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

**Yamhill Community Care (Medicaid)**

## Formulary Changes

| Drug Name | Formulary Status | Policy Name |
|---|---|---|
| **Amlodipine/valsartan/ HCTZ Tablet** | Remove from Medicaid formulary | N/A |
| **Doxepin HCl Tablet** | Medicaid: Remove Prior Authorization and Quantity Limit | N/A |
| **Emtricitabine/tenofov alafenam (Descovy) Tablet** | Add to formulary:<br>• Medicaid: Formulary<br>Effective 01/01/2025 | N/A |
| • **Guaifenesin Tablet**<br>• **Guaifenesin ER tablet** | Add to Medicaid formulary | N/A |
| • **Hydrocodone-acetaminophen 2.5/325 mg tablet**<br>• **Hydrocodone-acetaminophen 10-325 per 15 mL solution** | Add to Formulary<br>• Medicaid: Formulary | N/A |
| • **K-Phos Neutral (potassium and sodium phosphate)**<br>• **K-Phos Original (potassium phosphate, monobasic)** | Add to Formulary<br>• Medicaid: Formulary | N/A |

| Drug Name | Formulary Status | Policy Name |
|---|---|---|
| **Mesalamine 4 g/60 mL enema** | Add quantity limit to Medicaid of 60 mL per day | N/A |
| **Myrbetriq (mirabegron) tablet and suspension** | Retire step therapy and change formulary status as follows:<br>• Medicaid: Remove from formulary and add quantity limit (1 tablet per day or 10 mL per day) | N/A |
| **Naproxen DR 500 mg tablet** | Remove from Medicaid formulary | N/A |
| **Pentazocine/naloxone** | Remove from Medicaid formulary | N/A |
| **Sodium chloride 3% nebulizer vial** | Add to Medicaid formulary | N/A |
| **Yonsa (abiraterone submicronized)** | Remove from Medicaid formulary | Anti-Cancer Medications - Self-Administered |

# Medical Policy Changes

## Coverage Criteria Changes

| Drug/Policy Name(s) | Plans Affected | Summary of Change |
|---|---|---|
| **Anti-Cancer Medications - Medical Benefit** | ☒ Medicaid | Several therapies will be moved to the "T-Cell" policy (Columvi, Blincyto, Epkinly, Imdelltra, Kimmtrak, and Lunsumio). |

| Drug/Policy Name(s) | Plans Affected | Summary of Change |
|---|---|---|
| **Anti-Cancer Medications - Self-Administered** | ☒ Medicaid | Added new drug Danziten to policy and quantity limits added for the following medications: Afinitor, Akeega, Alecensa, Alunbrig, Ayvakit, Balversa, Besremi, Bosulif, Braftovi, Brukinsa, Calquence, Caprelsa, Cometriq, Copiktra, Daurismo, Erivedge, Erleada, Fotivda, Gavreto, Gilotrif, Inlyta, Inqovi, Inrebic, Iwilfin, Jaypirca, Koselugo, Krazati, Lenvima, Lonsurf, Lumakras, Lynparza, Mekinist, Nexavar, Ninlaro, Odomzo, Ogsiveo, Onureg, Orgovyx, Orserdu, Pemazyre, Piqray, Pomalyst, Qinlock, Rezlidhia, Rozlytrek, Rubraca, Rydapt, Sprycel, Stivarga, Tabrecta, Tafinlar, Talzenna, Tarceva, Targretin, Tasigna, Tazverik, Tepmetko, Tibsovo, Tukysa, Turalio, Tykerb, Vanflyta, Venclexta, Vitrakvi, Vizimpro, Votrient, Welireg, Xalkori, Xospata, Xpovio, Zolinza, Zykadia. |
| **Filspari** | ☒ Medicaid | Updated quantity limit to align with approved label dosing. Updated exclusion criteria to align with package insert list of contraindications. |
| **Gonadotropin Releasing Hormone Agonists** | ☒ Medicaid | Added criteria for premenstrual syndrome. Will allow several therapies to pay paired with diagnosis codes for prostate cancer. |
| **Hormone Replacement Therapy** | ☒ Medicaid | Policy was updated based on feedback from committee members to update policy name and language related to gender incongruence. Also billing information was updated to clarify coverage of drugs and administration codes. |
| **Hyperoxaluria Agents** | ☒ Medicaid | Update required medical criteria to remove fluid intake requirement. |
| **Medical Necessity - Medicaid** | ☒ Medicaid | Updated quantity exception criteria to require quantity to be both safe and ensure appropriate tablet is used instead of either or. Updated coverage duration to align duration with the drug prior authorization policy, if applicable. |

