This Update has been revised since its original publication. Revised information appears in red text on pages 10, 29, and 33-34.

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ForwardHealth UPDATE

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JANUARY 2026 PREFERRED DRUG LIST CHANGES AND OTHER PHARMACY POLICY

On November 5, 2025, the Wisconsin Medicaid Pharmacy Prior Authorization (PA) Advisory Committee met to review existing therapeutic drug classes on the Preferred Drug List (PDL).

This ForwardHealth Update announces changes to the PDL and certain PDL drug classes from the November 2025 PDL review, certain PA form changes, and other pharmacy policy changes.

All policy and form changes are effective January 1, 2026, unless otherwise noted.

Providers may refer to the ForwardHealth Online Handbook Standard Pharmacy Policy for Covered and Noncovered Drugs topic #22337 for general ForwardHealth policy for drugs that require PA approval. Providers may also refer to this topic about what may **not** be considered criteria to support the need for a drug.

AFFECTED PROGRAMS

BadgerCare Plus, Medicaid, SeniorCare

TO

Blood Banks, Community Health Centers, Dentists, Hospital Providers, Nurse Practitioners, Nursing Homes, Pharmacies, Pharmacists, Physician Assistants, Physician Clinics, Physicians, Podiatrists, Rural Health Clinics, Tribal Federally Qualified Health Centers, HMOs and Other Managed Care Programs

CONTACT INFORMATION

Provider Services and the Drug Authorization and Policy Override (DAPO) Center, 800-947-9627

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WISCONSIN DEPARTMENT of HEALTH SERVICES

Providers are responsible for staying current with ForwardHealth policy and procedures and billing information in the Online Handbook.

Refer to the following sections for more information about:

- Drug status changes on the PDL.
- Changes to pharmacy-related PA forms and instructions.
- A brief overview of the PDL.
- New antibiotics, other drug class.
- New antivirals, COVID-19 drug class.
- Changes to legacy exemptions for Alzheimer's agents.
- Changes to legacy exemptions for antipsychotic drugs.
- Changes to legacy exemptions for stimulant drugs.
- Changes to Alzheimer's agents drug class.
- Changes to anticonvulsants drug class.
- Changes to cytokine and cell adhesion molecule (CAM) antagonists drug class.
- Changes to headache agents, triptan injectable and headache agents, acute treatment drug classes.
- Changes to immunomodulators, asthma drug class.
- Changes to immunomodulators, atopic dermatitis drug class.
- Changes to ophthalmics, anti-inflammatory/immunomodulator drug class.
- Other pharmacy policy changes.

Drug Status Changes on the Preferred Drug List

Attachment A to this Update lists the drugs that have changed their preferred or non-preferred status as a result of the November 2025 PDL review. The Preferred Drug List Quick Reference data table contains a complete list of preferred and non-preferred drugs.

For drugs that were previously preferred and will become non-preferred, pharmacy providers should work with prescribers to transition members to a preferred drug or complete the appropriate PA request forms for non-preferred drugs.

As a reminder, new drugs are usually added to existing drug classes on the PDL as non-preferred drugs until the next scheduled drug class review by the Wisconsin Medicaid Pharmacy PA Advisory Committee. This means that some drugs listed in the table have not previously been reviewed and were added to

the PDL with an interim status of non-preferred. These drugs have now been reviewed, and their PDL status is included in Attachment A.

Changes to Pharmacy-Related PA Forms and Instructions

Attachment B lists the PA forms and instructions that have been created, revised, or revised and renamed as a result of the November 2025 PDL review or as a result of other pharmacy policy changes. The Forms page of the ForwardHealth Portal (the Portal) contains current copies of all PA forms and instructions.

More information regarding changes to clinical criteria or PA request submission options is noted in the applicable drug class or other pharmacy policy sections of this Update.

Archive Page for Pharmacy-Related Forms and Instructions

The Pharmacy-Related Forms and Instructions link under the Archives Quick Links box on the Pharmacy Resources page of the Portal contains previous versions of pharmacy-related forms and instructions for reference purposes.

A Brief Overview of the Preferred Drug List

ForwardHealth makes recommendations to the Wisconsin Medicaid Pharmacy PA Advisory Committee about whether certain PDL drugs should be preferred or non-preferred. These recommendations are based primarily on objective evaluations of a drug's relative safety, effectiveness, clinical outcomes, and relative cost (to Wisconsin Medicaid) in comparison with other therapeutically interchangeable, alternative agents in the same drug class.

New drugs are usually added to existing drug classes on the PDL as non-preferred drugs until their next scheduled class review by the Wisconsin Medicaid Pharmacy PA Advisory Committee.

The PDL is not a drug formulary and is not a comprehensive list of covered drugs.

Most drugs and drug classes included on the PDL are covered fee for service by BadgerCare Plus, Wisconsin Medicaid, and SeniorCare, but certain drugs may have restrictions (for example, diagnosis, quantity limits, age limits). Prescribers are encouraged to write prescriptions for preferred drugs if medically appropriate. Non-preferred drugs may be covered with an approved PA request. Most preferred drugs do not require PA, except in designated classes identified on the Preferred Drug List Quick Reference data table.

DID YOU KNOW?

Prescribers and pharmacy providers can find specific pharmacy-related PA forms on the Forms page by entering the form number into the Keyword or Form Number field of the Search Criteria and clicking Search.

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IMPORTANT REMINDERS OF CURRENT PA POLICY FOR PREFERRED DRUG LIST DRUGS

For prescribers' responsibilities for PA for PDL drugs, refer to A Prescriber's Responsibilities for Prior Authorization for Preferred Drug List Drugs topic #1987.

For pharmacy providers' responsibilities for PA for PDL drugs, refer to A Pharmacy Provider's Responsibilities for Prior Authorization for Preferred Drug List Drugs topic #10937.

New Antibiotics, Other Drug Class

Effective January 1, 2026, the antibiotics, other drug class will be added to the PDL.

Orlynvah, a non-preferred drug in the antibiotics, beta-lactam class, will move to the antibiotics, other drug class. Blujepa will become a non-preferred drug in the antibiotics, other drug class.

Blujepa and Orlynvah will have an interim status of non-preferred and will be reviewed during the May 2026 PDL review.

Blujepa and Orlynvah will require clinical PA.

New Clinical Criteria for Blujepa and Orlynvah

ForwardHealth has established the clinical PA criteria for Blujepa and Orlynvah.

Clinical criteria for approval of a PA request for Blujepa or Orlynvah are **all** of the following:

- The member is female.
- The member's age and weight are consistent with the Food and Drug Administration (FDA)-approved product labeling for the requested drug.
- The member is being treated for an uncomplicated urinary tract infection that is caused by an organism that is susceptible to the requested drug.
- The prescriber has determined that treatment with an alternative oral antibiotic is not appropriate for the member.

If the clinical criteria for Blujepa or Orlynvah are met, PA requests may be approved for up to five days.

New Prior Authorization/Preferred Drug List for Blujepa and Orlynvah Form

ForwardHealth has created the Prior Authorization/Preferred Drug List (PA/PDL) for Blujepa and Orlynvah form, F-03412 (01/2026). Effective January 1, 2026, pharmacy providers must submit PA requests for Blujepa or Orlynvah using the PA/PDL for Blujepa and Orlynvah form.

Submitting PA Requests for Blujepa and Orlynvah

PA requests for Blujepa and Orlynvah must be completed, signed, and dated by the prescriber. PA requests for Blujepa and Orlynvah must be submitted using the PA/PDL for Blujepa and Orlynvah form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/PDL for Blujepa and Orlynvah form and a completed Prior Authorization Request Form (PA/RF), F-11018 (05/2013), to ForwardHealth.

PA requests for Blujepa and Orlynvah may be submitted using the Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) system, on the Portal, by fax, or by mail.

New Antivirals, COVID-19 Drug Class

Effective January 1, 2026, the antivirals, COVID-19 drug class will be added to the PDL.

Paxlovid will be a preferred drug in the antivirals, COVID-19 drug class. Preferred drugs in the antivirals, COVID-19 drug class do not require PA.

Changes to Legacy Exemptions for Alzheimer's Agents

BadgerCare Plus, Medicaid, and SeniorCare members who were eligible for the legacy exemption for galantamine tablets or galantamine ER for dates of service (DOS) on and after January 1, 2012, and remained eligible throughout 2025 will no longer be allowed to receive the legacy exemption for

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galantamine tablets or galantamine ER for DOS on and after January 1, 2026, if **one** of the following is true:

- Members without other primary insurance on file with ForwardHealth have had no claim activity for galantamine tablets or galantamine ER for DOS in the last six months of 2025.
- Members with other primary insurance on file with ForwardHealth have had no claim activity for galantamine tablets or galantamine ER for DOS in calendar year 2025.

PA is required for galantamine tablets and galantamine ER for members who do not have a legacy exemption for either one of the drugs.

Changes to Legacy Exemptions for Antipsychotic Drugs

BadgerCare Plus, Medicaid, and SeniorCare members who were granted a legacy exemption for thioridazine for DOS on and after October 1, 2010, and remained eligible throughout 2025 will no longer be allowed to receive the legacy exemption for thioridazine for DOS on and after January 1, 2026, if **one** of the following is true:

- Members without other primary insurance on file with ForwardHealth have had no claim activity for thioridazine for DOS in the last six months of 2025.
- Members with other primary insurance on file with ForwardHealth have had no claim activity for thioridazine for DOS in calendar year 2025.

