli*
     - *Klebsiella pneumoniae*
     - *Citrobacter freundii* complex
     - *Staphylococcus saprophyticus*
     - *Enterococcus faecalis*; **AND**
   - There has been a failure of, and/or allergy to (not loose stool), and/or *clinical* contraindication (e.g., proven MDR bacteria, ligamentous injury, etc.) to *all* the following:
     - Nitrofurantoin or Macrobid
     - TMP-SMX or TMP-SMZ or trimethoprim
     - Fosfomycin
     - Amoxicillin-clavulanate or Augmentin
     - Cefpodoxime
     - Cefdinir
     - Cefadroxil
     - Cephalexin or Keflex
     - Ciprofloxacin
     - Levofloxacin
   - Quantity Limits: 20 tablets (5-day course of therapy)

3. **Bonsity (teriparatide) prefilled syringe** – a parathyroid hormone analog, (PTH 1-34), indicated for: Treatment of postmenopausal women with osteoporosis at high risk for fracture or patients who have failed or are intolerant to other available osteoporosis therapy, increase of bone mass in men with primary or hypogonadal osteoporosis at high risk for fracture or patients who have failed or are intolerant to other available osteoporosis therapy, and treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture or patients who have failed or are intolerant to other available osteoporosis therapy. **[PDL class: Osteoporosis Agents: Other; non-preferred] [PDL pg. 42]**

   Current Criteria:
   - Allergy to the preferred medications; **OR**
   - Contraindication or drug to drug interaction with the preferred medications; **OR**

- History of unacceptable side effects; **OR**
- Trial and failure with six months with one preferred medication
- Unique FDA approved indication not included in preferred medications
- See additional medication-specific criteria below:

See additional medication-specific criteria below:

- Treatment of osteoporosis in postmenopausal women who are at high risk for fractures
- Increase of bone mass in men with primary or hypogonadal osteoporosis who are at high risk for fractures
- Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy at high risk for fracture
- Length of authorization: maximum cumulative duration of 2 years per lifetime, unless clinical documentation is provided showing patient remains at or has returned to having a high risk for fracture

4. **Brynovin (sitagliptin) oral solution –** a dipeptidyl peptidase-4 (DPP-4) inhibitor indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. Limitations of Use: BRYNOVIN is not recommended in patients with type 1 diabetes. BRYNOVIN has not been studied in patients with a history of pancreatitis. **[Add as non-preferred to the PDL class: Oral Hypoglycemics – DPP-4 inhibitors] [PDL pg. 27]**

Current Criteria:

CLINICAL PA CRITERIA FOR PREFERRED AGENTS

- Discontinuation of GLP-1 agonists

NON-PREFERRED AGENT PA CRITERIA

- Discontinuation of GLP-1 agonists; **AND**
- Allergy to the preferred medications; **OR**
- Contraindication or drug to drug interaction with the preferred medications; **OR**
- History of unacceptable side effects; **OR**
- Therapeutic failure with a one-month trial with two preferred medications within the same class

See additional medication-specific criteria below:

- Patient has difficulty swallowing
- Quantity Limit: 4ml/day

5. **Ekterly (sebetralstat) tablet –** a plasma kallikrein inhibitor indicated for the treatment of acute attacks of hereditary angioedema (HAE) in adult and pediatric patients aged 12 years and older. **[Not a PDL class - Add to MPPL with PA] (NOTE: Falls in an existing MHP pharmacy carve-out drug class)**

Proposed criteria:

- Patient age ≥ 12 years; **AND**
- Diagnosis of Hereditary Angioedema (HAE) type I or type II; **AND**
- Prescribed by or in consultation with an allergist, hematologist, pulmonologist or immunologist; **AND**
- Quantity Limits: 8 tablets per 30 days
- Length of approval: 1 year

6. **ibuprofen 300 mg tablet –** Ibuprofen tablets are indicated for relief of the signs and symptoms of rheumatoid arthritis and osteoarthritis, for relief of mild to moderate pain, and for the treatment of primary dysmenorrhea. **[PDL class: Non-Steroidal Anti-Inflammatory Drugs (NSAIDs); non-preferred] [PDL pg. 2]**

