

DEPARTMENT OF WAR
PHARMACY AND THERAPEUTICS COMMITTEE

MINUTES AND RECOMMENDATIONS

August 2026

I. CONVENING

The Department of War (DoW) Pharmacy and Therapeutics (P&T) Committee convened at 0830 hours on August 5th and 6th, 2026.

II. ATTENDANCE

The attendance roster is listed in Appendix A.

A. Approval of February, May, August, November 2025, February 2026 and May 2026 Meeting Minutes—The UF Beneficiary Advisory Panel (UF BAP) was re-established, and virtual meetings were held over three days from June 22nd to June 24th, 2026. The P&T Committee meeting minutes that were delayed due to the UF BAP pause were signed on July 20, 2026. Corresponding implementation of the recommendations will occur in phases starting on August 5th to December 2nd, 2026.

B. Clarification of previous meeting minutes

- **May 2026**
 - **Glycerol phenylbutyrate oral liquid (Ravicti)**—the manual PA criteria were added to this drug along with other urea cycle agents to streamline use but were inadvertently omitted from the meeting minutes. These criteria were reviewed and approved by the BAP committee in June, 2026. Refer to the Appendix C-Utilization Management PA below for complete PA criteria details.
- **February 2026**
 - **Diuretics: furosemide 80 mg/2.67 mL subcutaneous (SC) injection (Lasix ONYU) prior authorization (PA) criteria**— The temporary PA criteria were clarified to state the PA will expire in six months, and that PA renewal will be allowed for an additional six months or until implementation of complete exclusion status on December 2, 2026, if the patient has responded to therapy and is stable clinically.
 - **Targeted Immunomodulatory Biologics (TICs): Interleukin-23 (IL-23) Inhibitors – ustekinumab products Adherence Safety Net Program**—All ustekinumab formulations will remain on Adherence Safety Net program managed by the TRICARE pharmacy contractor. The program identifies beneficiaries who have not received a prescription fill for either a step-preferred or non-step-preferred drug, after the initial reject and notifies the beneficiaries of formulary options.
- **November 2025**

- **Metabolic Dysfunction Agents: Weight Loss Agents: semaglutide (Wegovy) and tirzepatide (Zepbound) PA criteria**—In the renewal criteria, questions relating to patient history of multiple endocrine neoplasia type 2 (MEN 2) cancer and thyroid cancer were removed. These safety questions are asked in the initial PA criteria, and every patient is required to meet the initial PA criteria to be eligible for the renewal pathway.
- **Beta lactam antibiotics: sulopenem etzadroxil/probenecid (Orlynvah)**—Orlynvah was voluntarily discontinued from the market by the manufacturer in November 2025. If it returns, Orlynvah will retain the same formulary status (UF) and PA as recommended when it was reviewed as an innovator drug.

III. REQUIREMENTS

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

NF medications are generally restricted to the TRICARE Mail Order Pharmacy (TMOP) in accordance with 10 USC 1074g(a)(5) and 32 CFR 199.21(h)(3)(i) and (ii). Additionally, 10 USC 1074g(a)(9), added by Section 702(c)(2) of the NDAA for FY 2015, requires beneficiaries to generally fill select non-generic prescription maintenance medications at MTFs or the TMOP. Medications subject to either the NF or select non-generic prescription maintenance requirements are added to the TRICARE Maintenance Drug List formerly known as the Select Maintenance Drug List.

IV. UF DRUG CLASS REVIEWS

A. **Oncological Agents: B-Raf proto-oncogene, serine/threonine kinase (BRAF) Mitogen-Activated Extracellular Signal-Regulated Kinase (MEK) Inhibitors Subclass**

Background—The P&T Committee evaluated the relative clinical effectiveness of the BRAF-MEK inhibitor subclass used for advanced or metastatic melanoma as well as other malignancies. The drugs in the class include encorafenib (Braftovi), binimetinib (Mektovi), vemurafenib (Zelboraf), cobimetinib (Cotellic), dabrafenib (Tafinlar) and trametinib (Mekinist). The subclass has not previously been reviewed.

Relative Clinical Effectiveness Conclusion— The following clinical review focused on the uses of the BRAF MEK inhibitors for metastatic melanoma. For melanoma, the products are frequently used in combinations of Braftovi with Mektovi, Zelboraf with Cotellic and Tafenlar with Mekinist. The P&T Committee concluded (19 for, 0 opposed, 0 abstained, 0 absent) the following:

Efficacy

- For metastatic melanoma all BRAF/MEK combinations carry the same National Comprehensive Cancer Network (NCCN) recommendation for level of evidence.
- Indirect comparison between combinations of agents is challenging due to the varying treatment arms, study durations, and inclusion criteria in the respective clinical trials.
- These agents also carry FDA-approved indications outside of melanoma, in combination and as single agent therapy.

Safety

- Adverse events that are commonly associated with this class include rash, secondary squamous cell carcinoma, retinopathy, arthralgia/myalgia, fatigue and headache.
- Dabrafenib/trametinib (Tafenlar/Mekinist) has the highest rates of pyrexia.
- Encorafenib/binimetinib (Braftovi/Mektovi) has the most favorable tolerability profile, although it can cause gastrointestinal issues and blurred vision.
- Vemurafenib/cobimetinib (Zelboraf/Cotellic) has the highest rates of rash and hepatotoxicity.

Individual Product Characteristics

- The combination of dabrafenib/trametinib (Tafenlar/Mekinist) is unique in that it has clinical trial data in adjuvant settings for melanoma and is the only combination in the class indicated in pediatric populations. When brain metastases are present, dabrafenib/trametinib (Tafenlar/Mekinist) is the preferred combination.
- Compared to other agents, the vemurafenib/cobimetinib combination (Zelboraf/Cotellic) is preferred for treating histiocytic and central nervous system neoplasms.
- The preferred combinations for non-small cell lung carcinoma (NSCLC) are encorafenib/binimetinib (Braftovi/Mektovi) and dabrafenib/trametinib (Tafenlar/Mekinist). These combinations are also useful in thyroid cancer treatment.

- Encorafenib (Braftovi) is the only product in the class which is preferred for colorectal carcinoma treatment.

Overall Clinical Conclusion

- The BRAF-MEK inhibitors are used in a variety of malignancies and are supported by the NCCN guidelines.
- Although there is a high degree of therapeutic interchangeability among the BRAF-MEK inhibitors, the selection of agents is highly dependent on patient history and tolerance to adverse effects.
- At least one BRAF-MEK combination agent is required on the formulary in order to meet the needs of Military Health System (MHS) beneficiaries for treatment of metastatic melanoma. Other agents should remain available to treat other malignancies or special populations (e.g., brain metastases and children) and due to the differing toxicity profiles.

