



The following changes will be effective on **January 1, 2026**, unless otherwise specified and apply to the following plan:

Yamhill Community Care (Medicaid)

Formulary Changes

Drug Name	Formulary Status	Policy Name
Actemra (tocilizumab)	Remove from Medicaid formulary. Tyenne (tocilizumab-aazg) is preferred biosimilar	Therapeutic Immunomodulators
<ul style="list-style-type: none">• Amjevita (adalimumab-atto)• Adalimumab-fkjp• Simlandi (adalimumab-ryvk)	Add to Medicaid formulary as preferred product in parity with Humira: Medicaid: Formulary, Prior Authorization, Quantity Limit (2 doses per 28 days)	Therapeutic Immunomodulators
Cosentyx (secukinumab) syringe and pen injector	Remove from Medicaid formulary (non-preferred on Preferred Drug List): Non-formulary, Prior Authorization, Quantity limit (2 doses per 28 days)	Therapeutic Immunomodulators
Fasenra (benralizumab) Pen	Remove from Medicaid formulary (non-preferred on Preferred Drug List)	Therapeutic Immunomodulators

	Non-formulary, Prior Authorization, Quantity limit (1 mL per 56 days)	
Hymrizo (adalimumab-adaz) syringe and pen injector	Remove from Medicaid formulary (non-preferred on Preferred Drug List) Non-formulary, Prior Authorization, Quantity limit (2 doses per 28 days)	Therapeutic Immunomodulators
Jornavx (suzetrigine)	Add to Medicaid formulary, with Quantity Limit (5 tablets per 30 days). Claims above the quantity limit will need to meet medical necessity criteria outlined in policy	Jornavx
Leucovorin calcium 5 mg Tablet	<ul style="list-style-type: none"> Medicaid: Formulary, Step Therapy, Quantity Limit (3 tablets per day) 	Leucovorin
Leucovorin calcium 25 mg Tablet	<ul style="list-style-type: none"> Medicaid: Non-Formulary, Step Therapy, Quantity Limit (2 tablets per day) 	Leucovorin
Leucovorin calcium Tablet (10mg; 15mg)	<ul style="list-style-type: none"> Medicaid: Non-Formulary, Step Therapy, Quantity Limit (3 tablets per day) 	Leucovorin
Liraglutide pen injector	Generic for Victoza. Add to formulary:	GIP and GLP-1 Receptor Agonists

	<ul style="list-style-type: none"> Medicaid: Formulary, Prior Authorization, Quantity Limit (9 mL per 30 days) 	
Metformin 500 mg extended-release tablet (Glumetza)	Add to Medicaid formulary <ul style="list-style-type: none"> Medicaid: Formulary 	N/A
Opsumit (macitentan) tablet	<ul style="list-style-type: none"> Medicaid: Add to Formulary 	Pulmonary Hypertension
Otezla (apremilast) tablet	Add to Medicaid formulary as preferred product: Medicaid: Formulary, Prior Authorization, Quantity Limit (2 tablets per day)	Therapeutic Immunomodulators
Ontruzant (trastuzumab-dttb)	Added as a preferred biosimilar product.	Anti-cancer agents – Medical Administration
Pirfenidone 267 mg Tablet	Add to formulary <ul style="list-style-type: none"> Medicaid: Formulary, Prior Authorization, Quantity Limit (three tablet per day) 	<ul style="list-style-type: none"> Medicaid: Ofev, Pirfenidone