PA is required for thioridazine for members who do not have a legacy exemption for the drug.

Changes to Legacy Exemptions for Stimulant Drugs

BadgerCare Plus, Medicaid, and SeniorCare members who were granted a legacy exemption for designated amphetamine drugs for DOS on and after January 1, 2018, and remained eligible throughout 2025 will no longer be allowed to receive the legacy exemption for amphetamine drugs for DOS on and after January 1, 2026, if **one** of the following is true:

- Members without other primary insurance on file with ForwardHealth have had no claim activity for amphetamine drugs for DOS in the last six months of 2025.
- Members with other primary insurance on file with ForwardHealth have had no claim activity for amphetamine drugs for DOS in calendar year 2025.

QUICK LINKS

- Legacy Exemptions for Alzheimer's Agents topic #12897
- Legacy Exemptions for Antipsychotic Drugs topic #10659

Note: These topics will be updated on January 2, 2026.

QUICK LINKS

Legacy Exemptions for Stimulant Drugs topic #10662

Note: This topic will be updated on January 2, 2026.

PA is required for designated amphetamine drugs for members who do not have a legacy exemption for the drug. Below is the table that lists the allowed legacy exemptions for amphetamine drugs and their applicable legacy exemption details.

LEGACY EXEMPTION DRUGS—AMPHETAMINE	LEGACY EXEMPTION DETAILS
dextroamphetamine **dextroamphetamine ER**	Eligible members identified to be taking any of these two drugs **are allowed to receive any of the following as a legacy exemption drug**: • Generic dextroamphetamine • Generic dextroamphetamine ER Note: An approved PA request is not required for any child 6 years of age or younger for generic dextroamphetamine.
Adderall **Adderall XR** **dextroamphetamine-amphetamine** **dextroamphetamine-amphetamine ER**	Eligible members identified to be taking any of these four drugs **are allowed to receive any of the following as a legacy exemption drug**: • Brand name Adderall • Brand name Adderall XR • Generic dextroamphetamine-amphetamine • Generic dextroamphetamine-amphetamine ER Note: An approved PA request is not required for any child 6 years of age or younger for brand name Adderall or generic dextroamphetamine-amphetamine.

Changes to Alzheimer's Agents Drug Class

Changes for Memantine Products Policy Exceptions

Upon review of the applicable claim history for memantine products, no members were identified as needing the exception to continue receiving

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memantine or memantine XR. Therefore, the policy exception for memantine products will end on December 31, 2025.

Changes to Anticonvulsants Drug Class

Lamictal XR Tablets and Lamictal ODT Becoming Brand Medically Necessary

Effective January 1, 2026, non-preferred brand name drugs Lamictal XR tablets and Lamictal ODT will be subject to brand medically necessary (BMN) policy and will require BMN PA.

Lamotrigine ER, the generic for Lamictal XR, will remain a preferred drug in the anticonvulsants drug class. Preferred drugs in the anticonvulsants drug class do not require PA. Lamotrigine ODT, the generic drug for Lamictal ODT, will remain a non-preferred drug in the same drug class. Lamotrigine ODT will continue to use the Prior Authorization/Preferred Drug List (PA/PDL) Exemption Request form, F-11075 (07/2023), for PA requests.

For DOS on and after January 1, 2026:

- Members who have an approved PA request for Lamictal XR will need a BMN PA request to continue receiving the drug.
- Members who have an approved PA request for Lamictal ODT will be allowed to obtain the generic lamotrigine ODT until the PA for Lamictal ODT expires. Members who need the brand name Lamictal ODT will require BMN PA.

Revised Clinical Criteria for Vigadrone and Vigafyde

ForwardHealth has revised the clinical criteria for Vigadrone and Vigafyde.

The clinical criteria that must be documented for approval of a PA request for Vigadrone or Vigafyde includes **both** of the following:

- The prescriber has submitted detailed clinical justification for prescribing Vigadrone or Vigafyde instead of Sabril or vigabatrin (generic Sabril).
- The clinical information must document why the member cannot use Sabril or vigabatrin (generic Sabril), including why it is medically necessary that the member receive Vigadrone or Vigafyde instead of Sabril or vigabatrin (generic Sabril).

Supporting clinical documentation and a copy of the member's current medical records must be submitted with the PA request to support the member's need

QUICK LINKS

- Alzheimer's Agents topic #15037
- Anticonvulsants topic #21237
- Non-Preferred Drugs That Use the Prior Authorization/ Preferred Drug List Exemption Request Form topic #22218
- Brand Medically Necessary Drugs: A Prescriber's Responsibilities topic #2016
- Brand Medically Necessary Drugs: A Pharmacy Provider's Responsibilities topic #2017

Note: Topics #15037 and #21237 will be updated on January 2, 2026.

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for Vigadrone or Vigafyde. Initial PA requests for Vigadrone or Vigafyde may be approved for up to 183 days.

Renewal PA requests may be approved for up to 365 days. Medical records must be submitted demonstrating clinical improvement and must reflect member compliance with Vigadrone or Vigafyde.

Note: Vigadrone or Vigafyde are not available through expedited emergency supply.

Changes to Cytokine and Cell Adhesion Molecule Antagonists Drug Class

Hadlima, Selarsdi subQ, Steqeyma subQ, Taltz, Xeljanz Solution, and Xeljanz XR will become preferred drugs in the cytokine and CAM antagonists drug class. Preferred drugs do not require PA.

Cyltezo, a preferred drug in the cytokine and CAM antagonists drug class, will become a non-preferred drug. Otezla XR will be added to the cytokine and CAM antagonists drug class and will become a non-preferred drug. Non-preferred drugs require PA. Otezla XR will have an interim status of non-preferred and will be reviewed during the November 2026 PDL review.

New Clinical Condition

ForwardHealth has added oral ulcers associated with Behcet's disease to the list of clinical conditions for non-preferred cytokine and CAM antagonist drugs that require PA.

PA requests for non-preferred cytokine and CAM antagonist drugs will only be approved for use to treat the following identified clinical conditions:

- Ankylosing spondylitis
- Crohn's disease
- Deficiency of interleukin-1 receptor antagonist (DIRA)
- Enthesitis-related arthritis (ERA)
- Generalized pustular psoriasis (GPP)
- Giant cell arteritis
- Hidradenitis suppurativa
- Juvenile idiopathic arthritis (JIA) and systemic JIA
- Neuromyelitis optica spectrum disorder (NMOSD)
- Neonatal onset multisystem inflammatory disease (NOMID)
- Non-radiographic axial spondyloarthritis (nr-axSpA)

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Cytokine and Cell Adhesion Molecule Antagonist Drugs topic #16217

Note: This topic will be updated on January 2, 2026.

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- Oral ulcers associated with Behcet's disease
- Polymyalgia rheumatica (PMR)
- Psoriasis
- Psoriatic arthritis
- Rheumatoid arthritis (RA)
- Systemic sclerosis-associated interstitial lung disease (SSc-ILD)
- Ulcerative colitis
- Uveitis

PA requests for cytokine and CAM antagonist drugs will only be approved for **one cytokine and CAM antagonist drug per member**. ForwardHealth does not cover treatment with more than one cytokine and CAM antagonist drug.

PA requests will not be considered for subcutaneous dosage forms of cytokine and CAM antagonist drugs that will be administered in a medical office or medical facility.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for non-preferred cytokine and CAM antagonist drugs. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

Initial PA requests for non-preferred cytokine and CAM antagonist drugs may be approved for up to 183 days.

Renewal PA requests for non-preferred cytokine and CAM antagonist drugs may be approved for up to 365 days. Renewal PA requests for non-preferred cytokine and CAM antagonist drugs must include supporting clinical information and copies of the member's current medical records demonstrating that the member had a significant reduction in symptoms compared to their baseline prior to the initiation of the non-preferred cytokine and CAM antagonist drug.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

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New Indications for Otezla XR

Otezla XR will be added to the list of non-preferred cytokine and CAM antagonist drugs used to treat these clinical conditions:

- Oral ulcers associated with Behcet's disease
- Psoriasis
- Psoriatic arthritis

Revised PA Forms for Cytokine and Cell Adhesion Molecule Antagonist Drugs

ForwardHealth has revised the following PA forms for non-preferred cytokine and CAM antagonist drugs:

- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis form, F-11304 (01/2026)
- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form, F-01950 (01/2026)
- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Hidradenitis Suppurativa form, F-03174 (01/2026)
- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Giant Cell Arteritis and Non-Radiographic Axial Spondyloarthritis (nr-axSpA) form, F-01952 (01/2026)
- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriasis form, F-11306 (01/2026)
- Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA), and Psoriatic Arthritis form, F-01951 (01/2026)

ForwardHealth has also revised and renamed the Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Uveitis form, F-03224 (01/2025), to Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Oral Ulcers Associated With Behcet's Disease and Uveitis form, F-03224 (01/2026).

Effective January 1, 2026, pharmacy providers must submit PA requests for non-preferred cytokine and CAM antagonist drugs on the revised and

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revised and renamed PA forms (dated 01/2026). ForwardHealth will return PA requests that are not submitted with these revised forms.

