



Beta Blockers

NYRx Drug Utilization Review Board meeting
May 15, 2025

Drug to be added:
Hemangeol®



Clinical Information

Indication: treatment of proliferating infantile hemangioma requiring systemic therapy

Dosage & Administration: Initiate treatment at ages 5 weeks to 5 months starting as:

- 0.15 mL/kg (0.6 mg/kg) twice daily, taken at least 9 hours apart.
- After 1 week, increase the daily dose to 0.3 mL/kg (1.1 mg/kg) twice daily.
- After 2 weeks of treatment, increase the dose to 0.4 mL/kg (1.7 mg/kg) twice daily and maintain this for 6 months.
- Readjust the dose periodically as the child's weight increases.

Contraindications:

- Premature infants with corrected age < 5 weeks
- Infants weighing less than 2 kg
- Known hypersensitivity to propranolol or any of the excipients
- Asthma or history of bronchospasm
- Heart rate <80 beats per minute, greater than first degree heart block, or decompensated heart failure
- Blood pressure <50/30 mmHg
- Pheochromocytoma



Clinical Information, continued

Warnings & Precautions:

- Hypoglycemia
- Bradycardia
- Bronchospasm
- Cardiac failure
- Increased risk of stroke in *PHACE syndrome
- Hypersensitivity

Adverse Reactions:

- Sleep disorders,
- Aggravated respiratory tract infections such as bronchitis and bronchiolitis associated with cough and fever, diarrhea, and vomiting

Drug Interactions:

- Based on known adult information

Specific Populations:

- Pediatrics: safety & effectiveness haven't been established for treatment of hemangioma in those > 1yr
- There is no experience to inform with either hepatic or renal dysfunction.

Clinical Studies:

- None

*PHACE: where each letter stands for a different aspect of the syndrome: Posterior fossa malformations, Hemangioma, Arterial anomalies, Cardiac anomalies, and Eye anomalies



Beta Blocker Class – Current Status

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
Beta Blockers		
atenolol carvedilol labetalol metoprolol succ. XL metoprolol tartrate propranolol tablet propranolol ER	acebutolol betaxolol bisoprolol Bystolic® DO carvedilol ER Inderal LA® Inderal XL® InnoPran XL® Kapspargo™ Sprinkle Lopressor® nadolol DO nebivolol (gen Bystolic®) pindolol propranolol solution Tenormin® timolol Toprol XL® DO	DOSE OPTIMIZATION (DO) <ul style="list-style-type: none"> See Dose Optimization Chart for affected drugs and strengths

Antipsychotics, 2nd Generation

NYRx Drug Utilization Review Board meeting
May 15, 2025

New Drug: Cobenfy™

Label Revisions: Abilify®, Geodon®, Nuplazid®,
Versacloz® / Clozaril®, Class-wide

Cobenfy™ (xanomeline + trospium chloride)

Clinical Information

Indication: treatment of schizophrenia in adults

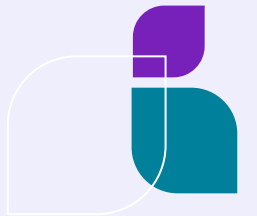
Dosage & Administration: starting dosage; 50 mg/20 mg orally twice daily for at least two days, then increase the dosage to 100 mg/20 mg twice daily for at least five days.

Contraindications:

- Urinary retention
- Moderate or severe hepatic impairment
- Gastric retention
- History of hypersensitivity to xanomeline or trospium chloride
- Untreated narrow-angle glaucoma

Warnings & Precautions:

- Use with caution in biliary disease
- Risk of angioedema
- May increase heart rate
- Anticholinergic adverse reactions in Patients with renal impairment
- CNS effects



Cobenfy™ (xanomeline + trospium chloride)

Clinical Information, continued

Adverse Reactions:

- Nausea, vomiting
- Dyspepsia, abdominal pain
- Constipation, diarrhea
- Dizziness
- Hypertension, tachycardia
- Gastrointestinal reflux disease

Drug Interactions:

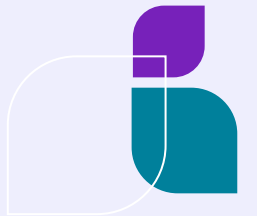
- Drugs Eliminated by Active Tubular Secretion
- Strong CYP2D6 Inhibitors
- Sensitive Substrates of CYP3A4 or P-glycoprotein
- Antimuscarinic Drugs

Specific Populations:

- Pregnancy / Lactation: no data to inform of risk
- Pediatrics: safety & effectiveness have not been established
- Geriatrics: no data to inform of risk
- Moderate to severe renal impairment: not recommended
- Mild hepatic impairment: not recommended

Clinical Studies:

- None



Abilify® (aripiprazole), Geodon® (ziprasidone), Nuplazid® (pimavanserin), Versacloz® / Clozaril® (clozapine)

Clinical Information

Label Revision: Abilify (aripiprazole):

- Approval of Abilify oral solution, DiscMelt and injection formulations has been withdrawn as posted by the Federal Register; subsequently, information related to these formulations has been removed from the labeling
- Fecal incontinence has been added to postmarket experience for all aripiprazole products

Label Revision: Geodon (ziprasidone):

- Package Insert (PI) updated to include a new contraindication: concomitant use of monoamine oxidase inhibitors (MAOIs) or within 14 days of stopping MAOIs. A new Dosage/Administration section was added on switching patients to or from an MAOI antidepressant. A new Warning/Precaution subsection on serotonin syndrome was also added.