| Drug/Policy Name(s) | Plans Affected | Summary of Change |
|---|---|---|
| • **Medical Nutrition – Medicaid** | ☒ Medicaid | Policy coding material was updated to clarify that certain B-codes require prior authorization to limit fraud, waste, and abuse concerns. |
| **Provenge** | ☒ Medicaid | Clarified coverage duration language. |
| **Rituximab** | ☒ Medicaid | Added criteria for Thrombotic Thrombocytopenic Purpura (TTP) to policy; clarified severity criteria for vasculitis indication. |
| **T-Cell Therapy** | ☒ Medicaid | Added bi-specific T-Cell engager (BiTE) antibodies to the policy, which brings all BiTEs into one policy and allows restriction to appropriate authorization lengths. Clarified policy exclusions. |

## Retired Medical Policies

- **Descovy –** Effective 01/01/2025
- **Overactive Bladder Medications Step Therapy**

**New Drugs**:

| Drug Name | Recommendations | Policy Name |
|---|---|---|
| **Aflibercept-ayyh (Pavblu) Vial/Syringe** | • Medicaid: Medical Benefit | N/A |
| **Carbamazepine Tab Chew** | • Medicaid: Non-Formulary | N/A |
| **Foscarbidopa-foslevodopa (Vyalev) Vial** | • Medicaid: Non-Formulary | N/A |
| **Hydrocodone-acetaminophen Solution** | • Medicaid: Formulary | N/A |
| **Iloprost tromethamine (Aurlumyn) Vial** | • Medicaid: Medical Benefit | N/A |
| **Inavolisib (Itovebi) Tablet** | • Medicaid: Formulary, Prior Authorization, Quantity Limit (two 3 mg tablets per day; one 9 mg tablet per day) | Anti-Cancer Medications – Self-administered |
| **Levacetylleucine (Aqneursa) Gran Pack** | • Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (4 packets per day) | Medications for Rare Indications |
| **Marstacimab-hncq (Hympavzi) Pen Injctr** | • Medicaid: Medical Benefit, Prior Authorization | Hympavzi |
| **Nemolizumab-ilto (Nemluvio) Pen Injctr** | • Medicaid: Non-Formulary, Prior Authorization, Quantity Limit (1 mL per 56 days) | Interleukin (IL)-31 Inhibitors |
| **Nilotinib tartrate (Danziten) Tablet** | • Medicaid: Formulary, Prior Authorization, Specialty | Anti-Cancer Medications - Self-Administered |

| | | |
|---|---|---|
| **Revumenib citrate (Revuforj) Tablet** | • Medicaid: Formulary, Prior Authorization, Quantity Limit ( 2 tablets per day) | Anti-Cancer Medications – Self-administered |

| | | |
|---|---|---|
| **Sacubitril-valsartan Tablet** | • Medicaid: Formulary | N/A |
| **Testosterone cypionate (Azmiro) Syringe** | • Medicaid: Medical Benefit | N/A |
| **Zolbetuximab-clzb (Vyloy) Vial** | • Medicaid: Medical Benefit, Prior Authorization | Anti-Cancer Medications – Medical Benefit |