Current Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications; **OR**
- Contraindication or drug to drug interaction with the preferred medications; **OR**
- History of unacceptable side effects; **OR**
- Therapeutic failure of one month each with two preferred medications

See additional medication-specific criteria below:

- Prescriber will need to justify medical necessity of unique strength
- Length of approval: For the duration of the prescription up to 1 year

7. **Imuldosa (ustekinumab-srlf) prefilled syringe and vial –** a human interleukin-12 and -23 antagonist indicated for the treatment of: Adult patients with: moderate to severe plaque psoriasis (PsO) who are candidates for phototherapy or systemic therapy, active psoriatic arthritis (PsA), moderately to severely active Crohn's disease (CD) and moderately to severely active ulcerative colitis. Pediatric patients 6 years and older with moderate to severe plaque psoriasis, who are candidates for phototherapy or systemic therapy and active psoriatic arthritis (PsA).
[Add as non-preferred to the PDL classes: Biologics: Agents to Treat Plaque Psoriasis; Agents to treat Psoriatic Arthritis; Agents to Treat Crohn's Disease; Agents to Treat Ulcerative Colitis] [PDL pgs. 35-39]

Current PDL Criteria:

- Allergy to the preferred medications; **OR**
- Contraindication or drug to drug interaction with the preferred medications; **OR**
- History of unacceptable side effects; **OR**
- The patient's condition is clinically stable at this time, so that switching medications would cause deterioration in their condition; **OR**
- Therapeutic failure with one preferred medication in the same subclass
- Bypass PDL criteria of a failure with a preferred agent when the non-preferred product has a unique FDA approved indication.

See additional biosimilar medication-specific criteria below:

- Diagnosis of plaque psoriasis or psoriatic arthritis; **AND**
  - Quantity limit:
    - 90 mg every 12 weeks with initial dose Week 0 and 4; **OR**
- Diagnosis of Crohn's disease or ulcerative colitis; **AND**
  - Quantity limit:
    - 520 mg for initial dose
    - 90 mg every 8 weeks
- Therapeutic failure with one preferred ustekinumab biosimilar to Stelara
- Length of approval: 1 year

8. **Leqselvi (deuruxolitinib) tablet –** a Janus kinase (JAK) inhibitor indicated for the treatment of adults with severe alopecia areata. Limitations of Use: LEQSELVI is not recommended for use in combination with other JAK inhibitors, biologic immunomodulators, cyclosporine or other potent immunosuppressants. **[Not a PDL class - Add to MPPL with PA]**

Proposed criteria:

- Patient is ≥ 18 years of age; **AND**
- Diagnosis of severe alopecia areata
- Quantity limits: 2 tablets per day
- Length of approval: 1 year

9. **Merilog (insulin aspart-szjj) vial and Merilog Solostar (insulin aspart-szjj) prefilled pen –** a rapid acting human insulin analog indicated to improve glycemic control in adults and pediatric patients with diabetes mellitus. A biosimilar to Novolog. **[PDL class: Insulins, Rapid Acting; non-preferred] [PDL pg. 25]**

Current Non-Preferred Agent PA Criteria:

- Allergy to the preferred medications; **OR**

- Contraindication or drug to drug interaction with the preferred medications; **OR**
- History of unacceptable side effects; **OR**
- Therapeutic failure with one preferred medication within same subgroup; **OR**
- Patient is clinically stable and switching would cause a deterioration in clinical condition
- Length of approval: 1 year
- Quantity Limits:
    - Injections: 90 mL per fill

10. **Tryptyr (acoltremon) vial for ophthalmic use –** a transient receptor potential melastatin 8 (TRPM8) thermoreceptor agonist indicated for the treatment of the signs and symptoms of dry eye disease. **[PDL class: Ophthalmic Anti-inflammatory/Immunomodulators; non-preferred] [PDL pg. 31]**

    Update PDL Drug Class Name to: Ophthalmic Anti-inflammatory/Immunomodulators/Dry Eye

    Current Non-Preferred Agent PA Criteria:
    - Allergy to the preferred medications; **OR**
    - Contraindication or drug to drug interaction with the preferred medications; **OR**
    - History of unacceptable side effects; **OR**
    - Therapeutic failure with a six-week trial with one preferred medication.