Label Revision: Nuplazid (pimavanserin):

- Fecal incontinence has been added to postmarket experience

Label Revision: Versacloz / Clozaril (clozapine):

- Food & Drug Administration (FDA) has eliminated clozapine Risk Evaluation & Mitigation Strategy (REMS) program requirement. While absolute neutrophil count (ANC) documentation is no longer required, FDA still recommends prescribers monitor ANC according to product labeling
- Updates to the Boxed Warning and Warning/Precautions subsection on pericarditis. Also, fecal incontinence added as a postmarketing experience adverse drug reaction

Label Revision: class-wide:

- Updates to the Warning/Precaution subsection on hyperprolactinemia and cancer



Antipsychotics, 2nd Generation – Current Status

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																				
IV. Central Nervous System																						
Antipsychotics – Second Generation CC, ST																						
aripiprazole tablet DO asenapine (gen Saphris®) clozapine lurasidone (gen Latuda®) olanzapine tablet DO paliperidone ER DO quetiapine F/Q/D quetiapine ER F/Q/D, DO risperidone ziprasidone capsule	Abilify® tablet DO Abilify MyCite® aripiprazole solution aripiprazole ODT Caplyta™ clozapine ODT Clozaril® Cobenfy™ capsules, starter pack Fanapt® Geodon® Invega® DO Latuda® DO Lybalvi® Nuplazid® olanzapine ODT DO olanzapine / fluoxetine Opipza™ Rexulti® DO Risperdal® Saphris® Secuado® Seroquel® F/Q/D Seroquel XR® DO, F/Q/D Versacloz® Vraylar® DO Zyprexa® DO Zyprexa® Zydis	DOSE OPTIMIZATION (DO) <ul style="list-style-type: none">See Dose Optimization Chart for affected drugs and strengths CLINICAL CRITERIA (CC) <ul style="list-style-type: none">Confirm diagnosis of FDA-approved or compendia-supported indicationClinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PAPrior authorization is required when an oral SGA is utilized above the highest MDD according to FDA labeling.Prior authorization is required for patients less than 21 years of age when there is concurrent use of 2 or more different oral antipsychotics for greater than 90 days.Prior authorization is required for patients 21 years of age or older when 3 or more different oral second-generation antipsychotics are used for more than 180 days.PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below: <table><tr><td>aripiprazole (Abilify®, Opipza™)</td><td>6 years</td></tr><tr><td>aripiprazole (Abilify MyCite®)</td><td>18 years</td></tr><tr><td>asenapine (Saphris®)</td><td>10 years</td></tr><tr><td>asenapine (Secuado®)</td><td>18 years</td></tr><tr><td>brexpiprazole (Rexulti®)</td><td>13 years</td></tr><tr><td>cariprazine (Vraylar®)</td><td>18 years</td></tr><tr><td>clozapine (Clozaril®, Versacloz®)</td><td>12 years</td></tr><tr><td>iloperidone (Fanapt®)</td><td>18 years</td></tr><tr><td>lumateperone (Caplyta™)</td><td>18 years</td></tr><tr><td>lurasidone HCl (Latuda®)</td><td>10 years</td></tr></table>	aripiprazole (Abilify®, Opipza™)	6 years	aripiprazole (Abilify MyCite®)	18 years	asenapine (Saphris®)	10 years	asenapine (Secuado®)	18 years	brexpiprazole (Rexulti®)	13 years	cariprazine (Vraylar®)	18 years	clozapine (Clozaril®, Versacloz®)	12 years	iloperidone (Fanapt®)	18 years	lumateperone (Caplyta™)	18 years	lurasidone HCl (Latuda®)	10 years
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iloperidone (Fanapt®)	18 years																					
lumateperone (Caplyta™)	18 years																					
lurasidone HCl (Latuda®)	10 years																					

PA = Prior Authorization

Antipsychotics, 2nd Generation – Current Status, continued

olanzapine (Zyprexa®)	10 years
olanzapine / fluoxetine (Symbyax®)	10 years
paliperidone ER (Invega®)	12 years
pimavanserin (Nuplazid®)	18 years
quetiapine fum. (Seroquel®, Seroquel XR®)	10 years
risperidone (Risperdal®)	5 years
xanomeline-trospium (Cobenfy™)	18 years
ziprasidone HCl (Geodon®)	10 years

- Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients < 18 years of age

STEP THERAPY (ST)

- For all Second Generation Antipsychotics used in the treatment of Major Depressive Disorder in the absence of other psychiatric comorbidities, trial with at least two different antidepressant agents is required
- olanzapine / fluoxetine: When prescribing for the treatment of major depressive disorder (MDD) in the absence of other psychiatric comorbidities, trial with at least one different antidepressant agent is required

FREQUENCY/QUANTITY/DURATION (F/Q/D)

- **quetiapine/quetiapine ER (Seroquel®/Seroquel XR®):** Minimum 50 mg/day
- **quetiapine (Seroquel®):** Maximum 3 units per day, 90 units per 30 days
- **quetiapine ER (Seroquel XR®):** 50mg, maximum 2 units/day, 60 units/30 days



Hemophilia Agents, Other

NYRx Drug Utilization Review Board meeting
May 15, 2025



New Drugs:

Hympavzi™

Alhemo®



Hympavzi™ (marstacimab-hncq)

Clinical Information

Indication: routine prophylaxis to prevent or reduce the frequency of bleeding episodes in adults and children ≥ 12 years with hemophilia A without factor VIII inhibitors, or hemophilia B without factor IX inhibitors.

Dosage & Administration: Initiate treatment with a loading dose of 300mg, follow this weekly with a 150mg dose.

- If more than one injection is needed, use a different site.
- Store product in the refrigerator but let it warm 15 to 30 min at room temperature (out of direct sunlight). Do not freeze or shake
- Inject in abdomen or thigh
- Dose may be adjusted based on weight ≥ 50 kg or bleeding deemed not controlled by Health Care Providers (HCPs)

Contraindications:

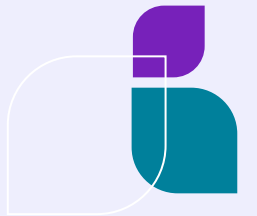
- None

Warnings & Precautions:

- Thromboembolic events
- Hypersensitivity reactions
- Embryofetal toxicity

Adverse Reactions:

- Injection site reaction
- Headache
- Pruritis



Clinical Information, continued

Drug Interactions:

- None

Specific Populations:

- Pregnancy: may cause harm, based on mechanism of action (MOA)
- Lactation: no data
- Pediatrics: safety & effectiveness not established in < 12 years of age.
- Geriatrics: no data

Clinical Studies

- Open label, multi-center, 2-phase



Clinical Information

Indication: routine prophylaxis to prevent or reduce the frequency of bleeding episode in adults and children ≥ 12 years and older with hemophilia A with factor VIII inhibitors, or hemophilia B with factor IX inhibitors.