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

- CMA results showed that encorafenib/binimetinib (Braftovi and Mektovi) and vemurafenib/cobimetinib (Zelboraf and Cotellic) were the most cost effective BRAF-MEK inhibitors.
- BIA was performed to evaluate the potential impact of designating selected agents as formulary, NF, or completely excluded on the UF. BIA results showed that designating all the BRAF MEK inhibitors as UF demonstrated cost avoidance for the MHS.

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

- UF
 - encorafenib (Braftovi)
 - binimetinib (Mektovi)
 - vemurafenib (Zelboraf)
 - cobimetinib (Cotellic)
 - dabrafenib (Tafinlar)
 - trametinib (Mekinist)
- NF
 - None
- Complete Exclusion

- None

2. **COMMITTEE ACTION: MANUAL PA CRITERIA**—PA currently applies to all the drugs. The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) updates to Zelboraf, Cotellic, Braftovi, Mektovi, and Mekinist PAs as outlined below. See Appendix C for the full criteria.
 - vemurafenib (Zelboraf), cobimetinib (Cotellic), encorafenib (Braftovi) and binimetinib (Mektovi): Adding automated specialist bypass in new users; no PA is needed when prescribed by a hematologist/oncologist.
 - encorafenib (Braftovi): remove the combination drug requirement.
 - trametinib (Mekinist): All of the drugs except Mekinist have been standardized for the wording regarding NCCN guidelines and simplified for the safety criteria. The Mekinist PA was updated in new users, consistent with the previous oncology PA standardization efforts.
3. **COMMITTEE ACTION: QUANTITY LIMITS (QLs)**—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) maintaining the current QL of a 60-day supply at all three points of service (POS) for all the drugs, except for cobimetinib (Cotellic), which has a 56-day supply at all POS. See Appendix D.
4. **COMMITTEE ACTION: SPECIALTY AND TRICARE MAINTENANCE DRUG LIST**—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) maintaining all six drugs on the list. See Appendix F.
5. **COMMITTEE ACTION: UF, PA, QLs, TRICARE MAINTENANCE DRUG LIST and IMPLEMENTATION PERIOD**—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) an effective date of the first Wednesday 60 days after signing of the minutes in all points of service. See Appendix G.

B. Attention Deficit Hyperactivity Disorder (ADHD): Stimulants

Background—The ADHD Stimulants were most recently reviewed for formulary status in November 2020. There are currently 41 products in the subclass, primarily comprised of methylphenidate, mixed amphetamine salts, and amphetamine formulations. Several products are available in generic formulations, including lisdexamfetamine capsules (Vyvanse), which saw generic competition in 2023.

The 10 remaining branded products without generic alternatives include methylphenidate formulations (Jornay PM, Quillichew ER, Quillivant XR, Azstarys, Cotelpla XR-ODT); amphetamine products (Adzenys XR-ODT, Dyanavel XR); one

mixed amphetamine salt (Mydayis); one dextroamphetamine (Xelstrym); and lisdexamfetamine (Arynta) oral solution.

The clinical review focused on new data published since the last review. The P&T Committee specifically evaluated the 10 branded products that do not have generic equivalents available. Factors discussed included duration of action, efficacy and safety, data from FDA summary reviews, published primary literature, previous clinical conclusions, formulary status from commercial health plans, and MHS provider feedback.

Relative Clinical Effectiveness Conclusion—The P&T Committee concluded (18 for, 0 opposed, 0 abstained, 1 absent) the following:

Professional Treatment Guidelines and Systematic Reviews

- Guidelines recommend medications only after behavioral or environmental modification have failed, particularly for children (e.g., American Academy of Pediatrics).
- The Canadian ADHD 2020 guidelines support previous P&T conclusions that methylphenidate and amphetamines have similar efficacy and tolerability profiles at the population level and that no specific clinical profile can predict which medication may result in improved symptom control over other agents.
- The Canadian Pediatric 2024 guidelines maintain that differences in effectiveness or adverse event profiles among stimulant brands are idiosyncratic. Switching from one stimulant formulation to another is recommended over switching from a stimulant medication to a nonstimulant.
- A 2025 systematic review and meta-analysis assessing the impact of pharmacological ADHD therapies on the quality of life (QoL) found that amphetamines, methylphenidate and the non-stimulant atomoxetine were significantly more efficacious than placebo in improving QoL. However, no one specific medication showed significantly improved QoL compared to the other drugs.

Efficacy

- No significant new clinical studies evaluating comparative efficacy between individual branded drugs or generic ADHD products were published since 2020.

Safety

- A 2025 systematic review and safety meta-analysis did not report significant differences between the ADHD medications for cardiovascular effects, including changes in systolic blood pressure, diastolic blood pressure, heart rate, or incidence of myocardial infarction or stroke. Specific adverse events that occurred at a higher rate in stimulant groups compared to placebo were

decreased appetite, headache, insomnia, dry mouth, nausea, irritability, and anxiety.

- Azstarys was shown to have a significantly lower incidence of insomnia and end-of-dose crashes compared to amphetamine ER and lisdexamfetamine in one small study of 700 patients. There was no difference in the incidence of poor appetite or return of symptoms. Study limitations include lack of information on patient treatments tried prior to observation period. This study was funded by the manufacturer of Azstarys.

Special Populations

- Many alternative dosage forms are available for patients with swallowing difficulties. The contents of Vyvanse capsules are dissolvable in water and lisdexamfetamine chewable tablets are also an option. Adderall XR, Focalin XR, Metadate CD, Ritalin LA, and Azstarys are formulated in capsules that can be opened and sprinkled into applesauce. Aptensio XR sprinkle capsule, Methylin oral solution, ProCentra oral solution, and Quillivant XR oral suspension are currently available on the UF for patients with swallowing difficulties.
- Multiple generic ADHD stimulants are currently on the formulary that are approved for children ranging in age from the 6 to 17 years.

Individual Product Characteristics for Select Branded Agents

- Lisdexamfetamine (Vyvanse) is now available as generic capsules or chewable tablets. It is the only ADHD medication with an additional approval for binge eating disorder.
- Lisdexamfetamine 10 mg/mL oral solution (Arynta) was designated NF when reviewed as a new drug in May 2026. It has no new clinical efficacy studies and was approved via the 505(b)(2) pathway, using data from Vyvanse. The duration of action ranges between 8 to 14 hours and is approved for children as young as 6 years. This new formulation provides little to no compelling clinical advantage over existing agents in the class.
- Methylphenidate ER sprinkle capsule nighttime dosing (Jornay PM) was the twelfth methylphenidate product marketed and is approved for patients as young as 6. Jornay PM is administered at night before bedtime and has a delayed onset of action, so that therapeutic effects occur 8 hours after administration, in the morning. Stimulating effects may last 10 to 14 hours.
- Methylphenidate ER orally disintegrating tablets (Cotempla XR ODT) effects can last 12 hours, similar to other methylphenidate ER formulations. Cotempla XR ODT offers no compelling advantages over the existing UF ADHD drugs.