    See additional medication-specific criteria below:
    - Patient is ≥ 18 years of age
    - Quantity Limits: 60 single dose vials (one vial can be used to dose both eyes) per 30 days
    - Length of approval: 1 year

11. **Yutrepia (Treprostinil sodium) inhalation capsule –** a prostacyclin mimetic indicated for the treatment of: Pulmonary arterial hypertension (PAH; WHO Group 1) to improve exercise ability. Studies establishing effectiveness predominately included patients with NYHA Functional Class III symptoms and etiologies of idiopathic or heritable PAH (56%) or PAH associated with connective tissue diseases (33%) and Pulmonary hypertension associated with interstitial lung disease (PHILD; WHO Group 3) to improve exercise ability. The study establishing effectiveness predominately included patients with etiologies of idiopathic interstitial pneumonia (IIP) (45%) inclusive of idiopathic pulmonary fibrosis (IPF), combined pulmonary fibrosis and emphysema (CPFE) (25%), and WHO Group 3 connective tissue disease (22%). **[PDL class: Pulmonary Arterial Hypertension (PAH) Agents; non-preferred] [PDL pg. 15]**

    Current Class Criteria to Approve:
    - Diagnosis of pulmonary arterial hypertension; **OR**
    - Diagnosis of pulmonary hypertension associated with interstitial lung disease; **AND**
    - Must be prescribed by or in consultation with a cardiologist or pulmonologist; **AND**
    - Allergy to the preferred medications; **OR**
    - Contraindication or drug to drug interaction with the preferred medications; **OR**
    - History of unacceptable side effects; **OR**
    - Therapeutic failure with one-month trial of one preferred medication

    See additional medication-specific criteria below:
    - Patient is ≥ 18 years of age; **AND**
    - Therapeutic failure with one month trial of preferred trepostinil sodium (e.g., Tyvaso Solution)

12. **Zelsuvmi (berdazimer) topical gel –** a nitric oxide (NO) releasing agent indicated for the topical treatment of molluscum contagiosum (MC) in adults and pediatric patients 1 year of age and older. **[Not a PDL class - Add to MPPL with PA]**

    Proposed criteria:
    - Patient is ≥ 1 years of age.
    - Diagnosis of molluscum contagiosum confirmed.
    - Full skin exam performed; no ocular mucosa involvement.

- Prescribed by or in consultation with a dermatologist.
- For adults ≥ 18 years: must have failed topical podofilox and not a candidate for cryotherapy, curettage, or laser.
- **Exclusions:** periocular lesions, sexually transmitted MC
- Counseling provided on proper application and self-limiting nature of MC.
- Quantity limit: 1 kit per 30 days; approval limited to one 12-week course per year

13. **Biosimilars to denosumab (Prolia) –** a RANK ligand (RANKL) inhibitor indicated for treatment: of postmenopausal women with osteoporosis at high risk for fracture, to increase bone mass in men with osteoporosis at high risk for fracture, of glucocorticoid-induced osteoporosis in men and women at high risk for fracture, to increase bone mass in men at high risk for fracture receiving androgen deprivation therapy for nonmetastatic prostate cancer, and to increase bone mass in women at high risk for fracture receiving adjuvant aromatase inhibitor therapy for breast cancer. ***[Not a PDL class - Typically physician-administered therefore add to MPPL as a covered pharmacy benefit only when not administered in the physician office/clinic]***
    a. **Bildyos (denosumab-nxxp) prefilled syringe**
    b. **Conexxence (denosumab-bnht) prefilled syringe**
    c. **Jubbonti (denosumab-bbdz) prefilled syringe**
    d. **Stoboclo (denosumab-bmwo) prefilled syringe**