Dosage & Administration: Initiate treatment with a loading dose on Day 1 of 1 mg/kg, then on Day 2 start daily dosing of 0.2 mg/kg until individualized maintenance dosing is achieved.

- Week 4: measure plasma concentration by Enzyme-Linked Immunosorbent Assay (ELISA) prior to administration of next scheduled dose.
- individualize the maintenance dose of Alhemo no later than 8 weeks after initiation of treatment based on plasma concentration results

Contraindications:

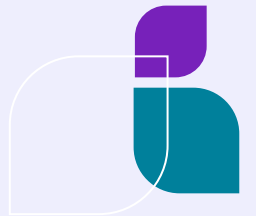
- Do not use if known serious hypersensitivity to the medication

Warnings & Precautions:

- Thromboembolic events
- Hypersensitivity reactions
- Altered laboratory values of Fibrin D dimer, Prothrombin fragment 1+2

Adverse Reactions:

- Injection site reaction
- Urticaria



Clinical Information, continued

Drug Interactions:

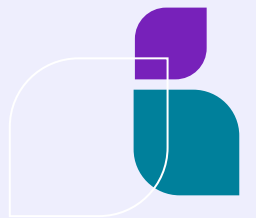
- High or frequent doses of bypassing agents

Specific Populations:

- Pregnancy: may cause harm, based on mechanism of action (MOA)
- Lactation: no data
- Pediatrics: safety & effectiveness not established in < 12 years of age.
- Geriatrics: no data

Clinical Studies

- multi-national, multi-center, open-label, phase 3 trial



Hemophilia Agents, Other

DRUG	DESCRIPTION	INDICATION
Alphanate®	antihemophilic factor/von Willebrand factor complex [human]	*Hemophilia A: control & prevention of bleeding and perioperative management (mgt). *von Willebrand Disease (dz): Invasive procedures when desmopressin is ineffective or contraindicated. Not for use in severe dz. IV only
Coagadex®	Coagulation Factor X (Human), is a plasma-derived human blood coagulation Factor	*Hereditary factor X deficiency: routine prophylaxis, on-demand treatment (tx) of active episodes, perioperative management of bleeding. IV only
Corifact®	Factor XIII Concentrate	*Congenital factor XIII deficiency: routine prophylactic tx, perioperative mgt of surgical bleeding. IV only
Feiba® NF	Anti-Inhibitor Coagulant Complex	*Hemophilia A & B: control & prevention of bleeding episodes, perioperative mgt, routine prophylaxis to prevent or reduce frequency of bleeding. IV only
Hemlibra®	Humanized monoclonal modified immunoglobulin G4 bispecific antibody binding factor IXa and factor X	*Hemophilia A (congenital factor VIII deficiency) with or without factor VIII inhibitors: routine prophylaxis to prevent or reduce frequency of bleeding. Subcutaneous injection
Novoseven® RT	Coagulation Factor VIIa (recombinant)	*Hemophilia A or B with inhibitors, congenital factor VII deficiency, Glanzmann's thrombasthenia with refractoriness to platelet transfusions, with or without antibodies to platelets: tx of bleeding episodes and perioperative mgt. IV only *acquired hemophilia: tx of bleeding episodes and perioperative mgt in adults. IV only

Hemophilia Agents, Other - continued

DRUG	DESCRIPTION	INDICATION
Sevenfact®	Coagulation Factor VIIa (recombinant)	*Hemophilia A or B with inhibitors: tx and control of bleeding occurring in adults and adolescents 12 years and older. IV only *Limitation of use: not for the tx of patients with congenital factor VII deficiency.
Tretten®	Coagulation Factor XIII A-Subunit (Recombinant)	*Congenital factor XIII A-subunit deficiency: routine prophylaxis for bleeding. IV only *Limitation of use: not for use in patients with congenital factor XIII B-subunit deficiency
Vonvendi®	recombinant von Willebrand factor	*von Willebrand disease (VWD) in those 18 years and older: on-demand tx of bleeding episodes, perioperative mgt, routine prophylaxis to reduce frequency of bleeding in those with severe Type 3 VWD receiving on-demand therapy. IV only
Wilate®	von Willebrand Factor/Coagulation Factor VIII Complex (Human)	*von Willebrand disease (severe) or patients (pts) with mild or moderate dz when the use of desmopressin is ineffective or contraindicated: tx of spontaneous and trauma-induced bleeding episodes. IV only *Limitation of use: not used for prevention of excessive bleeding during and after surgery in VWD pts. Not indicated for Hemophilia A
Alhemo®	humanized IgG4 monoclonal antibody produced by recombinant DNA technology in Chinese Hamster Ovary (CHO) cells	*Hemophilia A (congenital factor VIII deficiency) with factor VIII inhibitors, hemophilia B (congenital factor IX deficiency) with factor IX inhibitors: routine prophylaxis to prevent or reduce frequency of bleeding in those 12 years and older. Subcutaneous injection
Hympavzi™	tissue factor pathway inhibitor (TFPI) antagonist, human monoclonal immunoglobulin G Type 1 (IgG1) antibody, produced by Chinese hamster ovary (CHO) cells by recombinant DNA technology	*Hemophilia A (congenital factor VIII deficiency) without factor VIII inhibitors, hemophilia B (congenital factor IX deficiency) without factor IX inhibitors: routine prophylaxis to prevent or reduce frequency of bleeding episodes in those 12 years and older. Subcutaneous injection

