



Andrea Barton Reeves, J.D. Commissioner

Effective Date: January 1, 2026

Contact: See Below

TO: Pharmacies, Physicians, Advance Practice Registered Nurses, Nurse Midwives, Physician Assistants, Long Term Care Providers, Clinics, and Hospitals

RE: UPDATED Pharmacy Clinical Prior Authorization Criteria and Prior Authorization Forms for Non-Preferred Drugs in 11 Targeted Classes

This Provider Bulletin supersedes [PB 2025-59](#).

Effective **January 1, 2026**, the Department of Social Services (DSS) implemented new clinical criteria on non-preferred drugs specific to 11 Preferred Drug List (PDL) managed classes when prescribing for HUSKY A, HUSKY C, HUSKY D, Tuberculosis (TB), Emergency Medicaid Dialysis Service (EMDS), and Family Planning (FAMPL) clients.

The 11 drug classes include the following:

- Anticonvulsants
- Bladder Relaxant Preparations
- Cytokine & CAM Antagonists
- Growth Hormones
- Multiple Sclerosis Agents
- Pulmonary Arterial Hypertension Agents
- Immunomodulators, Asthma and Atopic Dermatitis (Injectable)*
- Antimigraine: Other (CGRP targeting therapies, 5-HT1F receptor agonist)*
- Colony Stimulating Factors
- Antipsoriatic Topical
- Hypoglycemics, Incretin Mimetics/ Enhancers (GLP-1 RA and combinations (as indicated for Diabetes))*

For classes denoted with an asterisk(*), only non-preferred drugs in the specific sub-class as indicated in parentheses, are subject to the new clinical prior authorization at this time.

90-Day Transitional Period

Members who are established on a non-preferred drug within the 11 drug classes listed will be allowed to continue therapy on or after January 1, 2026, until March 31, 2026. Starting April 1, 2026, all members with prescriptions for non-preferred drugs in the **Antipsoriatic topical, Antimigraine: Other (CGRP targeting therapies, 5-HT1F receptor agonist), and Hypoglycemics, Incretin Mimetics/ Enhancers (GLP-1 RA and combinations (as indicated for Diabetes) drug classes** will be subject to the clinical criteria with their next refill.

Members on medications in the other 8 drug classes will be subject to the clinical criteria when their current prior authorization expires.

Prescribers are encouraged to consider moving their patients to preferred options. If a preferred drug is not a clinically appropriate option for a member, prescribers must submit a prior authorization request with supporting clinical information and, if the prescriber chooses, also submit a Letter of Medical Necessity for continuation of therapy. A Letter of Medical Necessity may also be submitted subsequent to a denial of prior authorization as detailed below.

Previously approved Preferred Drug List Prior Authorizations

Beginning April 1, 2026, all previously approved PDL prior authorizations for the

Antipsoriatic topicals, Antimigraine: Other (CGRP targeting therapies, 5-HT1F receptor agonist), and Hypoglycemics, Incretin Mimetics/ Enhancers (GLP-1 RA and

combinations (as indicated for Diabetes) drug classes will no longer be valid at the member's next refill. Previously approved PDL prior authorizations for the remaining eight drug classes will remain valid until their expiration date – 12 months after initial approval for non-controlled substances and 6 months for controlled substances. **Providers must submit a new *clinical* prior authorization using the updated prior authorization forms for review and approval.**

Clinical Criteria and Prior Authorization Forms

New clinical criteria and new prior authorization forms specific to these 11 drug classes are available on www.ctdssmap.com → Pharmacy Information → Pharmacy Program Publications → Prior Authorization Form Directory Drug and Diabetic Product Search Link (NEW 1/1/2026). Coverage determinations for these 11 drug classes are made in accordance with the state's statutory definition of Medical Necessity (CGS § 17b-259b). Clinical criteria are guidelines only. Coverage determinations are based on an assessment of the member and their clinical needs and will be based upon a review of submitted and/or requested case-specific information.