- Methylphenidate ER oral suspension (Quillivant XR) is the only long-acting methylphenidate oral suspension marketed in the US. Immediate release methylphenidate (Methylin) and dextroamphetamine (ProCentra) oral solutions are therapeutic alternatives to Quillivant XR but must be dosed twice daily.
- Methylphenidate ER chewable tablet (Quillichew ER chew tab) is the first 8 hour duration chewable tablet. While Quillichew ER tablets provide an alternative ADHD dosage form, there are several UF products available for patients with swallowing difficulties. It is currently designated as NF.
- Methylphenidate ER tab (Relexxi) was approved in 2021 based on the data for Concerta. Several other extended-release methylphenidate formulations are available on the UF without PA, including generic Concerta and methylphenidate ER/CD/LA, Quillivant XR, and Aptensio XR.
- Amphetamine ER oral suspensions (Dyanavel XR OS and Adzenys ER OS) provide alternative amphetamine dosage formulations; however, they do not offer any additional clinical effectiveness, safety, or tolerability benefit over other amphetamine ER products. They are currently designated as NF.
- Amphetamine ER orally disintegrating tablet (Adzenys XR ODT) is the only amphetamine ER product available in an ODT formulation, however, amphetamine (as a single ingredient without the mixed amphetamine salts) is not a first-line drug for ADHD treatment in children, and other alternative dosage products are available.
- Amphetamine mixed salts ER capsule triphasic release (Mydayis) is approved for children down to 13 years of age, but not for younger children as the effects of insomnia and appetite suppression can last up to 16 hours. Mydayis offers no compelling advantage over existing formulary agents, and is currently designated as UF
- Serdexmethylphenidate/dexmethylphenidate (Azstarys) was approved in 2021 via the 505(b)(2) pathway using data from dexmethylphenidate. It is a prodrug and potentially is an option for managing symptoms in adults and adolescents who are responsive to Focalin, but at higher risk of abuse. It is classified as a schedule II drug, similar to the other ADHD drugs.
- Dextroamphetamine patch (Xelstry) provides no compelling clinical advantage over existing agents and has some precautions for use. It is NF with a PA and MN.

Therapeutic Interchangeability

- There is insufficient evidence to suggest that one stimulant is more effective or associated with fewer adverse events than another. The stimulants may

vary in terms of duration of action but are highly therapeutically interchangeable.

Overall Clinical Conclusion

- In order to treat the needs of MHS beneficiaries, a variety of ADHD drugs are required on the formulary, including amphetamine type products and methylphenidates, and both long-acting and short-acting formulations in each of these categories. Additionally, alternative dosage formulations in each category are needed to treat special populations, including young children or patients with developmental delays.

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

- CMA results showed that the products with generic formulations are generally significantly more cost-effective than brand-only products.
- CMA results for the branded products showed that the cost-effectiveness for several agents varied depending on formulary status, and that Vyvanse chewable tablet was the least costly agent, followed by Mydayis, Dyanavel XR, Quillichew, then Quilivant XR, and finally by Adzenys ODT, Xelstrym and Cotelpla XR ODT which were the costliest agents.
- BIA results for all branded products with generic formulations showed that maintaining the existing formulary status was the most cost-effective.

1. COMMITTEE ACTION: UF RECOMMENDATION—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) maintain the current formulary status for the ADHD drugs as described below:

- UF
 - dextroamphetamine ER (Dexedrine Spansule, generics; Dextrostat tabs, generics)
 - dextroamphetamine IR tablets (Zenzedi, generics)
 - dextroamphetamine oral solution (ProCentra, generics)
 - lisdexamfetamine capsules and chewable tablets (Vyvanse)
 - mixed amphetamine salts IR tablets (Adderall, generics)
 - mixed amphetamine salts XR capsules (Adderall XR, generics)
 - dexmethylphenidate IR (Focalin, generics)
 - dexmethylphenidate ER (Focalin XR, generics)
 - methylphenidate CD (Metadate CD, generics)

- methylphenidate chewable tablets and oral solution (Methylin, generics)
- methylphenidate ER (Methylin ER, generics)
- methylphenidate ER sprinkle caps (Aptensio XR, generics)
- methylphenidate ER sprinkle capsules nighttime dosing (Jornay PM)
- methylphenidate ER oral suspension (Quillivant XR)
- methylphenidate IR (Ritalin, generics)
- methylphenidate long-acting (LA) (Ritalin LA, generics)
- methylphenidate osmotic controlled release oral delivery system (OROS) tablets and other (Concerta, generics)
- serdexmethylphenidate/dexmethylphenidate (Azstarys)
- NF
 - amphetamine ER orally disintegrating tablets (ODT) (Adzenys XR-ODT)
 - amphetamine ER oral suspension (Dyanavel XR)
 - amphetamine ER chew tab (Dyanavel XR)
 - dextroamphetamine transdermal system (Xelstrym)
 - lisdexamfetamine dimesylate 10 mg/mL oral solution (Arynta)
 - mixed amphetamine salts ER capsules triphasic release (Mydayis)
 - methylphenidate ER (Relexxi)
 - methylphenidate transdermal system (generics)
 - methylphenidate ER chew tab (Quillichew ER)
 - methylphenidate XR-ODT (Cotempla XR ODT)
- Complete Exclusion
 - None
- For the products that were discontinued from the market, Evekeo ODT, Adzenys ER oral suspension and Adhansia XR if they return to market they will retain the previous formulary and PA status.

2. COMMITTEE ACTION: MANUAL PA CRITERIA—PA criteria currently apply to Azstarys, Arynta, Cotempla XR ODT, Jornay PM, Mydayis, Relexxi, Vyvanse, Xelstrym. The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) the PA updates below. See Appendix C for full criteria.

- Updating the current manual PA criteria for new users of Azstarys and Jornay PM to reflect changes to the required drugs that should be tried first.