Hemophilia Agents, Other – Current Status



Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VIII. Hematological Agents		
Hemophilia Agents – Other		
Alphanate® (von Willebrand factor/Factor VIII) Coagadex® (Factor X) Corifact® (Factor XIII) Feiba® NF (activated prothrombin complex) Hemlibra® (emicizumab-kxwh) Novoseven® RT (Factor VIIa) Sevenfact® (Factor VIIa-jncw) Tretten® (Factor XIII) Vonvendi® (von Willebrand factor) Wilate® (von Willebrand factor/Factor VIII)	Alhemo® Hympavzi™	



Prostaglandin Agonists, Ophthalmic

NYRx Drug Utilization Review Board meeting
May 15, 2025

Drug to be added: Rhopressa®

Label Revisions: Rocklatan®, Xelpros®

Clinical Information

Indication: reduction of elevated intraocular pressure (IOP) in patients with open-angle glaucoma or ocular hypertension.

Dosage & Administration: one drop in the affected eye(s) once daily in the evening

Contraindications:

- None

Warnings & Precautions:

- Epithelial Corneal Edema
- Bacterial Keratitis
- Contact Lenses

Adverse Reactions:

- Corneal verticillata
- Postmarketing experience: Epithelial corneal edema has been reported in some patients with pre-existing corneal stromal edema or following ocular procedures

Drug Interactions:

- None

Specific Populations:

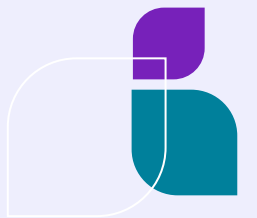
- Pregnancy / Lactation: no data to inform of risk
- Pediatrics: safety & effectiveness haven't been established
- Geriatrics: no differences in safety & effectiveness found



Clinical Information, continued

Clinical Studies:

- 3 randomized, controlled clinical trials conducted with Rhopressa vs timolol



Rocklatan® (netarsudil + latanoprost) Xelpros® (latanoprost)

Clinical Information

Label Revision: Rocklatan

- Package Insert (PI) updated to add a new Warning/Precaution on epithelial corneal edema

Label Revision: Xelpros

- PI updates to align with reference drug; latanoprost (Xalatan). Gastrointestinal (GI) disorders added to postmarketing experience Adverse Drug Reaction (ADR) subsection



Prostaglandin Agonists, Ophthalmic – Current Status



Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. Ophthalmics		
Prostaglandin Agonists – Ophthalmic		
latanoprost	bimatoprost lyuzeh™ Lumigan® Rocklatan™ tafluprost (gen Zioptan®) Travatan Z® travoprost (gen Travatan Z®) Xalatan® Xelpros™ Vyzulta™ Zioptan®	



Urinary Tract Antispasmodics

NYRx Drug Utilization Review Board meeting
May 15, 2025



New Indication: Gemtesa®
Label Revision: Gemtesa®



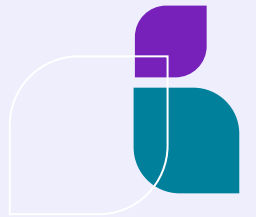
Clinical Information

New Indication: treatment of overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, & urinary frequency in adult males on pharmacologic treatment for benign prostatic hypertrophy (BPH).

Existing Indication: treatment of overactive bladder (OAB) with symptoms of urge urinary incontinence, urgency, and urinary frequency in adults

Label Revision:

- add angioedema as an example of a hypersensitivity reaction.
- Updates made to the Contraindications, Warnings/Precautions (new subsection added), and postmarketing experience Adverse Drug Reaction (ADR) sections



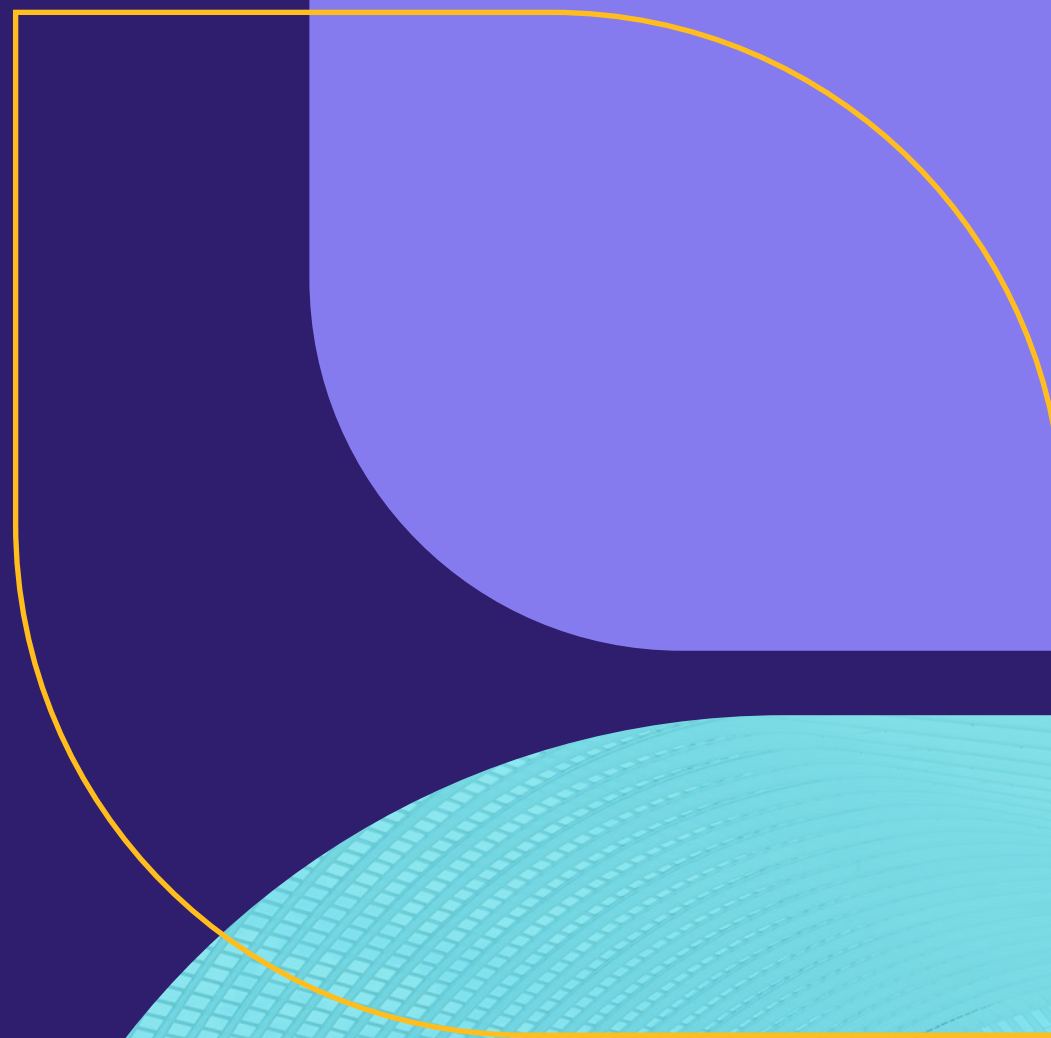
Urinary Tract Antispasmodics – Current Status