Submission of Clinical Prior Authorization

Prior authorizations must be submitted via fax similar to the existing process used today. The completed prior authorization form must be prepared and signed by the prescribing provider and faxed to 1-866-759-4110. **All required documentation as indicated on the prior authorization form must be submitted with the form.** Incomplete prior authorization forms or submissions without appropriate documentation will be denied.

New Prescriptions

For members who are not established on a non-preferred drug within the 11 drug classes listed prior to January 1, 2026, the prescribing provider must submit a prior authorization with the supporting clinical information as it relates to the criteria. If the prior authorization is not approved for the non-preferred drug, the prescriber will need to prescribe a preferred drug for their patient.

Preferred Drugs

Preferred drugs in the 11 drug classes listed will not require a prior authorization.

Non-Preferred Drugs in other classes

Non-preferred drugs which are NOT part of the 11 drug classes, will continue to require the standard PDL prior authorization. Prior authorization requests for these non-preferred drugs should continue to be submitted in Section 15 of the [Standard Prior Authorization Form](#) unless otherwise specified.

Pharmaceutical and Therapeutics Committee

The Pharmaceutical and Therapeutics Committee ("P&T Committee") for the Connecticut Medical Assistance Program is established under the authority of section 17b-274d of the Connecticut General Statutes. The purpose of the P&T Committee is to adopt one or more PDLs for use in the Connecticut Medical Assistance Program.

Fair Hearings / Appeals / Medically Necessary

Members who wish to appeal a denied prior authorization may do so following current guidelines, as outlined at the bottom of the prior authorization denial letter that is mailed to the member.

Prescribers may also exercise their right to submit a Letter of Medical Necessity for consideration along with the prior authorization

form and required documentation. A Letter of Medical Necessity must be submitted to the Department's Chief Medical Officer (rx.lmn@ct.gov) for consideration if a prior authorization request is denied.

Additional Information:

Additional information to include FAQs, criteria, prior authorization forms, and current PDL can be accessed on the Web site www.ctdssmap.com → Pharmacy Information.

Posting Instructions:

Policy transmittals can be downloaded from the Web site at www.ctdssmap.com.

Distribution:

This policy transmittal is being distributed to CMAP providers by Gainwell Technologies.

Responsible Unit:

DSS, Division of Health Services; Herman Kranc, Integrated Care, Pharmacy Unit, email herman.kranc@ct.gov.

Date Issued: March 2026

Connecticut Clinical Criteria Prior Authorization Pilot

Frequently Asked Questions (revised March 2026)

What is the Clinical Criteria Prior Authorization Pilot?

Today in Connecticut, the Medicaid Preferred Drug List (PDL) establishes a list of prescription medications selected by the Pharmaceutical and Therapeutics (P&T) committee that provide effective and safe treatment options for Connecticut Medical Assistance Program members while also delivering cost-effective options. The PDL supports clinical quality through the expertise of our P&T Committee members and maximizes the collection of supplemental rebates by aligning prescription drug utilization to preferred products. While CT has favorable PDL adherence overall, there are areas of concern where a high percentage of non-preferred medications are being prescribed and dispensed.

To increase utilization of preferred drugs and ensure appropriate clinical use, Connecticut is introducing new clinical prior authorization criteria across 11 targeted drug classes that were identified as having low PDL compliance. These criteria are supported by current literature, manufacturer guidelines and evidence-based clinical practice guidelines developed by specialists and professional organizations in various medical fields. Adoption of this process will shift from prescriber attestation to the review of clinical documentation based on these evidence-based clinical requirements. Meeting these clinical requirements will allow members to more rapidly access coverage of non-preferred drugs.

Coverage determinations for these 11 drug classes are made in accordance with the state's statutory definition of Medical Necessity (CGS § 17b-259b). Clinical criteria are guidelines only. Coverage determinations are based on an assessment of the member and their clinical needs and will be based upon a review of submitted and/or requested case-specific information.

What is changing, for whom, and when?

Beginning January 1, 2026, prior authorization of non-preferred drugs in 11 therapeutic classes will require providers to submit specific clinical information in order to demonstrate medical necessity. Members who obtain new prescriptions for a non-preferred drug in one of these classes will need their provider to complete and submit clinical information that will be reviewed. The member will either be approved for the non-preferred drug or will need to be prescribed a preferred drug.