ForwardHealth will honor PA requests for non-preferred cytokine and CAM antagonist drugs approved before January 1, 2026, until they expire or until the approved days' supply is used up.

New Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Oral Ulcers Associated With Behcet's Disease

ForwardHealth has established the clinical PA criteria for non-preferred drugs used to treat oral ulcers associated with Behcet's disease.

Otezla is a preferred drug used to treat oral ulcers associated with Behcet's disease. Preferred drugs in the cytokine and CAM antagonists drug class do not require PA.

Otezla XR is a non-preferred drug used to treat oral ulcers associated with Behcet's disease.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat oral ulcers associated with Behcet's disease are **all** of the following:

- The member has oral ulcers associated with Behcet's disease.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has taken **one** preferred cytokine and CAM antagonist drug for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

When initially accessing Online Handbook topic links available throughout this Update, providers need to click the "I Accept" button at the bottom of the licensure agreement page of the Online Handbook. After 30 minutes of inactivity, providers will need to click "I Accept" again before going to their intended topic.

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Otezla XR

The prescriber must submit detailed clinical justification for prescribing Otezla XR instead of Otezla. The clinical information must document why the member cannot use Otezla, including why it is medically necessary that the member receive Otezla XR instead of Otezla.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Oral Ulcers Associated With Behcet's Disease

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat oral ulcers associated with Behcet's disease must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Oral Ulcers Associated With Behcet's Disease and Uveitis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Oral Ulcers Associated With Behcet's Disease and Uveitis form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat oral ulcers associated with Behcet's disease may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ankylosing Spondylitis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat ankylosing spondylitis.

Cimzia, Enbrel, Hadlima, Humira, Simponi subQ, Taltz, Xeljanz, and Xeljanz XR are preferred drugs used to treat ankylosing spondylitis. Preferred drugs in the cytokine and CAM antagonists drug class do not require PA.

Adalimumab-xxxx, Bimzelx, Cosentyx subQ, and Rinvoq are non-preferred drugs used to treat ankylosing spondylitis.

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Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat ankylosing spondylitis are **all** of the following:

- The member has ankylosing spondylitis.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. Note: ForwardHealth will only consider use of:
  - Hadlima or Humira as one trial.
  - Xeljanz or Xeljanz XR as one trial.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira. The clinical information must document why the member cannot use Hadlima and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ankylosing Spondylitis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ankylosing spondylitis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Ankylosing Spondylitis form and a completed PA/RF to ForwardHealth.

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PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ankylosing spondylitis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Crohn's Disease

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease.

Cimzia, Hadlima, Humira, Selarsdi subQ, and Steqeyma subQ are preferred drugs used to treat Crohn's disease. Preferred drugs in the cytokine and CAM antagonists drug class do not require PA.

Adalimumab-xxxx, Entyvio subQ, Omvoh subQ, Rinvoq, Skyrizi subQ, Stelara subQ, Tremfya subQ, ustekinumab-xxxx subQ, and Zymfentra are non-preferred drugs used to treat Crohn's disease.

Note: Omvoh subQ and Skyrizi subQ will require an IV induction prior to initiating treatment with the subQ. A PA request for the IV induction must be approved before ForwardHealth will consider PA for the subQ. PA for the IV induction may be obtained through the physician-administered drug PA process. An IV induction for Tremfya subQ is optional prior to initiating treatment with the subQ.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease are **all** of the following:

- The member has Crohn's disease.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. Note: ForwardHealth will only consider use of:
    - Hadlima or Humira as one trial.
    - Selarsdi subQ or Steqeyma subQ as one trial.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira. The clinical information must document why the member cannot use Hadlima and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira.

Non-Preferred Ustekinumab-xxxx subQ Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ. The clinical information must document why the member cannot use Selarsdi subQ and Steqeyma subQ, including why it is medically necessary that the member receive a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Crohn's Disease

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat Crohn's disease may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

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Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Hidradenitis Suppurativa

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat hidradenitis suppurativa.

Hadlima and Humira are preferred drugs used to treat hidradenitis suppurativa. Preferred drugs do not require PA.

Adalimumab-xxxx, Bimzelx, and Cosentyx subQ are non-preferred drugs used to treat hidradenitis suppurativa.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat hidradenitis suppurativa are **all** of the following:

- The member has hidradenitis suppurativa.
- The prescription is written by a dermatologist or through a dermatology consultation.
- The member has taken **one** preferred cytokine and CAM antagonist drug for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira. The clinical information must document why the member cannot use Hadlima and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Hidradenitis Suppurativa

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat hidradenitis suppurativa must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Hidradenitis Suppurativa form.

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The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Hidradenitis Suppurativa form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat hidradenitis suppurativa may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Non-Radiographic Axial Spondyloarthritis

ForwardHealth has revised the clinical criteria for non-preferred drugs used to treat nr-axSpA.

Cimzia and Taltz are preferred drugs used to treat nr-axSpA. Preferred drugs in the cytokine and CAM antagonists drug class do not require PA.

Bimzelx, Cosentyx subQ, and Rinvoq are non-preferred drugs used to treat nr-axSpA.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat nr-axSpA are **all** of the following:

- The member has nr-axSpA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Non-Radiographic Axial Spondyloarthritis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred

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cytokine and CAM antagonist drugs used to treat nr-axSpA must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Giant Cell Arteritis and nr-axSpA form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Giant Cell Arteritis and nr-axSpA form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat nr-axSpA may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriasis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis.

Cimzia, Enbrel, Hadlima, Humira, Otezla, Selarsdi subQ, Steqeyma subQ, and Taltz are preferred drugs used to treat psoriasis. Preferred drugs in the cytokine and CAM antagonists drug class do not require PA.

Adalimumab-xxxx, Bimzelx, Cosentyx subQ, Otezla XR, Skyrizi subQ, Sotyktu, Stelara subQ, Tremfya subQ, and ustekinumab-xxxx subQ are non-preferred drugs used to treat psoriasis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis are **all** of the following:

- The member has psoriasis.
- The prescription is written by a dermatologist or through a dermatology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. Note: ForwardHealth will only consider use of:
    - Hadlima or Humira as one trial.

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- Selarsdi subQ or Steqeyma subQ as one trial.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira. The clinical information must document why the member cannot use Hadlima and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira.

Non-Preferred Ustekinumab-xxxx subQ Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ. The clinical information must document why the member cannot use Selarsdi subQ and Steqeyma subQ, including why it is medically necessary that the member receive a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ.

Otezla XR

The prescriber must submit detailed clinical justification for prescribing Otezla XR instead of Otezla. The clinical information must document why the member cannot use Otezla, including why it is medically necessary that the member receive Otezla XR instead of Otezla.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriasis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Psoriasis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

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Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Psoriasis form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriasis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriatic Arthritis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis.

Cimzia, Enbrel, Hadlima, Humira, Orencia subQ, Otezla, Selarsdi subQ, Simponi subQ, Steqeyma subQ, Taltz, Xeljanz, and Xeljanz XR are preferred drugs used to treat psoriatic arthritis. Preferred drugs in the cytokine and CAM antagonists drug class do not require PA.

Adalimumab-xxxx, Bimzelx, Cosentyx subQ, Otezla XR, Rinvoq, Rinvoq LQ, Skyrizi subQ, Stelara subQ, Tremfya subQ, and ustekinumab-xxxx subQ are non-preferred drugs used to treat psoriatic arthritis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis are **all** of the following:

- The member has psoriatic arthritis.
- The prescription is written by a dermatologist or rheumatologist or through a dermatology or rheumatology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. Note: ForwardHealth will only consider use of:
  - Hadlima or Humira as one trial.
  - Selarsdi subQ or Steqeyma subQ as one trial.
  - Xeljanz or Xeljanz XR as one trial.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira. The

clinical information must document why the member cannot use Hadlima and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira.

Non-Preferred Ustekinumab-xxxx subQ Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ. The clinical information must document why the member cannot use Selarsdi subQ and Steqeyma subQ, including why it is medically necessary that the member receive a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ.

Otezla XR

The prescriber must submit detailed clinical justification for prescribing Otezla XR instead of Otezla. The clinical information must document why the member cannot use Otezla, including why it is medically necessary that the member receive Otezla XR instead of Otezla.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Psoriatic Arthritis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat psoriatic arthritis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

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Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Rheumatoid Arthritis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat RA.

Cimzia, Enbrel, Hadlima, Humira, Orencia subQ, Simponi subQ, Tyenne subQ, Xeljanz, and Xeljanz XR are preferred drugs used to treat RA. Preferred drugs in the cytokine and CAM antagonists drug class do not require PA.

Actemra subQ, adalimumab-xxxx, Kevzara, Kineret, Olumiant, and Rinvoq are non-preferred drugs used to treat RA.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat RA are **all** of the following:

- The member has RA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. Note: ForwardHealth will only consider use of:
  - Hadlima or Humira as one trial.
  - Xeljanz or Xeljanz XR as one trial.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira. The clinical information must document why the member cannot use Hadlima and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Rheumatoid Arthritis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat RA must be submitted using

the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat RA may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Juvenile Idiopathic Arthritis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat JIA.

Cimzia, Enbrel, Hadlima, Humira, Orencia subQ, Tyenne subQ, Xeljanz, and Xeljanz Oral Solution are preferred drugs used to treat JIA. Preferred drugs in the cytokine and CAM antagonists drug class do not require PA.