14. **Biosimilars to denosumab (Xgeva) –** a RANK ligand (RANKL) inhibitor indicated for: Prevention of skeletal-related events in patients with multiple myeloma and in patients with bone metastases from solid tumors, treatment of adults and skeletally mature adolescents with giant cell tumor of bone that is unresectable or where surgical resection is likely to result in severe morbidity, and treatment of hypercalcemia of malignancy refractory to bisphosphonate therapy. ***[Not a PDL class - Typically physician-administered therefore add to MPPL as a covered pharmacy benefit only when not administered in the physician office/clinic]***
    a. **Bilprevda (denosumab-nxxp) vial**
    b. **Bomyntra (denosumab-bnht) prefilled syringe and vial**
    c. **Osenvelt (denosumab-bmwo) vial**
    d. **Wyost (denosumab-bbdz) vial**

15. **Emblaveo (aztreonam/avibactam sodium) vial –** EMBLAVEO is a combination of aztreonam, a monobactam antibacterial, and avibactam, a beta-lactamase inhibitor, that when used in combination with metronidazole, is indicated in patients 18 years and older who have limited or no alternative options for the treatment of complicated intra-abdominal infections (cIAI) including those caused by the following susceptible gram-negative microorganisms: Escherichia coli, Klebsiella pneumoniae, Klebsiella oxytoca, Enterobacter cloacae complex, Citrobacter freundii complex, and Serratia marcescens. Approval of this indication is based on limited clinical safety and efficacy data for EMBLAVEO. It is also indicated to reduce the development of drug-resistant bacteria and maintain the effectiveness of EMBLAVEO and other antibacterial drugs, EMBLAVEO should be used only to treat infections that are proven or strongly suspected to be caused by susceptible bacteria. When culture and susceptibility information are available, they should be considered in selecting or modifying antibacterial therapy. In the absence of such data, local epidemiology and susceptibility patterns may contribute to the empiric selection of therapy. ***[Not a PDL class - Typically physician-administered therefore add to MPPL as a covered pharmacy benefit only when not administered in the physician office/clinic]***

16. **Imaavy (nipocalmab-aahu) vial –** a neonatal Fc receptor blocker indicated 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-musclespecific tyrosine kinase (MuSK) antibody positive. ***[Not a PDL class - Typically physician-administered therefore add to MPPL as a covered pharmacy benefit only when not administered in the physician office/clinic]***

17. **Ryzneuta (efbemalenograstim alfa-vuxw) prefilled syringe –** a leukocyte growth factor indicated 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. Limitations of Use RYZNEUTA is not indicated for the mobilization of peripheral blood progenitor cells for hematopoietic stem cell transplantation. ***[Not a PDL class - Typically physician-administered therefore add to MPPL as a covered pharmacy benefit only when not administered in the physician office/clinic]***

18. **Xifyrm (meloxicam) vial –** an NSAID indicated for use in adults for the management of moderate-to-severe pain, alone or in combination with non-NSAID analgesics. Limitation of Use: because of delayed onset of analgesia, XIFYRM alone is not recommended for use when rapid onset of analgesia is required. ***[Not a PDL class - Typically physician-administered therefore add to MPPL as a covered pharmacy benefit only when not administered in the physician office/clinic]***

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Tuesday, December 2, 2025
Minutes - Final