- Adding manual PA criteria to new users of Adzenys ODT to require the provider justify the need for this drug, primarily an inability to tolerate chewable, sprinkled or liquid preparations.
 - Maintaining the current PA criteria for Vyvanse. At the February 2025 meeting, an automated lookback was added for both the Vyvanse capsules and chew tabs, allowing approval of the Vyvanse PA if a patient has had a trial of at least one amphetamine and one methylphenidate product within the past 720 days. Implementation occurred on July 1, 2026.
 - Maintaining the current manual PA criteria for Arynta, Mydayis, Cotempla XR-ODT, Relexxi and Xelstrym.
3. **COMMITTEE ACTION: MEDICAL NECESSITY (MN) CRITERIA**—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) maintaining the current MN criteria for the NF agents, Adzenys XR-ODT, Adzenys ER, Mydayis, Relexxi, methylphenidate patch, Quillichew ER, and Cotempla XR-ODT and updating the MN criteria for Dyanavel XR for the formulary alternatives. See Appendix B for the full criteria.
4. **COMMITTEE ACTION: TRICARE MAINTENANCE DRUG LIST REQUIREMENTS**—Schedule II drugs are exempted from the TRICARE Maintenance Drug List program requirements, as originally outlined in the August 2015 P&T Committee meeting minutes.
5. **COMMITTEE ACTION: UF, PAs, MN and IMPLEMENTATION PERIOD**—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) an effective date of the first Wednesday 60 days after signing of the minutes in all points of service.

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

The products were divided into two groups when presented at the P&T Committee meeting. The generic names are included below. Group 1 included Saphnelo, Atoncy, Baxfendy, Zolybus, Idvynso, duloxetine, Filkri, Xtoro, Quiofic, Lynavoy, Bysanti, Lifyorli, Widaplik, Nereus and Veppanu, and Group 2 included Hepcludex and Xocova.

Relative Clinical Effectiveness and Relative Cost-Effectiveness Conclusions—The P&T Committee agreed (Group 1: 18 for, 0 opposed, 0 abstained, 1 absent and Group 2: 17 for, 0 opposed, 0 abstained, and 2 absent) with the relative clinical and cost-effectiveness analyses presented for the newly approved drugs reviewed according to 32 CFR 199.21(g)(5). See Appendix E for the complete list of newly approved drugs reviewed at the August 2026 DoW P&T Committee meeting, a brief summary of their clinical attributes, and their formulary recommendations; see Appendix F for their restriction to or exemption from the TRICARE Maintenance Drug List.

1. COMMITTEE ACTION: UF RECOMMENDATION—The P&T Committee recommended (Group 1: 18 for, 0 opposed, 0 abstained, 1 absent and Group 2: 17 for, 0 opposed, 0 abstained, and 2 absent) the following:

- UF
 - anifrolimab-fnia injection (Saphnelo) – Immunosuppressive for Systemic Lupus Erythematosus (SLE)
 - bulevirtide-gmod injection (Hepcludex) – Hepatitis D Agents
 - doravirine/islatravir (Idvynso) – Antiretrovirals for HIV
 - ensitrelvir fumarate (Xocova) – Antivirals for COVID
 - relacorilant (Lifyorli) – Oncological Agents for Ovarian Cancer
 - telmisartan/amlodipine/indapamide (Widaplik) – Renin-Angiotensin Antihypertensives (RAAs)
 - vepdegestrant (Veppanu) – Breast Cancer Agents
- NF
 - atomoxetine 4 mg/mL oral solution (Atoncy) – ADHD Agents: Non-Stimulants
 - baxdrostat (Baxfendy) – Diuretics
 - bimatoprost 0.01% ophthalmic gel (Zolymbus) – Glaucoma drugs
 - duloxetine 80-, 90-, 120 mg delayed release (DR) capsules (no brand name) – Antidepressants and Non-Opioid Pain Syndrome
 - finafloxacin 0.3% otic suspension (Xtoro) – Antibiotics for acute otitis externa
 - linerixibat (Lynavoy) – GI-2 Agent for pruritus from primary biliary cholangitis
 - milsaperidone (Bysanti) – Antipsychotic Agents
 - tradipitant (Nereus) – Antiemetic-Antivertigo Agents
- Complete Exclusion: See Appendix H for additional detail regarding complete exclusion agents and formulary alternatives.
 - filgrastim-laha injection (Filkri) – White Blood Cell Stimulants biosimilar for Neupogen
 - Filkri was recommended for complete exclusion status as it has little to no clinical benefit relative to the other filgrastim formulations, and the needs of TRICARE beneficiaries are met by alternative agents. Formulary

alternatives include tbo-filgrastim (Granix), filgrastim-aafi (Nivestym), and filgrastim-sndz (Zarxio).

- folic acid 0.2 mg/mL oral solution (Quiofic and authorized generic) – Vitamins
 - Quiofic oral solution was recommended for complete exclusion status as it has little to no clinical benefit relative to the folic acid tablets, and the needs of TRICARE beneficiaries are met by alternative agents. Formulary alternatives include folic acid tablets.

2. COMMITTEE ACTION: MN CRITERIA—The P&T Committee recommended (Group 1: 18 for, 0 opposed, 0 abstained, 1 absent) MN criteria for Atoncy, Baxfendy, Zolymbus, duloxetine 80-, 90-, 120 mg DR capsules, Xtoro, Lynavoy, Bysanti, and Nereus. See Appendix B for the full criteria.

3. COMMITTEE ACTION: PA CRITERIA—The P&T Committee recommended (Group 1: 18 for, 0 opposed, 0 abstained, 1 absent and Group 2: 17 for, 0 opposed, 0 abstained, and 2 absent) the following PA criteria (see Appendix C for the full criteria):

- Applying manual PA criteria to new users of Bysanti, requiring a trial of at least two formulary atypical antipsychotics, similar to other antipsychotics (e.g., Vraylar, Caplyta, Rexulti). Accordingly, new PA criteria were recommended for new users of iloperidone (Fanapt) to ensure clinical consistency across the bioequivalent agents. See the utilization management section on page 19.
- Applying manual PA criteria to new users of duloxetine, Xtoro otic suspension, Nereus, Saphnelo, and Lynavoy, requiring a trial of other formulary agents first.
- Applying manual PA criteria to new users of Hepcludex, Lifyorli and Veppanu, consistent with what is in place for other drugs for hepatitis virus (Hepcludex) and for other oncology drugs (Lifyorli and Veppanu).
- Applying manual PA criteria to new users of Atoncy and its authorized generic, atomoxetine solution, similar to the PA criteria currently in place for other ADHD non-stimulants.
- Applying manual PA criteria to new users of Zolymbus, requiring a trial of generic formulary agents, similar to what is in place for the other preservative-free ocular prostaglandin, latanoprost 0.005% ophthalmic solution (Iyuzeh). Updates were also made to the PA criteria for Iyuzeh. See the utilization management section on page 19.
- Applying manual PA criteria to new users of Baxfendy, requiring use of at least two standard hypertensive agents, one of which must be a

diuretic, and a trial of spironolactone, in alignment with treatment guidelines for resistant hypertension. Accordingly, updates were made to aprocitenan (Tryvio), which is also indicated in resistant hypertension. See the utilization management section on page 20.