Actemra subQ, adalimumab-xxxx, Kevzara, Rinvoq, and Rinvoq LQ are non-preferred drugs used to treat JIA.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat JIA are **all** of the following:

- The member has JIA.
- The prescription is written by a rheumatologist or through a rheumatology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. Note: ForwardHealth will only consider use of:
    - Hadlima or Humira as one trial.
    - Xeljanz or Xeljanz Oral Solution as one trial.

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- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira. The clinical information must document why the member cannot use Hadlima and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira.

The clinical criteria for systemic JIA have not changed.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Juvenile Idiopathic Arthritis and Systemic Juvenile Idiopathic Arthritis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat JIA and systemic JIA must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for RA, JIA, and Psoriatic Arthritis form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat JIA and systemic JIA may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ulcerative Colitis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis.

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Hadlima, Humira, Selarsdi subQ, Simponi subQ, Steqeyma subQ, Xeljanz, and Xeljanz XR are preferred drugs used to treat ulcerative colitis. Preferred drugs in the cytokine and CAM antagonists drug class do not require PA.

Adalimumab-xxxx, Entyvio subQ, Omvoh subQ, Rinvoq, Skyrizi subQ, Stelara subQ, Tremfya subQ, ustekinumab-xxxx subQ, and Zymfentra are non-preferred drugs used to treat ulcerative colitis.

Note: Omvoh subQ, Skyrizi subQ, and Tremfya subQ will require an IV induction prior to initiating treatment with the subQ. A PA request for the IV induction must be approved before ForwardHealth will consider PA for the subQ. PA for the IV induction may be obtained through the physician-administered drug PA process.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis are **all** of the following:

- The member has ulcerative colitis.
- The prescription is written by a gastroenterologist or through a gastroenterology consultation.
- The member has taken **two** preferred cytokine and CAM antagonist drugs for **at least three** consecutive months each and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction. Note: ForwardHealth will only consider use of:
  - Hadlima or Humira as one trial.
  - Selarsdi subQ or Steqeyma subQ as one trial.
  - Xeljanz or Xeljanz XR as one trial.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira. The clinical information must document why the member cannot use Hadlima and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira.

Non-Preferred Ustekinumab-xxxx subQ Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and

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Steqeyma subQ. The clinical information must document why the member cannot use Selarsdi subQ and Steqeyma subQ, including why it is medically necessary that the member receive a non-preferred ustekinumab-xxxx subQ drug instead of Selarsdi subQ and Steqeyma subQ.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Ulcerative Colitis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Crohn's Disease and Ulcerative Colitis form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat ulcerative colitis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Revised Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Uveitis

ForwardHealth has revised the clinical criteria for non-preferred cytokine and CAM antagonist drugs used to treat uveitis.

Hadlima and Humira are preferred drugs used to treat uveitis. Preferred drugs in the cytokine and CAM antagonists drug class do not require PA.

Adalimumab-xxxx is a non-preferred drug used to treat uveitis.

Clinical criteria for approval of a PA request for non-preferred cytokine and CAM antagonist drugs used to treat uveitis are **all** of the following:

- The member has uveitis.
- The prescription is written by an ophthalmologist or through an ophthalmology consultation.

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- The member has taken **one** preferred cytokine and CAM antagonist drug for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why a non-preferred cytokine and CAM antagonist drug is being requested.

Non-Preferred Adalimumab-xxxx Drugs

The prescriber must submit detailed clinical justification for prescribing a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira. The clinical information must document why the member cannot use Hadlima and Humira, including why it is medically necessary that the member receive a non-preferred adalimumab-xxxx drug instead of Hadlima and Humira.

Submitting PA Requests for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Uveitis

PA requests for non-preferred cytokine and CAM antagonist drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred cytokine and CAM antagonist drugs used to treat uveitis must be submitted using the Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Oral Ulcers Associated With Behcet's Disease and Uveitis form.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed Prior Authorization Drug Attachment for Cytokine and CAM Antagonist Drugs for Oral Ulcers Associated With Behcet's Disease and Uveitis form and a completed PA/RF to ForwardHealth.

PA requests for non-preferred cytokine and CAM antagonist drugs used to treat uveitis may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

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Clinical Criteria for Cytokine and Cell Adhesion Molecule Antagonist Drugs for Other Clinical Conditions

The clinical criteria and PA submission options for the following clinical conditions have not changed:

- Alopecia areata
- DIRA
- ERA
- Giant cell arteritis
- GPP
- NMOSD
- NOMID
- PMR
- SSc-ILD

Omvoh IV for Crohn's Disease and Ulcerative Colitis

Omvoh IV is a physician-administered drug that requires clinical PA.

All PA requests for Omvoh IV must be submitted with Healthcare Common Procedure Coding System (HCPCS) code J2267 (Injection, mirikizumab-mrkz, 1 mg).

Note: Modifier JA (Administered intravenously) may be needed for billing.

Conditions for Which PA Requests for Use of Omvoh IV Will Be Considered for Review

ForwardHealth will only consider PA requests for Omvoh IV to treat these conditions:

- Crohn's disease
- Ulcerative colitis

Revised Clinical Criteria for Omvoh IV for Crohn's Disease

ForwardHealth has revised the clinical criteria for Omvoh IV for Crohn's disease.

Clinical criteria that must be documented for approval of a PA request for Omvoh IV for members with Crohn's disease are **all** of the following:

- The member has Crohn's disease.
- The member has been diagnosed by a gastroenterologist.

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Omvoh IV for Crohn's Disease and Ulcerative Colitis topic #23617

Note: This topic will be updated on January 2, 2026.

- **Two** of the following are true:
  - The member has taken Cimzia for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Hadlima or Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Selarsdi subQ or Steqeyma subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why Omvoh IV is being requested.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Omvoh IV for members with Crohn's disease. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan
- The member's current weight

If the clinical criteria for Omvoh IV for members with Crohn's disease are met, PA requests will only be approved for the three IV induction doses.

Note: A separate PA request must be obtained for maintenance treatment with Omvoh subQ. PA for Omvoh subQ must be obtained through the pharmacy PA process.

Revised Clinical Criteria for Omvoh IV for Ulcerative Colitis

ForwardHealth has revised the clinical criteria for Omvoh IV for ulcerative colitis.

Clinical criteria that must be documented for approval of a PA request for Omvoh IV for members with ulcerative colitis are **all** of the following:

- The member has ulcerative colitis.
- The member has been diagnosed by a gastroenterologist.

- **Two** of the following are true:
  - The member has taken Hadlima or Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Selarsdi subQ or Steqeyma subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Simponi subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Xeljanz or Xeljanz XR for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why Omvoh IV is being requested.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Omvoh IV. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If the clinical criteria for Omvoh IV are met, PA requests will only be approved for the three IV induction doses.

Note: A separate PA request must be obtained for maintenance treatment with Omvoh subQ. PA for Omvoh subQ must be obtained through the pharmacy PA process.

Submitting PA Requests for Omvoh IV

PA requests for Omvoh IV must be completed, signed, and dated by the prescriber. PA requests for Omvoh IV must be submitted using Section V (Clinical Information for Physician-Administered Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) on the Prior Authorization/Physician-Administered Drug Attachment (PA/PAD) form, F-11034 (07/2022). Clinical documentation supporting the use of Omvoh IV must be submitted with the PA request.

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Prescribers are required to submit the complete PA/PAD form and a completed PA/RF to ForwardHealth. PA requests for Omvoh IV may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Skyrizi IV for Crohn's Disease and Ulcerative Colitis

Skyrizi IV is a physician-administered drug that requires clinical PA.

All PA requests for Skyrizi IV must be submitted with HCPCS procedure code J2327 (Injection, risankizumab-rzaa, intravenous, 1 mg).

Conditions for Which PA Requests for Use of Skyrizi IV Will Be Considered for Review

ForwardHealth will only consider PA requests for Skyrizi IV to treat the following clinical conditions:

- Crohn's disease
- Ulcerative colitis

Revised Clinical Criteria for Skyrizi IV for Crohn's Disease

ForwardHealth has revised the clinical criteria for Skyrizi for Crohn's disease.

Clinical criteria that must be documented for approval of a PA request for Skyrizi IV for members with Crohn's disease are **all** of the following:

- The member has Crohn's disease.
- The member has been diagnosed by a gastroenterologist.
- **Two** of the following are true:
  - The member has taken Cimzia for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Hadlima or Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Selarsdi subQ or Steqeyma subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why Skyrizi IV is being requested.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Skyrizi IV for members with

QUICK LINKS

Skyrizi IV for Crohn's Disease and Ulcerative Colitis topic #22818

Note: This topic will be updated on January 2, 2026.

Crohn's disease. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan
- ~~The member's current weight~~

If the clinical criteria for Skyrizi IV for members with Crohn's disease are met, PA requests will only be approved for the three IV induction doses.

Note: A separate PA request must be obtained for maintenance treatment with Skyrizi subQ. PA for Skyrizi subQ must be obtained through the pharmacy PA process.

Revised Clinical Criteria for Skyrizi IV for Ulcerative Colitis

ForwardHealth has revised the clinical criteria for ulcerative colitis.

