**DEPARTMENT OF WAR**
**PHARMACY AND THERAPEUTICS COMMITTEE**

**MINUTES AND RECOMMENDATIONS**

**February 2026**

## I. CONVENING

The Department of War (DoW) Pharmacy and Therapeutics (P&T) Committee convened at 0830 hours on February 4th and 5th, 2026.

## II. ATTENDANCE

The attendance roster is listed in Appendix A.

**A. Approval of February, May, August and November 2025 Meeting Minutes—** On March 10, 2025, the Secretary of Defense directed a pause of all DoD Advisory Committees, including the Uniform Formulary Beneficiary Advisory Panel meeting (UF BAP). As a result, the UF BAP meeting is delayed, and the signing of the February, May, August and November 2025 P&T Committee meeting minutes will also be delayed.

**B. Clarification of previous meeting minutes**

- **August 2025**
  - **Antihypertensive Agents: chlorthalidone 12.5 mg (Hemiclor) Medical Necessity (MN) Criteria** – The MN criteria were clarified for the reason that no alternative formulary agent applies. The provider must document why the patient requires the 12.5 mg chlorthalidone tablets and can't take the 25 mg or 50 mg tablets. Acceptable reasons include that the patient has tried and failed chlorthalidone 25 mg and 50 mg tablets or hydrochlorothiazide 25 mg tabs. See Appendix B**.**
  - **Hematological Agents: iptacopan (Fabhalta) MN Criteria** – The criteria "no formulary alternative for complement 3 glomerulopathy (C3G)" no longer applies since Empaveli received FDA approval for C3G, and the Empaveli PA was updated at the November 2025 meeting. See Appendix B.
  - **Benign Prostatic Hyperplasia Agents: terazosin 1 mg/mL solution (Tezruly)** – In February 2026 the Tezruly manufacturer removed Tezruly from the market. If Tezruly is returned to the market, the nonformulary status will apply, along with the medical necessity and PA criteria.
- **November 2025**
  - **Migraine Agents: dihydroergotamine injection (Brekiya)** – Will not add Brekiya to the Rapid Response program.
  - **DPP-4 Inhibitors: sitagliptin (Brynovin)** –The PA criteria will apply only to new users.
  - **Beta lactam Antibiotic for UTI: sulopenem etzadroxil /probenecid (Orlynvah)** –The manufacturer announced that Orlynvah was being

voluntarily discontinued from the market. If it returns it will have the same formulary and PA status as recommended at the November meeting.

- **PAs not subject to CFR 32** were implemented on January 2, 2026 for the following: clemastine 2.68 mg tabs (Clemsza) dicyclomine 40 mg tablet, flurbiprofen 100 mg tabs (Lurbiro), using the P&T Committee Administrative Authorities.

## III. REQUIREMENTS

All clinical and cost evaluations for new drugs, including newly approved drugs reviewed according to 32 Code of Federal Regulations (CFR) 199.21(g)(5), and full drug class reviews included, but were not limited to, the requirements stated in 32 CFR 199.21(e)(1) and (g)(5). All pharmaceutical agents selected for complete exclusion status were reviewed for clinical and cost-effectiveness in accordance with 32 CFR 199.21(e)(3). When applicable, patient-oriented outcomes are assessed. All pharmaceutical agents recommended for uniform formulary (UF), basic core formulary (BCF), nonformulary (NF), and complete exclusion status considered the conclusions from the relative clinical effectiveness and relative cost-effectiveness determinations, and other relevant factors including those outlined in Section 702 of the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2018, permanently codified at 10 USC 1074g (a)(10). Medical Necessity (MN) criteria were based on the clinical and cost evaluations and the conditions for establishing MN for a NF medication.

NF medications are generally restricted to the TRICARE Mail Order Pharmacy (TMOP) in accordance with 10 USC 1074g(a)(5) and 32 CFR 199.21(h)(3)(i) and (ii). Additionally, 10 USC 1074g(a)(9) requires beneficiaries to generally fill select non-generic prescription maintenance medications at MTFs or the TMOP. Medications subject to either the NF or select non-generic prescription maintenance requirements are added to the TRICARE Maintenance Drug List formerly known as the Select Maintenance Drug List.

## IV. UF DRUG CLASS REVIEWS

### A. Targeted Immunomodulatory Biologics (TIBs): Interleukin (IL-23) Inhibitors Subclass: ustekinumab agents

*Background*—The IL-23 inhibitor subclass review for formulary status was completed in November 2024. New ustekinumab biosimilar products were reviewed as innovator drugs in February, May, and August 2025, however implementation is delayed due to the UF BAP pause. Two products, ustekinumab-aauz (unbranded Otulfi) and ustekinumab-hmny (Starjemza) are reviewed here as part of this subclass review. Previous P&T Committee conclusions regarding biosimilars are found in the August 2024 and November 2022 P&T Committee meeting minutes. In summary:

- FDA approved biosimilar products, whether officially designated as interchangeable or not, are equally safe and efficacious when compared to the reference product.
- Similar to the U.S. FDA draft biosimilar interchangeability, European Medicines Agency, and the United Kingdom Medicines and Healthcare Regulatory Agency

guidance, the P&T Committee will consider all approved biosimilars as highly interchangeable to the reference product for both efficacy and safety.

- The IL-23 inhibitor subclass, which included the originator ustekinumab (Stelara), was reviewed at the November 2024 P&T Committee meeting. At the February, May and August 2025 P&T Committee meetings, newly approved ustekinumab biosimilars were reviewed for formulary placement and considered therapeutically equivalent to the reference product and each other. A trial of the step-preferred ustekinumab will be required before use of the other UF non-step-preferred and NF non-step-preferred products once selected.
- In joint federal collaboration with the VA, DoW elected to participate in a Joint National Contract (JNC) for ustekinumab. The JNC future ustekinumab biosimilar (pending selection) was recommended and approved as the Uniform Formulary (UF) step-preferred IL-23 agent during the November 2024 subclass review. The expected 2025 solicitation was postponed until 2026, with an expected award date in March 2026. A contingency vote was taken in a virtual meeting held on January 16, 2026, in the event the JNC is canceled or delayed, to optimize use of cost-effective ustekinumab products based on currently available pricing.
- At this meeting, formulary recommendations are made for the formulary status, step-therapy and Prior Authorization (PA) criteria, and implementation period for both a scenario if a JNC is awarded, and also if a JNC is not awarded ("contingent scenario").
- The ustekinumab products evaluated include ustekinumab (Stelara), ustekinumab (unbranded Stelara), ustekinumab-auub (Wezlana), ustekinumab-kfce (Yesintek), ustekinumab-ttwe (Pyzchiva), ustekinumab-stba (Steqeyma), ustekinumab-aekn (Selarsdi), ustekinumab-aauz (Otulfi), ustekinumab-aauz (unbranded Otulfi), ustekinumab-hmny (Starjemza), and ustekinumab-srlf (Imuldosa). These products are all equally safe and efficacious. Private label products that are not intended for TRICARE patients are excluded from the TRICARE pharmacy benefit, as outlined in the November 2025 P&T Committee meeting minutes.

*Relative Clinical Effectiveness Conclusion*—The clinical review focused on the similarity and interchangeability of the available ustekinumab products. Additional discussion occurred for the evidence supporting ustekinumab in the pediatric population.

The P&T Committee concluded (19 for, 0 opposed, 0 abstained, 0 absent) the following:

*Special Populations*

- The FDA is currently evaluating the literature for expanded ages and indications for pediatric patients. Supplemental Biologic License Applications have been submitted for the indications of ulcerative colitis and Crohn's disease in patients aged two and older.

- Ustekinumab is currently approved by the European Medicines Association for use in pediatric patients with plaque psoriasis and Crohn's disease with no age limitations.
- Use of ustekinumab in pediatric patients for psoriatic arthritis, plaque psoriasis, ulcerative colitis, and Crohn's disease is supported by clinical evidence.

*Other Factors*

- Trade Agreements Act (TAA) Compliance: Two agents, ustekinumab-hmny (Starjemza) and ustekinumab-kfce (Yesintek) are not TAA compliant and are therefore not available for purchase for the MTF or TMOP points of service. These products are available in the retail pharmacies.
- Latex Content: All products are latex-free, with the exception of ustekinumab (Stelara and unbranded Stelara) and ustekinumab-hmny (Starjemza).
- Formulations: All products are available in both 45 mg/0.5 mL and 90 mg/mL prefilled syringes or prefilled pens. A 45 mg/0.5 mL single dose vial is available for all the products except ustekinumab-stba (Steqeyma).
- FDA Interchangeability: Ustekinumab-srlf (Imuldosa) is the only ustekinumab biosimilar that does not have FDA-labeled interchangeable status. As per the previous conclusions regarding biosimilars summarized above, for purposes of the TRICARE Pharmacy benefit, all biosimilars are interchangeable to one another and the reference product.

*Overall Clinical Conclusion*

- In terms of relative clinical effectiveness and safety, all ustekinumab products are interchangeable with each other.
- Only one ustekinumab product is needed to meet the needs of MHS beneficiaries.
- A trial of the ustekinumab product that will be selected for UF and step-preferred status will be required in all new and current users of the non-step-preferred products (e.g., "no grandfathering").
- Due to clinical literature supporting use in children, ustekinumab may be used to treat pediatric patients with diseases including plaque psoriasis, psoriatic arthritis, ulcerative colitis, and Crohn's disease, regardless of FDA-labeling.

*Relative Cost Effectiveness Analysis and Conclusion*—The Committee reviewed the solicited bids from manufacturers and conducted a cost minimization analysis (CMA), budget impact analysis (BIA), and sensitivity analysis. The P&T Committee concluded (19 for, 0 opposed, 0 abstained, 0 absent):

*JNC-Awarded Scenario*

- CMA results showed that the formulary placement of a JNC-awarded ustekinumab product as the UF step-preferred agent would be cost effective.
- The BIA demonstrated that a JNC-awarded ustekinumab product will generate cost avoidance.

*JNC Not-Awarded "Contingent" Scenario*

- CMA results showed that the formulary placement of ustekinumab-aauz (Otulfi) as the UF step-preferred agent is cost effective.
- The BIA results found that designating ustekinumab-aauz (Otulfi) as UF step-preferred demonstrated significant cost avoidance.

## JNC AWARDED SCENARIO USTEKINUMAB RECOMMENDATIONS

1. ***COMMITTEE ACTION: UF RECOMMENDATION—***The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) the formulary recommendations as outlined below.

   Per the November 2024 IL-23 inhibitor subclass review recommendations:

   - The JNC-awarded ustekinumab product will move to the UF step-preferred position

   Per the virtual meeting held on January 16, 2026 recommendations:

   - Reaffirms the JNC-awarded ustekinumab product will move to the UF step-preferred position.
   - Reaffirms implementation of the step therapy requiring a trial of the JNC-awarded ustekinumab product for all non-step-preferred IL-23 agents.

   Per this meeting:

   - Reaffirms the JNC-awarded ustekinumab product will move to the UF step-preferred position as stated above.
   - Defines which products are designated as UF and non-step-preferred and which are designated as NF and non-step-preferred.

   Note that the previous formulary recommendations for the ustekinumab biosimilars when they were reviewed as newly approved drugs at the February, May, and August 2025 P&T Committee meetings were not implemented, due to the UF BAP Pause. Accordingly, the formulary recommendations below supersede any previous formulary recommendations.

   JNC Awarded Scenario:

   - UF and step-preferred

        - JNC-awarded ustekinumab product-moves to UF and step-preferred status
    - UF and non-step-preferred
        - ustekinumab-aauz (unbranded Otulfi)
        - ustekinumab-hmny (Starjemza)
        - ustekinumab-srlf (Imuldosa)
    - NF and non-step-preferred
        - ustekinumab-aauz (branded Otulfi) *Refer to the May 2026 for updated information*
        - ustekinumab-ttwe (Pyzchiva)
        - ustekinumab-aekn (Selarsdi)
        - ustekinumab (unbranded Stelara)
        - ustekinumab-stba (Steqeyma)
        - ustekinumab (Stelara)
        - ustekinumab-auub (Wezlana)
        - ustekinumab-kfce (Yesintek)
    - Complete Exclusion
        - None
    - Note as part of the step therapy recommendation, a trial of the JNC selected product is required first in all new and current users of another ustekinumab product.
    - As per the November 2025 P&T Committee meeting, any private label ustekinumab biosimilars are not part of the TRICARE Pharmacy benefit.

2. ***COMMITTEE ACTION: MANUAL PA CRITERIA***—At the November 2024 P&T Committee meeting, several updates were made to the PA criteria for the IL-23 inhibitors. Additional updates recommended in subsequent P&T Committee meetings are summarized below, although implementation for some of these changes is delayed, due to the UF BAP pause.
    - February 2025: Updated the requirement for previous use of Humira to allow previous use of Humira or infliximab; and removed the requirement for failure of non-biologic therapy for ulcerative colitis.
    - February, May, August 2025: Ustekinumab biosimilar products were reviewed as innovator drugs, with PAs added.

    The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) updates to the PA criteria as discussed below in new and current users. See Appendix C for the full criteria.

- For the UF step-preferred ustekinumab product, if the prescribing physician specialist is identified as a dermatologist or gastroenterologist during adjudication, no PA will be required ("automated specialist bypass.") An automated drug-lookback will apply for adalimumab (Humira) and ustekinumab (Stelara) to allow for PA approval if the patient has received either of these two drugs in the last 720 days. The current age restrictions will be removed, allowing utilization in patients of any age for the treatment of plaque psoriasis, psoriatic arthritis, ulcerative colitis, and Crohn's disease.
- For the UF non-step-preferred agents, a trial of the UF step-preferred agent will be required in all new and current users. No changes will be made to automation or age restrictions.
- For the NF non-step-preferred agents, a trial of all UF agents will be required in all new and current users. No change will be made to the automation or age restrictions.

3. ***COMMITTEE ACTION: MEDICAL NECESSITY (MN) CRITERIA***—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) maintaining the current MN criteria for Otulfi, Pyzchiva, Selarsdi, Stelara, ustekinumab (unbranded), Steqeyma, Wezlana, and Yesintek that was previously recommended when the products were reviewed as innovator drugs (does not apply to JNC selection). A trial of all the formulary alternatives is required, including the Tumor Necrosis Factor (TNF)-inhibitor Humira, the IL-23 inhibitor Taltz, the JNC-awarded product (when selected), unbranded Otulfi, Starjemza, and Imuldosa. See Appendix B for the full criteria.

4. ***COMMITTEE ACTION: QUANTITY LIMITS (QLs)***—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) maintaining the current QL of 1 syringe/vial at Retail pharmacies and 3 syringes/vials at MTFs and TMOP for all ustekinumab products. See Appendix D.

5. ***COMMITTEE ACTION: SPECIALTY AND TRICARE MAINTENANCE DRUG LIST***—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) that the ustekinumab products are subject to the TRICARE Maintenance Drug List requirements, with exception of ustekinumab-hmny (Starjemza) and ustekinumab-aauz (unbranded Otulfi). All. See Appendix F.

6. ***COMMITTEE ACTION: THERAPEUTIC SUBSTITUTION***—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) that ustekinumab products will be subject to therapeutic substitution to the JNC-awarded ustekinumab product. The pharmacist will convert utilizing the same (1:1) dose conversion and the same dosing frequency from a non-preferred ustekinumab to the step-preferred ustekinumab for all prescriptions written by an MTF provider for dispensing at an MTF

pharmacy. Pharmacists may convert between dosage forms (pen, vial, syringe). New ustekinumab products will be added to the non-preferred list. See Appendix I.

7. ***COMMITTEE ACTION: IMPLEMENTATION PERIOD—***The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) the following implementation plan. See Appendix G.

    - The JNC-awarded ustekinumab product will be designated UF and step-preferred no later than two weeks after the JNC award date, as recommended at the November 2024 P&T Committee meeting.
    - Step therapy will require trial of the JNC preferred product in all new users for all non-step-preferred IL-23 inhibitors (ustekinumab, risankizumab, guselkumab, tildrakizumab, mirikizumab), and the PAs will be updated to implement this step therapy requirement two weeks after the JNC award date, as voted on at the November 2024 P&T meeting.
    - The formulary status of the non-step-preferred agents will not change unless reviewed by the UF BAP and Director's signature.
    - The formulary status of the ustekinumab products not selected by the JNC will have their formulary status change the first Wednesday 30 days after the date the P&T Committee meeting minutes are signed.
    - For current users of a non-step-preferred ustekinumab product, the required trial of the JNC step-preferred agent will be implemented the first Wednesday 60 days after the JNC effective date.
        - There will be no grandfathering between ustekinumab products. New and current users of a non-step-preferred ustekinumab product will be subject to the step at this implementation.
        - This timeline allows time to update the PA forms and for DHA to mail letters to beneficiaries affected by the NF copay change and PA step therapy requirements.
    - For current users of a non-ustekinumab IL-23 inhibitor (Skyrizi, Tremfya, Ilumya, Omvoh), grandfathering will be allowed and only new patients will be affected
    - The MTFs will optimize utilization of the therapeutic substitution to the UF Step-Preferred ustekinumab product.

**JNC NOT AWARDED "CONTINGENT" SCENARIO USTEKINUMAB RECOMMENDATIONS**

1. ***COMMITTEE ACTION: UF RECOMMENDATION—***The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) the formulary recommendation as outlined below.

   Per the November 2024 IL-23 inhibitor subclass-review recommendations

   - The UF Step-preferred position is currently open

   Per the virtual P&T Committee meeting held on January 16, 2026 recommendations:

   - ustekinumab-aauz (Otulfi) will be the UF step-preferred position.

   Per this meeting:

   - Defines which products will be designated as UF and non-step-preferred status, and which are designated as NF and non-step-preferred.

   Note that the previous formulary recommendations for the ustekinumab biosimilars when they were reviewed as newly approved drugs at the February, May, and August 2025 P&T Committee meetings were not implemented, due to the UF BAP Pause. Accordingly, the formulary recommendations below supersede any previous formulary decisions.

   Joint National Contract not Awarded "Contingent" Scenario

   - UF and step-preferred
     - ustekinumab-aauz (Otulfi)
   - UF and non-step-preferred
     - ustekinumab-aauz (unbranded Otulfi)
     - ustekinumab-hmny (Starjemza)
     - ustekinumab-stba (Steqeyma)
     - ustekinumab-srlf (Imuldosa)
   - NF and non-step-preferred
     - ustekinumab-ttwe (Pyzchiva)
     - ustekinumab-aekn (Selarsdi)
     - ustekinumab (unbranded Stelara)
     - ustekinumab (Stelara)
     - ustekinumab-auub (Wezlana)
     - ustekinumab-kfce (Yesintek)
   - Complete Exclusion
     - None

- Note as part of the step therapy recommendation, a trial of ustekinumab-aauz (Otulfi) is required first in all new and current users of another ustekinumab product.
- As per November 2025 P&T Committee meeting, any private label ustekinumab biosimilars are not part of the TRICARE Pharmacy benefit.

3. ***COMMITTEE ACTION: MANUAL PA CRITERIA***—At the November 2024 P&T Committee meeting, several updates were made to the PA criteria for the IL-23 inhibitors. Additional updates recommended in subsequent P&T Committee meetings are summarized below, although implementation for some of these changes is delayed, due to the UF BAP pause.

   - February 2025: Updated the requirement for previous use of Humira to state previous use of Humira or infliximab; removed requirement for failure of non-biologic therapy for ulcerative colitis.
   - February, May, August 2025: Ustekinumab biosimilar products were reviewed as innovator drugs, with PAs added.

   The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) updates to the PA criteria as discussed below in new and current users. See Appendix C for the full criteria.

   - For the UF step-preferred ustekinumab product, if the prescribing physician specialist is identified as a rheumatologist, dermatologist or gastroenterologist during adjudication, no PA will be required ("automated specialist bypass.") An automated drug-lookback will apply for adalimumab and ustekinumab to allow for PA approval if the patient has received either of these two drugs in the last 720 days. The current age restrictions will be removed, allowing utilization in patients of any age for the treatment of plaque psoriasis, psoriatic arthritis, ulcerative colitis, and Crohn's disease.
   - For the UF non-step-preferred agents, a trial of the UF step-preferred agent will be required. No changes will be made to automation or age restrictions.
   - For the NF non-step-preferred agents, a trial of all UF agents will be required. No change will be made to the automation or age restrictions.

2. ***COMMITTEE ACTION: MEDICAL NECESSITY (MN) CRITERIA***— The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) maintaining the current MN criteria for Pyzchiva, Selarsdi, Stelara, ustekinumab (unbranded), Wezlana, and Yesintek that was previously recommended when the products were reviewed as innovator drugs. A trial of all the formulary alternatives is required, including the Tumor

Necrosis Factor (TNF)-inhibitor Humira, the IL-23 inhibitor Taltz, Otulfi, unbranded Otulfi, Starjemza, Steqeyma, and Imuldosa. See Appendix B for the full criteria.

3. ***COMMITTEE ACTION: QUANTITY LIMITS (QLs)***—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) maintaining the current QL of 1 syringe/vial at Retail pharmacies and 3 syringes/vials at MTFs and TMOP for all ustekinumab products. See Appendix D
4. ***COMMITTEE ACTION: SPECIALTY AND TRICARE MAINTENANCE DRUG LIST REQUIREMENTS***— The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) that the ustekinumab products are subject to the TRICARE Maintenance Drug List requirements, with the exception of ustekinumab-hmny (Starjemza) and ustekinumab-aauz (unbranded Otulfi). See Appendix F.
5. ***COMMITTEE ACTION: THERAPEUTIC SUBSTITUTION***—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) that ustekinumab products will be therapeutically substituted to ustekinumab-aauz (Otulfi). The pharmacist will convert utilizing the same (1:1) dose conversion and the same frequency from a non-preferred ustekinumab to the step-preferred ustekinumab-aauz for all prescriptions written by an MTF provider for dispensing at an MTF pharmacy. Pharmacists may convert between dosage forms (pen, vial, syringe). New ustekinumab products will be added to the non-preferred list. See Appendix I.
6. ***COMMITTEE ACTION: IMPLEMENTATION PERIOD—***The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) the following implementation plan. Timelines refer to the signing of these minutes unless noted. Note that as part of this recommendation the ustekinumab products are not included in the Rapid Response/Safety Net program managed by the TPharm5 contractor. See Appendix G.