The 11 drug classes requiring prior authorization beginning on January 1 are:

Drug Class	What Do They Treat?
Cytokine & CAM	Autoimmune conditions like rheumatoid arthritis and Crohn's disease
Anticonvulsants	Seizures and epilepsy
Bladder Relaxants	Overactive bladder and urinary incontinence
Growth Hormone	Growth disorders in children and adults
Multiple Sclerosis Agents	Multiple sclerosis (nerve and muscle problems)
Pulmonary Arterial Hypertension	High blood pressure in the lungs
Asthma Immunomodulators	Severe asthma and allergic conditions
Antimigraine (Other)	Migraine headaches
Colony Stimulating Factors	Low white blood cell counts
Antipsoriatic Topicals	Psoriasis (skin condition causing red, scaly patches)
GLP-1 Receptor Agonists	Type 2 diabetes and weight management

Why is this change occurring?

Connecticut is an outlier by not having a clinical prior authorization process in place. Nationwide, it is standard practice for Medicaid programs as well as Medicare and commercial plans to implement prior authorization clinical policies for PDL adherence, best practices, and patient safety.

DSS requested Gainwell Technologies work with the DSS Pharmacy Team members to develop and implement a plan to evaluate and manage the safe and effective utilization of preferred drug products. Alignment to best practices through use of clinical criteria provides stronger clinical oversight and adherence to appropriate prescribing guidelines. This aims to improve clinical outcomes by following evidence-based clinical criteria to ensure the right care, at the right time, and at the right cost.

What if a patient is taking a non-preferred drug in one of the identified classes? Will the prescriber need to change the patient's medication?

Members taking a medication in one of the 11 classes will be permitted to continue these medications **for 90 days** from January 1, 2026. During this time, members are encouraged to discuss with their provider next steps, including the appropriateness of switching therapy. After the 90-day grace period (i.e. April 1, 2026) prescriptions in the **Antipsoriatic topicals, Antimigraine: Other (CGRP targeting therapies, 5-HT1F receptor agonist), and Hypoglycemics, Incretin Mimetics/ Enhancers (GLP-1 RA and combinations (as indicated for Diabetes))** drug classes will not be fillable at the pharmacy and will require the prescriber to submit clinical information with a prior authorization request to support the medical necessity of the non-preferred drug for the member. Previously approved PDL prior authorizations for the remaining 8 drug classes will continue until their expiration date, typically 12 months after initial approval for non-controlled substances and 6 months for controlled substances.

The required one-time 14-day emergency fill may be used so that members do not go without access to medication.

What is not changing?

Providers will still be able to send a letter of medical necessity for DSS to review if the provider believes it is medically appropriate. The state will provide a determination of the prior authorization request within 24 hours once a complete form with all necessary documentation has been submitted by the provider. In the event of an adverse decision, members retain their fair hearing rights to appeal an adverse decision; that process will not change.

How will this pilot be evaluated?

Data on utilization of preferred vs non-preferred drugs in these 11 classes was collected prior to implementation (4th quarter of 2025). Subsequent data will be collected in each quarter of 2026 to compare utilization of preferred vs non-preferred drugs in these classes. In addition, DSS pharmacy staff will provide ongoing oversight and monitoring as Gainwell implements review of these new prior authorizations to ensure patient access to medication is not compromised and clinical criteria are adhered to.

How are drugs selected to be preferred or non-preferred?

The Pharmaceutical and Therapeutics Committee (“P&T Committee”) for the Connecticut Medical Assistance Program is established under the authority of section 17b-274d of the Connecticut General Statutes. The purpose of the P&T Committee is to adopt one or more PDLs for use in the Connecticut Medical Assistance Program. As necessary and appropriate, the P&T Committee reviews and evaluates medical criteria, standards, and educational intervention methods concerning the establishment of one or more PDLs and make recommendations to the DSS. The P&T Committee may also make recommendations to the DSS regarding prior authorization of any prescribed drug covered by the Connecticut Medical Assistance Program.