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XIV. Renal and Genitourinary		
Urinary Tract Antispasmodics		
fesoterodine ER (gen Toviaz®) Myrbetriq® ^{DO, BLTG} oxybutynin oxybutynin ER ^{DO} solifenacin Toviaz® ^{DO}	darifenacin Detrol® Detrol LA® ^{DO} flavoxate Gemtesa® mirabegron (gen Myrbetriq®) Myrbetriq® solution ^{F/Q/D} Oxytrol® tolterodine tolterodine ER trospium trospium ER Vesicare® ^{DO} Vesicare® LS	DOSE OPTIMIZATION (DO) <ul style="list-style-type: none"> See Dose Optimization Chart for affected strengths FREQUENCY/QUANTITY/DURATION (F/Q/D) Myrbetriq® solution; limited to a 30-day supply



COPD Agents

NYRx Drug Utilization Review Board meeting
May 15, 2025





New Drug: Ohtuvayre™



Clinical Information

Indication: maintenance treatment of chronic obstructive pulmonary disease (COPD) in adult patients.

Dosage & Administration: 3 mg (one unit-dose ampule) twice daily, once in the morning and once in the evening, administered by oral inhalation using a standard jet nebulizer with a mouthpiece.

Contraindications:

- hypersensitivity to ensifentrine or any component of this product.

Warnings & Precautions:

- Acute bronchospasm
- Paradoxical bronchospasm
- Psychiatric events, including suicide

Adverse Reactions:

- Back pain
- Hypertension
- Urinary tract infection
- Diarrhea



Clinical Information, continued

Drug Interactions:

- CYP2C9 Inhibitors raise Cmax and AUC levels of ensifentrine

Specific Populations:

- Pregnancy: no data to inform on risk
- Lactation: no data to inform on risk
- Pediatrics: safety & effectiveness not established
- Geriatrics: no differences in safety & effectiveness observed
- Hepatic impairment: use with caution
- Renal impairment: no dosage adjustment for mild to moderate. No data with use in severe impairment

Clinical Studies:

- None other than comparing to placebo



COPD Agents Class – Current Status

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XV. Respiratory		
COPD Agents		
Anoro Ellipta® Atrovent HFA® Bevespi® Aerosphere® Combivent Respimat® Incruse Ellipta® ipratropium ipratropium / albuterol roflumilast (gen Daliresp®) Spiriva® HandiHaler® BLTG Spiriva Respimat® Stiolto Respimat® Trelegy Ellipta® Tudorza Pressair®	Breztri™ Aerosphere Daliresp® Duaklir® Pressair Ohtuvayre™ tiotropium (gen Spiriva® Handihaler®) Yupelri®	

BLTG = Brand Less Than Generic



Department
of Health

Over-the-Counter (OTC) Aluminum Chloride

NYS MEDICAID DRUG UTILIZATION REVIEW BOARD

May 15, 2025

GENERAL OVERVIEW

NYS Medicaid-covered Over-the-Counter (OTC) formulations

- Xerac AC 6.25% Solution

Food & Drug Administration OTC monograph for topical antiperspirant products

▪ Indications

- Topical treatment of hyperhidrosis
- Dose: Topical: Apply once daily at bedtime; once excessive sweating has stopped, may decrease to once or twice weekly, or as needed. Wash treated area in the morning.

▪ Warnings

- Skin irritation: Discontinue if skin irritation occurs.

GENERAL OVERVIEW

Compendia

▪ Mechanism of Action

- Aluminum chloride forms a gel-like plug within the sweat ducts. This plug obstructs the flow of sweat from the sweat glands to the surface of the skin. As a result, less sweat is produced and released, helping to control excessive sweating (hyperhidrosis).

Medical Necessity and Indications

▪ Medically Necessary Use

- Hyperhidrosis causing significant discomfort or impairment

▪ Non-Medical Use

- Primarily for cosmetic reasons, such as improving appearance or personal comfort

▪ Clinical Justification

- While excessive sweating can be distressing, it is generally not classified as a condition that, if untreated, would lead to worsening health or health outcomes



LITERATURE REVIEW

Guidelines

▪ International Hyperhidrosis Society

- Typically, aluminum chloride hexahydrate concentrations of 10% to 15% are recommended for excessive sweating of the underarms.
- For managing sweaty hands or sweaty feet, higher concentrations are needed - usually around 30%.

