The following changes will be effective on August 1, 2025, unless otherwise specified and apply to the following plan:

Yamhill Community Care (Medicaid)

Formulary Changes

Drug Name	Formulary Status	Policy Name
Tretinoin Gel (Gram)	Add to Medicaid formulary, Prior Authorization for ages 21 years and above	Acne Medications – Medicaid
Fenofibric Acid (Fibricor) 35, and 105 mg tablet	Remove from Medicaid formulary Effective: 09/01/2025	N/A
Pirfenidone 267 mg Tablet	Add generic to Formulary: • Medicaid: Formulary, Prior Authorization, Quantity Limit (6 tablets per day)	Ofev, Pirfenidone
Lomitapide (Juxtapid) Capsule	Remove from Medicaid formulary	N/A
Ambrisentan (Letairis) Tablet	• Medicaid: Add Quantity Limit (1 tablet per day) Effective 09/01/2025	Pulmonary Hypertension

Becaplermin (Regranex) Gel (Gram)	Remove from Medicaid formulary	Regranex
Antiretroviral Drugs for HIV	Positive formulary changes: • Add to Medicaid formulary: Cimduo® (lamuvidine/TDF) and Isentress® (raltegravir) chewable tablets Negative Medicaid formulary changes - Effective 1/1/2026: • Quantity limit addition: maraviroc 150 mg tablet (2 tablets per day) • Remove from formulary: all zidovudine products	N/A

Medical Policy Changes

Coverage Criteria Changes

Drug/Policy Name(s)	Plans Affected	Summary of Change
Anti-Cancer Medications - Medical Benefit	☒ Medicaid	Clarified that utilization of preferred products/biosimilars are required for patients established on therapy as well as for new starts.
Camzyos	☒ Medicaid	Added reauthorization criteria that Left ventricular ejection fraction (LVEF) must be 50% or greater to align with package labeling.

Drug/Policy Name(s)	Plans Affected	Summary of Change
CFTR Modulators	☒ Medicaid	Clarified quantity limit for new drug Alyftrek.
Denavir, Xerese, Zovirax Cream	☒ Medicaid	Medicaid criteria updated to include coverage in immunocompromised patients and those taking immunosuppressants. Treatment of cold sore in immunocompetent patients is an unfunded diagnosis.
Geographic Atrophy Agents	☒ Medicaid	Reauthorization criteria added for Izervay (avacincaptad pegol intravitreal solution) as the package labeling has been updated to allow therapy beyond 12 months. Additionally, reauthorization criteria has been updated to align with clinical trials.
Homozygous Familial Hypercholesterolemia (HoFH) Agents	☒ Medicaid	Update criteria to align with 2023 European Atherosclerosis Society Consensus Statement on Homozygous Familial Hypercholesterolemia.
Hyperhidrosis Agents	☒ Medicaid	Added reauthorization criteria.
Immune Gamma Globulin (IGG)	☒ Medicaid	Indication for B-cell chronic lymphocytic leukemia has been expanded to secondary hypoimmunodeficiency in patients with hematologic malignancy or cancer patients receiving therapies that affect B-cell function. Consolidated criteria for immune thrombocytopenic purpura. Updated reauthorization criteria for pediatric autoimmune neuropsychiatric disorders (PANDAS).
Intranasal Allergy Medications – Medicaid	☒ Medicaid	Updated coverage duration for members aged under 21 years old, as coverage criteria is more restrictive for adults.
Lodoco	☒ Medicaid	Decreased coverage duration to one year, added quantity limit, updated criteria to clarify definition of clinical atherosclerotic cardiovascular disease, and allowed approval for patients with multiple risk factors for cardiovascular disease to align with FDA indication.
Ofev, Pirfenidone	☒ Medicaid	Due to changes in pricing, added pirfenidone 267 mg tablet to policy and increased quantity limit to align with pirfenidone 267 mg capsule.

Drug/Policy Name(s)	Plans Affected	Summary of Change
Ohtuvayre	☒ Medicaid	Removed language for quantity limit duration of approval as any approvals for a quantity limit exception will align with the duration of the approval for the drug.
Ophthalmic Prostaglandin Implants	☒ Medicaid	Clarified that iDose is excluded from coverage, as the administration procedure is not covered per the medical benefit policy.
Ophthalmic Vascular Endothelial Growth Factor (VEGF) Inhibitors	☒ Medicaid	Susvimo added to Diabetic Macular Edema policy criteria as Susvimo is now FDA approved for this indication.
Oxervate	☒ Medicaid	Removed trial and failure requirements for Medicaid to align with the Oregon Health Authority (OHA) and added optometrist as a prescriber option.
Pulmonary Hypertension	☒ Medicaid	Added a quantity limit for ambrisentan (Letairis)
Saphnelo	☒ Medicaid	Removed lab requirements for the diagnosis of SLE and updated first-line therapies to align with current standard of practice.
Therapies for Resistant Hypertension	☒ Medicaid	Added endocrinologist to prescriber restrictions.
Transthyretin (TTR) Stabilizing Agents	☒ Medicaid	Removed NYHA class IV exclusion since criteria already requires class I-III
Upneeq	☒ Medicaid	Coverage duration for reauthorization reduced to 12 months to assess continued benefit of therapy.

Retired Medical Policies

Policy Name	Summary of Change
• **Cibinqo** • **Dupixent** • **Dupixent – Medicaid**	Drugs moved to Therapeutic Immunomodulators (TIMS) Policy.

• **IL-5 Inhibitors** • **Interleukin (IL)-13 Inhibitors** • **Interleukin (IL)-31 Inhibitors** • **Tezspire** • **Xolair**	Dupixent criteria updated to add coverage for new indication (Chronic Spontaneous Urticaria) in parity with omalizumab (Xolair).
Palforzia	Due to low utilization.
Topical Agents for Epidermolysis Bullosa	Drugs moved to Medications for Rare Indications policy.
Zinplava	Product has been discontinued.

New Drugs:

Drug Name	Recommendations	Policy Name
Axatilimab-csfr (Niktimvo) Vial	• Medicaid: Medical Benefit, Prior Authorization	Anti-Cancer Medications – Medical Benefit
Fitusiran sodium (Qfitlia) Pen Injctr & Vial	• Medicaid: Medical Benefit, Prior Authorization	Hemophilia Prophylactic Agents
Mirdametinib (Gomekli) Capsule and Tab Susp	• Medicaid: Formulary, Prior Authorization, Quantity Limit (1 mg capsule, 1 mg tablet suspension: 8 per day; 2 mg capsule: 4 per day)	Added to Anti-Cancer Medications – Self- Administered Policy
Remestemcel-l-rknd (Ryoncil) Kit and Vial	• Medicaid: Medical Benefit, Prior Authorization	Anti-Cancer Medications – Medical Benefit

Vimseltinib (Romvimza) Capsule	• Medicaid: Formulary, Prior Authorization, Quantity Limit (8 capsules per 28 days)	Added to Anti-Cancer Medications – Self-Administered Policy