- Applying temporary PA criteria to new users of Filkri, Quiofic, and the folic acid solution authorized generic, until implementation of Complete Exclusion status.
4. **COMMITTEE ACTION: QLs**—The P&T Committee recommended (Group 1: 18 for, 0 opposed, 0 abstained, 1 absent and Group 2: 17 for, 0 opposed, 0 abstained, and 2 absent) QLs for Lynavoy, Nereus, Saphnelo, Veppanu and Xocova. See Appendix D for the QLs.
 5. **COMMITTEE ACTION: ADHERENCE SAFETY NET PROGRAM**—The P&T Committee recommended adding Bysanti (18 for, 0 opposed, 0 abstained, 1 absent) and Hepcludex (17 for, 0 opposed, 0 abstained, and 2 absent) to the Adherence Safety Net program managed by the TRICARE pharmacy benefits contractor. The program identifies beneficiaries who have not received a prescription fill after the initial reject.
 6. **COMMITTEE ACTION: SPECIALTY AND TRICARE MAINTENANCE DRUG LISTS**—The P&T Committee recommended (Group 1: 18 for, 0 opposed, 0 abstained, 1 absent and Group 2: 17 for, 0 opposed, 0 abstained, and 2 absent) adding or exempting the drugs listed in Appendix F to/from the TRICARE Maintenance Drug List for the reasons outlined in the table. Note that the Add/Do Not Add recommendations listed in Appendix F pertain to the combined list of drugs under the TRICARE Maintenance Drug List which includes the NF medications subject to the TMOP requirement. Drugs recommended for addition to the Specialty Drug List are found in Appendix E.
 7. **COMMITTEE ACTION: UF, MN, PA, QL, ADHERENCE SAFETY NET PROGRAM, SPECIALTY AND TRICARE MAINTENANCE DRUG LISTS, and IMPLEMENTATION PERIOD**—The P&T Committee recommended (Group 1: 18 for, 0 opposed, 0 abstained, 1 absent and Group 2: 17 for, 0 opposed, 0 abstained, and 2 absent) an effective date of the following:
 - **New Drugs Recommended for UF and NF Status:** An effective date of the first Wednesday two weeks after signing of the minutes in all points of service; see Appendix G.
 - **New Drugs Recommended for Complete Exclusion Status:** 1) An effective date of the first Wednesday 120 days after signing of the minutes in all points of service; and 2) DHA will send letters to beneficiaries who are affected by the complete exclusion status at 30 days and 60 days prior to implementation; see Appendix G.

VI. UTILIZATION MANAGEMENT PA and MN Criteria

1. New Manual PA Criteria for Newly Approved Drugs Not Subject to 32 CFR 199.21(g)(5)

Manual PA criteria were recommended for two recently marketed drugs produced by a sole manufacturer which contain active ingredients that are widely available in low-cost generic formulations. Due to the pathway used to gain FDA approval, these products do not meet the criteria for innovators and cannot be reviewed for formulary status under this authority. Numerous cost-effective formulary alternatives are available that do not require prior authorization. All of the PAs below will require a provider to indicate clinical rationale explaining the need for the medication.

- a) **Antidepressants and Non-Opioid Pain Syndrome Agents: Gamma-aminobutyric Acid Analogs—gabapentin (Relgaabi) 200 mg, 300 mg, and 400 mg capsules**—There are a plethora of generic gabapentin capsules that can meet the beneficiaries' need at a more cost-effective price than these Relgaabi capsules.
- b) **Antianxiety Agents—buspirone 2.5 mg and 12.5 mg tablet**—Buspirone is readily available in cost-effective 5 mg and 7.5 mg tablets that can be split to achieve the same doses as in this product.

COMMITTEE ACTION: NEW PA CRITERIA FOR DRUGS NOT SUBJECT TO 32 CFR 199.21(g)(5) AND IMPLEMENTATION

PLAN—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) manual PA criteria for gabapentin (Relgaabi) 200 mg, 300 mg, and 400 mg capsules and buspirone 2.5 mg and 12.5 mg tablets in new and current users, due to the significant cost differences compared with other available alternative agents. The new PAs will become effective the first Wednesday 60 days after the signing of the minutes, and DHA will send letters to affected patients. See Appendix C for the full criteria.

2. New Manual PA Criteria

- a) **Antibiotics: Tetracyclines—omadacycline (Nuzyra)**—Nuzyra is a tetracycline antibiotic with a broad spectrum of activity indicated for the treatment of community-acquired bacterial pneumonia and acute bacterial skin and soft tissue infections (ABSSI). Nuzyra was reviewed as an innovator at the February 2019 meeting and designated as non-formulary; currently there is not a PA.

Guidelines do not recommend first-line use of Nuzyra for any indications. In support of antimicrobial stewardship, Nuzyra is reserved for patients unable to use first-line agents. Review of MHS data shows increasing utilization and spend, and signs of inappropriate prescribing. Many commercial health plans require a PA for Nuzyra. Provider outreach determined it was reasonable to require a PA and allow infectious disease (ID) physicians and pulmonologists

to bypass the PA, as these specialists commonly treat multidrug resistant infections.

The P&T committee recommended PA criteria in new users for Nuzyra, restricting use to the FDA-approved indication and one off-label use for non-tuberculous mycobacteria. Patients must have had an inadequate response, intolerance, contraindication or documented resistance to other antibiotics. ID physicians and pulmonologists will be allowed to bypass the PA. Nuzyra will be added to the Adherence Safety Net Program.

COMMITTEE ACTION: NEW PA CRITERIA, ADHERENCE SAFETY NET PROGRAM AND IMPLEMENTATION PLAN—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) manual PA criteria for Nuzyra in new users, due to provider feedback, clinical guidelines, and the significant cost differences compared with generic alternatives. Nuzyra will be added to the Adherence Safety Net program. The new PA will become effective the first Wednesday 60 days after the signing of the minutes. See Appendix C for the full criteria.