Where can I find information on the clinical criteria for these 11 classes, the prior authorization forms and the Preferred Drug List?

All of this information can be found on the Connecticut Medical Assistance Program website under the [Pharmacy Information](#) page. This page has been updated prior to Jan 1, 2026, to include the new information. The 11 drug classes with the current preferred drugs in each class are listed at the end of this document.

<https://www.ctdssmap.com/CTPortal/Pharmacy-Information>

How often are drugs, or drug classes, reviewed and changes made to the Preferred Drug List?

The P&T Committee meets twice a year in May and November via teleconference. Each therapeutic class is reviewed annually - half of the drug classes are reviewed in May and the other half are reviewed in November.

[TOP\\$ Therapeutic Class Review Schedule](#)

[Meeting Schedule](#)

How can I provide comments to the P&T Committee?

The public may provide comment during the P&T Committee meeting or attend by emailing connecticutpdlquestions@gainwelltechnologies.com. A link and login information to attend the meeting will be provided.

[Meeting Guidelines for Submission or Presentation to Committee.](#)

Where can I find more information about the P & T Committee meetings?

The schedule for review of therapeutic classes and meeting information can be found at [Pharmacy Information](#).

Do preferred drugs require a prior authorization?

No, preferred drugs do not require prior authorization in general, with some exceptions as listed on the [Pharmacy Information](#) page.

How are drugs new to the market being handled?

New drugs are generally reviewed at the subsequent P&T Committee Meeting in which the therapeutic class is [scheduled for review](#). Typically, until approved by the Committee, a medication will be designated as non-preferred.

Will the process to obtain a prior authorization change?

No, the process is not changing. The provider may submit the appropriate prior authorization form and supporting documentation via fax to 1-866-759-4110 or call Gainwell Technologies at 1-866-409-8386.

How can I find the appropriate Prior Authorization form and/or criteria for a specific drug?

To assist providers a new search link has been created on the Pharmacy Information tab on www.ctdssmap.com, under Pharmacy Program Publications. Click on: Prior Authorization Form Directory Drug and Diabetic Product SEARCH LINK (*NEW 1/1/2026*). Open the excel search document and enter the drug in question in the Drug Search field. Follow the instructions listed above the Drug Search field.

A B C D E

Drug Search Prior Authorization Form & Criteria Directory

Drug Search: 

- [1] CLICK IN YELLOW BOX BELOW
- [2] TYPE DRUG NAME
- [3] CLICK SPECIFIC FORMULATION (ROUTE) FROM DROP DOWN MENU

*Please visit [Criteria Link](#) to determine whether a Prior Authorization is required for the *specific formulation and strength* of the Drug in question

Last Revision Date: 2/1/2026

Drug Selected	Criteria Link	Prior Authorization Form Link*
Enter Drug Name in Search Box Above		
	#CALCI	#CALCI

Therapeutic Class List (as of Dec 1, 2025)