    - Ustekinumab-aauz (Otulfi) will be designated UF and step-preferred agent no more than two weeks after the signing of the contingency minutes, as recommended at the January 2026 virtual meeting.
    - Step therapy will require trial of ustekinumab-aaus (Otulfi) in all new users for all non-step-preferred IL-23 inhibitors (ustekinumab, risankizumab, guselkumab, tildrakizumab, mirikizumab) and the PAs will be updated to implement this step therapy requirement two weeks after the signing of the virtual meeting minutes from January 16, 2026.
    - The formulary status of all non-step-preferred agents will change the first Wednesday, 60 days after the signing of the minutes.

- For current users of a non-step-preferred ustekinumab product, the required trial of the step-preferred agent ustekinumab-aazu (Otulfi) will be implemented the first Wednesday 60 days after the signing of the P&T Committee meeting minutes.
    - There will be no grandfathering between ustekinumab products. New and current users of a non-step-preferred ustekinumab product will be subject to the step at this implementation.
    - This timeline allows time to update PA forms and for DHA to mail letters to beneficiaries affected by the NF copay change and PA step-therapy requirements.
- For current users of a non-ustekinumab IL-23 (Skyrizi, Tremfya, Ilumya, Omvoh), grandfathering will be allowed, and only new patients will be affected.
- The MTFs will optimize utilization of the therapeutic substitution to the UF Step-Preferred ustekinumab-aauz (Otulfi).

**B. Oncological Agents: Myelofibrosis**

*Background*—The P&T Committee evaluated the relative clinical effectiveness of the janus kinase (JAK) inhibitors in the myelofibrosis subclass. Two drugs, ruxolitinib (Jakafi) and fedratinib (Inrebic) were part of the original drug class review at the February 2022 P&T Committee meeting. Since then, two additional agents, pacritinib (Vonjo) and momelotinib (Ojjaara), were reviewed during new drug presentations at the May 2022 and February 2024 meetings, respectively.

*Relative Clinical Effectiveness Conclusion*—The P&T Committee concluded (19 for, 0 opposed, 0 abstained, 0 absent) the following:

*Efficacy*

- All four agents are FDA-approved for the treatment of myelofibrosis.
- A 2024 network meta-analysis for the JAK inhibitors supported continued first-line use of Jakafi for efficacy in spleen reduction volume (SVR) and total symptoms score reduction (TSSR).
    - Ojjaara was identified as a significant alternative option for SVR and TSSR.
- There are no high-quality head-to-head trials available directly comparing one JAK inhibitor with another to demonstrate superiority of any agent.
- No benefits in overall survival have been seen with the newer agents (Inrebic, Vonjo and Ojjaara) when compared to Jakafi.

*Professional Treatment Guidelines*

- The National Comprehensive Cancer Network (NCCN) guidelines recommend all four agents, ruxolitinib (Jakafi), fedratinib (Inrebic), pacritinib (Vonjo), and momelotinib (Ojjaara), for treating myelofibrosis.
    - Jakafi and Inrebic have a Category 1 recommendation for higher risk patients in non-transplant candidates with platelets above 50 x $10^9$/L.
    - Vonjo has a Category 1 recommendation for higher-risk myelofibrosis in non-transplant candidates with low platelet counts (<50 x $10^9$/L).
    - Ojjaara has a Category 1 recommendation for patients with myelofibrosis-associated anemia with ongoing symptomatic splenomegaly and/or constitutional symptoms.

*Safety*

- The safety profiles of the agents overlap, with anemia and gastrointestinal (GI) toxicity the most commonly reported class-related adverse events.
- Inrebic carries a unique Black Box Warning for Wernicke's encephalopathy and has the highest rate of Grade 3-4 anemia (43%) based on the JAKARTA trials when indirectly compared to the individual clinical trial data with the other drugs.
- Vonjo showed a significantly higher rate of other serious adverse events (47%) in the PERSIST-2 clinical trial. It has a significantly decreased risk Grade 3-4 anemia when compared to ruxolitinib (Jakafi).
- Ojjaara demonstrated a decreased risk of Grade 3-4 anemia (5.6%) when compared to Jakafi (23.1%), in the SIMPLIFY-1 trial.
- When compared to Jakafi, Ojjaara and Vonjo did not show a reduced risk of thrombocytopenia.

*Individual Product Comparison*

- Jakafi remains the standard first-line JAK inhibitor for myelofibrosis due to its mature efficacy and safety data and its long-standing NCCN Category 1 recommendation. It has additional indications for treating polycythemia vera, essential thrombocytopenia and graft versus host disease. Dose titration guidelines and NCCN recommendations are available to manage patients with thrombocytopenia and anemia. Provider feedback also indicated that ruxolitinib (Jakafi) is an appropriate first-line treatment choice.
- Vonjo is an option for patients with low platelets.
- Ojjaara is preferred for patients with anemia and has been shown noninferior for efficacy when compared to Jakafi.

- Inrebic is a reasonable alternative for patients who have failed prior JAK inhibitor therapy (refractory disease) but has a black box warning for Wernicke's encephalopathy.

*Overall Clinical Conclusion*

- In terms of clinical effectiveness for myelofibrosis, all four products are highly therapeutically interchangeable.
- In terms of safety, there is a moderate degree of therapeutic interchangeability among the four products
- To meet the needs of the beneficiaries, all four products should remain on the formulary.

*Relative Cost Effectiveness Analysis and Conclusion*—CMA and BIA were performed. The P&T Committee concluded (19 for, 0 opposed, 0 abstained, 0 absent) the following:

- Jakafi was the most cost-effective JAK inhibitor, while Ojjaara was the least cost-effective agent.
- A BIA was performed to evaluate the potential impact of designating selected agents as formulary or non-formulary. BIA results showed that designating all agents as UF was the most cost-effective course of action for the Military Health System (MHS).

1. ***COMMITTEE ACTION: UF RECOMMENDATION—***The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) the following.
   - UF
     - fedratinib (Inrebic)
     - momelotinib (Ojjaara)
     - pacritinib (Vonjo)
     - ruxolitinib (Jakafi)
   - NF – None
   - Complete Exclusion – None

2. ***COMMITTEE ACTION: MANUAL PA CRITERIA***—PA criteria currently apply only to Inrebic and Ojjaara. The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) updates to the PA criteria for the myelofibrosis drugs as outlined below in new users. See Appendix C for the full criteria.

- PA is not required for Jakafi, due to its long marketing history for efficacy and safety, provider feedback and low risk of inappropriate use. A trial of Jakafi is now required first in all new users of Inrebic, Vonjo, and Ojjaara.
- The current Inrebic PA will now include the Jakafi step preference.
- For Ojjaara, a trial of Jakafi is not required for patients with anemia who have been considered for treatment with Jakafi and erythropoietin-stimulating agents (e.g., Epoetin).
- New PA criteria for Vonjo in new users includes the Jakafi step, however a trial of Jakafi is not required in patients with thrombocytopenia.

3. ***COMMITTEE ACTION: QLs***—QLs currently apply to the class. The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) updating the QLs to Inrebic and Vonjo to a 60-day supply at all three pointes of service, consistent with the current 60-day supply QL in place for Jakafi and Ojjaara. See Appendix D.
4. ***COMMITTEE ACTION: TRICARE MAINTENANCE DRUG LIST REQUIREMENTS***—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) maintaining Inrebic on the TRICARE Maintenance Drug List and maintaining Jakafi, Vonjo and Ojjaara on the contingent list. See Appendix F.
5. ***COMMITTEE ACTION: UF, PA, QLs, TRICARE MAINTENANCE DRUG LIST and IMPLEMENTATION PERIOD—***The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) an effective date of the first Wednesday 60 days after signing of the minutes in all points of service. See Appendix G.

## V. NEWLY APPROVED DRUGS PER 32 CFR 199.21(g)(5)

*Relative Clinical Effectiveness and Relative Cost-Effectiveness Conclusions*—The P&T Committee agreed (18 for, 0 opposed, 0 abstained, 1 absent) with the relative clinical and cost-effectiveness analyses presented for the newly approved drugs reviewed according to 32 CFR 199.21(g)(5). See Appendix E for the complete list of newly approved drugs reviewed at the February 2026 DoW P&T Committee meeting, a brief summary of their clinical attributes, and their formulary recommendations; see Appendix F for their restriction to or exemption from the TRICARE Drug Maintenance List.

1. ***COMMITTEE ACTION: UF RECOMMENDATION—***The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 1 absent) the following:
   - UF
     - elinzanetant (Lynkuet) – Miscellaneous Gynecological Agent for Menopause

        - mitapivat (Aqvesme) – Miscellaneous Metabolic Agent: Replacement Agent for Alpha or Beta Thalassemia
        - nerandomilast (Jascayd) – Pulmonary I Agent for Idiopathic Pulmonary Fibrosis (IPF)
        - plozasiran injection (Redemplo) – Antilipidemic-2 Agent for Familial Chylomicronemia Syndrome (FCS)
        - sevabertinib (Hyrnuo) –Lung Cancer: Human Epidermal Growth Factor Receptor 2 (HER2) Agents
        - ziftomenib (Komzifti) – Oncological Agent for Acute Myeloid Leukemia (AML)
    - NF
        - elamipretide injection (Forzinity) – Miscellaneous Metabolic Agent for Barth Syndrome
        - omidenepag isopropyl 0.002% ophthalmic solution (Omlonti) – Glaucoma Agent
        - paltusotine (Palsonify) – Miscellaneous Endocrine Agent for Acromegaly
        - remibrutinib (Rhapsido) – Atopy Agent for Chronic Spontaneous Urticaria
        - sibeprenlimab injection (Voyxact) – Immunoglobulin A (IgA) Nephropathy
    - Complete Exclusion: See Appendix H for additional detail regarding complete exclusion agents and formulary alternatives.
        - celecoxib 10 mg/mL oral suspension (Vyscoxa) – Pain Agents: Non-Steroidal Anti-Inflammatory Drugs (NSAIDs)
            - Vyscoxa oral suspension was recommended for complete exclusion status as it has little to no clinical benefit relative to the other NSAIDs, and the needs of TRICARE beneficiaries are met by alternative agents. Formulary alternatives include celecoxib capsules, naproxen oral suspension and meloxicam oral suspension.
        - clonidine hydrochloride (HCl) 0.02 mg/mL oral solution (Javadin) –Anti-hypertensive Agent
            - Javadin was recommended for complete exclusion status as it has little to no clinical benefit relative to other clonidine formulations, and the needs of TRICARE beneficiaries are met by alternative agents. Formulary alternatives include clonidine tablets and clonidine transdermal systems.

- cyclobenzaprine 2.8 mg sublingual (SL) tab (Tonmya) – Skeletal Muscle Relaxants and Combinations
  - Tonmya was recommended for complete exclusion status as it has little to no clinical benefit relative to other cyclobenzaprine formulations, and the needs of TRICARE beneficiaries are met by alternative agents. Formulary alternatives include cyclobenzaprine tablets, pregabalin caps, and duloxetine caps.
- furosemide 80 mg/mL subcutaneous (SC) injection (Lasix ONYU) – Diuretics
  - Lasix ONYU was recommended for complete exclusion status as it has little to no clinical benefit relative to the other loop diuretics, and the needs of TRICARE beneficiaries are met by alternative agents. Formulary alternatives include furosemide tablets, bumetanide tablets, and torsemide tablets.

2. ***COMMITTEE ACTION: MN CRITERIA***—The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 1 absent) MN criteria for Forzinity, Omlonti, Palsonify, Rhapsido, and Voyxact. See Appendix B for the full criteria.

3. ***COMMITTEE ACTION: PA CRITERIA—***The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 1 absent for all the drugs except Jascayd and for Jascayd (19 for, 0 opposed, 0 abstained, 0 absent) the following PA criteria. See Appendix C for the full criteria.
   - Applying manual PA criteria to new users of Redemplo. Note that updates were also made to the PA for olezarsen (Tryngolza), the other drug approved for FCS, to require a trial of Redemplo first. See the utilization management section on page 21.
   - Applying temporary PA criteria to new and current users of the Vyscoxa, Javadin, Lasix ONYU, and Tonmya, until implementation of the recommended Compete Exclusion status.
   - Applying manual PA criteria to new users of Lynkuet, requiring a trial of other non-hormonal drugs first.
   - Applying manual PA criteria to new users of Forzinity. FDA accelerated approval was based on an intermediate clinical endpoint and continued approval may be contingent on confirmatory trials. As a result, manual PA criteria will require specialist prescribing with required renewal criteria for clinical reassessment of ongoing treatment response.

- Applying manual criteria to new users of Rhapsido, requiring specialist prescribing, and a trial of second-generation antihistamines, Xolair and Dupixent first.
- Applying manual PA criteria to new users of the oncology drugs and specialty drugs Aqvesme, Jascayd, Palsonify, Hyrnuo, Voyxact, and Komzifti.
- Applying manual PA criteria to new users of Omlonti, requiring a trial of generic latanoprost first.

4. ***COMMITTEE ACTION: QLs***—The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 1 absent) QLs for Aqvesme, Forzinity, Hyrnuo Jascayd, Komzifti, Lynkuet, Omlonti, Palsonify, Redemplo, Rhapsido, Tonmya, and Voyxact. See Appendix D for the QLs.
5. ***COMMITTEE ACTION: SPECIALTY AND TRICARE MAINTENANCE DRUG LISTS*** —The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 1 absent) adding or exempting the drugs listed in Appendix F to/from the TRICARE Maintenance Drug List for the reasons outlined in the table. Note that the Add/Do Not Add recommendations listed in Appendix F pertain to the combined list of drugs under the TRICARE Maintenance Drug List which includes the NF medications subject to the TMOP requirement. Drugs recommended for addition to the Specialty Drug List are found in Appendix E.
6. ***COMMITTEE ACTION: UF, MN, PA, QL, SPECIALTY AND TRICARE MAINTENANCE DRUG LISTS, and IMPLEMENTATION PERIOD***— The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 1 absent) an effective date of the following:
    - **New Drugs Recommended for UF and NF Status:** An effective date of the first Wednesday two weeks after signing of the minutes in all points of service; see Appendix G.
    - **New Drugs Recommended for Complete Exclusion Status:** 1) An effective date of the first Wednesday 120 days after signing of the minutes in all points of service; and 2) DHA will send letters to beneficiaries who are affected by the complete exclusion status at 30 days and 60 days prior to implementation; see Appendix G.

## VI. UTILIZATION MANAGEMENT

### A. PA and MN Criteria

#### 1. New Manual PA Criteria

a) **Anticonvulsants-Antimania Agents—lamotrigine 10 mg/mL oral suspension (Subvenite)—**This suspension formulation of lamotrigine is less cost-effective than lamotrigine tablets. The addition of a PA, similar to the existing PA for topiramate oral solution (Eprontia), was recommended to encourage use of the lamotrigine tablet formulation. An automated age edit

will allow patients younger than 12 years of age to bypass the PA. Additionally, both Subvenite suspension and Eprontia oral solution will be added to the Rapid Response/Safety Net Program managed by the TPharm5 pharmacy contractor.

b) **Antipsychotic Agents: Atypical—cariprazine (Vraylar)—**Vraylar is currently designated as NF without a PA. Based upon a review of guidelines, provider feedback and cost, PA criteria were recommended for Vraylar. The PA criteria were modeled off existing PA criteria for other nonformulary psychiatric medications and include the FDA-approved indication, requiring prescribing by or in consultation with a specialist, and requiring a trial of other generic agents first. Vraylar will be also added to the Rapid Response/Safety Net Program managed by the TPharm5 pharmacy contractor.

***COMMITTEE ACTION: NEW PA CRITERIA, RAPID RESPONSE PROGRAM AND IMPLEMENTATION PERIOD***—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) manual PA criteria for cariprazine (Vraylar) and lamotrigine suspension (Subvenite) in new users, due to the significant cost differences compared with other available alternative agents. The above agents and topiramate oral solution (Eprontia) will be added to the Rapid Response/Safety Net program. The new PAs will become effective the first Wednesday 60 days after the signing of the minutes. See Appendix C for the full criteria.

**2. Updated PA Criteria for New FDA-Approved Indications**

The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) updates to the PA criteria for several drugs, due to new FDA-approved indications and expanded age ranges. The updated PA criteria outlined below will apply to new users. See Appendix C for full criteria.

a) **Antipsychotic Agents: Atypical—lumateperone (Caplyta)—**The manual PA criteria for Caplyta were updated to include its use as adjunctive therapy for major depressive disorder in adults. The PA criteria were modeled off existing PA criteria for other nonformulary psychiatric medications and include FDA-approved indication, requiring prescribing by or in consultation with a specialist, and requiring a trial of other generic agents first, similar to what was done with Vraylar above. Caplyta will be also added to the Rapid Response/Safety Net Program managed by the TPharm5 pharmacy contractor.

b) **Atopy—tezepelumab (Tezspire)—**Tezspire is now indicated for add-on maintenance therapy in patients 12 years of age and older for inadequately controlled chronic rhinosinusitis with nasal polyps. The PA was updated mirroring Dupixent's criteria for this indication.

c) **Corticosteroids-Immune Modulators: Hereditary Angioedema (HAE) Agents berotralstat (Orladeyo)—**The manual PA criteria were updated

to expand use in pediatric patients 2 to 11 years of age for HAE prophylaxis.

d) **Leukemia and Lymphoma Agents: Bruton Tyrosine Kinase Inhibitors (BTKIs)—pirtobrutinib (Jaypirca)—**The manual PA criteria for Jaypirca were updated to allow use for relapsed or refractory chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) in patients who have previously been treated with a covalent BTK inhibitor.

e) **Oncological Agents—revumenib (Revuforj)—**The manual PA criteria for Revuforj were updated to allow for the treatment of relapsed or refractory acute myeloid leukemia (AML) with a susceptible nucleophosmin 1 mutation.

f) **Psoriasis Agents—roflumilast 0.05% cream (Zoryve)—**The manual PA for Zoryve was updated to allow for the expanded age indication for atopic dermatitis to include pediatric patients 2 to 5 years of age.

g) **TIBs: Tumor Necrosis Factor Inhibitors (TNFs)—golimumab (Simponi)—** Simponi received an expanded indication to include pediatric patients weighing 15 kg or more with ulcerative colitis. The updated PA criteria for this pediatric indication mirror the existing requirements for adults with ulcerative colitis.

h) **TIBs: Interleukin 23 (IL-23) inhibitors—guselkumab (Tremfya)—**The PA criteria for Tremfya were updated to allow for use in pediatric patients 6 years of age and older weighing 40 kg or more with moderate-to-severe plaque psoriasis or active psoriatic arthritis. A trial of adalimumab and a non-biologic systemic therapy will be required for both indications.

i) **TIBs: Miscellaneous—tofacitinib (Xeljanz)—**Xeljanz is now indicated in psoriatic arthritis patients 2 years and older. The manual PA was updated to include this expanded age indication and also incorporate the TIBs PA standardization updates, which included removing the automated look back for Humira and removal of safety monitoring information.

***COMMITTEE ACTION: UPDATED MANUAL PA CRITERIA AND IMPLEMENTATION PERIOD—***The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) updates to the manual PA criteria for Caplyta, Tezspire, Orladeyo, Jaypirca, Revuforj, Zoryve, Simponi, Tremfya and Xeljanz in new users. Implementation of the PA criteria updates will be effective the first Wednesday 60 days after the signing of the minutes. See Appendices C for the full criteria.

**3. Updated PA Criteria for Reasons other than New Indications**

Updates to the PA criteria for several drugs were recommended, due to reasons other than new FDA-approved indications. The updated PA criteria outlined below will apply to new users.

a) **Antilipidemic 2 Agents: olezarsen (Tryngolza)—**The manual PA criteria for Tryngolza was updated to require a trial of Redemplo first, in

new users, due to cost effectiveness. Refer to the new drug section on page 17.

b) **Antipsychotic Agents: Atypical—brexpiprazole (Rexulti)—**The Rexulti PA was updated to require prescribing by or in consultation with a psychiatrist for the major depressive disorder and schizophrenia indications, plus require a trial of two generic antidepressants. Additionally, the Alzheimer's disease indication was updated to allow prescribing by or in consultation with a neurologist, psychiatrist, or specialist in geriatric medicine. Rexulti will be added to the Rapid Response/Safety Net program.

c) **Beta Blockers and Hydrochlorothiazide Combinations—bisoprolol 2.5 mg tablet—**At the August 2025 P&T meeting, the P&T Committee recommended PA criteria for bisoprolol 2.5 mg tablets. Other bisoprolol formulations, including generic bisoprolol 5 mg tablets (scored), are more cost-effective than the 2.5 mg strength. A provider requested access to this lower strength for patients who require very low dose titration for heart failure or post myocardial infarction. In these instances, splitting the 2.5 mg tablet to attain even smaller doses may be desirable. As a result, this rationale will be added to the acceptable write-in PA criteria for approval.

d) **Hematological Agents—avacopan (Tavneos)—**The Tavneos manual PA was updated to allow for nephrologist prescribing, based on MTF feedback.

e) **Nephrology Agents Miscellaneous—sparsentan (Filspari)—**The Filspari PA criteria were updated to lower the baseline qualifying urine-protein creatinine ratio from at least 1.5 g/grams to at least 1.0 g/grams, based on a recent update to the Kidney Disease: Improving Global Outcomes (KDIGO) guidelines.

f) **Oncological Agents—**Efforts to standardize and streamline the PAs for oncology drugs are ongoing. Edits were made to the PA criteria for nine oncology drugs. As part of this standardization effort, the following actions were taken: editing the NCCN guideline question to cite specific guideline version and page number to ease approvals for new indications, updating indications to more closely match FDA label language, and removing lengthy clinical monitoring and counseling questions based on provider feedback. Other required updates identified at this time are detailed below.

- **Leukemia and Lymphoma Agents: Acute Myeloid Leukemia (AML)—azacitidine (Onureg)—**The PA was updated to include t-cell lymphoma indications that are in the NCCN guidelines and in other commercial health plan PAs.

- **Multiple Myeloma—ixazomib (Ninlaro)—**The PA was updated for the indications and limitations of use language, to better align with FDA labeling for Ninlaro.
- **Oncological Agents—avapritinib (Ayvakit)—**The PA was updated to allow allergists to write for Ayvakit. This update was based on MTF oncologist feedback that stated that allergist prescribing for mastocytosis is appropriate.
- **Oncological Agents—tazemetostat (Tazverik)—**Two FDA-approved indications for follicular lymphoma subtypes were added, as they were not on the current PA.
- **Oncological Agents: Lung Cancer—pralsetinib (Gavreto)—**The PA was updated to include an FDA-approved thyroid cancer indication that was not on the current PA.
- **Oncological Agents: Lung Cancer—crizotinib (Xalkori)—**The PA was updated for oncology standardization only.
- **Oncological Agents: Melanoma—cobimetinib (Cotellic)—**The Cotellic PA did not have the NCCN question that is present in all other oncology PAs; therefore, this question was added.
- **Oncological Agents: Non-BTKIs—duvelisib (Copiktra)—**The marginal zone lymphoma indication was removed, and limitations of use language was added to the PA. This aligns the Copiktra PA with current FDA labeling.
- **Oncological Agents: Non-BTKIs—idelalisib (Zydelig)—**The indications for small lymphocytic lymphoma and follicular lymphoma were withdrawn by the manufacturer and were removed from the PA.