Clinical criteria that must be documented for approval of a PA request for Skyrizi IV for members with ulcerative colitis are **all** of the following:

- The member has ulcerative colitis.
- The member has been diagnosed by a gastroenterologist.
- **Two** of the following are true:
  - The member has taken Hadlima or Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Selarsdi subQ or Steqeyma subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Simponi subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member has taken Xeljanz or Xeljanz XR for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why Skyrizi IV is being requested.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Skyrizi IV for members with

ulcerative colitis. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan
- ~~The member's current weight~~

If the clinical criteria for Skyrizi IV for members with ulcerative colitis are met, PA requests will only be approved for the three IV induction doses.

Note: A separate PA request must be obtained for maintenance treatment with Skyrizi subQ. PA for Skyrizi subQ must be obtained through the pharmacy PA process.

Submitting PA Requests for Skyrizi IV

PA requests for Skyrizi IV must be completed, signed, and dated by the prescriber. PA requests for Skyrizi IV must be submitted using Section V (Clinical Information for Physician-Administered Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) on the PA/PAD form. Clinical documentation supporting the use of Skyrizi IV must be submitted with the PA request.

Prescribers are required to submit the completed PA/PAD form and a completed PA/RF to ForwardHealth.

PA requests for Skyrizi IV may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Stelara IV and Ustekinumab-xxxx IV for Crohn's Disease and Ulcerative Colitis

Effective January 1, 2026, PA will no longer be required for Stelara IV and ustekinumab-xxxx IV for Crohn's disease and ulcerative colitis.

Tremfya IV for Crohn's Disease and Ulcerative Colitis

Tremfya IV is a physician-administered drug that requires clinical PA.

All PA requests for Tremfya IV must be submitted with HCPCS procedure code J1628 (Injection, guselkumab, 1 mg).

QUICK LINKS

- Forms page
- Stelara IV and Ustekinumab-xxxx IV for Crohn's Disease and Ulcerative Colitis topic #22697
- Tremfya IV for Crohn's Disease and Ulcerative Colitis topic #23842
- Prior Authorization/ Physician-Administered Drug Attachment topic #22580

Note: Topics #23842 and #22580 will be updated on January 2, 2026. Topic #22697 will be removed from the Online Handbook on January 2, 2026.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Conditions for Which PA Requests for Use of Tremfya IV Will Be Considered for Review

ForwardHealth will only consider PA requests for Tremfya IV to treat these conditions:

- Crohn's disease
- Ulcerative colitis

Revised Clinical Criteria for Tremfya IV for Crohn's Disease

ForwardHealth has revised the clinical criteria for Tremfya IV for Crohn's disease.

Clinical criteria that must be documented for approval of a PA request for Tremfya IV for members with Crohn's disease are **all** of the following:

- The member has Crohn's disease.
- The member has been diagnosed by a gastroenterologist.
- **Two** of the following are true:
    - The member has taken Cimzia for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
    - The member has taken Hadlima or Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
    - The member has taken Selarsdi subQ or Steqeyma subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why Tremfya IV is being requested.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Tremfya IV for members with Crohn's disease. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan
- The member's current weight

If the clinical criteria for Tremfya IV for members with Crohn's disease are met, PA requests will only be approved for three IV induction doses.

Note: A separate PA request must be obtained for maintenance treatment with Tremfya subQ. PA for Tremfya subQ must be obtained through the pharmacy PA process.

Revised Clinical Criteria for Tremfya IV for Ulcerative Colitis

ForwardHealth has revised the clinical criteria for Tremfya for ulcerative colitis.

Clinical criteria that must be documented for approval of a PA request for Tremfya IV for members with ulcerative colitis are **all** of the following:

- The member has ulcerative colitis.
- The member has been diagnosed by a gastroenterologist.
- **Two** of the following are true:
    - The member has taken Hadlima or Humira for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
    - The member has taken Selarsdi subQ or Steqeyma subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
    - The member has taken Simponi subQ for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
    - The member has taken Xeljanz or Xeljanz XR for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
- The prescriber has indicated the clinical reason(s) why Tremfya IV is being requested.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Tremfya IV for members with ulcerative colitis. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If the clinical criteria for Tremfya IV for members with ulcerative colitis are met, PA requests will only be approved for three IV induction doses.

Note: A separate PA request must be obtained for maintenance treatment with Tremfya subQ. PA for Tremfya subQ must be obtained through the pharmacy PA process.

Submitting PA Requests for Tremfya

PA requests for Tremfya IV must be completed, signed, and dated by the prescriber. PA requests for Tremfya IV must be submitted using Section V (Clinical Information for Physician-Administered Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) on the PA/PAD form. Clinical documentation supporting the use of Tremfya IV must be submitted with the PA request.

Prescribers are required to submit the completed PA/PAD form and a completed PA/RF to ForwardHealth.

PA requests for Tremfya IV may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

QUICK LINKS

Forms page

Changes to Headache Agents, Triptans Injectable and Headache Agents, Acute Treatment Drug Classes

Headache Agents, Triptans Injectable Drug Class

Effective January 1, 2026, the headache agents, triptans injectable drug class will be renamed headache agents, other. Sumatriptan injectable will remain a preferred drug in the renamed drug class.

Zembrace will also remain a non-preferred drug in the same drug class as sumatriptan injectable. PA requests for Zembrace will continue to be submitted on the PA/PDL Exemption Request form.

Headache Agents, Other Drug Class

Dihydroergotamine nasal and dihydroergotamine injectable will become preferred drugs in the headache agents, other drug class. Preferred drugs in the headache agents, other drug class do not require PA.

Brekiya will be added to the headache agents, other drug class as a non-preferred drug. Brekiya will have an interim status of non-preferred and will be reviewed during the May 2026 PDL review. PA requests for Brekiya will be submitted on the PA/PDL Exemption Request form.

QUICK LINKS

Headache Agents, Acute Treatment topic #21637

Note: This topic will be updated on January 2, 2026.

Effective January 1, 2026, Emgality 100 mg will move to the headache agents, other drug class from the headache agents, acute treatment drug class as a non-preferred drug. Emgality 100 mg will no longer have PA-specific criteria. PA requests for Emgality 100 mg will be submitted on the PA/PDL Exemption Request form.

ForwardHealth will honor PA requests for Emgality 100 mg submitted on the PA/DGA form before January 1, 2026, until they expire or until the approved days' supply is used up.

Diagnosis Restriction for Emgality 100 mg

ForwardHealth has established allowable diagnosis codes for Emgality 100 mg. Effective February 1, 2026, Emgality 100 mg will be diagnosis restricted. This is to allow for a one-month transition period for providers to have the required diagnosis documentation needed for claims and PA requests that will be submitted for DOS on and after February 1, 2026.

For DOS on and after February 1, 2026, a ForwardHealth-allowed diagnosis code must be indicated on claims for Emgality 100 mg.

Prescribers are required to indicate a diagnosis on prescriptions for all drugs that are identified by ForwardHealth as diagnosis restricted. If a diagnosis is not indicated on the prescription, pharmacy providers should contact the prescriber to obtain the diagnosis and document the diagnosis on the prescription or pharmacy health care record. It is not acceptable for pharmacy providers to obtain the diagnosis from the member.

For the most current list of allowable diagnosis codes, providers may refer to the Diagnosis Restricted Drugs data table on the Pharmacy Resources page of the Portal.

Changes to Immunomodulators, Asthma Drug Class

New Indication for Tezspire

The FDA approved a new indication for Tezspire, a non-preferred drug in the immunomodulators, asthma drug class. Tezspire for members with chronic rhinosinusitis with nasal polyposis (CRSwNP) will require PA.

Nucala and Tezspire require clinical PA.

QUICK LINKS

- Diagnosis-Restricted Drugs topic #15537
- Claims for Diagnosis-Restricted Drugs topic #4403

Note: These topics will be updated on January 2, 2026.

QUICK LINKS

- Immunomodulators, Asthma topic #22357
- Prior Authorization/Drug Attachment topic #15937

Note: These topics will be updated on January 2, 2026.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

Notes:

- Fasenra, Nucala, Tezspire, and Xolair in the immunomodulators, asthma drug class are available as physician-administered drugs, as well as through the pharmacy benefit. The PDL and clinical PA criteria apply only to drugs billed through the pharmacy benefit.
- If a member has more than one clinical condition for which ForwardHealth will approve a non-preferred immunomodulators, asthma drug and the provider would like to bypass the required trial of a ForwardHealth-preferred biologic drug, the provider must submit complete medical records for the clinical conditions. Additionally, the provider must clearly identify on the PA/DGA form that the member has more than one clinical condition for which the non-preferred drug is approved, and they must provide justification for bypassing the required ForwardHealth-preferred biologic drug. ForwardHealth will use the member's complete clinical picture to evaluate the PA request.

Conditions for Which PA Requests for Use of Tezspire Will Be Considered for Review

PA requests for Tezspire will only be approved for use to treat the identified clinical conditions:

- CRSwNP
- Severe asthma

New Clinical Criteria for Tezspire for Members With Chronic Rhinosinusitis With Nasal Polyposis

ForwardHealth has established clinical PA criteria for Tezspire for members with CRSwNP.

Clinical criteria that must be documented for approval of a PA request for Tezspire for members with CRSwNP are **all** of the following:

- The member's age is consistent with the FDA-approved product labeling for Tezspire.
- The member has CRSwNP.
- The prescription is written by or through consultation with an allergist or an ear, nose, and throat specialist.
- The member has been adherent to and maintained on a maximized CRSwNP treatment regimen, including an intranasal corticosteroid (INCS) for **at least three months** prior to requesting Tezspire. Documentation should include the CRSwNP drug treatment names, doses, and start dates.