Drug Class	Preferred Products (preferred brands are BOLD when generic is available but nonpreferred)	Non-preferred products
Anticonvulsants	CARBAMAZEPINE TAB CHEW, IR TABLET (not ER) CARBATROL ER CAPSULE CLOBAZAM SUSPENSION CLOBAZAM TABLET CLONAZEPAM IR TABLET (not ODT or ER) DEPAKOTE SPRINKLE CAPSULE (not TABLET) DIAZEPAM RECTAL GEL SYSTEM DIVALPROEX SOD DR TABLET (not SPRINKLE) DIVALPROEX SOD ER TABLET EPIDIOLEX SOLUTION EPITOL TABLET ETHOSUXIMIDE CAPSULE, SOLUTION LACOSAMIDE TABLET, SOLUTION LAMOTRIGINE CHEW DISPERS TAB (not ODT) LAMOTRIGINE TABLET (not ER) LEVETIRACETAM SOLUTION, IR TABLET (not ER) NAYZILAM NASAL SPRAY OXCARBAZEPINE TABLET PHENOBARBITAL ELIXIR, SOLUTION, TABLET PHENYTOIN CHEW TABLET, SUSPENSION PHENYTOIN SOD EXT 100 MG CAPS (not 200MG, 300MG) PRIMIDONE TABLET ROWEEPRA TABLET SABRIL 500 MG POWDER PACK SABRIL 500 MG TABLET SUBVENITE TABLET (not START KIT) TEGRETOL 100 MG/5 ML SUSPENSION TEGRETOL XR TABLET (ORAL) TIAGABINE TABLET TOPIRAMATE SPRINKLE CAPSULE TOPIRAMATE TABLET (not ER) TRILEPTAL 300 MG/5 ML SUSPENSION VALPROIC ACID CAPSULE, SOLUTION VALTOCO NASAL SPRAY ZONISAMIDE CAPSULE	APTIOM TABLET BANZEL SUSPENSION, TABLET BRIVIACT SOLUTION, TABLET CARBAMAZEPINE SUSPENSION CELONTIN CAPSULE CLONAZEPAM ODT DEPAKOTE DR, ER TABLET DIACOMIT CAPS, POWDER PACK DILANTIN CAPSULE, SUSPENSION DILANTIN INFATAB DIVALPROEX SPRINKLE CAPSULE ELEPSIA XR TABLET EPRONTIA SOLUTION EQUETRO CAPSULE ESLICARBAZEPINE TABLET FELBAMATE SUSPENSION, TAB FELBATOL SUSPENSION, TAB FINTEPLA SOLUTION FYCOMPA SUSPENSION, TABLET KEPPRA SOLUTION, TABLET KEPPRA XR TABLET KLONOPIN TABLET LAMICTAL TABLET LAMICTAL ODT, ODT START KIT LAMICTAL XR START KIT LAMICTAL XR TABLET LAMOTRIGINE ER TABLET LAMOTRIGINE ODT TABLET LAMOTRIGINE TAB START KIT LIBERVANT FILM METHSUXIMIDE CAPSULE MOTPOLY XR CAPSULE MYSOLINE TABLET ONFI SUSPENSION, TABLET OXCARBAZEPINE SUSPENSION OXTELLAR XR TABLET PHENYTEK CAPSULE PHENYTOIN SOD EXT CAP (200MG, 300MG)

		<p>RUFINAMIDE SUSP, TABLET SEZABY VIAL SPRITAM TABLET SUBVENITE SUSPENSION SUBVENITE TAB START KIT SYMPAZAN FILM TEGRETOL TABLET TOPAMAX SPRINKLE CAPSULE TOPAMAX TABLET TOPIRAMATE ER CAPSULE TOPIRAMATE ER SPRINK CAP TRILEPTAL TABLET TROKENDI XR CAPSULE VIGABATRIN POWDER PACKET VIGABATRIN TABLET VIGADRONE POWDER PACKET VIGADRONE TABLET VIGAFYDE SOLUTION VIGODER POWDER PACKET VIMPAT SOLUTION, TABLET VIMPAT STARTER KIT XCOPRI TAB, TITRATION PAK</p>
Bladder Relaxant Preparations	<p>FESOTERODINE ER TABLET (ORAL) MYRBETRIQ ER TABLET (ORAL) OXYBUTYNIN ER TABLET (ORAL) OXYBUTYNIN SOLUTION, TABLET (not 2.5MG) (ORAL) SOLIFENACIN TABLET (ORAL)</p>	<p>DARIFENACIN ER TABLET DETROL TABLET DETROL LA CAPSULE FLAVOXATE TABLET GEMTESA TABLET MIRABEGRON ER TABLET MYRBETRIQ ER SUSPENSION OXYBUTYNIN 2.5 MG TABLET OXYTROL PATCH (RX) OXYTROL FOR WOMEN OTC TOLTERODINE ER CAPSULE TOLTERODINE TABLET TOVIAZ ER TABLET TROSPIUM TABLET TROSPIUM ER CAPSULE VESICARE TABLET VESICARE LS SUSPENSION</p>
Cytokine and CAM Antagonists	<p>ADALIMUMAB-ADAZ PEN, SYRINGE ENBREL DISP SYRINGE, KIT, PEN ENBREL MINI CARTRIDGE ENBREL VIAL HADLIMA PUSH TOUCH, SYRINGE HUMIRA KIT, PEN INJ KIT INFLIXIMAB VIAL ORENCIA CLICKJET, SYRINGE</p>	<p>ABRILADA PEN, SYRINGE ACTEMRA PEN, VIAL ADALIMUMAB-AACF ADALIMUMAB-AATY ADALIMUMAB-ADB M ADALIMUMAB-FKJP ADALIMUMAB-RYVK</p>