▪ American Academy of Family Physicians

- Clinical recommendation – Evidence Rating “C”
 - Topical 20% aluminum chloride (Drysol) should be used as first-line treatment in most cases of primary hyperhidrosis, regardless of severity and location.
 - Iontophoresis may be effective as first- or second-line treatment for primary hyperhidrosis of the palms or soles.
 - Intradermal onabotulinumtoxinA (Botox) injections may be considered first- or second-line treatments for many cases of primary hyperhidrosis involving the axillae, palms, soles, or face.



**Department
of Health**

International Hyperhidrosis Society: Antiperspirant Basics. Available at: <https://www.sweathelp.org/hyperhidrosis-treatments/antiperspirants/antiperspirant-basics.html>.

MCCONAGHY JR, FOSSELMAN D. Am Fam Physician. 2018;97(11):729-734. Available at: <https://www.aafp.org/pubs/afp/issues/2018/0601/p729.html>.

SUPPORTING POLICY AND LEGISLATION

- **Relevant Regulations**

- SSA §1927(d)(2): Excludes drugs used for cosmetic purposes from coverage
- NYS Medicaid Policy: Reimburses drugs only for medically necessary conditions

- **Prior Examples**

- Drugs for cosmetic use, hair growth, or weight loss are excluded from Medicaid reimbursement

- **Conclusions**

- Since Xerac AC is primarily used for cosmetic purposes with no significant health benefit, if treated, it does not qualify for Medicaid coverage under current policies



**Department
of Health**

Social Security Act §1927: https://www.ssa.gov/OP_Home/ssact/title19/1927.htm.

NYRx Medicaid Pharmacy Program Pharmacy Manual Policy Guidelines:

https://www.emedny.org/ProviderManuals/Pharmacy/PDFS/Pharmacy_Policy_Guidelines.pdf.



Department
of Health

Current NYRx Preferred Drug List for the Drug Classes on the Agenda

NYS MEDICAID DRUG UTILIZATION REVIEW BOARD

May 15, 2025

CLINICAL CRITERIA FOR NON-PREFERRED PRODUCTS

Non-Preferred Products remain available through the prior authorization process.

1. The preferred drug has been tried by the patient and has failed to produce the desired health outcome.

Q: Has your patient experienced treatment failure with a preferred product?

2. The patient has tried the preferred drug and has experienced unacceptable adverse effects.

Q: Has your patient experienced an adverse drug reaction with a preferred product?

3. The patient has been stabilized on a non-preferred drug and transition to the preferred drug would be medically contraindicated

Q: Is there a documented history of successful therapeutic control with a non-preferred product and transition to a preferred product is medically contraindicated?

4. Other clinical indications for use of a non-preferred drug, which shall include consideration of the medical needs of special populations.

New York State Medicaid Drug Utilization Review Board Meeting – May 15, 2025
Preferred Drug Program – Drug Class Review

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
II. Anti-Infectives		
Anti-Virals – Oral		
acyclovir valacyclovir	famciclovir Valtrex®	

New York State Medicaid Drug Utilization Review Board Meeting – May 15, 2025
Preferred Drug Program – Drug Class Review

Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
III. Cardiovascular		
Beta Blockers		
atenolol carvedilol labetalol metoprolol succ. XL metoprolol tartrate propranolol tablet propranolol ER	acebutolol betaxolol bisoprolol Bystolic® DO carvedilol ER Inderal LA® Inderal XL® InnoPran XL® Kaspargo™ Sprinkle Lopressor® nadolol DO nebivolol (gen Bystolic®) pindolol propranolol solution Tenormin® timolol Toprol XL® DO	DOSE OPTIMIZATION (DO) <ul style="list-style-type: none"> See Dose Optimization Chart for affected drugs and strengths