- **At least one** of the following is true:
  - The member is 12–17 years old.
  - The member is 18 years of age or older and has taken Xolair for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member is 18 years of age or older and has a serum immunoglobulin E (IgE) level less than 30 IU/mL. A current serum IgE level completed within the past 90 days must be submitted.
- The member will not use Tezspire in combination with any biologic immunomodulator.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Tezspire for members with CRSwNP. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If clinical criteria for Tezspire are met for members with CRSwNP, initial PA requests may be approved for up to 183 days.

Renewal PA requests for Tezspire for members with CRSwNP may be approved for up to 365 days. Renewal PA requests for members who have CRSwNP must include supporting clinical information and copies of the member's current medical records demonstrating that the member had a significant reduction in CRSwNP symptoms compared to the member's baseline prior to the initiation of Tezspire. Members must also continue to take their maximized CRSwNP treatment regimen, including the INCS, during treatment with Tezspire.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Revised Clinical Criteria for Tezspire for Members With Severe Asthma

ForwardHealth has revised the clinical criteria for Tezspire for members with severe asthma.

Clinical criteria that must be documented for approval of a PA request for Tezspire for members with severe asthma are **all** of the following:

- The member's age is consistent with the FDA-approved product labeling for Tezspire.
- The member has severe asthma.
- The prescription is written by or through consultation with an asthma specialist (for example, an allergist, an immunologist, or a pulmonologist).
- The member has a history of two or more asthma exacerbations that required treatment with systemic corticosteroids or an emergency department visit or hospitalization for the treatment of asthma in the past year. Documentation should include the approximate dates and what interventions took place for each exacerbation.
- The member has been adherent to and maintained on a maximized asthma treatment regimen, including a high-dose inhaled corticosteroid (ICS) in combination with a long-acting beta agonist (LABA) for **at least three** months prior to requesting Tezspire. Documentation should include the ICS and LABA names, doses, and start dates.
- Exacerbating factors that may contribute to the member's asthma, such as member non-compliance with therapy, environmental factors, dietary factors, and other similar respiratory conditions, have been ruled out.
- The member will not use Tezspire in combination with any biologic immunomodulator.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for Tezspire for members with severe asthma. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If clinical criteria for Tezspire for members with severe asthma are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for Tezspire for members with severe asthma may be approved for up to 365 days. Renewal PA requests for members who have severe asthma must include supporting clinical information and copies of the member's current medical records demonstrating that the member had a decrease in the number of asthma exacerbations compared to the member's

baseline prior to the initiation of Tezspire. Members must also continue to take their maximized asthma treatment regimen, including an ICS and a LABA, during treatment with Tezspire.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Clinical Criteria for Nucala

The clinical criteria for Nucala for the identified clinical conditions have not changed:

- Asthma with an eosinophilic phenotype
- Chronic obstructive pulmonary disease
- CRSwNP
- Eosinophilic granulomatosis with polyangiitis
- Hypereosinophilic syndrome

Submitting PA Requests for Nucala and Tezspire

PA requests for Nucala or Tezspire must be completed, signed, and dated by the prescriber. PA requests for Nucala or Tezspire must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form. Clinical documentation supporting the use of Nucala or Tezspire must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for Nucala or Tezspire may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Changes to Immunomodulators, Atopic Dermatitis Drug Class

Rhapsido will be added to the immunomodulators, atopic dermatitis drug class and will become a non-preferred drug used to treat chronic spontaneous

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urticaria (CSU). Rhapsido will have an interim status of non-preferred and will be reviewed during the November 2026 PDL review.

Ebglyss will become a preferred drug in the immunomodulators, atopic dermatitis drug class. Effective January 1, 2026, PA will no longer be required for Ebglyss used to treat atopic dermatitis.

Note: Members with atopic dermatitis who have past PA approvals for Dupixent, Rinvoq, Cibinqo, and Nemluvio and had pharmacy claims paid by ForwardHealth for DOS between July 1, 2025, and December 31, 2025, will not be required to transition to the new preferred drug Ebglyss.

Members with atopic dermatitis may continue to receive PA approval for Cibinqo, Dupixent, Nemluvio, or Rinvoq as long as the member continues to meet the PA criteria for moderate to severe atopic dermatitis. Members are also required to have been adherent with the prescribed treatment regimen.

Revised Clinical Criteria of Immunomodulators, Atopic Dermatitis Drugs for Atopic Dermatitis

ForwardHealth has revised the clinical criteria for non-preferred immunomodulators, atopic dermatitis drugs for atopic dermatitis.

Adbry and Ebglyss are preferred drugs used to treat atopic dermatitis. Preferred drugs in the immunomodulators, atopic dermatitis drug class do not require PA.

Cibinqo, Dupixent, Nemluvio, and Rinvoq are non-preferred drugs used to treat atopic dermatitis.

Clinical criteria that must be documented for approval of a PA request for non-preferred drugs for members with atopic dermatitis are **all** of the following:

- The member's age is consistent with the FDA-approved product labeling for the drug requested.
- The member has moderate to severe atopic dermatitis. Documentation must include the approximate body surface area involved and the area(s) affected.
- The prescription is written by or through consultation with a dermatologist, an allergist, or an immunologist.
- Exacerbating factors that may contribute to the member's atopic dermatitis, such as member non-compliance with therapy, environmental

QUICK LINKS

Immunomodulators, Atopic Dermatitis topic #8857

Note: This topic will be updated on January 2, 2026.

factors, dietary factors, and other similar dermatologic conditions, have been ruled out.

- The member will not use the requested drug in combination with any biologic immunomodulator.
- **At least one** of the following is true:
  - The member has a recent history (within a year of the clinical visit when the requested drug was first prescribed) of use of at least a medium-potency topical corticosteroid for at least two months and experienced an unsatisfactory therapeutic response.
  - The member has used at least a medium-potency corticosteroid and experienced a clinically significant adverse drug reaction.
- **One** of the following is true:
  - The member is 6 months–11 years old (Dupixent PA requests).
  - The member is 12–20 years of age and has taken Adbry **or** Ebglyss for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.
  - The member is 21 years of age or older and has taken **both** Adbry **and** Ebglyss for **at least three** consecutive months and experienced an unsatisfactory therapeutic response or experienced a clinically significant adverse drug reaction.

If the clinical criteria for non-preferred immunomodulators, atopic dermatitis drugs are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for non-preferred immunomodulators, atopic dermatitis drugs may be approved for up to 365 days. Renewal PA requests for members who have moderate to severe atopic dermatitis must include supporting clinical information and copies of the member's current medical records demonstrating that the member has had a significant reduction in the area(s) affected and/or severity of atopic dermatitis.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Other Clinical Criteria for Non-Preferred Immunomodulators, Atopic Dermatitis Drugs

The clinical criteria for these clinical conditions have not changed:

- Bullous pemphigoid

- Chronic obstructive pulmonary disease
- CRSwNP
- CSU
- Eosinophilic asthma
- Eosinophilic esophagitis
- Oral corticosteroid asthma
- Prurigo nodularis

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for non-preferred immunomodulators, atopic dermatitis drugs. The supporting clinical information and medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

Note: If a member has more than one clinical condition for which ForwardHealth will approve a non-preferred immunomodulators, atopic dermatitis drug and the provider would like to bypass the required trial of a ForwardHealth-preferred biologic drug, the provider must submit complete medical records for the clinical conditions. Additionally, the provider must clearly identify on the PA/DGA form that the member has more than one clinical condition for which the non-preferred drug is approved and provide justification for bypassing the required ForwardHealth-preferred biologic drug. ForwardHealth will use the member's complete clinical picture to evaluate the PA request.

Submitting PA Requests for Non-Preferred Immunomodulators, Atopic Dermatitis Drugs

PA requests for non-preferred immunomodulators, atopic dermatitis drugs must be completed, signed, and dated by the prescriber. PA requests for non-preferred immunomodulators, atopic dermatitis drugs must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form. Clinical documentation supporting the use of non-preferred immunomodulators, atopic dermatitis drugs must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The

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pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth. PA requests for non-preferred immunomodulators, atopic dermatitis drugs may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

PA requests will not be considered for subcutaneous dosage forms of immunomodulators, atopic dermatitis drugs that will be administered in a medical office or medical facility.

Changes to Ophthalmics, Anti-Inflammatory/ Immunomodulator Drug Class

Effective January 1, 2026, the ophthalmics, anti-inflammatory/ immunomodulator drug class will be renamed the ophthalmics, dry eye agents drug class. Non-preferred drugs require PA.

Preferred drugs in the renamed drug class are:

- Restasis
- Xiidra

Other Pharmacy Policy

Hetlioz and Hetlioz LQ

Effective for January 1, 2026, Hetlioz tablets will become a BMN drug. Hetlioz tablets will be subject to BMN policy and will require BMN PA.

Tasimelteon tablets (generic Hetlioz) will require clinical PA for members with Non-24-Hour Sleep-Wake Disorder (Non-24) or nighttime sleep disturbances in Smith-Magenis Syndrome (SMS).