OTEZLA STARTER PACK, TABLET
PYZCHIVA SYRINGE, VIAL
(SUBCUTANEOUS)
SELARSDI SYRINGE
STEQEYMA SYRINGE, VIAL
TYENNE AUTOINJECT, SYRINGE
TYENNE VIAL
XELJANZ IR TABLET (not XR or SOLUTION)

AMJEVITA AUTOINJECT, SYRINGE
ARCALYST VIAL
AVASOLA VIAL
AVTOZMA VIAL
BIMZELX AUTOINJECTOR, SYRINGE
CIBINQO TABLET
CIMZIA SYRINGE, VIAL
COSENTYX SENSOREADY PEN, SYRINGE
CYLTEZO PEN, SYRINGE
ENSPRYNG SYRINGE
ENTYVIO PEN, VIAL
HULIO PEN, SYRINGE
HYRIMOZ PEN, SYRINGE
IDACIO PEN SYRINGE
INFLECTRA VIAL
ILARIS VIAL
ILUMYA
IMULDOSA
KEVZARA PEN, SYRINGE KINERET
SYRINGE
LEQSELVI TABLET
LITFULO CAPSULE
OLUMIANT TABLET
OMVOH
ORENCIA VIAL
OTEZLA XR TABLET
OTULFI
PYZCHIVA VIALS (IV)
REMICADE VIAL
RENFLEXIS VIAL
RINVOQ ER TABLET
RINVOQ LQ SOLUTION
SIMLANDI AUTOINJECT, PEN
SIMPONI PEN, SYRINGE
SIMPONI ARIA VIAL
SILIQ SYRINGE
SKYRIZI
SOTYKTU TABLET
SPEVIGO SYRINGE, VIAL
STARJEMZA
STELARA
TALTZ AUTOINJECTOR, SYRINGE
TOFIDENCE VIAL
TREMFYA
UPLIZNA VIAL
USTEKINUMAB
USTEKINUMAB-AEKN
USTEKINUMAB-TTWE

		VELSIPITY TABLET XELJANZ SOLUTION XELJANZ XR TABLET YESINTEK YUFLYMA PEN YUSIMRY PEN ZYMFENTRA PEN, SYRINGE
Growth Hormone	GENOTROPIN CARTRIDGE GENOTROPIN MINIQUICK NORDITROPIN FLEXPRO	HUMATROPE CARTRIDGE NGENLA PEN NUTROPIN AQ NUSPIN PEN OMNITROPE CARTRIDGE OMNITROPE VIAL SEROSTIM VIAL SKYTROFA CARTRIDGE SOGROYA PEN ZOMACTON VIAL
Multiple Sclerosis Agents	AVONEX PEN, PREFILLED SYRINGE BETASERON 0.3 MG KIT COPAXONE 20 MG/ML SYRINGE (not 40 MG/ML) DALFAMPRIDINE ER TABLET DIMETHYL FUMARATE DR CAPSULE DIMETHYL FUMARATE DR STARTER PACK FINGOLIMOD CAPSULE KESIMPTA PEN TERIFLUNOMIDE TABLET	AMPYRA ER TABLET AUBAGIO TABLET BAFIERTAM DR CAPSULE BETASERON VIAL BRIUMVI VIAL COPAXONE 40 MG/ML SYRINGE GILENYA CAPSULE GLATIRAMER SYRINGE GLATOPA SYRINGE LEMTRADA VIAL MAVENCLAD TABLET PK MAYZENT TABLET OCREVUS VIAL OCREVUS ZUNOVO VIAL PLEGRIDY PEN PONVORY STARTER PACK PONVORY TABLET REBIF SYRINGE REBIF REBIDOSE REBIF TITRATION PACK TASCENSO ODT TABLET TECFIDERA DR CAPSULE TECFIDERA STARTER PACK TYRUKO VIAL TYSABRI VIAL VUMERITY DR CAPSULE ZEPOSIA CAPSULE ZEPOSIA STARTER PACK
Pulmonary Arterial Hypertension Agents	ALYQ 20 MG TABLET <i>(DX CODE REQ.)</i> AMBRISENTAN TABLET SILDENAFIL 20 MG TABLET <i>(DX CODE REQ.)</i> TADALAFIL 20 MG TABLET (ADCIRCA) <i>(DX CODE REQ.)</i> TRACLEER 62.5 MG & 125 MG TABLET	ADCIRCA TABLET ADEMPAS TABLET BOSENTAN TABLET LETAIRIS TABLET OPSUMIT TABLET OPSYNVI TABLET ORENITRAM ER TABLET