**g) TIBs: TNFs—adalimumab (Humira, biosimilars)—**An MTF provider requested that the adalimumab PA be updated to allow use for refractory sarcoidosis and to allow prescribing by pulmonologists. These updates were made along with TIBs standardization updates.

***COMMITTEE ACTION: UPDATED MANUAL PA CRITERIA, IMPLEMENTATION PERIOD AND RAPID RESPONSE/SAFETY NET—***The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) updates to the manual PA criteria for Tryngolza, Rexulti, bisoprolol 2.5 mg, Tavneos, Filspari, Onureg, Ninlaro, Ayvakit, Gavreto, Xalkori, Cotellic, Copiktra, Zydelig, and adalimumab in new users. Implementation will be effective the first Wednesday 60 days after the signing of the minutes. Additionally, Rexulti will be added to the Rapid Response/Safety Net program. See Appendix C for the full PA criteria.

**B. Line Extensions**

The P&T Committee clarified the formulary status for six product line extensions by the original manufacturer. Line extensions have the same FDA indication(s) as the "parent" drug and retain the same formulary and copayment status as the "parent" drug.

1. **TIBs: IL-23 Inhibitors—**designating **ustekinumab-aekn (Selardsi) single dose vial** with the same formulary status (NF non-step-preferred), PA, MN, QL, Specialty and TRICARE Maintenance Drug Lists status as the parent Selarsdi prefilled syringe.
2. **Parkinson's Agents**—designating the authorized generic formulation of **carbidopa-levodopa ER capsules** with the same formulary status (UF) and PA criteria as Rytary ER capsules.
3. **Oncological Agents**—designating **selumetinib (Koselugo) oral granule** with the same formulary status (UF), PA, QL, and Specialty Drug List status as Koselugo capsules.
4. **Corticosteroids-Immune Modulators: HAE Agents**—designating **berotralstat (Orladeyo) pellet** with the same formulary status (UF), PA, QL, and Specialty Drug List status as Orladeyo capsule. Note that the PA for Orladeyo was updated to allow the new pediatric age range on page 19. The same PA will apply for both the capsules and pellets.
5. **Neurological Agents Miscellaneous** — designating **trofinetide (Daybue Stix)** with the same formulary status (UF), PA, QL, and Specialty Drug List status as Daybue oral solution.
6. **Metabolic Dysfunction Agents: Weight Loss Agents**—designating **semaglutide tablets (Wegovy)** with the same formulary status (UF) and PA as the parent Wegovy pen. The QL for the tablets was slightly adjusted to prevent a quantity of greater than one tablet a day from being dispensed. Note that the drug class was reclassified into two subclasses, Weight Loss and Diabetic Agents, which is an update from the November 2025 P&T Committee meeting.

   ***COMMITTEE ACTION: LINE EXTENSION AND IMPLEMENTATION PERIOD—***The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) the formulary, QL, PA, MN, Specialty and TRICARE Maintenance Drug Lists status for the six products listed above. Implementation will occur the first Wednesday two weeks after signing of the minutes.

**D. TRICARE Maintenance Drug List Updates**

Octreotide (Bynfezia Pen) was previously discontinued by the manufacturer for business reasons but is expected to return to the market. It will return to its previous status, which is designated UF without a PA. Bynfezia was previously included on the TRICARE Maintenance Drug List. The pricing of Bynfezia Pen was evaluated at the MHS different points of service. It is now cost advantageous to remove Bynfezia Pen from the TRICARE Maintenance Drug List.

***COMMITTEE ACTION: TRICARE MAINTENANCE DRUG LIST AND IMPLEMENTATION PERIOD—***The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) removing Bynfezia Pen from the TRICARE Maintenance Drug List. Implementation will occur the first Wednesday two weeks after signing of the minutes. See Appendix F.

**E. Automated Specialist Bypass and Clinical PA Criteria from the February 2025 P&T Committee meeting**

**Wakefulness Promoting Agents: solriamfetol (Sunosi) and Dry Eye Disease Agents: cyclosporine ophthalmic (Restasis)—**At the February 2025 P&T Committee meeting, PA updates for Sunosi and Restasis recommended limiting prescribing to specialists only and the PA criteria were also streamlined to only include automated specialist bypass. After the meeting, it was determined that PA criteria that were solely comprised of an automated specialist bypass without clinical criteria cannot be operationalized, and a one-year expiration for PA renewals could not be implemented.

***COMMITTEE ACTION: SUNOSI AND RESTASIS PA CRITERIA AND AUTOMATED SPECIALIST BYPASS—***The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) adding the clinical PA criteria back to the Sunosi and Restasis PAs and also including the new automated specialist bypass. See Appendix C.

## VII. BRAND OVER GENERIC AUTHORIZATION AND TIER 1 COPAY

**A. Menopausal Hormone Therapy: Oral Single Agents—conjugated equine estrogens (Premarin) tablets—**Premarin tablets are designated as UF with a PA required for certain populations (e.g., males). A generic formulation is now marketed; however, this product is less cost-effective compared to the branded agent. Therefore, the branded Premarin tablets will continue to be dispensed at all three points of service, and the generic will only be available with prior authorization. Accordingly, the Tier 1 (generic) copay for brand Premarin tablets is recommended.

***COMMITTEE ACTION: BRAND OVER GENERIC REQUIREMENT AND PA CRITERIA IMPLEMENTATION PERIOD***—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) requiring brand Premarin tablets over the generic in new and current users at all points of service, based on cost effectiveness. The prescriber will provide patient specific justification as to why the brand cannot be used. Brand Premarin will be available at a Tier 1 copay. The effective date will be no later than the first Wednesday 60 days after signing of the minutes. The "brand over generic" requirement for Premarin tablets will be removed administratively when it is no longer cost-effective compared to the AB-rated generics.

## VIII. MISCELLANEOUS ITEMS FOR INFORMATION BRIEFED TO THE COMMITTEE

**A. DoW P&T Committee Charter—**The DoW P&T Committee Charter was signed. The document is updated every five years and is available online at https://www.health.mil/About-MHS/Federal-Advisory-Committees/DOD-PT-Committee. Revisions included updating the language for Complete Exclusion status. An additional section was added that criteria for use (CFU) can be recommended for medications that are ordered and dispensed from MTFs (i.e., both MTF employed healthcare providers and MTF pharmacy). CFU may include automatic therapeutic substitution protocols for all new patients or new and current patients.

**B. Discontinued drugs returning to market: Formulary Status and PA criteria for desloratadine oral solution and butalbital/acetaminophen/caffeine oral solution—**Two products previously discontinued by the manufacturer for business reasons have now returned to the market and will return to their previous status on the formulary with previous applicable PA criteria. Desloratadine oral solution is NF, and subject to the TRICRE Maintenance Drug List Requirements, while butalbital/acetaminophen/caffeine is UF with PA required, but not subject to the TRICARE Maintenance Drug List requirement (acute use exception).

**C. Pulmonary Arterial Hypertension PA updates—**The prostacyclin iloprost (Ventavis) was voluntarily withdrawn from the market in 2025. Ventavis and treprostinil (Tyvaso) previously shared the same manual PA form. Following the Ventavis market withdrawal, the Tyvaso manual PA form was updated on December 10, 2025, to remove mention of Ventavis.

**D. Continuous Glucose Monitoring Systems (CGMS)—FreeStyle Libre 2, FreeStyle Libre 3, Dexcom G6 and Dexcom G7—**The automated PA criteria were updated to clarify that the basal insulin/GLP-1RA fixed dose combinations of insulin degludec/liraglutide (Xultophy) or insulin glargine/lixisenatide (Soliqua) qualify as acceptable insulin products for the automatic look-back to allow approval of the CGM.

## IX. ADJOURNMENT

The meeting adjourned at 1600 hours on February 5th. The next meeting will be in May 2026.

**Appendix A—Attendance: February 2026 DoW P&T Committee Meeting**
**Appendix B—Table of Medical Necessity Criteria**
**Appendix C—Table of Prior Authorization Criteria**
**Appendix D—Table of Quantity Limits**
**Appendix E—Table of Formulary Recommendations for Newly Approved Drugs per 32 CFR 199.21(g)(5)**

**Appendix F—TRICARE Maintenance Drug List Status of Medications Designated Formulary or Nonformulary during the February 2026 DoW P&T Committee Meeting**
**Appendix G—Implementation Dates**
**Appendix H—Drugs with Complete Exclusion Status and Formulary Alternatives**
**Appendix I—Ustekinumab Therapeutic Substitution**

## DECISION ON RECOMMENDATIONS

**SUBMITTED BY**:

\Signed\Signature on file

John P. Kugler, M.D., MPH
DoW P&T Committee Chair

**The Director, DHA**:

☒ concurs with all recommendations.

☐ concurs with the recommendations, with the following modifications:

☐ concurs with the recommendations, except for the following:

Bill A. Soliz, BG \Signed\Signature on file
Acting Assistant Director
Health Care Administration and
Operations

Date *20 July 2026*

**Appendix A—Attendance**

| **Voting Members Present** | |
|---|---|
| John Kugler, MD, COL (Ret.), USA | DoW P&T Committee Chair |
| CAPT P. Thien Nguyen, USPHS | Chief, DHA Pharmacy Operations Division (POD); Beneficiary Advisory Panel DFO Alternate |
| Ed VonBerg, PharmD, CAPT (Ret.) MSC, USN | Chief, Formulary Management Branch (Recorder) |
| Ruben Salinas, MD, COL (Ret.), USA | DHA, Family Medicine Physician |
| LTC Megan Donahue, MC | Army, Physician at Large |
| LTC Ryan Burkhart, MC | Army, Internal Medicine Physician |
| COL James Masterson, MSC | Army, Pharmacy Consultant |
| CDR Derek Larson, MC | Navy, Internal Medicine Physician |
| CDR Danielle Barnes, MC | Navy, Pediatrics |
| MAJ Loraine Baraki, MC | Army, OBGYN |
| CAPT Peter Cole, MC | Navy, Physician at Large |
| CAPT Katie Jaudon, MSC | Navy, Pharmacy Consultant |
| Maj Callie Cheatham, MC | Air Force, Internal Medicine Physician |
| Col Soo Sohn, BSC | Air Force, Pharmacy Consultant |
| Walter Downs, MD, CAPT (Ret.), USN | DHA, Physician at Large |
| Maj Matt Rendo, MC | Army, Oncology Physician |
| David Nowinski, PharmD, BCOP | DHA, Oncology Pharmacist |
| CAPT Jackie Finocchio, USCG | Coast Guard, Pharmacy Consultant |
| Richard Ruck, MD, COL (Ret.), MC, USA | TRICARE Health Plan Chief Medical Officer |

**Appendix A—Attendance**

| **Nonvoting Members Present** | |
|---|---|
| Dennis Dyke, DHA | Attorney Advisor, Contract Law |
| Megan Gemunder, DHA | Attorney Advisor, Contract Law |
| Peter Glassman, MBBS | Department of Veteran's Affairs |
| Eric Dill, PharmD | Department of Veteran's Affairs |
| Marsha Peterson | DHA Contracting Officer |
| Eric Parsons, PharmD | TPharm5 Clinical COR, Pharmacy Benefit Integration Branch |
| Maj Daniel Corwin | Defense Logistics Agency, CPOC |
| **Guests** | |
| CDR Brett Whitehead | Indian Health Service |
| Hazel Richardson, PharmD | CDC World Trade Center Health Plan |
| **Others Present** | |
| CAPT Tiffany Cline, PharmD USN | Deputy Chief, DHA Pharmacy Operations Division (POD); Beneficiary Advisory Panel DFO |
| CAPT Scott Raisor, USPHS | Chief, P&T Section, DHA POD Formulary Manager Branch |
| Angela Allerman, PharmD, BCPS | DHA POD Formulary Management Branch |
| Shana Trice, PharmD | DHA POD Formulary Management Branch |
| CDR Elizabeth Hall, BCPS, USPHS | DHA POD Formulary Management Branch |
| Maj Angelina Escano, MC | DHA POD Formulary Management Branch |
| MAJ Kehinde Adesina | DHA POD Formulary Management Branch |
| Heather Johnson, PharmD, BCCP | DHA POD Formulary Management Branch |
| Darrilyn Bihm, PharmD | DHA POD Formulary Management Branch |
| Thinh Ha, PharmD | DHA POD Formulary Management Branch |
| CPT Ji Yoon Kim | DHA POD Formulary Management Branch |
| Dean Valibhai, PharmD | TPharm5 Clinical ACOR, Pharmacy Benefit Integration Branch |
| Mr. Mike Lee | DHA POD Formulary Management Branch |
| Mr. David Folmar | DHA POD Formulary Management Branch |

**Appendix A—Attendance**

| | |
|---|---|
| Dr. Mat Garber, PharmD | DHA POD Formulary Management Branch |
| Dr. Helen Feinstein, PharmD | DHA POD Formulary Management Branch |
| **DHA Contracting** | |
| Jules Canaley | DHA Contracting |
| Kirk Heyen | DHA Contracting |
| Keith Marasigan | DHA Contracting |
| Tracy Banks | DHA Contracting |
| Dwight Bonham | DHA Contracting |
| Julia Trang | DHA Contracting |
| Stephanie Erpelding | DHA Contracting |
| Patricia Legra | DHA Contracting |
| Viktoria Reed | DHA Contracting |
| Brooke Wolfe | DHA Contracting |

## Appendix B—Table of Medical Necessity Criteria

| Drug / Drug Class | Medical Necessity (MN) Criteria |
|---|---|
| **Drug Class Reviews MN Criteria** | |
| JNC Awarded scenario<br>• ustekinumab (Stelara)<br>• ustekinumab (unbranded Stelara)<br>• ustekinumab-ttwe (Pyzchiva)<br>• ustekinumab-auub (Wezlana)<br>• ustekinumab-aekn (Selardsi)<br>• ustekinumab-stba (Steqeyma)<br>• ustekinumab-kfce (Yesintek)<br>**TIBs: IL-23** | **Updates from the February 2026 meeting are in bold and strikethrough**<br>• Patient has experienced ~~or is likely to experience~~ significant adverse effects from formulary agents<br>~~• No alternative formulary agent: Patient has tried brand Stelara~~<br><br>**Formulary alternatives**: adalimumab (Humira), ixekizumab (Taltz), **ustekinumab-aauz (unbranded Otulfi), ustekinumab-hmny (Starjemza),** ~~ustekinumab-stba (Steqeyma),~~ **ustekinumab-srlf (Imuldosa)** ~~ustekinumab-auub (Wezlana), ustekinumab (Stelara)~~ |
| JNC Contingency scenario<br>• ustekinumab (Stelara)<br>• ustekinumab (unbranded Stelara)<br>• ustekinumab-ttwe (Pyzchiva)<br>• ustekinumab-auub (Wezlana)<br>• ustekinumab-aekn (Selardsi)<br>• ustekinumab-kfce (Yesintek)<br>**TIBs: IL-23** | **Updates from the February 2026 meeting are in bold and strikethrough**<br>• Patient has experienced ~~or is likely to experience~~ a significant adverse effects from formulary agents<br>~~• No alternative formulary agent: Patient has tried brand Stelara~~<br><br>**Formulary alternatives**: adalimumab (Humira), ixekizumab (Taltz), ustekinumab-aauz (Otulfi), **ustekinumab-aauz (unbranded Otulfi), ustekinumab-hmny (Starjemza),** ustekinumab-stba (Steqeyma), **ustekinumab-srlf (Imuldosa)** ~~ustekinumab-auub (Wezlana), ustekinumab (Stelara)~~ |
| **New Drugs MN Criteria** | |
| • elamipretide injection (Forzinity)<br><br>**Metabolic agents: Miscellaneous** | • No alternative formulary agent<br><br>**Formulary alternatives**: Patient has failed supportive therapy. |
| • Omidenepag isopropyl 0.002% ophthalmic solution (Omlonti)<br><br>**Glaucoma Agents** | • Use of formulary agent is contraindicated<br>• Patient has experienced significant adverse effects from at least two formulary agents<br><br>**Formulary alternatives**: latanoprost 0.005% drops, bimatoprost 0.03% |
| • paltusotine (Palsonify)<br><br>**Endocrine Agents: Miscellaneous** | • Use of formulary agents is contraindicated<br>• Patient has experienced significant adverse effects from formulary agents<br>• Formulary agents resulted in therapeutic failure<br><br>**Formulary alternatives**: octreotide, pasireotide |
| • remibrutinib (Rhapsido)<br><br>**Atopy Agents** | • Use of formulary agents is contraindicated<br>• Patient has experienced significant adverse effects from formulary agents<br>• Formulary agents resulted in therapeutic failure<br><br>**Formulary alternatives**: dupilumab (Dupixent), omalizumab (Xolair) |
| • sibeprenlimab injection (Voyxact)<br><br>**Nephrology Agents: Miscellaneous** | • Use of formulary agents is contraindicated<br>• Patient has experienced significant adverse effects from formulary agents<br>• Formulary agents resulted in therapeutic failure<br><br>**Formulary alternatives**: sparsentan (Filspari); atrasentan (Vanrafia), iptacopan (Fabhalta) |