PDL Classes for Review

A. Analgesics: (Uren, Liroff, Railling)

1. **Opioids, Long acting [PDL pg 1]**
   a. No change to the current classification of drug products
2. **Opioids, Short and intermediate acting [PDL pg 1]**
   a. No change to the current classification of drug products
3. **Opioids, Transdermal [PDL pg 1]**
   a. No change to the current classification of drug products
4. **NSAIDs [PDL pg 2]**
   a. **Add ibuprofen 300mg tablet to non-preferred**
5. **NSAIDs: COX-II Inhibitors [PDL pg 2]**
   a. No change to the current classification of drug products
6. **Opioid Use Disorder Treatments [PDL pg 2]**
   a. No change to the current classification of drug products
7. **Opioid Withdrawal Symptom Management [PDL pg 2]**
   a. No change to the current classification of drug products
8. **Class Criteria Review**
   a. **Opioids – Transdermal:**
      1. **Butrans: Quantity Limit reduced to 4 per 28 days (FDA max dosing)**
   b. **NSAIDS:**
      1. **Add ibuprofen 300mg tablet medication specific criteria**

B. Central Nervous System Drugs: (Uren, Ehelou, Railling)

1. **Alzheimer's Agents [PDL pg 16]**
   a. No change to the current classification of drug products
2. **Anti-Anxiety Agents [PDL pg 16]**
   a. No change to the current classification of drug products
3. **Drugs for ADHD – Amphetamines [PDL pgs 16 - 17]**
   a. No change to the current classification of drug products
4. **Drugs for ADHD – Pseudoamphetamines [PDL pg 17]**
   a. No change to the current classification of drug products
5. **Drugs for ADHD - Non-stimulants [PDL pgs 17 - 18]**
   a. No change to the current classification of drug products
6. **Neuropathic Pain [PDL pg 18]**
   a. No change to the current classification of drug products
7. **Multiple Sclerosis Agents [PDL pg 19]**
   a. No change to the current classification of drug products
8. **Anti-Parkinson's Agents – Dopamine Agonists [PDL pg 19]**
   a. No change to the current classification of drug products
9. **Anti-Parkinson's Agents – Other [PDL pgs 19 - 20]**
   a. No change to the current classification of drug products
10. **Sedative Hypnotics - Non-barbiturates [PDL pg 20]**
    a. No change to the current classification of drug products
11. **Antimigraine Agents, Acute Treatment – Triptans [PDL pgs 20 - 21]**
    a. No change to the current classification of drug products
12. **Antimigraine Agents, Acute Treatment – Other [PDL pg 21]**
    a. **Move Ubrelvy (ubrogepant) tablets to preferred with existing Preferred agent clinical PA**
13. **Antimigraine Agents, Preventive Treatment [PDL pg 21]**
    a. **Move Qulipta (atogepant) tablets to preferred**
14. **Skeletal Muscle Relaxants [PDL pgs 21 - 22]**
    a. **Move methocarbamol 1,000mg tablet to non-preferred with new medication specific criteria:**
       1. **Bypass PDL criteria except require trial and failure of both PDL preferred methocarbamol 500mg and 750mg tablets**

b. **Keep methocarbamol 500mg tablet and 750mg tablet preferred**

15. **Class Criteria Review**
    a. **Antimigraine Agents, Acute Treament – Other:**
        1. **Elyxyb (celecoxib) – clarify quantity limit as 14 doses (67.2 ml) per 30 days**
    b. **Skeletal Muscle Relaxants:**
        1. **Add new medication specific PA criteria for methocarbamol 1,000mg tablet as proposed above**

C. **Dermatological Agents:** (Uren, Orow, Railling)
1. **Acne Agents - Combination Benzoyl Peroxide/Clindamycin [PDL pg 23]**
    a. No change to the current classification of drug products
2. **Topical Steroids - Low Potency [PDL pg 23]**
    a. No change to the current classification of drug products
3. **Topical Steroids - Medium Potency [PDL pg 23]**
    a. **Move fluocinolone acetonide solution (topical) to preferred**
4. **Topical Steroids - High Potency [PDL pgs 23 - 24]**
    a. No change to the current classification of drug products
5. **Topical Steroids - Very High Potency [PDL pg 24]**
    a. No change to the current classification of drug products
6. **Class criteria review**
    a. No changes recommended

Meeting Dates for 2026

- March 3, 2026
- June 2, 2026
- September 1, 2026
- December 1, 2026

Adjourn

Meeting adjourned at 7:57 PM