Conditions for Which PA Requests for Use of Tasimelteon tablets and Hetlioz LQ Will Be Considered for Review

PA requests for tasimelteon tablets or Hetlioz LQ will only be approved for use to treat the identified clinical conditions:

- Non-24 (tasimelteon tablets PA requests only)
- Nighttime sleep disturbances in SMS (tasimelteon tablets and Hetlioz LQ PA requests)

QUICK LINKS

Hetlioz and Hetlioz LQ topic #17857

Note: This topic will be updated on January 2, 2026, and the topic title renamed Tasimelteon Tablets and Hetlioz LQ.

Revised Clinical Criteria for Tasimelteon Tablets for Members With Non-24-Hour Sleep-Wake Disorder

ForwardHealth has revised the clinical criteria for tasimelteon tablets for members with Non-24.

Clinical criteria that must be documented for approval of a PA request for tasimelteon tablets for members with Non-24 are **all** of the following:

- The member's age is consistent with the FDA-approved product labeling for tasimelteon tablets.
- The member has Non-24.
- **One** of the following is true:
  - The member is totally blind (no light perception in either eye).
  - The member is sighted (has light perception in either eye), and the following documentation has been submitted:
    - The member has a history of insomnia, excessive daytime sleepiness, or both that alternates with time periods of being asymptomatic as the member rotates between alignment and misalignment with the environmental light-dark schedule.
    - The member's symptoms have been present for at least three months.
    - The member's daily sleep logs and actigraphy (for at least 14 days) have been submitted and demonstrate a gradual daily drift (typically later) in rest-activity patterns.
    - The member's symptoms are not better explained by another current sleep, medical, neurologic, mental, or substance abuse disorder or medication use.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for tasimelteon tablets. The supporting clinical information and the medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If the clinical criteria for tasimelteon tablets are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for tasimelteon tablets may be approved for up to 365 days. Renewal PA requests for members who have Non-24 must include

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supporting clinical information and copies of the member's current medical records demonstrating that the member had a significant increase in nighttime total sleep time or a decrease in daytime nap duration compared to the member's baseline prior to the initiation of tasimelteon tablets.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Revised Clinical Criteria for Tasimelteon Tablets and Hetlioz LQ for Members With Nighttime Sleep Disturbances in Smith-Magenis Syndrome

ForwardHealth has revised the clinical criteria for tasimelteon tablets and Hetlioz LQ for members with nighttime sleep disturbances in SMS.

Clinical criteria that must be documented for approval of a PA request for tasimelteon tablets or Hetlioz LQ for members with nighttime sleep disturbances in SMS are **all** of the following:

- The member's age is consistent with the FDA-approved product labeling for the drug requested.
- The member has nighttime sleep disturbances.
- The member has SMS.

Supporting clinical information and a copy of the member's current medical records must be submitted with all PA requests for tasimelteon tablets or Hetlioz LQ. The supporting clinical information and the medical records must document the following:

- The member's medical condition being treated
- Details regarding previous medication use
- The member's current treatment plan

If the clinical criteria for tasimelteon tablets or Hetlioz LQ are met, initial PA requests may be approved for up to 183 days.

Renewal PA requests for tasimelteon tablets or Hetlioz LQ may be approved for up to 365 days. Renewal PA requests for members who have nighttime sleep disturbances in SMS must include supporting clinical information and copies of the member's current medical records demonstrating that the member had a significant improvement in nighttime sleep quality compared to the member's baseline prior to the initiation of tasimelteon tablets or Hetlioz LQ.

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

All renewal PA requests require the member to be adherent with the prescribed treatment regimen.

Submitting PA Requests for Tasimelteon Tablets and Hetlioz LQ

PA requests for tasimelteon tablets or Hetlioz LQ must be completed, signed, and dated by the prescriber. PA requests for tasimelteon tablets or Hetlioz LQ must be submitted using Section VI (Clinical Information for Drugs With Specific Criteria Addressed in the ForwardHealth Online Handbook) of the PA/DGA form. Clinical documentation supporting the use of tasimelteon tablets or Hetlioz LQ must be submitted with the PA request.

The PA form must be sent to the pharmacy where the prescription will be filled. The prescriber may send the PA form to the pharmacy, or the member may carry the PA form with the prescription to the pharmacy. The pharmacy provider will use the completed PA form to submit a PA request to ForwardHealth. Prescribers should **not** submit the PA form to ForwardHealth.

Pharmacy providers are required to submit the completed PA/DGA form and a completed PA/RF to ForwardHealth.

PA requests for tasimelteon tablets or Hetlioz LQ may be submitted on the Portal, by fax, or by mail (but **not** using the STAT-PA system).

Quantity Limit Changes

Quantity Limit Reduction for Short-Acting Opioids

Due to a systems issue, the intended quantity limit of 240 units for short-acting opioids that was announced in Update 2024-52, "January 2025 Preferred Drug List Changes and Other Pharmacy Policy Changes," did not go into effect on March 1, 2025. As a result, ForwardHealth reinstated the quantity limit for short-acting opioids to 360 units.

Effective for DOS on and after March 1, 2026, the quantity limits for short-acting opioids will be reduced from 360 units to 240. Drugs impacted by the quantity-limit reduction are listed on the Quantity Limit Drugs and Diabetic Supplies pharmacy data table on the Pharmacy Resources page of the Portal.

All short-acting opioids will have a cumulative quantity limit of 240 units per month. Members will be limited to 240 units per month. When a claim is submitted with a quantity that exceeds the quantity limit, the claim will be denied.

QUICK LINKS

Forms page

A transition period will be allowed for this upcoming quantity-limit reduction for short-acting opioids. During this period, pharmacy providers should work with prescribers to consolidate, adjust, or change members' short-acting and long-acting opioid medication(s) and dosage(s) as appropriate. The most cost-effective strength and quantity of the medication(s) is encouraged.

Transition Period for One-Time Quantity Limit Override for Short-Acting Opioids

ForwardHealth will allow a one-time quantity limit override request for short-acting opioids during the transition period from March 1, 2026, through March 31, 2026. To request an override of the quantity limit, providers may call the DAPO Center.

Providers should not contact the DAPO Center to request the one-time short-acting opioids drug quantity limit override before March 1, 2026.

Effective April 1, 2026, if a member does not qualify for a short-acting opioid quantity limit override through the DAPO Center and the submitted claim exceeds the allowed quantity limit, the claim will be denied.

For more information on current quantity limit policy, providers may refer to the Quantity Limits topic #3444.

Copay for Brand Name Drugs Preferred Over Generic Drugs

ForwardHealth generally applies a generic copay to a brand name drug when a drug that previously required BMN PA becomes a preferred drug on the PDL and the available generic equivalents are non-preferred drugs.

This does not include brand name drugs that were preferred over generic equivalents because the generic equivalents are new to the marketplace and not yet cost-effective when compared to brand pricing.

For drugs included in this policy, ForwardHealth will automatically apply the generic copay when a specific brand name drug is preferred over a generic equivalent. Providers do not need to indicate a National Council for Prescription Drug Program Dispense as Written/Product Selection code on claims to ensure the generic copay deduction.

Refer to Attachment C for the Copay for Brand Name Drugs Preferred Over Generic Drugs table for the most current list of drugs for which this copay

HOURS OF OPERATION

Hours of operation for the DAPO Center are from 8 a.m.–5:30 p.m., Monday–Friday. After business hours and on weekends, providers may leave a voicemail message for DAPO Center staff to return the next business day.

QUICK LINKS

Amounts topic #1927

The information provided in this ForwardHealth Update is published in accordance with Wis. Stat. § 49.45(49) and Wis. Admin. Code § DHS 107.10.

policy applies. This information is also available on the Preferred Drug List Quick Reference data table.

Expedited Emergency Supply Request Drugs Data Table

As a result of the changes made during the November 2025 PDL review, the Expedited Emergency Supply Request Drugs data table on the Pharmacy Resources page will be updated effective January 1, 2026.

Documentation Retention

Providers are reminded that they must follow the documentation retention requirements per Wis. Admin. Code § DHS 106.02(9). Providers are required to produce or submit documentation, or both, to the Wisconsin Department of Health Services (DHS) upon request. Per Wis. Stat. § 49.45(3)(f), providers of services shall maintain records as required by DHS for verification of provider claims for reimbursement. DHS may audit such records to verify the actual provision of services and the appropriateness and accuracy of claims. DHS may deny or recoup payment for services that fail to meet these requirements. Refusal to produce documentation may result in denial of submitted claims, recoupment of paid claims, application of intermediate sanctions, or termination from the Medicaid program.

Information Regarding Managed Care Organizations

This Update applies to Family Care, Family Care Partnership, BadgerCare Plus, and SSI Medicaid managed care program members because pharmacy services for members of these programs are provided on a fee-for-service basis. Pharmacy services for Medicaid members enrolled in the Program of All-Inclusive Care for the Elderly (PACE) are provided by the member's managed care organization.

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This Update was issued on 12/19/2025 and information contained in this Update was incorporated into the Online Handbook on 01/02/2026.

ATTACHMENT A
Changes to Preferred or Non-Preferred Status of Drugs on the Preferred Drug List

This table lists the drugs that changed their preferred or non-preferred status as a result of the November 2025 Preferred Drug List (PDL) review. Unless otherwise noted, the updated statuses are effective January 1, 2026. Drugs that have not been previously reviewed by the Wisconsin Medicaid Pharmacy Prior Authorization (PA) Advisory Committee are marked with a footnote ([1]). Drugs that will be reviewed by the Wisconsin Medicaid Pharmacy PA Advisory Committee during the May 2026 PDL Review are marked with a second footnote ([2]). The current Preferred Drug List Quick Reference data table can be referenced on the Pharmacy Resources page of the ForwardHealth Portal.