## Appendix C—Table of Prior Authorization (PA) Criteria

| Drug / Drug Class | Prior Authorization Criteria |
|---|---|
| **Drug Class Review PAs** | |
| JNC Awarded scenario<br>• JNC selected ustekinumab product<br><br>**TIBs: IL-23 Inhibitors**<br><br>JNC Contingency scenario<br>• ustekinumab-aauz (Otulfi)<br><br>**TIBs: IL-23 Inhibitors** | **New PA reflecting UF Step-Preferred Status**<br><br>Automated PA Criteria: When prescribed by a dermatologist or gastroenterologist a prior authorization is not required. Once therapy is initiated by a dermatologist or gastroenterologist, an automated drug look back will apply, allowing continuation of coverage by any other prescriber if the patient has received the requested medication in the past 720 days.<br><br>Automated PA Criteria: The patient has filled a prescription for adalimumab (Humira) or another ustekinumab product at any MHS pharmacy point of service (MTFs, retail network pharmacies, or TRICARE mail order pharmacy) during the previous 180 days.<br><br>Manual PA criteria apply to all **new** users of **[JNC: ustekinumab JNC awarded product] or [Contingent: ustekinumab-aauz (Otulfi)]**<br><br>Manual PA Criteria: If automated PA criteria are not met, coverage is approved if all criteria are met:<br>• The patient had an inadequate response to Humira OR the patient experienced an adverse reaction to Humira that is not expected to occur with ustekinumab OR the patient has a contraindication to Humira<br>• Patients may have used infliximab in lieu of Humira for UC and CD<br>• Coverage is approved for patients with:<br>▪ Active psoriatic arthritis<br>▪ Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy<br>▪ Moderately to severely active Crohn's Disease (CD)<br>▪ Moderately to severely active ulcerative colitis (UC)<br>~~• Coverage is approved for patients ages 6 to 17 years of age with:~~<br>~~▪ Active psoriatic arthritis~~<br>~~▪ Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy~~<br>• The criteria below apply to all patients unless noted:<br>▪ Patient has had an inadequate response, intolerance, or contraindication to nonbiologic systemic therapy (for example – methotrexate, aminosalicylates (e.g. sulfasalazine, mesalamine) corticosteroids, or immunosuppressants (e.g. azathioprine). (Note: Does not apply to CD, UC)<br>▪ Coverage is NOT provided for concomitant use with other TIBs including, but not limited to, TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, S1p, JAK inhibitors<br><br>Non-FDA approved uses are not approved except as noted above for the pediatric indications<br><br>PA does not expire |
| JNC Awarded scenario<br>• ustekinumab-aauz (unbranded Otulfi)<br>• ustekinumab-hmny (Starjemza)<br>• ustekinumab-srlf (Imuldosa) | **Updates from the February 2026 meeting are in bold**<br><br>**UF Non-Step-Preferred ustekinumab PA**<br><br>Manual PA criteria apply to all new **and current** users of<br><br>**[JNC: ustekinumab-aauz (unbranded Otulfi), ustekinumab-hmny (Starjemza), ustekinumab-srlf (Imuldosa)] or**<br><br>**[Contingent: ustekinumab-aauz (unbranded Otulfi), ustekinumab-hmny (Starjemza), ustekinumab-stba (Steqeyma), ustekinumab-srlf (Imuldosa)]** |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| **TIBs: IL-23 Inhibitors**<br><br>JNC Contingency scenario<br>• ustekinumab-aauz (unbranded Otulfi)<br>• ustekinumab-hmny (Starjemza)<br>• ustekinumab-stba (Steqeyma)<br>• ustekinumab-srlf (Imuldosa)<br><br>**TIBs: IL-23 Inhibitors** | Manual PA Criteria: Coverage is approved if all criteria are met:<br>• **The provider acknowledges that the step-preferred product [JNC awardee or Otulfi] is TRICARE's preferred ustekinumab product**<br>• The patient had an inadequate response to Humira OR the patient experienced an adverse reaction to Humira that is not expected to occur with ustekinumab OR the patient has a contraindication to Humira AND<br>• **Please provide patient-specific justification as to why the step-preferred ustekinumab cannot be used in this patient.**<br>▪ **Acceptable reasons include: the patient has an allergy to an inactive ingredient found in the step-preferred product that is not in the non-step-preferred product**<br>• Patients may have used infliximab in lieu of Humira for UC and CD<br>• Coverage is approved for patients 18 years of age or older with:<br>▪ Active psoriatic arthritis<br>▪ Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy<br>▪ Moderately to severely active Crohn's Disease (CD)<br>▪ Moderately to severely active ulcerative colitis (UC)<br>• Coverage is approved for patients ages 6 to 17 years of age with:<br>▪ Active psoriatic arthritis<br>▪ Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy<br>• The criteria below apply to all patients unless noted:<br>▪ Patient has had an inadequate response, intolerance, or contraindication to nonbiologic systemic therapy (for example – methotrexate, aminosalicylates (e.g. sulfasalazine, mesalamine) corticosteroids, or immunosuppressants (e.g. azathioprine). (Note: Does not apply to CD, UC)<br>▪ Coverage is NOT provided for concomitant use with other TIBs including, but not limited to, TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, S1p, JAK inhibitors<br>Non-FDA approved uses are not approved<br>PA does not expire |
| JNC Awarded scenario<br>• ustekinumab-aauz (Otulfi)<br>• ustekinumab-ttwe (Pyzchiva)<br>• ustekinumab-aekn (Selarsdi)<br>• ustekinumab (Stelara)<br>• ustekinumab (unbranded Stelara)<br>• ustekinumab-stba (Steqeyma)<br>• ustekinumab-auub (Wezlana)<br>• ustekinumab-kfce (Yesintek)<br><br>**TIBs: IL-23 Inhibitors** | **Updates from the February 2026 meeting are in bold ~~and strikethrough~~**<br>**NF Non-Step-Preferred ustekinumab PA**<br>Manual PA criteria apply to all new **and current** users of<br>**[JNC: ustekinumab-aauz (Otulfi), ustekinumab-ttwe (Pyzchiva), ustekinumab-aekn (Selarsdi), ustekinumab (Stelara), ustekinumab (unbranded Stelara), ustekinumab-stba (Steqeyma), ustekinumab-auub (Wezlana), ustekinumab-kfce (Yesintek)] or**<br>**[Contingency: ustekinumab-ttwe (Pyzchiva), ustekinumab-aekn (Selardsi), ustekinumab (Stelara), ustekinumab (unbranded Stelara), ustekinumab-auub (Wezlana), ustekinumab-kfce (Yesintek)]**<br>Manual PA Criteria: Coverage is approved if all criteria are met:<br>• ~~Provider acknowledges that Taltz is available for treatment of plaque psoriasis without the requirement to try Humira~~<br>• The patient had an inadequate response to Humira OR the patient experienced an adverse reaction to Humira that is not expected to occur with ustekinumab OR the patient has a contraindication to Humira |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| JNC Contingency scenario<br>• ustekinumab-ttwe (Pyzchiva)<br>• ustekinumab-aekn (Selarsdi)<br>• ustekinumab (Stelara)<br>• ustekinumab (unbranded Stelara)<br>• ustekinumab-auub (Wezlana)<br>• ustekinumab-kfce (Yesintek)<br><br>**TIBs: IL-23 Inhibitors** | • **Please provide patient-specific justification as to why the step-preferred ustekinumab [JNC: upon selection or Contingency: Otulfi] and the UF non-step-preferred products [(JNC: unbranded Otulfi, Starjemza, Imuldosa) or (Contingency: unbranded Otulfi, Starjemza, Steqeyma, Imuldosa)] cannot be used in this patient.**<br>▪ **Acceptable reasons include: the patient has an allergy to an inactive ingredient found in the UF products that is not in the NF non-step-preferred product**<br>• Patients may have used infliximab in lieu of Humira for UC and CD<br>• Coverage is approved for patients 18 years of age or older with:<br>▪ Active psoriatic arthritis<br>▪ Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy<br>▪ Moderately to severely active Crohn's Disease (CD)<br>▪ Moderately to severely active ulcerative colitis (UC)<br>• Coverage is approved for patients ages 6 to 17 years of age with:<br>▪ Active psoriatic arthritis<br>▪ Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy<br>• The criteria below apply to all patients unless noted:<br>▪ Patient has had an inadequate response, intolerance, or contraindication to nonbiologic systemic therapy (for example – methotrexate, aminosalicylates (e.g. sulfasalazine, mesalamine) corticosteroids, or immunosuppressants (e.g. azathioprine). (Note: Does not apply to CD, UC)<br>▪ Coverage is NOT provided for concomitant use with other TIBs including, but not limited to, TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, S1p, JAK inhibitors<br>Non-FDA approved uses are not approved<br>PA does not expire |
| • fedratinib (Inrebic)<br><br>**Oncological Agents: Myelofibrosis** | **Updates from the Feb 2026 meeting are in bold and strikethrough**<br>Manual PA criteria apply to all new users of fedratinib (Inrebic)<br>Manual PA Criteria: Coverage is approved if all criteria are met:<br>• Patient is 18 years of age or older<br>• The drug is prescribed by or in consultation with a hematologist/oncologist<br>• **Provider is aware that ruxolitinib (Jakafi) is the preferred agent for myelofibrosis and that it is available without a PA**<br>• **Patient has tried and progressed on ruxolitinib (Jakafi) or had an inadequate response to, experienced an adverse reaction to, or has a contraindication to ruxolitinib (Jakafi) that is not expected to occur with fedratinib**<br>• Fedratinib will be used for intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis<br>• The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. **Note that the presence of the NCCN recommendation does not allow a trial of fedratinib without first trying ruxolitinib if ruxolitinib is also recommended.** To facilitate approval, please list the diagnosis, guideline version, and page number: _____.<br>Non-FDA-approved uses are not approved, except as noted above<br>PA does not expire |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| • momelotinib (Ojjaara)<br><br>**Oncological Agents: Myelofibrosis** | **Updates from the Feb 2026 meeting are in bold and strikethrough**<br>Manual PA Criteria: apply to all new users of momelotinib (Ojjaara)<br>Manual PA Criteria: Coverage is approved if all criteria are met:<br>• The patient is 18 years of age or older<br>• The drug is prescribed by or in consultation with a hematologist/oncologist<br>• **Provider is aware that ruxolitinib (Jakafi) is the preferred agent for myelofibrosis and that it is available without a PA**<br>• **Patient has tried and progressed on ruxolitinib (Jakafi) or had an inadequate response to, experienced an adverse reaction to, or has a contraindication to ruxolitinib (Jakafi) that is not expected to occur with momelotinib**<br>• Patient has diagnosis of intermediate or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis<br>• ~~Provider is aware of the warnings, screenings, and monitoring precautions of Ojjaara~~<br>• ~~If female of reproductive potential patient is not pregnant and not planning to become pregnant~~<br>• ~~If female of reproductive potential patient will avoid breast feeding for at least 1 week after discontinuation~~<br>• **A trial of Jakafi is not required if the patient has anemia with a Hg<8 g/dL and has been considered for Jakafi and erythropoiesis stimulating agents (e.g., Procrit, Epogen, Aranesp)**<br>• The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation**. Note that the presence of the NCCN recommendation does not allow a trial of momelotinib without first trying ruxolitinib if ruxolitinib is also recommended**. To facilitate approval, please list the diagnosis, guideline version, and page number: _____.<br><br>Non-FDA approved uses are not approved, except as noted above<br>PA does not expire. |
| • pacritinib (Vonjo)<br><br>**Oncological Agents: Myelofibrosis** | **New PA criteria from the Feb 2026 meeting**<br>Manual PA criteria apply to all new users of pacritinib (Vonjo)<br>Manual PA Criteria: Coverage is approved if all criteria are met:<br>• Patient is 18 years of age or older<br>• The drug is prescribed by or in consultation with a hematologist/oncologist<br>• Provider is aware that ruxolitinib (Jakafi) is the preferred agent for myelofibrosis and that it is available without a PA<br>• Patient has tried and progressed on Jakafi or had an inadequate response to, experienced an adverse reaction to, or has a contraindication to Jakafi that is not expected to occur with Vonjo OR<br>• A trial of Jakafi is not required if Vonjo will be used for intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis with a platelet count below 50 x $10^9$ /L.<br>• The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation**.** Note that the presence of the NCCN recommendation does not allow a trial of pacritinib without first trying ruxolitinib if ruxolitinib is also recommended. To facilitate approval, |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| | please list the diagnosis, guideline version, and page number: _____.<br>Non-FDA-approved uses are not approved, except as noted above<br>PA does not expire |
| **Newly Approved Drug PAs** | |
| • celecoxib 10 mg/mL oral suspension (Vyscoxa)<br><br>**NSAIDs** | **Updates from the February 2026 meeting are in bold**<br>Manual PA criteria apply to all new and current users of celecoxib oral suspension (Vyscoxa))<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• **Provider acknowledges that Vyscoxa will be completely excluded from the TRICARE pharmacy benefit 120 days after the signing of the P&T meeting minutes by the Director, DHA**<br>• **Provider acknowledges that other celecoxib formulations are available to TRICARE beneficiaries, including celecoxib capsules and do not require prior authorization**<br>• Provider must document why the patient cannot take celecoxib capsules<br>▪ Acceptable responses include: the patient has experienced a serious allergic reaction (i.e., hives/anaphylaxis) to an excipient in celecoxib capsules.<br>Non-FDA approved uses are not approved<br>PA does not expire **until after implementation of complete exclusion status** |
| • clonidine HCl 0.02 mg/ml oral solution (Javadin)<br><br>**Anti-Hypertensive Agents** | **Updates from the February 2026 meeting are in bold**<br>Manual PA criteria apply to all new and current users of clonidine oral solution (Javadin)<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• **Provider acknowledges that Javadin will be completely excluded from the TRICARE pharmacy benefit 120 days after the signing of the P&T meeting minutes by the Director, DHA**<br>• **Provider acknowledges that other clonidine formulations are available to TRICARE beneficiaries, including clonidine tablets and clonidine transdermal system and do not require prior authorization**<br>• Patient is 18 years of age or older<br>• Patient has hypertension<br>• Provider must document why the patient cannot take clonidine tablets and transdermal system.<br>▪ Acceptable responses include the patient cannot swallow tablets due to documented medical condition (e.g., dysphagia, oral candidiasis, systemic sclerosis), and not due to convenience, and has had significant skin irritation with clonidine transdermal system<br>Non-FDA approved uses are not approved<br>PA does not expire **until after implementation of complete exclusion status** |
| • cyclobenzaprine 2.8 mg SL tab (Tonmya)<br><br>**Skeletal Muscle Relaxants** | **Updates from the February 2026 meeting are in bold**<br>Manual PA criteria apply to all new and current users of cyclobenzaprine 2.8 mg sublingual tabs (Tonmya)<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• **Provider acknowledges that Tonmya will be completely excluded from the TRICARE pharmacy benefit 120 days after the signing of the P&T meeting minutes by the Director, DHA** |

| | |
|---|---|
| | • **Provider acknowledges that other cyclobenzaprine formulations are available to TRICARE beneficiaries, including generic cyclobenzaprine tablets and do not require prior authorization**<br>• Patient is 18 years of age or older<br>• Patient has a diagnosis of fibromyalgia based on American College of Rheumatology (ACR) diagnostic criteria<br>• Patient has had a trial and failed or had intolerance to one or more generic medications used to treat fibromyalgia, such as cyclobenzaprine, pregabalin, and duloxetine<br>• Provider must document the clinical reason as to why the patient is unable to use cyclobenzaprine tablets<br>▪ Acceptable responses include the patient cannot swallow tablets due a documented medical condition (e.g., dysphagia, oral candidiasis, systemic sclerosis) and not due to convenience, or allergy to excipient<br>Non-FDA approved uses are not approved<br>~~PA does not expire~~ **PA expires in 6 months. A new PA must be submitted until implementation of complete exclusion status** |
| • elamipretide injection (Forzinity)<br><br>**Metabolic Agents Miscellaneous** | **Updates from the February 2026 meeting are in bold**<br>Manual PA criteria apply to all new users of elamipretide (Forzinity)<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Patient is 12 years of age or older<br>• Patient weighs at least 30 kg<br>• Medication is prescribed by a physician with expertise in mitochondrial medicine or genetic disorders<br>• Patient has genetically confirmed Barth syndrome (BTHS)<br>• Patient is ambulatory, yet impaired as assessed by the 6-minute walk test<br>• **Patient must not have any of the following: undergoing a pubertal growth spurt, uncontrolled hypertension, history of heart transplant, implantation of cardiac defibrillator, receiving chemotherapeutic or immunosuppressant agents, or prior radiation therapy to the chest**<br>• **Provider acknowledges FDA-accelerated approval is based on improvement in knee extensor muscle strength and continued FDA approval may be contingent upon verification of clinical benefit in confirmatory trials**<br>Non-FDA approved uses are not approved<br>PA ~~does not expire~~ **expires in 6 months. Provider must fill out a new PA form.** |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| • elinzanetant (Lynkuet)<br><br>**Gynecological Agents Miscellaneous** | Manual PA criteria apply to all new users of elinzanetant (Lynkuet)<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Patient has moderate to severe vasomotor symptoms due to menopause<br>• Patient has a contraindication to menopausal hormone therapy (estrogens with or without progestins) OR<br>• Patient has an intolerance to menopausal hormone therapy OR<br>• Based on individual patient characteristics and risk factors, the provider has determined that the patient is not a candidate for menopausal hormone therapy<br>• Patient has tried and failed or had an adverse reaction to at least one of the following non-hormonal treatments for vasomotor symptoms: an SSRI (for example, paroxetine, escitalopram, or citalopram), an SNRI (for example, venlafaxine, desvenlafaxine, or duloxetine), OR gabapentin<br>Non-FDA approved uses are not approved<br>PA expires in 6 months<br>Renewal criteria: Note initial TRICARE PA approval required for renewal. Coverage will be approved indefinitely if the following applies:<br>• Patient had a positive response to therapy as noted by a decrease in the number of moderate to severe hot flashes |
| • furosemide 80 mg/mL SC injection (Lasix ONYU)<br><br>**Diuretics** | **Updates from the February 2026 meeting are in bold**<br>Manual PA criteria apply to all new and current users of furosemide SC injection (Lasic ONYU)<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• **Provider acknowledges that Lasic ONYU will be completed excluded from the TRICARE pharmacy benefit 120 days after signing of the P&T Committee meeting minutes by the Director, DHA**<br>• **Provider acknowledges that other loop diuretics are available to TRICARE beneficiaries and do not require prior authorization, including bumetanide tablets, furosemide tablets and torsemide tablets**<br>• Patient is 18 years of age or older<br>• Patient has edema associated with congestive heart failure<br>• Patient is experiencing an increase in signs and symptoms of fluid overload<br>• Patient has failed a trial of two oral loop diuretics including<br>▪ furosemide<br>▪ bumetanide<br>▪ torsemide<br>▪ ethacrynic acid<br>• Patient is stable and does not require emergency care or hospitalization for heart failure, acute pulmonary edema or other condition that could result in hospitalization<br>Non-FDA approved uses are not approved<br>PA does not expire **until after implementation of complete exclusion status** |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| • mitapivat (Aqvesme)<br><br>**Metabolic Agents: Miscellaneous** | Manual PA criteria apply to all new users of mitapivat (Aqvesme)<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Patient is 18 years of age or older<br>• Medication is prescribed by or in consultation with a hematologist or oncologist<br>• Patient has a diagnosis of anemia associated with transfusion dependent or non-transfusion dependent alpha-thalassemia or beta-thalassemia<br>Off-label uses are not approved unless supporting documentation is provided<br>PA expires in 6 months<br>Renewal criteria: Note initial TRICARE PA approval required for renewal. Coverage will be approved indefinitely if the following applies:<br>• Patient had a positive response to therapy as noted by a decrease in the number of RBC units transfused or an increase in hemoglobin |
| • nerandomilast (Jascayd)<br><br>**Pulmonary-1 Agents: Idiopathic Pulmonary Fibrosis** | Manual PA criteria apply to all new and current users of nerandomilast (Jascayd)<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>Idiopathic Pulmonary Fibrosis (IPF)<br>• Provider acknowledges pirfenidone (Esbriet generic) is the Department of Defense's preferred drug for Idiopathic Pulmonary Fibrosis (IPF)<br>• Patient is 18 years of age or older<br>• Prescribed by a pulmonologist<br>• Patient is non-smoking<br>• Patient has documented diagnosis of idiopathic pulmonary fibrosis (IPF) AND<br>▪ Patient requires add-on therapy with nerandomilast (Jascayd) and:<br>– Patient tried and failed pirfenidone (Esbriet generic) due to progression of disease as defined as greater than 10% decline of forced vital capacity (FVC) OR<br>– Patient tried and failed nintedanib (Ofev) due to progression of disease as defined as greater than 10% decline of forced vital capacity (FVC)<br>OR<br>▪ Patient requires monotherapy with nerandomilast (Jascayd) and:<br>– Patient tried and failed pirfenidone (Esbriet generic) due to experiencing intolerable adverse effects (e.g., rash, photosensitivity; GI adverse events) or is taking a drug that will interact with pirfenidone (Esbriet generic) OR<br>– Patient tried and failed nintedanib (Ofev) due to experiencing intolerable adverse effects (e.g., rash, photosensitivity; GI adverse events) or is taking a drug that will interact with nintedanib (Ofev)<br>• Patient is not receiving triple therapy with nerandomilast (Jascayd), pirfenidone (Esbriet, generics), and nintedanib (Ofev)<br>Non-FDA approved uses are not approved; usage for progressive pulmonary fibrosis is not approved at this time<br>PA expires in 12 months<br>Renewal criteria: Note that initial TRICARE PA approval required for renewal. Coverage will be approved indefinitely if all criteria are met:<br>• Prescribed by a pulmonologist<br>• Patient has shown clinical benefit with therapy |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| | • ~~Patient has experienced a significant reduction in the annual rate of decline of forced vital capacity (FVC)~~ |
| • omidenepag isopropyl 0.002% ophthalmic solution (Omlonti)<br><br>**Glaucoma Agents** | Manual PA criteria apply to all new users of omidenepag isopropyl (Omlonti)<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Patient is 18 years of age or older<br>• Patient has elevated intraocular pressure (IOP) due to open-angle glaucoma or ocular hypertension<br>• Patient has tried and failed or had an adverse reaction or contraindication to generic latanoprost 0.005%<br>Non-FDA approved uses are not approved<br>PA does not expire |
| • paltusotine (Palsonify)<br><br>**Endocrine Agents Miscellaneous** | **Updates from the February 2026 meeting are in bold**<br>Manual PA criteria apply to all new users of paltusotine (Palsonify)<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Patient is 18 years of age or older<br>• Prescribed by or in consultation with an endocrinologist<br>• Patient has a diagnosis of acromegaly<br>• The patient has had inadequate response to surgery or is not a candidate for surgery<br>• The patient has had an inadequate response to, intolerability to, or has a contraindication to ~~an~~ **one** injectable somatostatin analog (for example, octreotide, lanreotide, pasireotide)<br>Non-FDA approved uses are not approved<br>PA does not expire |
| • plozasiran (Redemplo)<br><br>**Antilipidemics-2 Agents** | **Updates from the February 2026 meeting are in bold**<br>Manual PA criteria apply to all new users of plozasiran<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Patient is 18 years of age or older<br>• Prescribed by cardiologist, an endocrinologist, or an internal medicine physician experienced in disorders related to severe hypertriglyceridemia<br>• Patient has undergone genetic testing to confirm the diagnosis of familial chylomicronemia syndrome OR<br>• **Patient has evidence of symptomatic persistent chylomicronemia with recurrent pancreatitis**<br>• Patient has a fasting triglyceride level of **880** ~~1,000~~ mg/dL or greater<br>• Patient will adhere to a low fat-diet (less than or equal to 20 g fat per day) while receiving Redemplo<br>Non-FDA approved uses are not approved<br>PA does treating not expire |
| • remibrutinib (Rhapsido)<br><br>**Atopy Agents** | **Updates from the February 2026 meeting are in bold**<br>Manual PA criteria apply to all new users of remibrutinib (Rhapsido)<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Patient is 18 years of age or older<br>• Prescribed by an allergist, immunologist or dermatologist |

| | |
|---|---|
| | • Patient has chronic spontaneous urticaria with symptoms lasting greater than 6 weeks<br>• The patient remains symptomatic despite trial of at least 4 weeks with recommended second generation H1 antihistamine (e.g., cetirizine, levocetirizine, loratadine, desloratadine, fexofenadine)<br>• **The patient has had an inadequate response to, intolerability to, or has a contraindication to both Xolair and Dupixent**<br>Non-FDA approved uses are not approved<br>PA expires in 12 months<br>Renewal criteria: Note that initial TRICARE PA approval is required for renewal. Coverage will be approved indefinitely if the following applies:<br>• The patient's disease severity has improved and stabilized to warrant continued therapy |
| • sevabertinib (Hyrnuo)<br><br>**Lung Cancer: Human Epidermal Growth Factor Receptor 2 (HER2) Agents** | Manual PA criteria apply to all new users of sevabertinib (Hyrnuo)<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Patient is 18 years of age or older<br>• Prescribed by or in consultation with a hematologist or oncologist<br>• Patient has locally advanced or metastatic non-squamous non-small cell lung cancer (NSCLC)<br>• Patient's tumor has human epidermal growth factor receptor 2 (HER2) (ERBB2) tyrosine kinase domain activating mutations<br>• Patient has received prior systemic therapy<br>• The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation: to facilitate approval, please list the diagnosis, guideline version, and page number:<br>Other non-FDA approved uses are not approved except as noted above<br>PA does not expire |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| • sibeprenlimab injection (Voyxact)<br><br>**Nephrology Agents: Miscellaneous** | Manual PA criteria apply to all new users of sibeprenlimab-szsi (Voyxact)<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Patient is 18 years of age or older<br>• Prescribed by a nephrologist<br>• Patient has biopsy verified primary immunoglobulin A nephropathy (IgAN) without cellular crescents in more than 25% of sampled glomeruli<br>• Patient have an estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min/1.73m2<br>• Patient has urinary protein excretion greater than or equal to 1.0 g/day or urine protein-to-creatinine ratio (UPCR) greater than or equal to 0.75<br>• Patient continues to have proteinuria despite maximal Angiotensin-Converting Enzyme (ACE) inhibitor or Angiotensin II receptor blockers (ARB) therapy and an SGLT-2 inhibitor (for example, empagliflozin, dapagliflozin) and is at high risk for disease progression<br>• Patient will not use Voyxact concomitantly with Filspari or Vanrafia or Fabhalta<br>Non-FDA approved uses are not approved<br>PA expires in 9 months<br>Renewal criteria: Note initial TRICARE PA approval required for renewal. Coverage will be approved indefinitely if the following applies:<br>• The patient experienced a reduction in urine protein-to-creatinine ratio (UPCR) from baseline or reduction in proteinuria from baseline |
| • ziftomenib (Komzifti)<br><br>**Oncological Agents: Acute Myeloid Leukemia (AML)** | Manual PA criteria apply to all new users of Komzifti<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Patient is 18 years of age or older<br>• Prescribed by or in consultation with an oncologist<br>• Patient has relapsed or refractory acute myeloid leukemia<br>• Patient has a susceptible NPM1-mutation with no satisfactory alternative treatment options<br>• Patient does not have concomitant KMT2A gene translocation<br>• The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. To facilitate approval please list the diagnosis, guidelines version and page number. ._____<br>Other non-FDA approved uses are not approved, except as noted above<br>PA does not expire |