3. Updated PA Criteria for New FDA-Approved Indications

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

- a) **Antidepressants and Non-Opioid Pain Syndrome Agents—dextromethorphan/ bupropion (Auvelity)**—The manual PA and MN criteria for Auvelity were updated for the new indication for agitation associated with Alzheimer’s disease. The criteria mirror existing criteria for Rexulti for this indication, except for the removal of the requirement for prescribing by or in consultation with a specialist. Provider feedback recommended allowing primary care physicians to prescribe Auvelity, given the lack of a black-box warning for use in the elderly.
- b) **Antihemophilic Agents: Non-Factor Agents—marstacimab-hncq (Hympavzi)**—The manual PA criteria for Hympavzi were updated to allow for the new hemophilia A and B with inhibitors indication and for the expanded age indication down to age six years.
- c) **Antilipidemics-2 Agents—olezarsen (Tryngolza)**—Tryngolza received a new indication for use as adjunct to diet to decrease triglycerides and the risk of acute pancreatitis in adults with severe hypertriglyceridemia. The manual PA criteria were updated to reflect this new indication and to remove the Redemplo preference in the PA, as these two agents are now similarly priced. Additionally, PA language was added to prevent the concurrent use with Redemplo.

- d) **Atopy: IL-13, IL-31—dupilumab (Dupixent)**—Dupixent received an expanded indication for chronic spontaneous urticaria in patients two years and older. Additionally, the prurigo nodularis indication was updated for clarity and to align with the commercial standard for this indication.
- e) **Breast Cancer Agents: PIK3CA—capivasertib (Truqap)**—The manual PA criteria for Truqap were updated to allow for a new metastatic prostate cancer indication. In addition, the NCCN guideline question was updated to reflect the wording used in other oncology PAs.
- f) **Metabolic Agents: Miscellaneous—setmelanotide (Imcivree)**—The manual PA criteria for Imcivree were updated to allow for the new indication for acquired hypothalamic obesity in patients 4 years of age and older.
- g) **Nephrology Agents Miscellaneous—sparsentan (Filspari)**—The manual PA criteria for Filspari were updated for the new focal segmental glomerulosclerosis (FSGS) without nephrotic syndrome indication.
- h) **Neurologic Agents Miscellaneous—efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo)**—The FDA updated the labeling for Vyvgart Hytrulo to no longer limit the myasthenia gravis indication to patients with anti-acetylcholine receptor (AChR) antibody positive disease. Therefore, this previous requirement was removed from the PA requirements.
- i) **Pain Agents: Pain Topical—diclofenac epolamine 1.3% patch (Licart)**—The manual PA criteria for Licart were updated to include patients six years of age or older with acute pain.
- j) **TIBs: IL-17s—secukinumab (Cosentyx)**—The manual PA criteria for Cosentyx were updated to allow use for hidradenitis suppurativa and ankylosing spondylitis in patients aged 12 and older.
- k) **TIBs: IL-23s—risankizumab (Skyrizi) pens and syringes**—The manual PA criteria for Skyrizi pens and syringes were updated to allow use for plaque psoriasis and psoriatic arthritis in patients aged 6 and older. Note that the PA for Skyrizi On-Body- Injector (OBI) is only approved for adults.
- l) **TIBs: IL-23s—ustekinumab-aauz (unbranded), ustekinumab-hmny (Starjemza), ustekinumab-srlf (Imuldosa), ustekinumab-ttwe (Pyzchiva), ustekinumab-aekn (Selarsdi), ustekinumab (Stelara), ustekinumab (unbranded Stelara), ustekinumab-stba (Steqeyma), ustekinumab-auub (Wezlana), ustekinumab-kfce (Yesintek)**—The manual PA criteria for the UF non-step preferred and NF non-step preferred ustekinumab products were updated to reflect the expanded age indication for pediatric Crohn's disease, now approved in patients as young as two years old. Of note, the PA for the preferred Otulfi product was not updated as there is no age restriction on this PA.

COMMITTEE ACTION: PA AND MN UPDATES AND IMPLEMENTATION PLAN—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) the PA updates for Auvelity, Hympavzi, Tryngolza, Dupixent, Truqap, Imcivree, Filspari, Vyvgart Hytrulo, Licart patch, Cosentyx, Skyrizi, and ustekinumabs (not including Otulfi). Implementation will be effective the first Wednesday 60 days after signing of the minutes in all points of service.

4. Updated and New PA and MN Criteria for Reasons other than New Indications

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

- a) **Antiemetic/Antivertigo Agents—meclizine 25 mg chewable tablet (Antivert)**—Meclizine is an older antiemetic widely available in 12.5 mg and 25 mg tablets in prescription and over-the-counter (OTC) formulations. A PA requiring documentation of a trial of generic meclizine tablets has been in place since May 2022 for the prescription chewable tablets. The “write-in” PA criteria were amended to require both a trial of the meclizine 25 mg tablet and the meclizine 25 mg OTC chewable tablet for the branded prescription Antivert 25 mg chewable tablet.
- b) **Antilipidemics-2 Agents—plozasiran (Redemplo)**—The Redemplo PA was updated to prevent concurrent use with Tryngolza.
- c) **Antipsychotic Agents—iloperidone (Fanapt)**—New PA criteria will apply to new users of Fanapt, requiring a trial of at least two second-generation antipsychotics, based on clinical practice guidelines and provider feedback. The PA will align with the PA criteria for Bysanti. (See the new drugs section on page 14.) Fanapt was also added to the Adherence Safety Net Program managed by the TPharm5 pharmacy contractor.
- d) **Atopy: IL-13, 31—nemolizumab (Nemluvio)**—The prurigo nodularis indication was updated for clarity, to match the changes made to the Dupixent PA.
- e) **Breast Cancer Agents: Polyadenosine Diphosphate-Ribose Polymerase (PARP) Inhibitors—niraparib (Zejula)**—The manual PA criteria for Zejula were updated to improve the PA flow and to remove the current homologous recombination deficiency (HRD) requirement, to align with NCCN comments on the value of HRD testing.
- f) **Gastrointestinal-2 Agents: Chronic Idiopathic Constipation (CIC) and Constipation-Predominant Irritable Bowel Syndrome (IBS-C)—prucalopride (Motegrity), plecanatide (Trulance), tenapanor**

(Ibsrela)—All PAs were updated to change the concomitant use wording to reflect the agents' mechanisms of actions. The renewal criteria were updated to require one renewal and then allow for indefinite approval.