	VENTAVIS SOLUTION	ORENITRAM TITR KIT REVATIO SUSP & TABLET SILDENAFIL SUSPENSION TADLIQ SUSPENSION TRACLEER TABLET FOR SUSP TYVASO INHALATION TYVASO DPI INHALATION UPTRAVI TABLET YUTREPIA INHALATION
Asthma & Allergy Immunomodulators	ADBRY AUTOINJECTOR, SYRINGE (DX CODE REQ) DUPIXENT PEN, SYRINGE (DX CODE REQ) EBGLYSS PEN, SYRINGE (DX CODE REQ) FASENRA PEN, SYRINGE (DX CODE REQ) TEZSPIRE PEN, SYRINGE (DX CODE REQ) XOLAIR AUTOINJECTOR, SYRINGE, VIAL (DX CODE REQ)	CINQAIR VIAL NEMLUVIO PEN NUCALA AUTOINJECTOR, SYRINGE, VIAL
Antimigraine: other	AJOVY AUTOINJECTOR, SYRINGE EMGALITY 120 MG PEN, SYRINGE NURTEC ODT TABLET QULIPTA TABLET UBRELVY TABLET	AIMOVIG AUTOINJECTOR EMGALITY 100 MG SYRINGE REYVOW TABLET VYEPTI VIAL ZAVZPRET NASAL SPRAY
Colony Stimulating Factors	FYLNETRA SYRINGE NEUPOGEN DISP SYRINGE, VIAL	GRANIX SYRINGE, VIAL FULPHILA SYRINGE LEUKINE VIAL NEULASTA KIT, SYRINGE NIVESTYM SYRINGE, VIAL NYVEPRIA SYRINGE RELEUKO SYRINGE, VIAL ROLVEDON SYRINGE RYZNEUTA SYRINGE STIMUFEND SYRINGE UDENYCA AUTOINJECT, ONBODY, SYRINGE ZARXIO SYRINGE ZIEXTENZO SYRINGE
Antipsoriatic topical	CALCIPOTRIENE 0.005% CREAM, OINTMENT CALCIPOTRIENE 0.005% SOLUTION CALCIPOTRIENE-BETAMETH DP OINTMENT VECTICAL 3 MCG/G OINTMENT	CALCIPOTRIENE FOAM CALCIPOTRIENE/BETAMETHASONE SUSPENSION CALCITRIOL OINTMENT (generic Vectical) ENSTILAR FOAM SORILUX FOAM TACLONEX OINTMENT TACLONEX SCALP SUSPENSION ZORYVE 0.3% CREAM

GLP-1/GIP Agonists for Type 2 Diabetes	OZEMPIC DOSE PEN, SYRINGE (<i>DX CODE REQ.</i>) TRULICITY PEN (<i>DX CODE REQ.</i>) VICTOZA PEN (<i>DX CODE REQ.</i>)	BYDUREON BCISE AUTOINJECT EXENATIDE PEN LIRAGLUTIDE PEN (generic VICTOZA) MOUNJARO PEN RYBELSUS TABLET SOLIQUA PEN XULTOPHY PEN
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