| | |
|---|---|
| • semaglutide **tablets** (Wegovy)<br><br>**Metabolic Dysfunction Agents: Weight Loss Agents** | **Updates from February 2026 are in bold and ~~strikethrough~~**<br>Manual PA criteria apply to all new **users of Wegovy tablets,** Wegovy injection ~~and Zepbound~~<br><br>Manual PA Criteria: Coverage for Wegovy or Zepbound is approved if:<br>• The provider will acknowledge that "Under penalties for false claims against the United States government, I declare that I have examined the patient, and the statements made are true, correct, and complete to the best of my professional knowledge"<br>• Is the prescriber an MTF or TRICARE Network provider who has billed TRICARE for the professional services provided to assess the patient and develop a treatment plan?<br>▪ If yes subject to verification, proceed to the next question<br>▪ If no, coverage is not approved<br>• What Tricare Plan is the patient enrolled in?<br>▪ TRICARE Select – proceed to the next question<br>▪ TRICARE Prime – proceed to the next questions<br>▪ TRICARE For Life – Coverage not approved; if patient is diabetic and meets the prior authorization criteria for Trulicity, Victoza, Ozempic, or Mounjaro, please consider these alternatives.<br>• **If the diagnosis is Diabetes Mellitus and meets the prior authorization criteria for Trulicity, Victoza, Ozempic, or Mounjaro, please consider these alternatives**. *(November 2025 meeting update)*<br>• The provider has verified and documented in the medical record that the patient engaged in a comprehensive lifestyle intervention that includes diet, exercise, and behavioral health modification for at least 6 months, has failed to achieve the desired weight loss and will remain engaged throughout course of therapy. Medical record documentation will be made available to TRICARE for audit, if requested.<br>• The provider will document the major condition and comorbidities treated selecting all that apply:<br>▪ Obesity<br>▪ Diabetes or impaired glucose tolerance<br>▪ Obstructive sleep apnea<br>▪ Osteoarthritis<br>▪ Metabolic syndrome<br>▪ Dyslipidemia<br>▪ Hypertension<br>▪ Metabolic dysfunction-associated steatohepatitis (MASH)<br>▪ Established cardiovascular disease with a history of stroke<br>▪ Established cardiovascular disease with a history of myocardial infarction<br>▪ Established cardiovascular disease with a history of peripheral artery disease<br>For Wegovy **injection and tablets** and Zepbound for adults for obesity<br>• Patient is 18 years of age or older<br>• Patient has a BMI greater than or equal to 30, or a BMI greater than or equal to 27 in the presence of at least one weight-related comorbidity for those with risk factors in addition to obesity<br>▪ The provider will document the BMI |

| | |
|---|---|
| | – For BMI less than 27, coverage is not approved<br>– For BMI ranging between 27 and 29 with a comorbidity<br>– For BMI ranging between 30to 34<br>– For BMI ranging between 35 to 39<br>– For BMI greater than or equal to 40<br>• Patient has tried 3 months of generic phentermine, benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR and had an inadequate response<br>▪ Phentermine: Date_____ Duration of therapy _____ OR<br>• **Patient has achieved greater than equal to 5 percent weight loss from baseline while on phentermine, benzphetamine, diethylpropion IR/SR or phendimetrazine IR/SR but BMI and central adiposity remain high, and further reduction is needed to attain optimal outcomes** *(November 2025 meeting update)*<br>• The patient has a contraindication to generic phentermine (e.g., arrhythmias, coronary artery disease, heart failure, stroke, ~~**uncontrolled hypertension**~~ **or a patient not meeting blood pressure goal on 2 or more antihypertensives)** OR *(August 2025 meeting update)*<br>• The patient has experienced an adverse reaction to phentermine benzphetamine, diethylpropion (IR/SR) or phendimetrazine IR/SR that is not expected to occur with Wegovy or Zepbound<br>For Wegovy **injection** for adolescents for obesity (note that Zepbound **and Wegovy tablets are** ~~is~~ not currently FDA-approved for adolescents **or children**)<br>• Patient is 12 years of age or older and younger than 18 years of age<br>• Patient has a BMI greater than or equal to 95th percentile standardized for age<br>For Zepbound for moderate to severe obstructive sleep apnea (OSA) in adults with obesity:<br>• Patient is 18 years of age or older<br>• Patient has moderate to severe OSA (documented apnea-hypopnea index greater than 15 events per hour) and a BMI greater than 30<br>For all patients<br>• Concomitant use of this medication with another GLP1-RA is not allowed (e.g., **exenatide** ~~**Bydureon**~~, Trulicity, ~~**Byetta**~~, ~~**Adlyxin**~~, Victoza, **liraglutide**, Soliqua, Xultophy) *(November 2025 meeting updates)*<br>• The patient does not have a history of or family history of medullary thyroid cancer or multiple endocrine neoplasia syndrome type 2<br>• Patient is not pregnant<br>Non-FDA approved uses are not approved including diabetes mellitus<br>PA expires in 12 months for initial therapy; annual renewal required<br><u>Renewal PA Criteria</u>: Note that initial TRICARE PA approval is required for renewal. Wegovy and Zepbound will be approved for an additional 12 months if the following are met:<br>• The provider will document the BMI for renewal:<br>▪ BMI less than 27,<br>▪ BMI ranging between 27 and 29<br>▪ BMI ranging between 30 to 34<br>▪ BMI ranging between 35 to 39<br>▪ BMI greater than or equal to 40 |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| | For Obesity:<br>• The provider continues to verify and will maintain documentation in the medical record that the patient is currently engaged in a comprehensive lifestyle intervention that includes diet, exercise, and behavioral health modification. Medical record documentation will be made available to TRICARE for audit, if requested.<br>• For Wegovy: for patients older than 12 years of age and younger than 18 years of age, the patient has lost greater than or equal to 4% of baseline body weight since starting medication with full dosage titration<br>• For Wegovy and Zepbound: for patients older than 18 years of age, the patient has lost greater than or equal to 5% of baseline body weight since starting medication<br>• The patient is not pregnant<br>• **The patient does not have a history of or a family history of medullary thyroid cancer or multiple endocrine neoplasia syndrome type 2** (November 2025 meeting update)<br>For OSA:<br>• The patient has shown improvement in OSA symptoms based on the improvement of apnea hypopnea index |
| **Utilization Management PAs** | |
| • lamotrigine 10 mg/mL suspension (Subvenite)<br><br>**Anticonvulsants-Antimania Agents** | Manual PA criteria apply to all new users of lamotrigine oral suspension (Subvenite)<br>PA does not apply to patients younger than 12 years of age (age edit)<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Drug is prescribed by or in consultation with an adult or pediatric neurologist or psychiatrist<br>• Patient requires a liquid formulation due to swallowing difficulty or has a feeding tube<br>Prior Authorization does not expire |
| • cariprazine (Vraylar)<br><br>**Antipsychotic Agents: Atypical** | Manual PA criteria apply to all new users of cariprazine (Vraylar)<br>Manual PA Criteria: Coverage is approved if all criteria are met:<br>• Drug is prescribed by or in consultation with a psychiatrist<br>• Major Depressive Disorder<br>▪ Patient is 18 years of age or older<br>▪ Patient has had treatment failure of at least two other formulary antidepressants, for example:<br>– SSRI (e.g. citalopram, escitalopram, fluoxetine)<br>– SNRI (e.g. venlafaxine IR, venlafaxine ER, desvenlafaxine succinate ER)<br>– TCA (e.g. amitriptyline, desipramine, imipramine, nortriptyline)<br>– mirtazapine<br>– bupropion<br>– trazodone immediate-release<br>– nefazodone<br>– MAOI<br>▪ Patient has had an inadequate response, intolerance to, or contraindication to aripiprazole<br>▪ Patient has concurrent use of an antidepressant<br>• Schizophrenia<br>▪ Patient is 13 years of age or older |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| | ▪ Patient has tried and failed at least two other formulary atypical antipsychotics (e.g., risperidone, aripiprazole, lurasidone, quetiapine)<br>• Manic or mixed episodes associated with Bipolar I<br>▪ Patient is 10 years of age or older<br>▪ Patient has tried and failed at least two formulary atypical antipsychotics<br>• Depressive episodes associated with Bipolar I<br>▪ Patient is 18 years of age or older<br>▪ Patient has tried and failed at least two formulary atypical antipsychotics (e.g., risperidone, aripiprazole, lurasidone, quetiapine)<br>Non-FDA-approved uses are not approved<br>Prior Authorization does not expire |
| • lumateperone (Caplyta)<br><br>**Antipsychotic Agents: Atypical** | **Updates from the February 2026 meeting are in bold and strikethrough**<br>Manual PA criteria apply to all new users of lumateperone (Caplyta)<br>Manual PA Criteria: Coverage is approved if all criteria are met:<br>• Patient is 18 years of age or older<br>• Drug is prescribed by or in consultation with a psychiatrist<br>• **Major Depressive Disorder**<br>▪ **The patient has had treatment failure of at least two other formulary antidepressants:**<br>– **SSRI (e.g. citalopram, escitalopram, fluoxetine),**<br>– **SNRI (e.g. venlafaxine IR, venlafaxine ER, desvenlafaxine succinate ER)**<br>– **TCA (e.g. amitriptyline, desipramine, imipramine, nortriptyline)**<br>– **mirtazapine**<br>– **bupropion**<br>– **trazodone immediate-release**<br>– **nefazodone**<br>– **MAOI**<br>▪ **Patient has had an inadequate response, intolerance to, or contraindication to aripiprazole**<br>▪ **Patient has concurrent use of an antidepressant**<br>• Schizophrenia<br>▪ Patient has tried and failed at least two formulary atypical antipsychotics (e.g., risperidone, aripiprazole, lurasidone, quetiapine)<br>• Depressive episodes associated with bipolar disorder I or II and used as monotherapy or as adjunct to lithium or valproate<br>▪ Patient has tried and failed at least two formulary atypical antipsychotics (e.g., risperidone, aripiprazole, lurasidone, quetiapine)<br>Non-FDA-approved uses are not approved ~~**including sleep disorders, depression, and other neuropsychiatric and neurological disorders.**~~<br>Prior Authorization does not expire |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| • tezepelumab (Tezspire)<br><br>**Atopy Agents** | **Updates from the February 2026 meeting are in bold**<br>Note that there were no changes to the PA criteria for the other indications.<br>Manual PA is required for all new users of tezepelumab (Tezspire)<br>Manual PA Criteria: Coverage is approved if all criteria are met:<br>**For chronic rhinosinusitis with nasal polyposis:**<br>• **The patient is 12 years of age or older**<br>• **The drug is prescribed by an allergist, immunologist, pulmonologist, or otolaryngologist**<br>• **The patient has chronic rhinosinusitis with nasal polyposis defined by all of the following:**<br>▪ **Presence of nasal polyposis is confirmed by imaging or direct visualization AND**<br>▪ **At least two of the following: mucopurulent discharge, nasal obstruction and congestion, decreased or absent sense of smell, or facial pressure and pain**<br>• **Will only be used as add-on therapy to standard treatments, including nasal steroids and nasal saline irrigation**<br>• **The symptoms of chronic rhinosinusitis with nasal polyposis must continue to be inadequately controlled despite all of the following:**<br>▪ **Adequate duration of at least TWO different high-dose intranasal corticosteroids AND**<br>▪ **Nasal saline irrigation AND**<br>▪ **Patient has a past surgical history or endoscopic surgical intervention or has a contraindication to surgery**<br>**Non-FDA-approved uses are not approved**<br>**Prior authorization expires after 12 months**<br>Renewal Criteria: Note initial Tricare PA approval is required for renewal. Renewal PA criteria will be approved indefinitely if all the following apply<br>**For chronic rhinosinusitis with nasal polyposis:**<br>• **The patient's disease severity has improved and stabilized to warrant continued therapy** |
| • berotralstat (Orladeyo)<br><br>**Corticosteroids-Immune Modulators: Hereditary Angioedema (HAE) Agents** | **Updates from the February 2026 meeting are in bold and strikethrough**<br>Manual PA criteria apply to all new users of Orladeyo or Takhzyro<br>Manual PA criteria: Orladeyo or Takhzyro is approved if all apply:<br>• Patient Age<br>▪ For Orladeyo, the patient is ~~12~~ **2** years of age or older<br>▪ For Takhzyro, the patient is 2 years of age or older<br>• The patient has a diagnosis of hereditary angioedema (HAE)<br>• Prescribed by an allergist, immunologist, or rheumatologist, or in consultation with an HAE specialist<br>• The patient must have monthly HAE attacks or a history of severe attacks that require prophylaxis treatment (i.e., ≥2 HAE attacks/month, laryngeal attacks, etc.)<br>• The patient is not currently receiving another drug for HAE prophylaxis (e.g., Orladeyo, Takhzyro, Cinryze or Haegarda will not be used concomitantly)<br>Non-FDA-approved uses NOT approved.<br>Prior Authorization does not expire. |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| • pirtobrutinib (Jaypirca)<br><br>**Leukemia and Lymphoma Agents: Bruton Tyrosine Kinase Inhibitors** | **Updates from the February 2026 meeting are in bold and strikethrough**<br>Manual PA criteria apply to all new users of pirtobrutinib (Jaypirca)<br>Manual PA criteria**:** Coverage is approved if all criteria are met:<br>• Patient is 18 years of age or older<br>• The medication is prescribed by or in consultation with a hematologist or oncologist<br>• Patient has a diagnosis of either:<br>▪ Pathologically confirmed relapsed or refractory mantle cell lymphoma (MCL) OR<br>▪ Chronic lymphocytic leukemia or small lymphocytic lymphoma (CLL/SLL) and has received ~~**at least two prior lines of therapy, including**~~ a **covalent** BTK inhibitor ~~**and a BCL-2 inhibitor**~~<br>• The diagnosis Is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. If so, please list the diagnosis, guideline version, and page number:_____<br>Other non-FDA approved uses are not approved, except as noted above<br>PA does not expire |
| • revumenib (Revuforj)<br><br>**Oncological Agents** | **Updates from the February 2026 meeting are in bold**<br>Manual PA criteria apply to all new users of revumenib<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Prescribed by or in consultation with an oncologist<br>• Patient has relapsed or refractory acute leukemia and disease is positive for lysine methyltransferase 2A (KMT2A) gene translocation **OR**<br>• **Patient has relapsed or refractory acute myeloid leukemia (AML) with a susceptible nucleophosmin 1 (NPM1) mutation and has no satisfactory alternative treatment options**<br>• The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. To facilitate approval please list the diagnosis, guidelines version and page number _____<br>Other non-FDA approved uses are not approved, except as noted above<br>PA does not expire |
| • roflumilast 0.05% cream (Zoryve)<br><br>**Psoriasis Agents** | Manual PA criteria apply to all new users of Zoryve 0.05% cream<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Patient is 2 to 5 years of age<br>• The medication is being prescribed by or in consultation with a dermatologist, allergist, or immunologist<br>• The patient has mild to moderate atopic dermatitis<br>• The patient must have tried for at least 2 weeks and failed, have a contraindication to, or have had an adverse reaction to both of the following:<br>▪ Topical corticosteroid<br>– For patients 18 years of age or older: high potency class 1 topical corticosteroid (e.g., clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream)<br>– For patients 2 to 17 years of age: any topical corticosteroid<br>▪ Topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus) |

| | |
|---|---|
| | Non-FDA-approved uses are not approved<br>PA expires in 12 months<br>Renewal criteria: (Initial TRICARE PA approval required for renewal) Coverage will be approved indefinitely if the following applies:<br>• The patient's disease severity has improved and stabilized to warrant continued therapy. |
| • golimumab (Simponi)<br><br>**TIBs: Tumor Necrosis Factors** | **Updates from the February 2026 meeting are in bold and strikethrough**<br>Manual PA criteria apply to all new users of golimumab (Simponi).<br>Automated PA Criteria: The patient has filled a prescription for adalimumab (Humira), at any MHS pharmacy point of service (MTFs, retail network pharmacies, or TRICARE mail order pharmacy) during the previous 180 days. AND<br>Manual PA Criteria: If automated criteria are not met, Simponi is approved if all criteria are met.<br>• Humira is the Department of Defense's preferred targeted biologic agent. The patient must have tried Humira AND: The patient had an inadequate response to Humira OR the patient experienced an adverse reaction to Humira that is not expected to occur with the requested agent OR the patient has a contraindication to Humira<br>• Patients 18 years of age or older with one of the following diagnoses/indications:<br>▪ Moderate to severe active rheumatoid arthritis (RA)<br>▪ Active psoriatic arthritis (PsA)<br>▪ Active ankylosing spondylitis (AS)<br>▪ Moderately to severely active ulcerative colitis (UC)<br>• **Pediatric patients weighing at least 15 kg with one of the following diagnoses/indications:**<br>▪ **Moderately to severely active ulcerative colitis (UC)**<br>• Below criteria applies to all patients unless noted:<br>▪ Patient has had an inadequate response to non-biologic systemic therapy. (For example - methotrexate, aminosalicylates [e.g., sulfasalazine, mesalamine], corticosteroids, immunosuppressant's [e.g. azathioprine], etc.) (Note: AS**, Ulcerative Colitis** indication does not apply)<br>▪ Patient has had an inadequate response to at least two NSAIDs over a period of at least two months (Note: applies to AS indication ONLY)<br>▪ ~~**Patient has evidence of a negative TB test result in past 12 months (or TB is adequately managed)**~~<br>▪ ~~**May not be used concomitantly with other TIBs agents**~~<br>▪ **Patient will not be receiving any other targeted immunomodulatory biologics concurrently, including but not limited to the following: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, JAK inhibitors**<br>Non-FDA-approved uses are not approved.<br>Prior Authorization does not expire. |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| • guselkumab (Tremfya)<br><br>**TIBs: IL-23 Inhibitors** | ~~**Note: Taltz is available for treatment of plaque psoriasis without the requirement to try Humira.**~~<br>Step therapy and Manual PA Criteria apply to all new users of guselkumab (Tremfya)<br>Manual PA criteria apply to all new users of guselkumab (Tremfya)<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Patient had inadequate response to Humira OR had adverse reaction to Humira that is not expected to occur with the requested agent OR has a contraindication to Humira AND<br>• Patient is 18 years of age or older with the following indication/diagnosis:<br>▪ Active psoriatic arthritis (PsA)<br>▪ Moderate to severe plaque psoriasis (PsO) who are candidates for phototherapy or systemic therapy<br>▪ Moderately to severely active ulcerative colitis (UC)<br>▪ Moderately to severely active Crohn's Disease (CD)<br>• **Patient is 6 years of age or older and weighs at least 40 kg with the following indication/diagnosis:**<br>▪ **Active psoriatic arthritis (PsA)**<br>▪ **Moderate to severe plaque psoriasis (PsO) who are candidates for phototherapy or systemic therapy**<br>• Patient had inadequate response, intolerance, or contraindication to non-biologic systemic therapy (For example: methotrexate, aminosalicylates, corticosteroids, immunosuppressants etc.) (Note: Does not apply to CD, UC)<br>• Patient has received IV induction with requested agent and demonstrated positive response and modification of therapy would result in undue risk (Note: Applies to CD, UC only)<br>• Patient will not be receiving any other targeted immunomodulatory biologics concurrently, including but not limited to the following: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, JAK inhibitors<br>Non-FDA approved uses are not approved.<br>PA does not expire. |
| • tofacitinib (Xeljanz)<br><br>**TIBs: Miscellaneous** | Step therapy and manual PA criteria apply to new users of tofacitinib (Xeljanz, Xeljanz XR, Xeljanz oral solution).<br>~~**Automated PA Criteria: The patient has filled a prescription for adalimumab (Humira) at any MHS pharmacy point of service (MTFs, retail network pharmacies, or mail order) during the previous 180 days. AND**~~<br>Manual PA Criteria: ~~**If automated criteria are not met,**~~ Coverage for Xeljanz, Xeljanz XR, or Xeljanz oral solution is approved if all criteria are met:<br>• Humira is the Department of Defense's preferred targeted biologic agent. The patient must have tried Humira AND:<br>▪ The patient had an inadequate response to Humira OR experienced an adverse reaction to Humira that is not expected to occur with the requested agent OR has a contraindication to Humira<br>• Coverage approved for patients 18 years of age or older with one of the following diagnoses/indications:<br>▪ Moderately to severely active rheumatoid arthritis (RA) ~~**who have had an inadequate response or intolerance to methotrexate**~~<br>~~**– The prescription is for 5 mg BID or 11 mg once a day**~~ |