- g) **Gastrointestinal-2 Agents: Opioid Induced Constipation (OIC)--naloxegol (Movantik), naldemedine (Symproic), methylnaltrexone (Relistor)**—All PAs were updated to change the concomitant use wording to reflect the agents' mechanisms of action.
- h) **Glaucoma Drugs—latanoprost 0.005% ophthalmic solution (Iyuzeh)**—The recent approval of Zolymbus (see new drugs section on page 14) prompted an update to the manual PA criteria for Iyuzeh, in new users. The three preservative-containing therapies previously trialed must be documented, along with the trial dates.
- i) **Hematological Agents—ropeginterferon alfa-2b-njft (Besremi)**—An MTF oncologist requested a review of the Besremi MN criteria to allow for providers to select contraindications as a reason for MN approval. This change was added to the criteria, in addition to existing criteria which allow use in the setting of significant adverse effects or therapeutic failure to one previous agent.
- j) **Oncological Agents: Multiple Myeloma—selinexor (Xpovio)**—Xpovio's indication for diffuse large B-cell lymphoma was FDA approved via accelerated approval in 2020. The manufacturer did not complete the required phase 3 study and instead requested to voluntarily withdraw this indication. The withdrawn indication was removed from the PA.
- k) **Pulmonary Arterial Hypertension (PAH)—sotatercept (Winrevair)**—The manual PA criteria for Winrevair were updated to expand access to World Health (WHO) Functional Class IV PAH. Additionally, automated specialist bypass was added for pulmonologists, cardiologists, cardiac transplant surgeons, and cardiothoracic transplant surgeons if the patient is 18 years of age or older.
- l) **Renin-Angiotensin Antihypertensives—aproцитentan (Tryvio)**—The manual PA criteria for Tryvio was updated in new users due to the recent approval of baxdrostat (Baxfendy), (see new drugs section on page 14). A trial of three antihypertensive drugs will be required, of which one must be spironolactone. The contraindications for spironolactone were also added to the criteria.

COMMITTEE ACTION: PA AND MN UPDATES AND IMPLEMENTATION PLAN

—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) the PA updates for Antivert 25 mg chewable tablets, Redemplo, Nemludio, Zejula, Motegrity, Trulance, Ibsrela, Movantik, Symproic, Relistor, Besremi, Xpovio Winrevair, Iyuzeh and Tryvio, and the new PA criteria for Fanapt in new users. Implementation will be effective the first Wednesday 60 days after signing of the minutes.

C. Quantity Limits

1. **Anti-infectives: Miscellaneous—tedizolid (Sivextro)**—QLs do not currently apply to Sivextro, an oxazolidinone antibiotic indicated for ABSSI. A review of MHS prescribing patterns showed frequent dispensing of large quantities, exceeding the six tablets the label recommends for the ABSSI indication. Sivextro is less cost-effective than other antibiotics including linezolid, which has a similar spectrum of activity. Feedback from ID physicians was also discussed. The P&T Committee recommended applying a QL of six tablets along with an automated specialist bypass to allow ID physicians and pulmonologists to bypass the QL. Pulmonologists were included in the specialist bypass to allow for larger quantities to treat non-tuberculosis mycobacteria infections.

COMMITTEE ACTION: SIVEXTRO QL AND IMPLEMENTATION

PERIOD—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) the QL, for Sivextro. Implementation will occur the first Wednesday two weeks after signing of the minutes.

D. Line Extensions

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

1. **Oncological Agents: Myelofibrosis**—designating **ruxolitinib (Jakafi) XR tablets** with the same formulary status (UF), QL, Specialty, and TMDL status as Jakafi IR tablets.
2. **Hematological Agents**—designating **ropeginterferon alfa-2b-njft (Besremi) prefilled pen** with the same formulary status (NF), PA, MN, and Specialty status as Besremi syringe.

COMMITTEE ACTION: LINE EXTENSION AND IMPLEMENTATION

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

VI. BRAND OVER AUTHORIZED GENERIC AUTHORIZATION AND TIER 1 COPAY

A. Brand over Generic Additions

1. **Leukemia and Lymphoma Agents: Breakpoint cluster (BCR)-Ableson (ABL) Tyrosine Kinase Inhibitors (TKIs)**—**bosutinib (Bosulif) tablets**
2. **Diabetes Non-Insulin: Dipeptidyl Peptidase 4 (DPP-4) inhibitors**—**sitagliptin (Januvia) tablets**

3. TIBS: Miscellaneous—tofacitinib (Xeljanz) IR and ER tablets

Generic formulations are now marketed for Bosulif tablets, Januvia tablets, and Xeljanz immediate release (IR) and ER tablets; however, these generics are less cost-effective compared to the branded agents. Therefore, the branded agents will continue to be dispensed at all three points of service, and the generics will only be available with prior authorization. Accordingly, the Tier 1 (generic) copay for brand Bosulif tablets, Januvia tablets, and Xeljanz IR and ER tablets is recommended.

B. Brand over Generic Removals

1. Leukemia and Lymphoma Agents: BCR-ABL TKIs—nilotinib (Tasigna)—

Tasigna capsules were recommended for brand over generic status at the November 2025 P&T meeting. Generic nilotinib capsules are now more cost effective than the branded agent. The brand over generic criteria for the Tasigna capsules will be removed, and the Tier 2 copay will apply.

COMMITTEE ACTION: BRAND OVER GENERICS ADDITIONS AND REMOVALS AND IMPLEMENTATION PERIOD—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 0 absent) adding brand over generic criteria for Bosulif tablets, Januvia, and Xeljanz IR and ER tablets, plus the removal of brand over generic requirements for Tasigna. Implementation will occur the first Wednesday 60-days after signing of the minutes. The “brand over generic” requirement will be removed administratively when it is no longer cost-effective compared to the AB-rated generics.

VII. OVER-THE-COUNTER (OTC) DRUG BENEFIT—ACETAMINOPHEN 325 mg TABLETS and ORAL SUSPENSION AND ASPIRIN 81 mg TABLETS

Background: In accordance with 10 U.S.C. 1074g(a)(2)(F), implemented by 32 CFR 199.21(h)(5)(i), an OTC drug may be included on the UF upon the recommendation of the P&T Committee and approval of the Director, DHA, based on a finding that it is cost-effective and clinically effective, as compared to other drugs in the same therapeutic class of pharmaceutical agents. OTC drugs placed on the UF, in general, will be treated the same as generic drugs on the UF for purposes of availability in the MTF pharmacies, retail pharmacies, and TMOP. However, upon the recommendation of the P&T Committee and approval of the Director, DHA, the requirement for the prescription may be waived for a particular OTC drug for certain emergency care treatment situations. In addition, a special copayment may be established under 32 CFR 199.21 (i)(2)(xii) for OTC drugs specifically used in certain emergency care treatment situations. Copayment for OTC drugs may be waived at Retail pharmacies, but not at TMOP. Acetaminophen and aspirin were evaluated for clinical effectiveness and cost effectiveness for inclusion on the UF. Formulary inclusion would also result in dispensed prescriptions being noted on the patient’s medication profile.