Prolia/Xgeva (denosumab)	Add prior authorization for Medicaid. Preferred biosimilar products will be covered without prior authorization: <ul style="list-style-type: none"> • Stoboclo/Osenvelt (denosumab-bmwo) • Bldyos/Bilprevda (denosumab-nxxp) 	Denosumab
Ruxience (rituximab-pvvr)	Removed as a preferred biosimilar product. Riabni (rituximab-arrx) will be added as a preferred biosimilar option.	Rituximab
Taltz (ixekizumab) syringe and auto-injector	Add to Medicaid formulary as preferred product: Medicaid: Formulary, Prior Authorization, Quantity Limit (One injection per 28 days)	Therapeutic Immunomodulators
Tyvaso DPI	Remove from Medicaid formulary	Pulmonary Hypertension
Xeljanz (tofacitinib) tablet	Add to Medicaid formulary as preferred product: Formulary, Prior Authorization, Quantity Limit (tablet: 2 tablets per day; oral solution: 10 mL per day; ER tablets: one per day)	Therapeutic Immunomodulators
Xifaxan (rifaximin) tablet	Remove from Medicaid formulary.	Xifaxan
Xolair (benralizumab) syringe and auto-injector	Remove from Medicaid formulary (non-preferred on Preferred Drug List): Non-	Therapeutic Immunomodulators

	formulary, Prior Authorization, Quantity limit (one dose per 28 days)	
Ycanth (cantharidin) 0.7% solution	Add prior authorization. Medical benefit for all lines of business	Medications for Molluscum Contagiosum
Yutrepia (treprostinil) inhalation powder	<ul style="list-style-type: none"> Medicaid: Non-Formulary, Prior Authorization, Specialty 	Pulmonary Hypertension
Zepbound (tirzepatide)	Add to Medicaid formulary: Formulary, Prior Authorization, Quantity Limit (Four injections per 28 days)	Weight Management Medications

Medical Policy Changes

Coverage Criteria Changes

Drug/Policy Name(s)	Plans Affected	Summary of Change
Complement Inhibitors	<input checked="" type="checkbox"/> Medicaid	Added policy criteria for primary IgA nephropathy for Fabhalta®.
Continuous Glucose Monitors for Personal Use	<input checked="" type="checkbox"/> Medicaid	<ul style="list-style-type: none"> Added criteria to allow for individuals with type 1 diabetes regardless of insulin use. Updated quantity limits for the sensors to align with sensors duration. Updated replacement of reader/receiver criteria. Autopay already set up for patients with claims for insulin; however, added age edits so will only pay if they meet the FDA-approved minimum age.
FcRn Antagonists	<input checked="" type="checkbox"/> Medicaid	<ul style="list-style-type: none"> Changed trial and failure criteria for Myasthenia Gravis to one drug from two classes: AChE inhibitors, corticosteroids, non-steroidal immunosuppressive agents

		<ul style="list-style-type: none"> Added criterion for medically-administered products require medical rational why self-administered Vyvgart Hytrulo is not appropriate
GIP and GLP-1 Receptor Agonists	<input checked="" type="checkbox"/> Medicaid	Liraglutide (generic for Victoza®) added as co-preferred product.
Interleukin-1 Inhibitors	<input checked="" type="checkbox"/> Medicaid	Added criteria that dosing and frequency must be in accordance with FDA labeling.
Ketamine	<input checked="" type="checkbox"/> Medicaid	New policy created to clarify coverage of intravenous ketamine is limited to FDA-approved treatments related to anesthesia. The health plan does not cover IV ketamine for behavioral health disorders.
Lupkynis	<input checked="" type="checkbox"/> Medicaid	Added lab requirement (eGFR and urinary protein to creatine ratio) to the initial auth to allow assessment of treatment response at reauth. Clarified wording to the reauth criteria.
Medical Necessity – Medicaid	<input checked="" type="checkbox"/> Medicaid	Updated coverage duration to address quantity limit exception authorization duration.
Medical Drug Quantity Limit Exceptions	<input checked="" type="checkbox"/> Medicaid	New policy to outline criteria for coverage of medically administered medications above FDA or compendia-supported dosing regimens.
Medically Administered Multiple Sclerosis Agents	<input checked="" type="checkbox"/> Medicaid	Added step through Ocrevus IV for Ocrevus Zunovo.
Medications For Rare Indications	<input checked="" type="checkbox"/> Medicaid	Added Procsybi to policy, updated criteria to Aqneursa and Miplyffa, removed Niemann-Pick disease type C indication from Opfolda and added it to Zevaskyn.
New Medications and Formulations without Established Benefit	<input checked="" type="checkbox"/> Medicaid	Several agents were removed from this policy due to no longer being available on the market, or due to generic availability and costs more aligned with current formulary options.