| | |
|---|---|
| | ▪ Active psoriatic arthritis (PsA)<br>▪ Active ankylosing spondylitis (AS)<br>– ~~**The prescription is for 5 mg BID or 11 mg once a day**~~<br>▪ Moderately to severely active ulcerative colitis (UC)<br>– ~~**Will allow doses up to 10 mg BID OR up to 22mg once a day**~~<br>• Coverage approved for pediatric patients 2 years of age or older with:<br>▪ Active polyarticular course juvenile idiopathic arthritis (pcJIA)<br>– ~~**The prescription is for 5 mg BID or weight-based equivalent BID (oral solution and IR tablet may be converted on a mg to mg equivalent; for example, 5 mg oral solution may be switched to 5 mg IR tablet)**~~<br>▪ **Active psoriatic arthritis**<br>• Below criteria applies to all patients unless noted:<br>▪ ~~**Patient has no history of thromboembolic disease**~~<br>▪ ~~**Patient hemoglobin (Hgb) must be > 9 g/dL**~~<br>▪ ~~**Patient absolute neutrophil count (ANC) < 1,000/mm3**~~<br>▪ ~~**Patient absolute lymphocyte count (ALC) < 500/ mm3**~~<br>▪ ~~**The patient is not receiving potent immunosuppressant's (for example, azathioprine and cyclosporine) concomitantly**~~<br>▪ ~~**Patient has evidence of a negative TB test result in past 12 months (or TB is adequately managed)**~~<br>▪ ~~**Patient has had an inadequate response or intolerance to methotrexate or other disease-modifying antirheumatic drugs (DMARDs) (Note: RA indication doesn't apply as already has to have inadequate response or intolerance to methotrexate)**~~<br>▪ Patient has had an inadequate response**, intolerance, or contraindication** to non-biologic systemic therapy. (For example - methotrexate, aminosalicylates [e.g., sulfasalazine, mesalamine], corticosteroids, immunosuppressant's [e.g. azathioprine], etc.) (Note: does not apply to UC, RA, ax-SpA, pJIA)<br>▪ Patient experienced an inadequate response to at least two nonsteroidal anti-inflammatory drugs (NSAIDs) (for example: ibuprofen, naproxen, diclofenac) over a period of at least two months (Note: Applies to ax-SpA only)<br>▪ **Patient will not be receiving any other targeted immunomodulatory biologics concurrently, including but not limited to the following: TNF inhibitors interleukins, or JAK inhibitors**<br>▪ ~~**May not be used concomitantly with other TIBs agents except for Otezla**~~<br>▪ Provider is aware of the FDA safety alerts and boxed warnings<br>Non-FDA-approved uses are not approved.<br>Prior Authorization does not expire. |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| • olezarsen (Tryngolza)<br><br>**Antilipidemics-2 Agents** | **Updates from the February 2026 Meeting are in bold**<br>Manual PA criteria apply to all new users of olezarsen<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Patient is 18 years of age or older<br>• Prescribed by cardiologist, an endocrinologist, or an internal medicine physician experienced in treating disorders related to severe hypertriglyceridemia<br>• **Patient has Familial Chylomicronemia Syndrome (FCS)** or<br>• **Patient has evidence of symptomatic persistent chylomicronemia with recurrent pancreatitis**<br>• Patient has undergone genetic testing to confirm the diagnosis of familial chylomicronemia syndrome<br>• Patient has fasting triglyceride level of 880 mg/dL or greater<br>• Patient will adhere to a low fat-diet (less than or equal to 20 g fat per day) while receiving Tryngolza<br>• **Patient has tried and failed therapy with plozasiran (Redemplo)**<br>Non-FDA approved uses are not approved<br>PA does not expire |
| • brexpiprazole (Rexulti)<br><br>**Antipsychotic Agents: Atypical** | **Updates from the February 2026 meeting are in bold and strikethrough**<br>Manual PA criteria apply to all new users of brexpiprazole (Rexulti)<br>Manual PA Criteria: Coverage is approved if all criteria are met:<br>• Provider acknowledges that generic aripiprazole does not need a prior authorization and is available at a lower copay.<br>• Major Depressive Disorder<br>▪ Patient is 18 years of age or older<br>▪ **Drug is prescribed by or in consultation with a psychiatrist**<br>▪ Patient has concurrent use of an antidepressant<br>▪ The patient has had treatment failure of at least two other **formulary** antidepressant**s ~~augmentation therapies~~ for example:**<br>– **SSRI (e.g., citalopram, escitalopram, fluoxetine)**<br>– **SNRI (e.g., venlafaxine IR, venlafaxine ER, desvenlafaxine succinate ER)**<br>– **TCA (e.g., amitriptyline, desipramine, imipramine, nortriptyline)**<br>– **mirtazapine**<br>– **bupropion**<br>– **trazodone immediate-release**<br>– **nefazodone**<br>– **MAOI**<br>▪ **The patient has had an inadequate response, intolerance, or contraindication to ~~(one of which must be~~** aripiprazole**~~) OR had an adverse event with aripiprazole that is not expected to occur with brexpiprazole (Rexulti)~~**<br>• Schizophrenia<br>▪ Patient is 13 years of age or older<br>▪ **Drug is prescribed by or in consultation with a psychiatrist**<br>▪ The patient has had treatment failure of at least two other **formulary** atypical antipsychotics (one of which must be aripiprazole)**; ~~OR~~** |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| | ~~▪ Patient has had an adverse event with aripiprazole that is not expected to occur with brexpiprazole (Rexulti)~~<br>• Alzheimer's Disease<br>▪ Patient is 18 years of age or older<br>▪ Patient is being treated for agitation associated with dementia due to Alzheimer's Disease (AD)<br>▪ Prescribed by **or in consultation with** a neurologist, psychiatrist, or specialist in geriatric medicine<br>▪ Other causes of agitation have been ruled out or treated<br>▪ Non-pharmacologic management of agitation has failed<br>▪ Provider is aware ~~**of the warnings, screening and monitoring precautions**~~ **that elderly patients with dementia-related psychosis treated with antipsychotic drugs are at increased risk of death**<br>Non-FDA-approved uses are not approved<br>Prior Authorization does not expire |
| • bisoprolol 2.5 mg tablet<br><br>**Beta Blockers and Hydrochlorothiazide Combinations** | **Updates from the February 2026 Meeting are in bold**<br>Manual PA criteria apply to all new users of bisoprolol 2.5 mg tablet.<br><u>Manual PA criteria</u>: bisoprolol 2.5 mg tablet is approved if all criteria are met:<br>• Provider acknowledges other formulations of bisoprolol tablets are available without prior authorization.<br>• Provider must explain why the patient requires bisoprolol 2.5 mg tablets and cannot take the cost-effective generic bisoprolol formulations<br>▪ Acceptable responses include:<br>– The patient has experienced a serious allergic reaction (i.e., hives/anaphylaxis) to one or more inactive ingredients in currently available bisoprolol formulations **OR**<br>– **The patient requires very low dose titration of bisoprolol for heart failure or post myocardial infarction**<br>Non-FDA-approved uses are not approved<br>Prior authorization does not expire |
| • avacopan (Tavneos)<br><br>**Hematological Agents** | **Updates from the February 2026 Meeting are in bold**<br>Manual PA criteria apply to new users of Tavneos<br><u>Manual PA criteria</u>: Coverage is approved if <u>all</u> criteria are met:<br>• Patient is 18 years of age or older<br>• The medication is prescribed by or in consultation with a rheumatologist **or nephrologist**<br>• Patient has a documented diagnosis of granulomatosis with polyangiitis (GPA) (Wegener's) and microscopic polyangiitis (MPA)<br>• Patient meets one of the following criteria (either a or b):<br>▪ Positive ELISA test for anti-proteinase-3 (PR-3)<br>▪ Positive ELISA test for anti-myeloperoxidase (MPO)<br>• Patient has experienced or has a high probability to experience significant adverse effect from prednisone<br>• Tavneos is prescribed in combination with cyclophosphamide or rituximab, unless clinically significant adverse effects are experienced or both cyclophosphamide or rituximab are contraindicated |

| | |
|---|---|
| | Non-FDA-approved used are not approved including Immunoglobulin A nephropathy, Hidradenitis suppurativa, acne inversa, and C3 Glomerulopathy (C3G)<br>Prior Authorization expires after 6 months<br>Renewal criteria: (Initial TRICARE PA approval required for renewal) Coverage will be approved indefinitely for continuation of therapy if one of the following apply:<br>• Patient has responded positively to therapy as evidenced by a reduction in symptoms or remission AND<br>• If request is for a dose increase, new dose does not exceed 60 mg (2 tabs) per day |
| • sparsentan (Filspari)<br><br>**Nephrology Agents Miscellaneous** | **Updates from the February 2026 meeting are in bold and strikethrough**<br>Manual PA criteria apply to all new users of sparsentan (Filspari)<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Provider acknowledges that Filspari is only available through a Risk Evaluation and Mitigation Strategies (REMS) program due to the risk of hepatotoxicity and embryo-fetal toxicity, and will follow the monitoring requirements<br>• Patient is 18 years of age or older<br>• Filspari is prescribed by a nephrologist<br>• The patient has a diagnosis of biopsy-verified primary immunoglobulin A nephropathy (IgAN) without cellular crescents in more than 25% of sampled glomeruli<br>• Patient has a urine protein-to-creatinine ratio (UPCR) greater than or equal to **1.0 g/gram ~~1.5 g/gram~~**<br>• Patient has an estimated glomerular filtration rate (eGFR) greater than or equal to 30 mL/min/1.73 $m^2$<br>• Patient is not currently receiving dialysis or has not undergone kidney transplant<br>• Patient has not received immunosuppressants, including corticosteroids, in the past 2 weeks and is not expected to need immunosuppressants in the next 6 months<br>• Patient has continued to have proteinuria despite maximal ACE-inhibitor or ARB therapy and is at high risk for disease progression<br>• The patient is not receiving concomitant renin-angiotensin-aldosterone system inhibitors (for example ACE-inhibitors or ARBs such as irbesartan, telmisartan, losartan; or spironolactone), endothelin receptors antagonists (for example ambrisentan or bosentan) or aliskiren).<br>• The patient's baseline liver aminotransferase (AST and ALT) levels are not elevated to greater than 3 times the upper limit of normal<br>• If patient is a female of child-bearing age, the patient must be tested for pregnancy before, during and 1 month after treatment discontinuation<br>• If patient can become pregnant, they will use effective contraception before starting treatment, during and for 1 month after treatment discontinuation<br><br>Non-FDA approved uses are NOT approved, including IgAN due to systemic lupus erythematosus, liver cirrhosis, Henoch-Schonlein purpura, or pulmonary arterial hypertension, or focal segmental glomerulosclerosis (FSGS)<br>PA expires in 9 months<br>Renewal criteria: coverage will be approved indefinitely if all the following apply |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| | • Patient has had a response to Filspari defined by:<br>▪ reduction in urine protein-to-creatinine ratio (UPCR) from baseline OR<br>▪ reduction in proteinuria from baseline<br>• Patient's eGFR rate ≥ 30 mL/min/1.73 m2<br>• Filspari is not being used in combination with any RAAS blocker (e.g., ACE-Is, ARB), endothelin receptor antagonists, or aliskiren |
| • azacitidine (Onureg)<br><br>**Leukemia and Lymphoma Agents: Acute Myeloid Leukemia (AML)** | **Updates from the February 2026 Meeting are in bold and strikethrough**<br>Manual PA apply to new users of azacitidine (Onureg)<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Prescribed by or in consultation with a hematologist/oncologist<br>• Patient is 18 years of age or older<br>• Patient does not have a myelodysplastic syndrome (MDS)<br>• Patient is using Onureg for:<br>▪ Post-remission maintenance treatment of Acute Myeloid Leukemia (AML) after first achieving complete remission OR complete remission with incomplete blood count recovery following intensive induction chemotherapy and not able to complete intensive curative therapy (e.g. transplant ineligible) OR<br>▪ **T-cell Lymphoma as an initial palliative intent therapy or second-line and subsequent therapy:**<br>– **Angioimmunoblastic T-cell lymphoma (AITL) OR**<br>– **Nodal peripheral T-cell lymphoma with TFH phenotype (PTCL, TFH) OR**<br>– **Follicular T-cell lymphoma (FTCL)**<br>• ~~**Patient will use Onureg for maintenance therapy of acute myeloid leukemia (with poor-risk features?) following complete remission (CR) or complete remission with incomplete blood count recovery (CRi) achieved after intensive induction chemotherapy with or without consolidation therapy**~~<br>• ~~**Patient is not able to complete intensive curative therapy**~~<br>• ~~**Onureg will not be used for parenteral routes of administration**~~<br>• ~~**Monitor for myelosuppression/cytopenias**~~<br>• ~~**Female patients of childbearing age are not pregnant confirmed by (-) HCG.**~~<br>• ~~**Female patients will not breastfeed during treatment and for at least 1 week after the cessation of treatment.**~~<br>• ~~**Both male and female patients of childbearing potential agree to use effective contraception during treatment and for at least 6 months after cessation of therapy if female; 3 months if male.**~~<br>• The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation**: to facilitate approval, please list the diagnosis, guideline version, and page number.** ~~**If so, please list the diagnosis**~~: _____.<br>Non-FDA-approved uses are not approved, **except as noted above**<br>PA does not expire |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| • ixazomib (Ninlaro)<br><br>**Multiple Myeloma** | **Updates from the February 2026 Meeting are in bold and strikethrough**<br>Manual PA criteria apply to all new users of ixazomib (Ninlaro).<br>Manual PA Criteria: Ninlaro is approved if all criteria are met:<br>• Prescribed by or in consultation with a hematologist or oncologist<br>• Patient is greater than or equal to 18 years of age<br>• **Provider acknowledges Ninlaro is not recommended for use in the maintenance setting, or in newly diagnosed multiple myeloma in combination with lenalidomide and dexamethasone outside of clinical trials due to increased risk of death**<br>• Patient is diagnosed **with multiple myeloma and**:<br>▪ **Patient will receive Ninlaro in combination with dexamethasone AND either lenalidomide (Revlimid), pomalidomide (Pomalyst), or thalidomide (Thalomid) AND**<br>– **Patient did not progress on a bortezomib NOR carflizomib containing regimen AND**<br>– **Patient will be starting ixazomib as a third (or higher) line of therapy OR**<br>~~▪ Multiple myeloma AND patient must not have progressed on bortezomib NOR carfilzomib – containing regimen OR One or more of the following:~~<br>~~– Patient must have failed or not be a candidate for bortezomib AND carfilzomib~~<br>~~– Patient has failed or is not a candidate for carfilzomib and has high risk cytogenetics~~<br>~~– Patient will be starting ixazomib as third (or higher) line of therapy~~<br>~~– Must be used in combination with lenalidomide, pomalidomide, OR thalidomide~~<br>~~– Must be used in combination with dexamethasone OR~~<br>▪ ~~Multiple myeloma and~~ **Patient has** received a hematopoietic cell transplant (HCT) AND patient will receive Ninlaro as maintenance therapy following primary therapy and HCT<br>• Must not be used concurrently with bortezomib NOR carfilzomib<br>• The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. **To facilitate approval, please list the diagnosis, guideline version, and page number** ~~**If so, please list the diagnosis**~~:_____.<br>Non-FDA-approved uses are not approved, except as noted above<br>Prior authorization does not expire |
| • avapritinib (Ayvakit)<br><br>**Oncological Agents** | **Updates from the February 2026 Meeting are in bold and strikethrough**<br>Manual PA criteria apply to all new users of avapritinib (Ayvakit).<br>Manual PA criteria: Ayvakit is approved if all criteria are met:<br>• Prescribed by or in consultation with a hematologist, oncologist, **or allergist**<br>• Patient is 18 years of age or older<br>• Patient has a diagnosis of:<br>▪ Pathologically confirmed unresectable or metastatic GIST harboring a platelet-derived growth factor receptor alpha (PDGFRA) exon 18 mutation with or without the D842V mutation OR |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| | ▪ Advanced systemic mastocytosis (includes patients with aggressive systemic mastocytosis, systemic mastocytosis with an associated hematologic neoplasm, and mast cell leukemia) OR<br>▪ Indolent Systemic Mastocytosis (ISM) with a platelet count ≥ 50 x $10^9$/L<br>• ~~**Provider agrees to monitor for intracranial blooding and other central nervous system (CNS) adverse effects**~~<br>• The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. **To facilitate approval** If so, please list the diagnosis**, guideline version, and page number**: _____.<br>• ~~**Female patients of childbearing age are not pregnant confirmed by (-) HCG**~~<br>• ~~**Female patients will not breastfeed during treatment and for at least 2 weeks after the cessation of treatment**~~<br>• ~~**Both male and female patients of childbearing potential agree to use effective contraception during treatment and for at least 6 weeks after the cessation of therapy**~~<br>Non-FDA-approved uses are not approved, **except as noted above**<br>Prior authorization does not expire |
| • tazemetostat (Tazverik)<br><br>**Oncological Agents** | **Updates from the February 2026 Meeting are in bold and strikethrough. Note market withdrawal of Tazverik was announced in March 2026**<br>Manual PA applies to new users of tazemetostat (Tazverik)<br><u>Manual PA criteria</u>: Coverage is approved if all criteria are met:<br>• Prescribed by or in consultation with a hematologist/oncologist<br>• **Patient has:**<br>▪ **Relapsed or refractory follicular lymphoma with tumors positive for an EZH2 mutation and has received at least two lines of systemic therapy**<br>▪ **Relapsed or refractory follicular lymphoma who have no satisfactory alternative treatment options**<br>▪ Pathologically confirmed metastatic or locally advanced epithelioid sarcoma not eligible for complete resection (in patients ≥ 16 years of age)<br>• ~~**Monitor for secondary malignancies (esp. T-cell lymphoblastic lymphoma, myelodysplastic syndrome, and acute myeloid leukemia)**~~<br>• ~~**Female patients of childbearing age are not pregnant confirmed by (-) HCG.**~~<br>• ~~**Female patients will not breastfeed during treatment and for at least 1 week after the cessation of treatment**~~<br>• ~~**Both male and female patients of childbearing potential agree to use effective contraception during treatment and for at least 3 months after cessation of therapy for males and 6 months for females**~~<br>• The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation**: to facilitate approval, please list the diagnosis, guideline version, and page number.** ~~**If so, please list the diagnosis**~~: _____.<br>Non-FDA-approved uses are not approved**, except as noted above**<br>PA does not expire |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| • pralsetinib (Gavreto)<br><br>**Oncological Agents: Lung Cancer** | **Updates from the February 2026 Meeting are in bold and strikethrough**<br>Manual PA criteria apply to all new users of Gavreto<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Prescribed by or in consultation with a hematologist/oncologist<br>• Patient is ~~**18+ y.o.**~~ **12 years of age or older**<br>• Patient has:<br>▪ ~~**Unresectable locally advanced or**~~ Metastatic RET fusion-positive non-small cell lung cancer (NSCLC)<br>▪ **Advanced or metastatic RET fusion-positive thyroid cancer who require systemic therapy and are radioactive iodine-refractory**<br>• ~~**Provider will monitor for hepatotoxicity**~~<br>• ~~**Patient does not have uncontrolled hypertension**~~<br>• ~~**Provider is aware and has counseled patient that pralsetinib can cause life-threatening lung disease and hemorrhage**~~<br>• ~~**Female patients of childbearing age are not pregnant confirmed by (-) HCG**~~<br>• ~~**Female patients will not breastfeed during treatment and for at least 1 week after the cessation of treatment**~~<br>• ~~**Both male and female patients of childbearing potential agree to use effective contraception during treatment and for at least 1 week after cessation of therapy if male; 2 weeks, if female**~~<br>• The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation**. To facilitate approval, please list the diagnosis, guideline version, and page number.** ~~**If so, please list the diagnosis:**~~ _____.<br>Non-FDA approved uses are not approved, **except as noted above**<br>PA does not expire |
| • crizotinib (Xalkori)<br><br>**Oncological Agents: Lung Cancer** | **Updates from the February 2026 Meeting are in bold and strikethrough**<br>Manual PA criteria apply to all new users of crizotinib oral pellets (Xalkori)<br>Age edit: PA does not apply to children 12 years of age and younger<br>Manual PA criteria: Coverage is approved if all criteria are met:<br>• Prescribed by or in consultation with a hematologist/oncologist<br>• **Patient has a diagnosis of:**<br>▪ Metastatic non-small cell lung cancer (NSCLC)<br>– NSCLC tumor is anaplastic lymphoma kinase (ALK) positive or ROS1-positive (as detected by an FDA-approved test)<br>▪ Relapsed or refractory systemic anaplastic large cell lymphoma (ALK positive)<br>– Patient is 1 year of age and older or a young adult (Note - limitation of use: safety and efficacy of Xalkori have not been established in older adults with refractory or refractory systemic ALK-positive anaplastic large cell lymphoma)<br>▪ Unresectable, recurrent, or refractory inflammatory myofibroblastic tumor<br>– ~~**Patient is 1 year of age or older**~~<br>– Tumor is anaplastic lymphoma kinase (ALK) positive |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| | • Provider must explain why the patient cannot take Xalkori tablets._____<br>▪ Acceptable responses include the patient cannot swallow tablets due to some documented medical condition (e.g., dysphagia, oral candidiasis, systemic sclerosis), and not due to convenience<br>• The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. ~~**If so,**~~ **To facilitate approval,** the provider must list the diagnosis**, guideline version, and page number:**_____<br>Non-FDA approved uses are not approved, except as noted above<br>PA does not expire |
| • cobimetinib (Cotellic)<br><br>**Oncological Agents: Melanoma** | **Updates from the February 2026 Meeting are in bold**<br>Manual PA apply to all new users of Cotellic<br>Manual PA Criteria: Cotellic is approved if:<br>• Prescribed by or in consultation with a hematologist or oncologist<br>• The patient is 18 years of age or older.<br>• Patient has one of the following:<br>▪ Unresectable metastatic melanoma AND has confirmed BRAF V600E or V600K mutation by an FDA-approved test AND Cotellic is being taken in combination with vemurafenib (Zelboraf) AND Patient is not on concurrent encorafenib (Braftovi), binimetinib (Mektovi), dabrafenib (Tafinlar), nor trametinib (Mekinist) OR<br>▪ Histiocytic neoplasms<br>• **The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. To facilitate approval, please list the diagnosis, guideline version, and page number: _____.**<br>Non-FDA-approved uses are not approved, **except as noted above**<br>Prior authorization does not expire |
| • duvelisib (Copiktra)<br><br>**Oncological Agents: Non-Bruton Tyrosine Kinase Inhibitors** | **Updates from the February 2026 Meeting are in bold and strikethrough**<br>Manual PA applies to all new users of Copiktra<br>Manual PA Criteria: Copiktra is approved if all criteria are met:<br>• Drug is prescribed by a hematologist or oncologist<br>• ~~**Patient is greater than or equal to 18 years of age**~~<br>• **Patient is 18 years of age or older**<br>• Patient has evidence and pathologic confirmation of the following<br>▪ relapsed or refractory chronic lymphocytic leukemia (CLL)<br>▪ relapsed or refractory small lymphocytic lymphoma (SLL)<br>▪ ~~**marginal zone lymphoma (MZL)**~~<br>• Patient has undergone at least two prior systemic therapies<br>• **Provider acknowledges duvelisib (Copiktra) is not indicated and is not recommended for the treatment of any patient with CLL or SLL as initial or second line treatment due to an increased risk of treatment-related mortality**<br>• ~~**Provider is aware and has informed patient of risk of serious, life-threatening, and fatal: infections, including PJP and CMV; diarrhea; colitis; cutaneous reactions including DRESS and Stevens Johnson**~~ |