DRUG CLASS	DRUG NAME	STATUS EFFECTIVE JANUARY 1, 2026, UNLESS OTHERWISE NOTED
Alzheimer's Agents	memantine/donepezil ER caps (Gen-Namzaric)[1]	Non-Preferred
	Zunveyl tablets[1]	Non-Preferred
Analgesics, Miscellaneous	ibuprofen Rx 300 mg tablet[1]	Non-Preferred
	Journavx tablets[1]	Non-Preferred
Antibiotics, Other (New Drug Class)	Blujepa tablets[2]	Non-Preferred
	Orlynvah tablets[2]	Non-Preferred
Anticonvulsants	eslicarbazepine tablet (Gen-Aptiom)[1]	Non-Preferred
	levetiracetam 250 mg tablet (Gen-Spritam)[1]	Non-Preferred
	oxcarbazepine ER tablets (Gen-Oxtellar XR)[1]	Non-Preferred
	perampanel tablets (Gen-Fycompa)[1]	Non-Preferred
	topiramate solution (Gen-Eprontia solution)[1]	Non-Preferred
	Gabarone tablets[1]	Non-Preferred

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DRUG CLASS	DRUG NAME	STATUS EFFECTIVE JANUARY 1, 2026, UNLESS OTHERWISE NOTED
Antidepressants, Other	Raldesy solution[1]	Non-Preferred
Antipsychotics	Cobenfy[1]	Non-Preferred
	Opipza film[1]	Non-Preferred
Antipsychotics, Injectable	Erzofri[1]	Non-Preferred
Antivirals, COVID-19 (New Drug Class)	Paxlovid[1]	Preferred
Anxiolytics	Bucapsol capsule[1]	Non-Preferred
Bile Salts	Ctexli tablet[1]	Non-Preferred
	Livmarli tablet[1]	Non-Preferred
COPD Agents	umeclidinium/vilanterol (Gen-Anoro Ellipta)[1]	Non-Preferred
Cytokine and CAM Antagonists	ustekinumab (Stelara SubQ)[1]	Non-Preferred
	ustekinumab-aekn (Selarsdi subQ)[1]	Non-Preferred
	ustekinumab-ttwe (Pyzchiva subQ)[1]	Non-Preferred
	Cyltezo (adalimumab-adbm)	Non-Preferred
	Hadlima (adalimumab-bwwd)	Preferred
	Imuldosa subQ[1]	Non-Preferred
	Leqselvi[1]	Non-Preferred
	Litfulo[1]	Non-Preferred
	Otulfi subQ (ustekinumab-aauz)[1]	Non-Preferred
	Pyzchiva subQ (ustekinumab-ttwe)[1]	Non-Preferred
	Selarsdi subQ (ustekinumab-aekn)[1]	Preferred
	Steqeyma subQ (ustekinumab-stba)[1]	Preferred
	Taltz	Preferred
	Xeljanz solution	Preferred
	Xeljanz XR	Preferred
	Yesintek subQ (ustekinumab-kfce)[1]	Non-Preferred
Epinephrine, Self-Administered	Neffy nasal spray[1]	Non-Preferred
Glucocorticoids, Inhaled	fluticasone ellipta (Gen-Arnuity Ellipta)[1]	Non-Preferred

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DRUG CLASS	DRUG NAME	STATUS EFFECTIVE JANUARY 1, 2026, UNLESS OTHERWISE NOTED
Glucocorticoids, Oral	Khindivi solution[1]	Non-Preferred
Immunomodulators, Atopic Dermatitis	Ebglyss[1]	Preferred
	Nemluvio[1]	Non-Preferred
Immunomodulators, Atopic Dermatitis – Topical	Anzupgo cream[1]	Non-Preferred
Neuropathic Pain	Gabarone tablets[1]	Non-Preferred
NSAIDS	Dolobid tablet[1]	Non-Preferred
Ophthalmics, Dry Eye Agents (Formerly Ophthalmics, Anti-Inflammatory/ Immunomodulators)	Tryptyr eye drop[1]	Non-Preferred
Ophthalmics, Glaucoma-Beta Blockers	timolol (Gen-Betimol)[1]	Non-Preferred
Sickle Cell Anemia	Xromi solution[1]	Preferred
Steroids, Topical High	clobetasol 0.025% cream[1]	Non-Preferred
	halcinonide 0.1% solution (Gen-Halog solution)[1]	Non-Preferred
Steroids, Topical Low	hydrocortisone solution (Gen-Texacort solution)[1]	Non-Preferred

[1] The drug was not previously reviewed by the Wisconsin Medicaid Pharmacy PA Advisory Committee. For more information, providers should refer to the Drug Status Changes on the Preferred Drug List section of this ForwardHealth Update.

[2] The drug will be reviewed by the Wisconsin Medicaid Pharmacy PA Advisory Committee during the May 2026 PDL Review.

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ATTACHMENT B
Changes to Pharmacy-Related Prior Authorization Forms and Instructions

This table lists the pharmacy-related prior authorization (PA) forms and instructions that have been created, revised, or revised and renamed as the result of the November 2025 Preferred Drug List review or other pharmacy policy changes. Providers should refer to the Forms page of the ForwardHealth Portal for current copies of these forms and instructions. Effective January 1, 2026, the previous versions of these forms and instructions will be moved to the Archived Pharmacy-Related Forms and Instructions page. For more information regarding clinical criteria or PA request submission options, refer to the applicable section in this ForwardHealth Update.

FORM NAME	FORM NUMBER	NEW, REVISED, OR REVISED AND RENAMED	EFFECTIVE DATE
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Ankylosing Spondylitis	F-11304	Revised	01/2026
Instructions	F-11304A	Revised	01/2026
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Crohn's Disease and Ulcerative Colitis	F-01950	Revised	01/2026
Instructions	F-01950A	Revised	01/2026
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Hidradenitis Suppurativa	F-03174	Revised	01/2026
Instructions	F-03174A	Revised	01/2026
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Giant Cell Arteritis and Non-Radiographic Axial Spondyloarthritis (nr-axSpA)	F-01952	Revised	01/2026
Instructions	F-01952A	Revised	01/2026

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FORM NAME	FORM NUMBER	NEW, REVISED, OR REVISED AND RENAMED	EFFECTIVE DATE
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Psoriasis	F-11306	Revised	01/2026
Instructions	F-11306A	Revised	01/2026
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Rheumatoid Arthritis (RA), Juvenile Idiopathic Arthritis (JIA), and Psoriatic Arthritis	F-01951	Revised	01/2026
Instructions	F-01951A	Revised	01/2026
Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Uveitis form	F-03224	**Revised and Renamed:** Prior Authorization Drug Attachment for Cytokine and Cell Adhesion Molecule (CAM) Antagonist Drugs for Oral Ulcers Associated With Behcet's Disease and Uveitis	01/2026
Instructions	F-03224A	Revised and Renamed	01/2026
Prior Authorization/Preferred Drug List (PA/PDL) for Blujepa and Orlynvah	F-03412	New	01/2026
Instructions	F-03412A	New	01/2026

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ATTACHMENT C
Copay for Brand Name Drugs Preferred Over Generic Drugs

ForwardHealth generally applies a generic copay to a brand name drug when a drug that previously required brand medically necessary prior authorization becomes a preferred drug on the Preferred Drug List and the available generic equivalents are non-preferred drugs. This table lists the drugs with generic copay. The Preferred Drug List Quick Reference data table, which also includes the current Brand Name Drugs With Generic Copay table, is available on the Pharmacy Resources page of the ForwardHealth Portal.

DRUG CLASS	DRUG NAME	EFFECTIVE DATE
Anticonvulsants	Carbatrol ER	01/01/2021
	Depakote sprinkle	01/01/2021
	Tegretol suspension	01/01/2016
	Tegretol tablet	01/01/2016
	Tegretol XR	01/01/2021
Antiemetics/Antivertigo	Transderm-Scop	07/01/2022
Bronchodilators, Beta Agonists	Ventolin HFA	01/01/2023
HIV/AIDS	Intelence	07/01/2023
	Selzentry solution, tablet	07/01/2023
	Symfi	07/01/2023
	Symfi Lo	07/01/2023
Hypoglycemics, Insulins	Humalog Jr Kwikpen	05/01/2020
	Humalog Mix	05/01/2020
	Humalog U-100 cartridge/kwikpen/vial	07/01/2019
Hypoglycemics, Insulins Long-Acting	Lantus	06/01/2022
Ophthalmics, Antibiotic-Steroid Combinations	Tobradex suspension	01/01/2012
Ophthalmics, Glaucoma-Other	Alphagan P 0.15%	01/01/2012
Ophthalmics, Glaucoma-Prostaglandins	Xalatan	01/01/2023

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DRUG CLASS	DRUG NAME	EFFECTIVE DATE
Opioid Dependency Agents—Buprenorphine	Suboxone film	07/01/2020
Stimulants	Concerta	01/01/2018
	Vyvanse capsule	01/01/2024

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