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																				
IV. Central Nervous System																						
Antimigraine Agents, Other F/Q/D																						
Aimovig® Ajovy® Emgality® 120mg syringe, pen Nurtec™ ODT CC, ST Ubrelvy™ ST	Emgality® 100mg syringe Qulipta™ Reyvow™ ST Zavzpret™ ST	CLINICAL CRITERIA (CC) <ul style="list-style-type: none">Confirm diagnosis of FDA-approved or compendia-supported indication STEP THERAPY (ST) Acute treatment of migraine <ul style="list-style-type: none">Trial of a product from the Antimigraine Agents-Triptan class <table><tr><th>Agent</th><th>F/Q/D</th></tr><tr><td>Aimovig</td><td>1 syringe/30 days</td></tr><tr><td>Emgality 120 mg</td><td>2 syringes/30 days</td></tr><tr><td>Emgality 100 mg</td><td>3 syringes/30 days</td></tr><tr><td>Ajovy</td><td>3 syringes/90 days</td></tr><tr><td>Reyvow</td><td>8 units/30 days</td></tr><tr><td>Ubrelvy</td><td>16 units/30 days</td></tr><tr><td>Nurtec™ ODT</td><td>24 units/40 days</td></tr><tr><td>Qulipta</td><td>30 units/30 days</td></tr><tr><td>Zavzpret®</td><td>8 units/30 days</td></tr></table>	Agent	F/Q/D	Aimovig	1 syringe/30 days	Emgality 120 mg	2 syringes/30 days	Emgality 100 mg	3 syringes/30 days	Ajovy	3 syringes/90 days	Reyvow	8 units/30 days	Ubrelvy	16 units/30 days	Nurtec™ ODT	24 units/40 days	Qulipta	30 units/30 days	Zavzpret®	8 units/30 days
Agent	F/Q/D																					
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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																				
IV. Central Nervous System																						
Antipsychotics – Second Generation CC, ST																						
aripiprazole tablet DO asenapine (gen Saphris®) clozapine lurasidone (gen Latuda®) olanzapine tablet DO paliperidone ER DO quetiapine F/Q/D quetiapine ER F/Q/D, DO risperidone ziprasidone capsule	Abilify® tablet DO Abilify MyCite® aripiprazole solution aripiprazole ODT Caplyta™ clozapine ODT Clozaril® Cobenfy™ capsules, starter pack Fanapt® Geodon® Invega® DO Latuda® DO Lybalvi® Nuplazid® olanzapine ODT DO olanzapine / fluoxetine Opipza™ Rexulti® DO Risperdal® Saphris® Secuado® Seroquel® F/Q/D Seroquel XR® DO, F/Q/D Versacloz® Vraylar® DO Zyprexa® DO Zyprexa® Zydis	DOSE OPTIMIZATION (DO) <ul style="list-style-type: none">See Dose Optimization Chart for affected drugs and strengths CLINICAL CRITERIA (CC) <ul style="list-style-type: none">Confirm diagnosis of FDA-approved or compendia-supported indicationClinical editing will allow patients currently stabilized on a non-preferred agent to continue to receive that agent without PAPrior authorization is required when an oral SGA is utilized above the highest MDD according to FDA labeling.Prior authorization is required for patients less than 21 years of age when there is concurrent use of 2 or more different oral antipsychotics for greater than 90 days.Prior authorization is required for patients 21 years of age or older when 3 or more different oral second-generation antipsychotics are used for more than 180 days.PA is required for initial prescription for beneficiaries younger than the drug-specific minimum age as indicated below:<table><tr><td>aripiprazole (Abilify®, Opipza™)</td><td>6 years</td></tr><tr><td>aripiprazole (Abilify MyCite®)</td><td>18 years</td></tr><tr><td>asenapine (Saphris®)</td><td>10 years</td></tr><tr><td>asenapine (Secuado®)</td><td>18 years</td></tr><tr><td>brexpiprazole (Rexulti®)</td><td>13 years</td></tr><tr><td>cariprazine (Vraylar®)</td><td>18 years</td></tr><tr><td>clozapine (Clozaril®, Versacloz®)</td><td>12 years</td></tr><tr><td>iloperidone (Fanapt®)</td><td>18 years</td></tr><tr><td>lumateperone (Caplyta™)</td><td>18 years</td></tr><tr><td>lurasidone HCl (Latuda®)</td><td>10 years</td></tr></table>	aripiprazole (Abilify®, Opipza™)	6 years	aripiprazole (Abilify MyCite®)	18 years	asenapine (Saphris®)	10 years	asenapine (Secuado®)	18 years	brexpiprazole (Rexulti®)	13 years	cariprazine (Vraylar®)	18 years	clozapine (Clozaril®, Versacloz®)	12 years	iloperidone (Fanapt®)	18 years	lumateperone (Caplyta™)	18 years	lurasidone HCl (Latuda®)	10 years
aripiprazole (Abilify®, Opipza™)	6 years																					
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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters																
IV. Central Nervous System																		
		<table><tr><td>olanzapine (Zyprexa®)</td><td>10 years</td></tr><tr><td>olanzapine / fluoxetine (Symbyax®)</td><td>10 years</td></tr><tr><td>paliperidone ER (Invega®)</td><td>12 years</td></tr><tr><td>pimavanserin (Nuplazid®)</td><td>18 years</td></tr><tr><td>quetiapine fum. (Seroquel®, Seroquel XR®)</td><td>10 years</td></tr><tr><td>risperidone (Risperdal®)</td><td>5 years</td></tr><tr><td>xanomeline-trospium (Cobenfy™)</td><td>18 years</td></tr><tr><td>ziprasidone HCl (Geodon®)</td><td>10 years</td></tr></table> <ul style="list-style-type: none">Require confirmation of diagnosis that supports the concurrent use of a Second Generation Antipsychotic and a CNS Stimulant for patients < 18 years of age <p>STEP THERAPY (ST)</p> <ul style="list-style-type: none">For all Second Generation Antipsychotics used in the treatment of Major Depressive Disorder in the absence of other psychiatric comorbidities, trial with at least two different antidepressant agents is requiredolanzapine / fluoxetine: When prescribing for the treatment of major depressive disorder (MDD) in the absence of other psychiatric comorbidities, trial with at least one different antidepressant agent is required <p>FREQUENCY/QUANTITY/DURATION (F/Q/D)</p> <ul style="list-style-type: none">quetiapine/quetiapine ER (Seroquel®/Seroquel XR®): Minimum 50 mg/dayquetiapine (Seroquel®): Maximum 3 units per day, 90 units per 30 daysquetiapine ER (Seroquel XR®): 50mg, maximum 2 units/day, 60 units/30 days	olanzapine (Zyprexa®)	10 years	olanzapine / fluoxetine (Symbyax®)	10 years	paliperidone ER (Invega®)	12 years	pimavanserin (Nuplazid®)	18 years	quetiapine fum. (Seroquel®, Seroquel XR®)	10 years	risperidone (Risperdal®)	5 years	xanomeline-trospium (Cobenfy™)	18 years	ziprasidone HCl (Geodon®)	10 years
olanzapine (Zyprexa®)	10 years																	
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ziprasidone HCl (Geodon®)	10 years																	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
Sedative Hypnotics/Sleep Agents F/Q/D		
estazolam CC eszopiclone ramelteon (gen Rozerem®) temazepam 15 mg, 30 mg CC zolpidem tablet CC zolpidem ER CC	Ambien® CC Ambien CR® CC Belsomra® Dayvigo™ Doral® CC doxepin Edluar® CC flurazepam CC Halcion® CC Lunesta® DO quazepam CC (gen Doral®) Quviviq™ Restoril® CC Rozerem® temazepam 7.5 mg, 22.5 mg CC triazolam CC zaleplon zolpidem sublingual, capsule CC	DOSE OPTIMIZATION (DO) <ul style="list-style-type: none"> See Dose Optimization Chart for affected strengths CLINICAL CRITERIA (CC) <ul style="list-style-type: none"> Zolpidem products: Confirm dosage is consistent with FDA labeling for initial prescriptions Benzodiazepine Agents (estazolam, Doral®, flurazepam, Halcion®, quazepam, Restoril®, temazepam, triazolam): <ul style="list-style-type: none"> Confirm diagnosis of FDA-approved or compendia-supported indication PA required for initiation of benzodiazepine therapy in patients currently on opioid or oral buprenorphine therapy PA required for any additional benzodiazepine prescription in patients currently on benzodiazepine therapy PA required when greater than a 14-day supply of a benzodiazepine is prescribed for someone on a CNS stimulant FREQUENCY/QUANTITY/DURATION (F/Q/D) <ul style="list-style-type: none"> Frequency and duration limits for the following products: <ul style="list-style-type: none"> For non-zaleplon and non-benzodiazepine containing products: <ul style="list-style-type: none"> 30 dosage units per fill/1 dosage unit per day/30 days For zaleplon-containing products: <ul style="list-style-type: none"> 60 dosage units per fill/2 dosage units per day/30 days Duration limit equivalent to the maximum recommended duration: <ul style="list-style-type: none"> 180 days for immediate-release zolpidem (Ambien®, Edluar®) products 180 days for eszopiclone and ramelteon (Rozerem®) products 180 days for lemborexant (Dayvigo™) 168 days for zolpidem ER (Ambien CR®) products