| | |
|---|---|
| | ~~**Syndrome spectrum reactions, including Toxic Epidermal Necrolysis; pneumonitis; hepatotoxicity; and neutropenia**~~<br>• ~~**Patient has no evidence of: active infection, diarrhea, colitis, serious cutaneous disease, pneumonitis, hepatitis, significantly elevated liver-associated enzymes, nor neutropenia**~~<br>• ~~**Female patients of childbearing age and are not pregnant confirmed by ( ) HCG**~~<br>• ~~**Female patients will not breastfeed during treatment and for at least 1 month after the cessation of treatment**~~<br>• ~~**Female patients of childbearing potential and male patients with female partners agree to use contraception during treatment and for at least 1 month after the cessation of treatment**~~<br>• ~~**Male patients are aware that Copiktra may cause male infertility**~~<br>• Prescriber is enrolled in Copiktra REMS program<br>• The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation**: to facilitate approval, please list the diagnosis, guideline version, and page number. ~~If so, please list the diagnosis~~**: _____.<br>Non-FDA-approved uses are not approved**, except as noted above**<br>PA does not expire |
| • idelalisib (Zydelig)<br><br>**Oncological Agents: Non-Bruton Tyrosine Kinase Inhibitors** | **Updates from the February 2026 Meeting are in bold and strikethrough**<br>Manual PA criteria apply to new users of Zydelig.<br><u>Manual PA Criteria</u>: Coverage for Zydelig is approved if all criteria are met:<br>• Prescribed by or in consultation with a hematologist or oncologist<br>• Patient is greater than or equal to 18 years of age<br>• **Provider acknowledges Zydelig is not indicated and is not recommended for first-line treatment of any patient, including patients with chronic lymphocytic leukemia (CLL), small lymphocytic lymphoma (SLL), follicular lymphoma (FL), and other indolent non-Hodgkin lymphomas**<br>• **Provider acknowledges the indications for small lymphocytic lymphoma and follicular lymphoma were withdrawn by the manufacturer**<br>• **Patient has relapsed chronic lymphocytic leukemia (CLL)**<br>▪ **Will be used in combination with rituximab in patients for whom rituximab alone would be considered appropriate therapy due to other co-morbidities**<br>• ~~**Zydelig will be used in one of the following indications:**~~<br>▪ ~~**Relapsed/refractory therapy for CLL/SLL without del(17p)/TP53 mutation**~~<br>– ~~**Patient fits one of the following categories:**~~<br>– ~~**Frail patient with significant comorbidity (not able to tolerate purine analogues)**~~<br>– ~~**Patient ≥ 65 years old with significant comorbidity**~~<br>– ~~**Patient < 65 years old**~~<br>▪ ~~**Relapsed/refractory therapy for CLL/SLL with del(17p)/TP53 mutation**~~ |

| | |
|---|---|
| | • ~~**Provider has reviewed the REMS program including the letter to healthcare providers and the fact sheet and has shared the medication guide and patient safety information card with the patient**~~<br>• ~~**Will monitor for hepatotoxicity, colitis, intestinal perforation, pneumonitis, infection, neutropenia, and Steven Johnson Syndrome/toxic epidermal necrolysis**~~<br>• ~~**Will monitor for cytomegalovirus reactivation**~~<br>• ~~**Will prophylax for Pneumocystis jiroveci pneumonia**~~<br>• ~~**If the patient is female, she is not pregnant or planning to become pregnant**~~<br>• ~~**Female patients will not breastfeed**~~<br>• ~~**Female patients of reproductive potential will use effective contraception during treatment and for at least 30 days after discontinuation**~~<br>• ~~**Male patients of reproductive potential will use effective contraception during treatment and for at least 3 months after discontinuation**~~<br>• The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation**: to facilitate approval, please list the diagnosis, guideline version, and page number.** ~~**If so, please list the diagnosis**~~: _____.<br>Non-FDA approved uses are not approved**, except as noted above.**<br>Prior Authorization does not expire. |
| • adalimumab (Humira and biosimilars)<br><br>**TIBs: Tumor Necrosis Factors** | **Updates from the February 2026 Meeting are in bold and strikethrough**<br><u>Automated PA Criteria</u>: If the provider is a rheumatologist, dermatologist, or gastroenterologist prior authorization is not required.<br>Once therapy is initiated by a rheumatologist, dermatologist, or gastroenterologist and automated drug look back will apply, allowing continuation of coverage by any other prescriber if the patient has received the requested medication in the past 720 days.<br><u>Manual PA Criteria</u>: If automated criteria are not met, Humira is approved if all manual criteria are met:<br>• The prescriber is a rheumatologist, dermatologist, or gastroenterologist or the drug is prescribed in consultation with a rheumatologist, dermatologist, ~~**or**~~ gastroenterologist**, or pulmonologist** then continue with the questions below:<br>• Coverage is approved for patients 18 years of age or older with one of the following diagnoses/indications:<br>▪ Moderate to severe active rheumatoid arthritis (RA)<br>▪ Active psoriatic arthritis (PsA)<br>▪ Active ankylosing spondylitis (AS)<br>▪ Active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation<br>▪ Moderately to severe chronic plaque psoriasis (Ps) in patients who are candidates for systemic therapy or phototherapy<br>▪ Moderately to severely active Crohn's disease (CD)<br>▪ Moderate to severely active ulcerative colitis (UC)<br>▪ Moderate to severe hidradenitis suppurativa (HS)<br>▪ Non-infectious intermediate, posterior, and panuveitis |

| | |
|---|---|
| | ▪ Moderately to severely active pyoderma gangrenosum (PG) that is refractory to high-potency corticosteroids<br>▪ Generalized pustular psoriasis (GPP) with a history of at least two GPP flares of moderate-to-severe intensity in the past<br>▪ **Refractory sarcoidosis** OR<br>• Coverage approved for pediatric patients 2-17 years of age with one of the following diagnoses/indications:<br>▪ Moderate to severe active juvenile idiopathic arthritis (JIA), including subtypes<br>▪ Non-infectious intermediate, posterior, and panuveitis<br>▪ Moderate to severe plaque psoriasis (Ps) in patients who are candidates for systemic or phototherapy<br>▪ Moderate to severe hidradenitis suppurativa (HS)<br>▪ Moderately to severely active Crohn's disease (CD)<br>▪ Moderately to severely active ulcerative colitis (UC)<br>▪ Generalized pustular psoriasis (GPP) in patients with a history of at least two GPP flares of moderate-to-severe intensity in the past<br>▪ **Refractory sarcoidosis** AND<br>• Below criteria applies to AS and nr-axSpA indications only:<br>▪ Patient has had an inadequate response to at least two NSAIDs over a period of at least two months<br>• Below criteria apply to **all patients unless noted: ~~adult patients for all indications except for fistulizing Crohn's disease, ankylosing spondylitis (AS), nr-axSpA, psoriatic arthritis (PsA) and applies to pediatric patients with plaque psoriasis or Crohn's disease:~~**<br>▪ Patient has had an inadequate response**, intolerance, or contraindication** to non-biologic systemic therapy. (For example: methotrexate, aminosalicylates [e.g., sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g., azathioprine]), antibiotics or anti-androgens **(Note: does not apply to CD, UC, AS, nr-axSpA, PsA, or pediatric plaque psoriasis.)**<br>• Coverage is NOT provided for concomitant use with other TIBs including, but not limited to, the following: **~~certolizumab (Cimzia), etanercept (Enbrel), golimumab (Simponi), infliximab (Remicade), apremilast (Otezla), ustekinumab (Stelara), abatacept (Orencia), anakinra (Kineret), tocilizumab (Actemra), tofacitinib (Xeljanz/Xeljanz XR), rituximab (Rituxan), secukinumab (Cosentyx), ixekizumab (Taltz), brodalumab (Siliq), sarilumab (Kevzara), guselkumab (Tremfya), baricitinib (Olumiant), tildrakizumab (Ilumya), risankizumab (Skyrizi), or upadacitinib (Rinvoq ER).~~ TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, JAK inhibitors**<br>**Coverage for non-FDA-approved uses not listed above: Please provide the diagnosis and rationale for treatment. Supportive evidence will be considered.**<br>Prior authorization does not expire. |

## Appendix C—Table of Prior Authorization (PA) Criteria

| | |
|---|---|
| • conjugated equine estrogens (Premarin) tablets<br><br>**Menopausal Hormone Therapy: Oral Single Agents** | Manual PA criteria apply to new and current users of generic conjugated equine estrogens tablets at all points of service<br>The following will be added to the existing PA criteria<br><u>Manual PA criteria</u>: conjugated equine estrogen generics are approved if all criteria are met:<br>• The provider acknowledges that the brand Premarin tablet is the preferred product over generic conjugated equine estrogen tablets and is covered at the lowest copayment, which is the generic formulary copayment for non-Active-Duty patients, and at no cost share for Active-Duty patients. (Although Premarin is a branded product, it will be covered at the generic formulary copayment or cost share)<br>• A patient-specific justification must be provided as to why the brand Premarin product cannot be used in this patient.<br>▪ Acceptable reasons include the patient has had an adverse reaction to an excipient in the brand Premarin |
| • solriamfetol (Sunosi)<br><br>**Sleep Disorders: Wakefulness Promoting Agents** | **Updates from February 2025 are in bold and strikethrough**<br>Manual PA is required for all new users of solriamfetol (Sunosi)<br>**<u>Automated PA Criteria:</u> When the patient is 18 years or older and when prescribed by a neurologist, psychiatrist, sleep medicine specialist, pulmonologist, or cardiologist, prior authorization is not required**<br><u>Manual PA Criteria</u>: If automated PA criteria is not met, Sunosi is approved if all criteria are met:<br>• Provider acknowledges that PA is not required for modafinil or armodafinil<br>• Patient is 18 years of age of older<br>• ~~**When prescribed by a neurologist, psychiatrist, sleep medicine specialist, pulmonologist, or cardiologist, prior authorization is not required**~~<br>• Sunosi is prescribed for either:<br>▪ Excessive daytime sleepiness associated with narcolepsy:<br>– Prescribed by a neurologist, psychiatrist, or sleep medicine specialist<br>– Narcolepsy was diagnosed by polysomnogram or mean sleep latency time (MSLT) objective testing<br>– Other causes of sleepiness have been ruled out or treated including but not limited to obstructive sleep apnea<br>– The patient must have tried and failed, had a contraindication to, or had an inadequate response to modafinil or armodafinil<br>– The patient must have tried and failed, had a contraindication to, or had an inadequate response to stimulant-based therapy (amphetamine or methylphenidate)<br>▪ Excessive daytime sleepiness associated with obstructive sleep apnea:<br>– Prescribed by a specialist who treats patients with obstructive sleep apnea (e.g., pulmonologist, cardiologist, sleep medicine)<br>– Patient's underlying airway obstruction has been treated with continuous positive airway pressure (CPAP) for at least one month prior to initiation, and the patient demonstrated adherence to therapy during this time, and the patient will |

| | |
|---|---|
| | continue treatment for underlying airway obstruction (CPAP or similar) throughout duration of therapy<br>– The patient must have tried and failed, had a contraindication to, or had an inadequate response to modafinil or armodafinil<br>• The patient is not concurrently taking central nervous system depressants, such as a narcotic analgesic (including tramadol), a benzodiazepine, or a sedative hypnotic<br>Non-FDA-approved uses are not approved<br>Prior authorization expires in 1 year<br>**A new PA must be submitted annually**<br>Renewal PA criteria: No renewal allowed. A new prescription will require a new PA to be submitted. |
| • cyclosporine 0.05% ophthalmic emulsion unit dose (Restasis, generic unit dose)<br><br>**Ophthalmic: Dry Eye Agents** | **Updates from the February 2025 meeting are in bold and strikethrough**<br>• **When prescribed by an ophthalmologist or optometrist, prior authorization is not required**<br>• **Once therapy is initiated by an ophthalmologist or optometrist, an automated drug look back will apply, allowing continuation of coverage by any other prescriber if the patient has received the requested medication in the past 720 days**<br>Manual PA criteria apply to all new users of cyclosporine 0.05% ophthalmic emulsion unit-dose (Restasis unit-dose, generic)<br>Manual PA Criteria: **If automated criteria are not met,** Restasis is approved if all manual criteria are met:<br>• ~~**If the physician is an ophthalmologist or optometrist, then PA is not required**~~<br>• The drug is prescribed by an ophthalmologist or optometrist<br>• A diagnosis of moderate to severe dry eye disease is supported by both of the criteria below:<br>▪ Positive symptomatology screening for moderate to severe dry eye disease from an appropriate measure<br>▪ At least one positive diagnostic test (e.g., Tear Film Breakup Time, Osmolarity, Ocular Surface Staining, Schirmer Tear Test)<br>• Patient must try and fail the following:<br>▪ At least 1 month of one ocular lubricant used at optimal dosing and frequency (e.g., carboxymethylcellulose [Refresh, Celluvisc, Thera Tears, Genteal, etc.], polyvinyl alcohol [Liquitears, Refresh Classic, etc.], or wetting agents [Systane, Lacrilube])<br>▪ Followed by at least 1 month of a different ocular lubricant that is nonpreserved at optimal dosing and frequency (e.g., carboxymethylcellulose, polyvinyl alcohol)<br>• Concomitant use of Restasis, Cequa, or Xiidra is NOT allowed.<br>• Restasis unit-dose is also approved for the following conditions: graft rejection/graft versus host disease (GvHD), corneal transplant, atopic keratoconjunctivitis (AKC) / vernal keratoconjunctivitis (VKC), and LASIK associated dry eye (limited to 3 months of therapy)<br>Other Non-FDA-approved uses are not approved.<br>PA does not expire. |

## Appendix D—Table of Quantity Limits (QL)

| Drug / Drug Class | Quantity Limits |
|---|---|
| • ustekinumab-srlf (Imuldosa)<br>• ustekinumab-aauz (Otulfi)<br>• ustekinumab-aauz (unbranded Otulfi)<br>• ustekinumab-ttwe (Pyzchiva)<br>• ustekinumab-aekn (Selarsdi)<br>• ustekinumab-hmny (Starjemza)<br>• ustekinumab (Stelara)<br>• ustekinumab (unbranded Stelara)<br>• ustekinumab-stba (Steqeyma)<br>• ustekinumab-auub (Wezlana)<br>• ustekinumab-kfce (Yesintek)<br><br>**TIBs: IL-23 inhibitors** | ▪ Retail: 1 syringe or vial per fill<br>▪ MTF/TMOP: 3 syringes or vials per fill |
| • fedratinib (Inrebic)<br><br>**Oncological Agents: Myelofibrosis** | **Updates from the Feb 2026 meeting are in bold and strikethrough**<br>▪ Retail: ~~30-day supply~~ **60-day supply**<br>▪ MTF/TMOP: ~~30-day supply~~ **60-day supply** |
| • momelotinib (Ojjaara)<br>• ruxolitinib (Jakafi)<br><br>**Oncological Agents: Myelofibrosis** | ▪ MTF/TMOP/Retail: 60-day supply |
| • pacritinib (Vonjo)<br><br>**Oncological Agents: Myelofibrosis** | **Updates from the Feb 2026 meeting are in bold and strikethrough**<br>▪ Retail: ~~30-day supply~~ **60-day supply**<br>▪ MTF/TMOP: 60-day supply |
| • cyclobenzaprine 2.8 SL tab (Tonmya)<br><br>**Skeletal Muscle Relaxants & Combinations: Tricyclic Antidepressants (TCAs)** | ▪ MTF/TMOP/Retail: 60 tabs per 30 days<br>▪ Note this is a temporary QL until implementation of complete exclusion status |
| • elamipretide injection (Forzinity)<br><br>**Metabolic agents: Miscellaneous** | ▪ MTF/TMOP/Retail: 30-day supply |
| • elinzanetant (Lynkuet)<br><br>**Gynecological Agents Miscellaneous** | ▪ MTF/TMOP/Retail: 60 caps per 30 days |
| • mitapivat (Aqvesme)<br><br>**Metabolic Agents: Miscellaneous** | ▪ MTF/TMOP/Retail: 30-day supply |

## Appendix D—Table of Quantity Limits (QL)

| Drug / Drug Class | Quantity Limits |
|---|---|
| • nerandomilast (Jascayd)<br><br>**Pulmonary-1 Agents: Idiopathic Pulmonary Fibrosis** | ▪ MTF/TMOP/Retail: 60 tabs per 30 days |
| • paltusotine (Palsonify)<br><br>**Endocrine Agents miscellaneous** | ▪ MTF/TMOP/Retail: 30-day supply |
| • plozasiran injection (Redemplo)<br><br>**Antilipidemics-2** | ▪ MTF/TMOP/Retail: 90-day supply |
| • remibrutinib (Rhapsido)<br><br>**Atopy Agents** | ▪ MTF/TMOP/Retail: 60-day supply |
| • sevabertinib (Hyrnuo)<br><br>**Lung Cancer: HER2+**<br>**Lung Cancer: Human Epidermal Growth Factor Receptor 2 (HER2) Agents** | ▪ MTF/TMOP/Retail: 120 tabs per 30 days |
| • sibeprenlimab injection (Voyxact)<br><br>**Miscellaneous:**<br>**Nephrology Agents** | ▪ MTF/TMOP/Retail: 30-day supply |
| • ziftomenib (Komzifti)<br><br>**Leukemia and Lymphoma: Acute Myelogenous Leukemia** | ▪ MTF/TMOP/Retail: 90 capsules per 30 days |
| • semaglutide tablets (Wegovy)<br><br>**Metabolic Dysfunction Agents: Weight Loss Agents** | ▪ Retail: 30 tabs per 30 days with a 30-day supply limit<br>▪ MTF/TMOP: 60 tabs per 60 days with a 60-day supply limit |

## Appendix E—Formulary Recommendations for Newly Approved Drugs per 32 CFR 199.21(g)(5)

| Generic (Trade)<br>UF Class | Comparators | Strength/ Form/ Dosing | Indications | Adverse Events | Clinical Summary | Recommendation |
|---|---|---|---|---|---|---|
| • celecoxib 10 mg/mL oral solution (Vyscoxa)<br><br>**Pain Agents: Non-Steroidal Anti-inflammatory Drugs (NSAIDs)** | • celecoxib capsules<br>• celecoxib oral solution (Elyxyb)<br>• naproxen suspension<br>• meloxicam suspension | • Oral suspension: 10mg/ml | • Indicated in adults for osteoarthritis, rheumatoid arthritis, ankylosing spondylitis, and in pediatric patients 2 years and older for juvenile rheumatoid arthritis | • abdominal pain<br>• diarrhea<br>• dyspepsia<br>• flatulence<br>• peripheral edema<br>• dizziness<br>• pharyngitis<br>• rhinitis<br>• rash | • Oral suspension formulation of celecoxib requiring administration on an empty stomach<br>• No new clinical efficacy studies; approved via 505(b)(2)<br>• Vyscoxa has a maximum single dose of 200 mg and higher doses may result in higher than intended plasma concentrations<br>• Vyscoxa must be discarded 21 days after opening<br>• For those who cannot swallow pills, celecoxib capsules can be opened and sprinkled on applesauce, naproxen and meloxicam suspensions are available on formulary, and ibuprofen suspension is OTC<br>• Provides no compelling clinical advantage over existing agents | • Complete Exclusion |
| • clonidine 0.02 mg/mL oral solution (Javadin)<br><br>**Anti-hypertensive Agents** | • clonidine IR/ER tablets<br>• clonidine transdermal patch | • 0.02 mg/mL supplied in 250 mL bottles<br>• 0.2 mg BID daily; titrate up to 0.6 mg/day in divided doses<br>• Max dose 2.4 mg/day | • Treatment of hypertension in adults to lower blood pressure | • dry mouth<br>• drowsiness<br>• dizziness<br>• constipation<br>• sedation | • First liquid oral formulation of clonidine<br>• No new clinical studies; approved via 505(b)(2) pathway using data from Catapress tablets<br>• Mixed berry flavor<br>• Not for pediatric use; FDA approval letter states “This product does not represent a meaningful therapeutic benefit over existing therapies for pediatric patients and is unlikely to be used in a substantial number of pediatric age patients”<br>• Requires an oral dosing syringe or oral dosing cup for correct dosing but is not supplied. Can not use teaspoons for dosing<br>• Provides no compelling clinical advantage over existing agents | • Complete Exclusion |

## Appendix E—Formulary Recommendations for Newly Approved Drugs per 32 CFR 199.21(g)(5)

| Generic (Trade)<br>UF Class | Comparators | Strength/ Form/ Dosing | Indications | Adverse Events | Clinical Summary | Recommendation |
|---|---|---|---|---|---|---|
| • cyclobenzaprine SL tablet (Tonmya)<br><br>**Skeletal Muscle Relaxants & Combinations: Tricyclic Antidepressants (TCAs)** | • cyclo-benzaprine<br>• pregabalin<br>• duloxetine | • Tab: 2.8 mg<br>• 5.6mg QD QHS | • Fibromyalgia in adults | • oral hypoesthesia<br>• oral discomfort<br>• abnormal product taste<br>• somnolence<br>• oral paresthesia<br>• oral pain<br>• dry mouth<br>• aphthous ulcer | • First sublingual formulation of cyclobenzaprine<br>• Approved via 505(b)(2) pathway using data from cyclobenzaprine tablets<br>• Two phase 3 trials demonstrated greater reductions in daily pain scores from baseline versus placebo<br>• A third trial did not find statistical significance between treatment with Tonmya and placebo<br>• Trials excluded patients on common agents used for fibromyalgia and no patients aged 65 or older were included in the trials by design<br>• Provides no compelling clinical advantage over existing agents | • Complete Exclusion |
| • elamipretide (Forzinity)<br><br>**Metabolic agents Miscellaneous** | • No formulary alternatives | • single use vial: 280mg/3.5ml<br>• 40mg SC QD | • Indicated to improve muscle strength in patients with Barth syndrome weighing at least 30 kg | • Injection site reactions | • FDA approval drawn from several sources including a randomized trial with open label extension period and a retrospective natural cohort study<br>• Consideration for approval was based on an acceptance of higher level of uncertainty of data based upon the rarity of the disease and the unmet need for treatment<br>• FDA Advisory Committee Meeting voted 10 'yes' and 6 'no' with regards to the available evidence and effectiveness of elamipretide for Barth Syndrome<br>• Provides a treatment option for this rare disorder | • NF<br>• PA<br>• MN<br>• QL<br>• Specialty Drug List<br>• TRICARE Maintenance Drug List |
| • elinzanetant (Lynkuet)<br><br>**Gynecological Agents Miscellaneous** | • fezolinetant (Veozah)<br>• venlafaxine<br>• escitalopram<br>• gabapentin | • Cap: 60 mg<br>• 120mg PO QHS | • Treatment of moderate to severe vasomotor symptoms (VMS) due to menopause | • headache<br>• fatigue<br>• dizziness<br>• somnolence | • Two phase 3 studies demonstrated improvement in the frequency and severity of VMS due to menopause vs. placebo at Week 4 and Week 12<br>• No direct comparative trials with Lynkuet and Veozah<br>• Veozah has a Boxed Warning for hepatoxicity; where monitoring is required; Lynkuet has a warning for hepatic | • UF<br>• PA<br>• QL |