Oral Rinses	<input checked="" type="checkbox"/> Medicaid	Gelx and Caphosol removed from policy as obsolete.
Rezurock (now Medications for Graft-versus-Host-Disease)	<input checked="" type="checkbox"/> Medicaid	<ul style="list-style-type: none"> • Changed name to Medications for Graft-versus-Host-Disease and added Niktimvo and Ryoncil (these medications were previously on the anti-cancer policy) • Added quantity limit exception criteria requiring medical rationale why patient cannot switch to Jakafi or Imbruvica instead of dose escalation on these medications
Saphnelo	<input checked="" type="checkbox"/> Medicaid	Prescriber restrictions updated to include providers with experience treating systemic lupus erythematosus (SLE)
Self-Administered Drugs (SAD)	<input checked="" type="checkbox"/> Medicaid	List of applicable medications was updated to clarify when transition period would be allowed vs requiring self-administration at initiation of therapy.
<ul style="list-style-type: none"> • Therapeutic Immunomodulators (TIMS) – Comm • Therapeutic Immunomodulators (TIMS) - Medicaid 	<input checked="" type="checkbox"/> Medicaid	Updated preferred agents, coverage durations, prescriber restrictions, defined response to therapy, changed reauthorization to established, updated criteria, added durations for trial and failure.
Tysabri	<input checked="" type="checkbox"/> Medicaid	Trail and failure of Entyvio added to Crohn's criteria to align with TIMs policy. Additionally, add in a one year timeframe for negative JCV antibody testing as patients on Tysabri should be getting JCV antibody testing at least every 6 months even if previous test was negative.
Weight Management Medications - Medicaid	<input checked="" type="checkbox"/> Medicaid	Added criteria for metabolic dysfunction-associated steatohepatitis and updated/clarified other criteria to align with Oregon Health Authority criteria

Xifaxan	<input checked="" type="checkbox"/> Medicaid	This medication is no longer covered by Oregon Medicaid. The health plan will maintain coverage for hepatic encephalopathy despite this state change.
Zeposia	<input checked="" type="checkbox"/> Medicaid	Preferred agents updated in the ulcerative colitis policy criteria to mirror preferred agents in the Therapeutic Immunomodulators policy.

Retired Medical Policies

- **Procysbi** - Medication added to Medications for Rare Indications Policy

New Drugs:

Drug Name	Recommendations	Policy Name
Acoltremon (Tryptyr) Droperette	<ul style="list-style-type: none"> • Medicaid: Non- Formulary, Quantity Limit (2 vials per day) 	N/A
Berdazimer sodium (Zelsuvmi) Gel (Gram)	<ul style="list-style-type: none"> • Medicaid: Non- Formulary, Prior Authorization 	Medications for Molluscum Contagiosum
Ceftobiprole medocartil (Zevtera) Vial	<ul style="list-style-type: none"> • Medicaid: Medical Benefit, Prior Authorization 	Zevtera
Garadacimab-gxii (Andembry Autoinjector) Auto Injct	<ul style="list-style-type: none"> • Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (1 mL per 28 days) 	Prophylactic Hereditary Angioedema Therapy Policy
Linvoseltamab-gcpt (Lynozytic) Vial	<ul style="list-style-type: none"> • Medicaid: Medical Benefit, Prior Authorization 	T-Cell Therapy Policy
Sebetralstat (Ekterly) Tablet	<ul style="list-style-type: none"> • Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (4 tablets per 30 days) 	Acute Hereditary Angioedema Therapy