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
IV. Central Nervous System		
		<ul style="list-style-type: none"> o 90 days for daridorexant (Quviviq™) o 90 days for suvorexant (Belsomra®) o 90 days for doxepin o 30 days for zaleplon (Sonata®) products o 30 days for benzodiazepine agents (estazolam, flurazepam, Halcion®, quazepam, Restoril®, temazepam, triazolam) for the treatment of insomnia <p>Additional/Alternate parameters: For patients naïve to non-benzodiazepine sedative hypnotics (NBSH): First-fill duration and quantity limit of 10 dosage units as a 10-day supply, except for zaleplon-containing products which the quantity limit is 20 dosage units as a 10-day supply</p>

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Glucagon Agents		
Baqsimi® glucagon vial glucagon HCl emergency kit (Fresenius) Gvoke® pen, syringe, vial Zegalogue® pen, syringe	glucagon emergency kit (Eli Lilly, Amphastar)	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VI. Endocrine and Metabolic Agents		
Insulin – Rapid-Acting		
Apidra® insulin aspart (gen Novolog®) cartridge, vial, pen insulin lispro (gen Humalog® U100) vial, pen insulin lispro junior (gen Humalog® Jr.)	Admelog® Afrezza® Fiasp® Penfill, FlexTouch, Pumpcart, vial Humalog® Jr. 100 U/mL Kwikpen Humalog® 100 U/mL vial, pen, cartridge, Tempo™ Humalog® 200 U/mL Lyumjev® Lyumjev® Tempo™ Novolog® cartridge, vial, FlexPen	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VIII. Hematological Agents		
Colony Stimulating Factors		
Neupogen® Nyvepria™	Fylmetra® Fulphila™ Granix® Leukine® Neulasta® Nivestym™ Releuko™ Rolvedon® Stimufend® Udenyca® Zarxio® Ziextenzo®	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VIII. Hematological Agents		
Hemophilia Agents – Other		
Alphanate® (von Willebrand factor/Factor VIII) Coagadex® (Factor X) Corifact® (Factor XIII) Feiba® NF (activated prothrombin complex) Hemlibra® (emicizumab-kxwh) Novoseven® RT (Factor VIIa) Sevenfact® (Factor VIIa-jncw) Tretten® (Factor XIII) Vonvendi® (von Willebrand factor) Wilate® (von Willebrand factor/Factor VIII)	Alhemo® Hympavzi™	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
VIII. Hematological Agents		
Platelet Inhibitors		
Brilinta® clopidogrel dipyridamole dipyridamole/aspirin	Effient® Plavix® prasugrel	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XII. Ophthalmics		
Prostaglandin Agonists – Ophthalmic		
latanoprost	bimatoprost lyuzeh™ Lumigan® Rocklatan™ tafluprost (gen Zioptan®) Travatan Z® travoprost (gen Travatan Z®) Xalatan® Xelpros™ Vyzulta™ Zioptan®	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XIV. Renal and Genitourinary		
Alpha Reductase Inhibitors for BPH		
finasteride	Avodart® dutasteride dutasteride/tamsulosin Proscar®	

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XIV. Renal and Genitourinary		
Urinary Tract Antispasmodics		
fesoterodine ER (gen Toviaz®) Myrbetriq® DO, BLTG oxybutynin oxybutynin ER DO solifenacin Toviaz® DO	darifenacin Detrol® Detrol LA® DO flavoxate Gemtesa® mirabegron (gen Myrbetriq®) Myrbetriq® solution F/Q/D Oxytrol® tolterodine tolterodine ER trospium trospium ER Vesicare® DO Vesicare® LS	DOSE OPTIMIZATION (DO) <ul style="list-style-type: none"> See Dose Optimization Chart for affected strengths FREQUENCY/QUANTITY/DURATION (F/Q/D) Myrbetriq® solution; limited to a 30-day supply

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Preferred Drugs	Non-Preferred Drugs	Prior Authorization/Coverage Parameters
XV. Respiratory		
COPD Agents		
Anoro Ellipta® Atrovent HFA® Bevespi® Aerosphere® Combivent Respimat® Incruse Ellipta® ipratropium ipratropium / albuterol roflumilast (gen Daliresp®) Spiriva® HandiHaler® <u>BLTG</u> Spiriva Respimat® Stiolto Respimat® Trelegy Ellipta® Tudorza Pressair®	Breztri™ Aerosphere Daliresp® Duaklir® Pressair Ohtuvayre™ tiotropium (gen Spiriva® Handihaler®) Yupelri®	