## Appendix E—Formulary Recommendations for Newly Approved Drugs per 32 CFR 199.21(g)(5)

| Generic (Trade) UF Class | Comparators | Strength/ Form/ Dosing | Indications | Adverse Events | Clinical Summary | Recommendation |
|---|---|---|---|---|---|---|
| | | | | | transaminase elevations that requires follow-up monitoring<br>• Veozah is contraindicated in patients with cirrhosis and severe renal impairment or end-stage renal disease while Lynkuet is contraindicated only in pregnancy<br>• Lynkuet is an alternative to Veozah in patients who cannot tolerate or are unable to use hormone therapy for the treatment of moderate to severe VMS | |
| • furosemide 80 mg SQ injection (Lasix Onyu)<br><br>**Diuretics** | • Furoscix SC on body infusor<br>• Enbumyst nasal spray<br>• furosemide tablets | • 80 mg/2.67 mL SQ delivered over 5 hours (30 mg 1st hour; 12.5 mg/hr x 4 hrs)<br>• Single-dose prefilled cartridge is packaged with a disposable infusor | • Treatment of edema in adults with chronic heart failure | • fluid/electrolyte /metabolic abnormalities<br>• postural hypotension<br>• ototoxicity<br>• same warnings as furosemide tablets | • 3rd loop diuretic available in an alternative dosage form for heat failure (after Furoscix and Enbumyst)<br>• Available in a drug-device combination; required a bulky power-charging cord; the unit is reusable<br>• No new clinical studies; approved via 505(b)(2) pathway using data from Lasix tablets<br>• Pharmacokinetic study was conducted in only 18 patients<br>• No data available to show Lasix ONYOU prevents ER admissions or hospitalizations<br>• Not for chronic use; must transition to oral diuretics “as soon as practical”<br>• Complicated patient instructions<br>• Provides no compelling clinical advantage over existing agents | • Complete Exclusion |
| • mitapivat (Aqvesme)<br><br>**Metabolic Agents: Misc** | • Reblozyl | • Tablet: 100mg<br>• 100mg PO BID | • Treatment of anemia in adults with alpha- or beta-thalassemia | • headache<br>• insomnia | • One study in transfusion dependent alpha- or beta- thalassemia resulted in a statistically significant reduction in transfusion burden with Aqvesme vs. pbo<br>• One study in non-transfusion dependent alpha- or beta-thalassemia resulted in a statistically significant positive hemoglobin response with Aqvesme vs. pbo<br>• Aqvesme is well tolerated, however it has a black box warning, REMS requirement due to hepatocellular injury<br>• Offers an additional treatment option for these conditions | • UF<br>• PA<br>• QL<br>• Specialty Drug List |

## Appendix E—Formulary Recommendations for Newly Approved Drugs per 32 CFR 199.21(g)(5)

| Generic (Trade)<br>UF Class | Comparators | Strength/ Form/ Dosing | Indications | Adverse Events | Clinical Summary | Recommendation |
|---|---|---|---|---|---|---|
| • nerandomilast (Jascayd)<br><br>**Pulmonary-1 Agents: Idiopathic Pulmonary Fibrosis** | • Esbriet<br>• Ofev | • Tablet:18mg PO BID | • Treatment of idiopathic pulmonary fibrosis (IPF) in adult patients | • diarrhea<br>• depression<br>• weight loss<br>• anorexia<br>• nausea<br>• fatigue<br>• headache<br>• vomiting<br>• back pain<br>• dizziness | • Jascayd is the first IPF therapy studied in combination with other antifibrotic agents<br>• One phase 3 study and one phase 2 study demonstrated differences in the adjusted change in forced vital capacity (FVC) favoring Jascayd over placebo (with or without background antifibrotic therapies)<br>• Jascayd has no warnings or precautions as compared to other agents for IPF<br>• Rate of trial discontinuation due to adverse events with Jascayd was comparable to that observed with pirfenidone (around 15%), but slightly lower compared with Ofev (21%)<br>• Therapeutic alternative to Ofev and pirfenidone, or as combination therapy, but did not improve survival and did not improve patient quality of life scores | • UF<br>• PA<br>• QL<br>• Specialty Drug List |
| • omidenepag isopropyl 0.002% ophthalmic solution (Omlonti)<br><br>**Glaucoma Agents** | • latanoprost,<br>• bimatoprost | • 0.002% solution in 5mL multi-dose bottle<br>• 1 drop in affected eye QD QHS | • Reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension | • conjunctival hyperemia<br>• photophobia<br>• vision blurred<br>• dry eye<br>• eye pain<br>• ocular hyperemia<br>• punctate keratitis<br>• headache<br>• visual impairment | • Three unpublished phase 3 studies. Two demonstrated noninferiority to latanoprost 0.005% and timolol 0.5%. The third study failed to demonstrate non-inferiority to timolol 0.5%<br>• Omlonti has more ADEs associated with ocular discomfort and conjunctival hyperemia but has fewer ADEs relating to eyelash and eyelid discoloration/changes compared to other prostaglandin analogs<br>• Provides another therapeutic alternative for these conditions | • NF<br>• PA<br>• MN<br>• TRICARE Maintenance Drug List |

## Appendix E—Formulary Recommendations for Newly Approved Drugs per 32 CFR 199.21(g)(5)

| Generic (Trade)<br>UF Class | Comparators | Strength/ Form/ Dosing | Indications | Adverse Events | Clinical Summary | Recommendation |
|---|---|---|---|---|---|---|
| • paltusotine (Palsonify)<br><br>**Endocrine Agents miscellaneous** | • octreotide<br>• Mycapssa<br>• Somavert | • Tablet: 20 mg, 30 mg<br>• 20 to 60 mg PO QD | • Treatment of adults with acromegaly who has an inadequate response to surgery and/or for whom surgery is not an option | • diarrhea<br>• abdominal pain<br>• nausea<br>• gastroenteritis<br>• anorexia<br>• hyperglycemia<br>• palpitations<br>• sinus bradycardia | • Two phase 3 studies demonstrated statistically significant achievement or maintenance of biochemical control as measured by IGF-1 levels when compared with placebo<br>• Overall, well tolerated with mostly mild adverse events consistent with known mechanism of the drug<br>• Provides an additional treatment option for this disorder | • NF<br>• PA<br>• MN<br>• QL<br>• Specialty Drug List<br>• TRICARE Maintenance Drug List |
| • plozasiran (Redemplo)<br><br>**Antilipidemics-2** | • Tryngolza | • PFS: 25mg/0.5ml<br>• 25mg SC once every 3 months | • Adjunct to diet to reduce triglycerides (TG) in familial chylomicronemia syndrome (FCS) | • hyperglycemia<br>• headache<br>• nausea<br>• site reaction | • One phase 3 study demonstrated -80% TG reduction at 10 months v -17% for placebo<br>• Patients who received Redemplo or Tryngolza had a lower numerical incidence of acute pancreatitis vs. placebo<br>• Rate of trial discontinuation due to adverse events with Redemplo was comparable to that observed with Tryngolza<br>• Redemplo requires less frequent administration compared to Tryngolza<br>• Therapeutic alternative to Tryngolza in the management of FCS in adults | • UF<br>• PA<br>• QL<br>• Specialty Drug List<br>• TRICARE Maintenance Drug List |
| • remibrutinib (Rhapsido)<br><br>**Atopy Agents** | • Xolair<br>• Dupixent | • Tablet 25mg<br>• 25mg PO BID | • Treatment of chronic spontaneous urticaria in adult who remain symptomatic despite antihistamines | • nasopharyngitis<br>• bleeding<br>• headache<br>• nausea<br>• abdominal pain | • Two identical phase 3 studies demonstrated statistically significant reductions in Urticaria Activity Scores compared to placebo<br>• Overall, well tolerated with mild adverse events (e.g. nasopharyngitis, headache)<br>• Provides an additional treatment option for this disease state | • NF<br>• PA<br>• MN<br>• QL<br>• Specialty Drug List |

## Appendix E—Formulary Recommendations for Newly Approved Drugs per 32 CFR 199.21(g)(5)

| Generic (Trade) UF Class | Comparators | Strength/ Form/ Dosing | Indications | Adverse Events | Clinical Summary | Recommendation |
|---|---|---|---|---|---|---|
| • sevabertinib (Hyrnuo)<br><br>**Lung Cancer: Human Epidermal Growth Factor Receptor 2 (HER2) Agents** | • Hernexeos<br>• Enhertu | • Tablet: 10 mg<br>• 20mg PO BID | • Treatment of adults with locally advanced or metastatic non-squamous non-small cell lung cancer (NSCLC) with HER2 tyrosine kinase domain activating mutations, as detected by an FDA-approved test, and received a prior systemic therapy | • diarrhea<br>• rash<br>• paronychia<br>• stomatitis<br>• nausea | • Single arm study demonstrated Hyrnuo was effective with an objective response rate (ORR) of 71% in patients previously treated with prior platinum chemotherapy and/or immunotherapy<br>• In a cohort of 52 patients, Hyrnuo demonstrated an ORR of 38% in patients previously treated with a HER-2 targeted antibody-drug conjugates (e.g., Enhertu)<br>• Ongoing Phase III study comparing Hyrnuo with current standard of care regimen containing a checkpoint inhibitor + platinum chemotherapy + pemetrexed in the first-line setting; Hernexeos has a similar ongoing trial<br>• NCCN guidelines recommend Hyrnuo, Hernexeos, and Enhertu as “Preferred” subsequent therapy options for HER2-mutation positive NSCLC<br>• Alternative to Hernexeos and Enhertu for its FDA-approved indication | • UF<br>• PA<br>• QL<br>• Specialty Drug List<br>• TRICARE Maintenance Drug List |
| • sibeprenlimab injection (Voyxact)<br><br>**Miscellaneous Nephrology Agents for IgAN** | • Vanrafia<br>• Fabhalta<br>• Tarpeyo<br>• Filspari | • SC- prefilled single dose syringe as 400mg/2ml: 400mg Q4W | • Reduces proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk for disease progression | • Upper respiratory tract infection<br>• Injection site erythema | • Based on an interim analysis from the ongoing pivotal VISIONARY trial, Voyxact demonstrated favorable efficacy vs. placebo in urinary-protein creatinine ratio reduction; in contrast to the other IgAN drugs, background use of SGLT2s was allowed; no difference was seen in the results with or without SGLTs<br>• Filspari is the only agent indicated to slow kidney function decline based on completed confirmatory studies<br>• Indirect comparison of the interim results with the other IgAN drugs shows a similar relative reduction in proteinuria<br>• ACE inhibitors and ARBs should be continued with Voyxact, Vanrafia, and Fabhalta, but discontinued before starting Filspari (since it contains an angiotensin II receptor antagonist) | • NF<br>• PA<br>• MN<br>• QL<br>• Specialty Drug List<br>• TRICARE Maintenance Drug List |

## Appendix E—Formulary Recommendations for Newly Approved Drugs per 32 CFR 199.21(g)(5)

| Generic (Trade) UF Class | Comparators | Strength/ Form/ Dosing | Indications | Adverse Events | Clinical Summary | Recommendation |
|---|---|---|---|---|---|---|
| | | | | | • Voyxact is a therapeutic alternative to Fabhalta, Filspari, and Vanrafia, and although it works via a different mechanism of action, confirmatory trials are needed | |
| • ustekinumab-hmny (Starjemza)<br><br>**Targeted Immuno-modulatory Biologics: IL23** | • Stelara<br>• Wezlana<br>• Steqeyma<br>• Otulfi<br>• Pyzchiva<br>• Selarsdi<br>• Yesintek<br>• Imuldosa | • SC-prefilled syringe as 45mg/0.5mL, 90mg/1mL<br>• SC-single dose vial as 45mg/0.5mL | • Adults: moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy, active psoriatic arthritis, moderate to severely active Crohn's, moderate to severely active ulcerative colitis<br>• Pediatrics 6 or older: moderate to severe plaque psoriasis for candidates of phototherapy or systemic therapy, active psoriatic arthritis | • indication specific | • 12th biosimilar to Stelara<br>• Approved via 351(k); no new clinical studies were completed<br>• Non-Trade Agreement Act compliant<br>• Provides no compelling clinical advantage over existing agents | • UF<br>• PA<br>• QL<br>• Specialty Drug List |
| • ziftomenib (Komzifti)<br><br>**Leukemia and Lymphoma: Acute Myelogenous Leukemia** | • Revuforj | • Tablet: 600 mg po daily, continue for at least 6 months | • Adult patients with relapsed or refractory AML with NPM1 mutation without satisfactory alternative options | • edema<br>• pruritus<br>• electrolyte abnormalities<br>• GI upset<br>• hemorrhage<br>• LFT elevations<br>• acute kidney failure<br>• infection<br>• fatigue | • Phase 2 open label study demonstrated activity in heavily pretreated adults with relapsed/refractory NPM1-mutated AML, achieving a 21.4% CR/CRh rate and a median response duration of 5 months<br>• Komzifti can only be used in adults while Revuforj can be used adults and pediatric patients ≥ 1 year of age<br>• Indirect efficacy comparison reveals similar efficacy profiles for this indication<br>• Both agents have a boxed warning for differentiation syndrome, but Revuforj has additional boxed warning for QT prolongation | • UF<br>• PA<br>• QL<br>• Specialty Drug List<br>• TRICARE Maintenance Drug List |

## Appendix E—Formulary Recommendations for Newly Approved Drugs per 32 CFR 199.21(g)(5)

| Generic (Trade)<br>UF Class | Comparators | Strength/ Form/<br>Dosing | Indications | Adverse Events | Clinical Summary | Recommendation |
|---|---|---|---|---|---|---|
| | | | | | • NCCN guidelines list both medications as category 2A for relapsed/refractory AML with NPM1 mutation<br>• Compared to Revuforj pivotal study AUGMENT-01, Komzifti patients experienced less QTc interval prolongation, less anemia, less febrile neutropenia and less thrombocytopenia | |

## Appendix F—TRICARE Maintenance Drug List Status of Medications Designated Formulary or Nonformulary*

### Table 1: TRICARE Maintenance Drug List Status of Medications Designated Formulary or Nonformulary with implementation the first Wednesday 2 weeks after signing of the minutes*

| P&T Meeting | ADD to the TRICARE Maintenance Drug List (if Formulary, Add; if NF, NOT Exempted from NF TMOP Requirement) | Do NOT Add to the TRICARE Maintenance Drug List (if Formulary, Do Not Add; if NF, Exempted from NF TMOP Requirement) |
|---|---|---|
| February 2026 | **Drug Class Reviews**<br><br>**Oncological Agents: Myelofibrosis**<br>***Designated UF***<br>*Retain current status on the TMDL*<br>• fedratinib (Inrebic)<br><br>**Targeted Immunomodulatory Biologics: IL-23 Inhibitors: ustekinumab products**<br>***Designated UF***<br>*Retain current status on the TMDL*<br>• All UF ustekinumab products except for ustekinumab-hmnv (Starjemza; not compliant with the Trade Agreement Act) and ustekinumab-aauz (unbranded Otulfi only; not cost advantageous)<br>***Designated NF***<br>*Retain current status on the TMDL*<br>• All NF ustekinumab products<br><br>**Newly Approved Pharmaceutical Agents per 32 CFR 199.21(g)(5)~~)~~**<br>***Designated NF***<br>*Add – no reason to exempt from NF TMOP requirement)*<br>• omidenepag isopropyl 0.002% ophthalmic solution (Omlonti) | **Newly Approved Pharmaceutical Agents per 32 CFR 199.21(g)(5)**<br>***Designated UF***<br>*Do not add–acute use*<br>• mitapivat (Aqvesme)<br>*Do not add–not cost advantageous*<br>• elinzanetant (Lynkuet)<br>• nerandomilast (Jascayd)<br><br>***Designated NF***<br>*Exempt from NF TMOP requirement–not cost advantageous*<br>• remibrutinib (Rhapsido)<br><br>**Other Items Endocrine Agents Miscellaneous**<br>***Designated UF***<br>*Remove from/do not add to TMDL –not cost advantageous to government*<br>• octreotide (Bynfezia Pen) |

***Legal/Regulatory Authorities**

- 10 USC 1074g(a)(9) requires beneficiaries generally to fill non-generic prescription maintenance medications at MTFs or TMOP. Medications subject to these requirements are listed on the TRICARE Maintenance Drug List (TMDL).
- 32 CFR 199.21(r) implements 10 USC 1074g(a)(9) and sets out operation of the TMDL in detail.
- 32 CFR 199.21(h)(2)(ii) requires that non-formulary pharmaceutical agents be "generally not available in military treatment facilities or in the retail point of service." As a result, NF/Tier 3 agents (including generics) must be on the TMDL unless a reason exists to exempt the agent from the NF TMOP requirement (e.g., acute use, clinical considerations, not available at TMOP, cost effectiveness).
- 32 CFR 199.21(g)(5) covers formulary status and review of newly approved drugs (other than generics), which are added to the UF unless the P&T Committee recommends NF/Tier 3 status within 120 days of approval. In the meantime, newly approved drugs are considered to be in a classification pending status and available under the same terms as NF/Tier 3 medications.

## Appendix F—TRICARE Maintenance Drug List Status of Medications Designated Formulary or Nonformulary

### Table 2: TRICARE Maintenance Drug List Status of Medications Designated Formulary or Nonformulary with an Implementation Date Contingent on Cost Effectiveness & Operational Considerations

| P&T Meeting | ADD to the TRICARE Maintenance Drug List (if Formulary, Add; if NF, NOT Exempted from NF TMOP Requirement) | Do NOT Add to the TRICARE Maintenance Drug List (if Formulary, Do Not Add; if NF, Exempted from NF TMOP Requirement) |
|---|---|---|
| February 2026 | **Drug Class Reviews**<br><br>**Oncological Agents: Myelofibrosis**<br>***Designated UF***<br>*Retain current status on the TMDL*<br>• momelotinib (Ojjaara)<br>• pacritinib (Vonjo)<br>• ruxolitinib (Jakafi)<br><br>**Targeted Immunomodulatory Biologics: IL-23 Inhibitors: ustekinumab products**<br>***Designated UF***<br>*Add if not already on the TMDL*<br>• All ustekinumab products except for ustekinumab-hmnv (Starjemza; not compliant with the Trade Agreement Act) and ustekinumab-aauz (unbranded Otulfi only; not cost advantageous)<br><br>**Newly Approved Pharmaceutical Agents per 32 CFR 199.21(g)(5)**<br>***Designated UF***<br>• plozasiran (Redemplo)<br>• sevabertinib (Hyrnuo)<br>• ziftomenib (Komzifti)<br><br>***Designated NF***<br>*No reason to exempt from TMOP requirement*<br>• elamipretide (Forzinity)<br>• paltusotine (Palsonify)<br>• sibeprenlimab injection (Voyxact) | |

**Implementation Dates for UF Recommendations/Decisions***
*Due to the volume of recommendations requiring implementation due to the UF Beneficiary Advisory Panel pause, one week was added to implementation, which is reflected in the dates below.*

**Upon signing:** July 20, 2026

**Two weeks after signing:** August 12, 2026

**30 days after Signing**: August 26, 2026

**60 days after signing:** September 29, 2026

**90 days after signing:** October 28, 2026

**120 days after signing:** December 2, 2026, due to the Thanksgiving Day holiday

* Note that implementation occurs the first Wednesday following "X" days after signing of the minutes in all points of service.

† P&T Committee Administrative Authorities were used to implement some recommendations not requiring UF BAP comment. See the November 2023 Table of Administrative Authorities.

.

## Appendix H—Complete Exclusion Drugs and Therapeutic Alternatives*

| P&T Date | Drug Class | Completely Excluded Products | Formulary Alternatives | Implementation |
|---|---|---|---|---|
| February 2026 | Pain Agents: NSAIDs | • celecoxib 20 mg/mL oral suspension (Vyscoxa) | • celecoxib caps<br>• meloxicam oral suspension<br>• naproxen oral suspension | • 120 days |
| February 2026 | Antihypertensive Agents | • clonidine HCl 0.02 mg/mL oral solution (Javadin) | • clonidine tablets<br>• clonidine transdermal system | • 120 days |
| February 2026 | Skeletal Muscle Relaxants and Combinations | • cyclobenzaprine 2.8 mg sublingual tablets (Tonmya) | • cyclobenzaprine tabs<br>• pregabalin caps<br>• duloxetine caps | • 120 days |
| February 2026 | Diuretics | • furosemide 80 mg/mL subcutaneous injection (Lasix ONYU) | • furosemide tablets<br>• bumetanide tablets<br>• torsemide tablets | • 120 days |

*The P&T Committee may recommend complete exclusion of any pharmaceutical agent from the TRICARE pharmacy benefits program the Director determines provides very little or no clinical effectiveness relative to similar agents. All TRICARE complete exclusion agents that are not eligible for cost-sharing were reviewed for clinical and cost-effectiveness in accordance with 32 CFR 199.21(e)(3).

Drugs recommended for complete exclusion will not be available at the MTFs or TMOP points of service. Beneficiaries will be required to pay the full out-of-pocket cost for the complete exclusion agents at the Retail points of service.

For a cumulative listing of all completely excluded agents to date, refer to previous versions of the P&T Committee quarterly meeting minutes, found on the health.mil website.

## Ustekinumab Therapeutic Substitution

All orders written by an MTF provider for dispensing at an MTF pharmacy for a non-preferred ustekinumab product will be therapeutically interchanged by the MTF pharmacy to the preferred ustekinumab product unless the provider indicates "dispense as written"; additional PA and MN criteria apply in these situations. See Table 1.

Orders will be converted with the same (1:1) dosage and frequency between products.

Orders may be converted between dosage forms (i.e. prefilled syringe, prefilled pen, vials).

Newly approved ustekinumab products will be added to the non-preferred list.

**Table 1: Ustekinumab Therapeutic Substitution**

| Preferred Product | Non preferred Product |
|---|---|
| **ustekinumab-aauz (Otulfi)** | ▪ ustekinumab-srlf (Imuldosa)<br>▪ ustekinumab-aauz (unbranded Otulfi)<br>▪ ustekinumab-ttwe (Pyzchiva)<br>▪ ustekinumab-aekn (Selarsdi)<br>▪ ustekinumab-hmny (Starjemza)<br>▪ ustekinumab (Stelara)<br>▪ ustekinumab (unbranded Stelara)<br>▪ ustekinumab-stba (Steqeyma)<br>▪ ustekinumab-auub (Wezlana)<br>▪ ustekinumab-kfce (Yesintek) |