- **acetaminophen 325 mg tablets and oral suspension:** All single-ingredient oral formulations of acetaminophen are solely available as OTC products,

therefore formulary inclusion would provide an additional non-opioid pain agent on the UF. The suspension formulation is commonly used to treat fever and pain in the pediatric population.

Multiple professional organizations and clinical practice guidelines support the use of acetaminophen, including the American Academy of Pediatrics (AAP), WHO Pain Ladder, American Academy of Orthopaedic Surgeons (AAOS), and the Department of Veterans Affairs (VA)/DoW clinical practice guidelines on osteoarthritis and headache. The safety profile of acetaminophen differs from that of other pain agents, e.g., NSAIDs risk of adverse GI effect.

The cost of acetaminophen tablets and suspension is generally comparable to or lower than generically available legend pain agents (e.g., diclofenac, celecoxib, meloxicam, ibuprofen suspension) and both formulations are clinically preferred in some populations and situations due to adverse effect considerations.

- ***aspirin 81 mg***: Clinical evidence supporting aspirin use was reviewed. The US Preventive Services Task Force (USPSTF) recommends aspirin as a preventive medication after 12 weeks of gestation in persons who are at high risk for preeclampsia. (Category B Recommendation). Private health insurers are required to cover (without cost sharing) medications with a USPSTF Category A or Category B recommendation. Guidelines from the American College of Cardiology/American Heart Association also recommend aspirin for secondary prevention of atherosclerotic cardiovascular disease.

The cost analysis concluded that low-dose aspirin in general occupies a unique clinical niche and is cost-effective relative to legend medications used for cardiovascular prevention.

COMMITTEE ACTION: UF RECOMMENDATION, COPAY, PRESCRIPTION REQUIREMENT, QUANTITY LIMITS, AND

IMPLEMENTATION PERIOD—The P&T Committee recommended (18 for, 0 opposed, 0 abstained, 1 absent) the following, based on clinical and cost effectiveness:

- Adding acetaminophen 325 mg tablets to the UF (GCN 16964)
 - Maintaining the copay and prescription requirement
 - Applying QLs as follows: Retail: 200 tabs; MTF/Mail 600 tabs
- Adding acetaminophen 160 mg/5 mL oral suspension to the UF (GCN 26911)
 - Waiving the copay and prescription requirement (emergency use)

- Applying QLs as follows: 480 mL per prescription fill (accommodates 118 and 120 mL bottles)
- Adding aspirin 81 mg delayed release (DR) tab to the UF (GCN 00161)
 - Maintaining the copay and prescription requirements
 - Applying QLs as follows: Retail: 100 tabs; MTF/Mail 300 tabs
- Implementation will occur the first Wednesday 30 days after signing of the minutes by the Director, DHA
- The QL and prescription requirements may be determined by local MTFs that have self-care programs

VIII. DRUGS DESIGNATED WITH COMPLETE EXCLUSION STATUS: ANNUAL REVIEW

Background—P&T Committee reviewed all drugs designated with complete exclusion from the TRICARE pharmacy benefit program under 32 CFR 199.21(e)(3), which allows the P&T Committee to recommend special Uniform Formulary actions “to encourage use of pharmaceutical agents that provide the best clinical effectiveness to covered beneficiaries and DoW, including consideration of better care, healthier people, and smarter spending.” This specifically includes “a complete or partial exclusion from the pharmacy benefits program of any pharmaceutical agent the Director determines provides very little or no clinical effectiveness relative to similar agents to covered beneficiaries and DoW.”

Drugs designated with complete exclusion are not available at the MTFs or TMOP points of service, and beneficiaries are required to pay the full out-of-pocket cost at retail pharmacies. The Committee plans to review complete exclusion status drugs on an annual basis.

The P&T Committee reviewed all the drugs currently designated with complete exclusion status. The P&T Committee found no significant new clinical data, guidelines, or indications for the majority of the products that would change the previous conclusion that the drug offers little or no clinical effectiveness relative to similar agents. The Committee also found that all the complete exclusion drugs remain substantially more costly than similar agents, although prices have decreased for a few generically available products, which will continue to be monitored.

One drug was discussed in detail.

- ***Antihypertensive Agents—clonidine hydrochloride (HCl) 0.02 mg/mL oral solution (Javadin):*** Javadin was recommended for complete exclusion status at the February 2026 P&T Committee meeting, with implementation slated for December 2, 2026. This drug is the first liquid oral immediate-release formulation of clonidine. No new clinical studies were conducted; FDA-approval was granted via the 505(b)(2) pathway using data from clonidine tablets (Catapres). While Javadin is solely approved for adults with hypertension, MTFs

utilize liquid formulations to meet specific dosing needs. The FDA approval letter stated the product did not represent a meaningful therapeutic benefit over existing therapies for pediatric patients.

Feedback from the MTFs requested formulary inclusion for Javadin, due to operational issues. Javadin's IR formulation and concentration of 0.02 mg/mL allow for smaller dosing increments than the other liquid clonidine formulation, Onyda XR, a 0.1 mg/mL extended-release preparation solely approved for ADHD. Since Javadin is now commercially available as a clonidine liquid preparation, compound clonidine is no longer allowed.

COMMITTEE ACTION: UF RECOMMENDATION FOR DRUGS CURRENTLY DESIGNATED WITH COMPLETE EXCLUSION

STATUS—The P&T Committee recommended (19 for, 0 opposed, 0 abstained, 1 absent) moving Javadin from complete exclusion status back to NF. The PA and MN criteria originally recommended at the February 2026 P&T Committee meeting were updated to include an age edit for pediatric patients younger than 12 years of age. Additionally, Onyda XR was added to the list of formulary alternatives for the MN criteria. The original recommendation for complete exclusion status will not be implemented, and Javadin will retain its current NF status, as the BAP pause delayed the original implementation. The PA will apply to new users. Due to operational issues, the PA and MN criteria updates will occur no later than August 26th, using the P&T Committee administrative authorities. (See Appendices B and C.)

No changes were recommended to the other drugs currently designated with complete exclusion status, as the products have little to no clinical benefit relative to other drugs in their respective classes, and the needs of TRICARE beneficiaries are met by alternative agents.

IX. MISCELLANEOUS ITEMS FOR INFORMATION BRIEFED TO THE COMMITTEE

A. Insulin glargine (Lantus) shortage—There are national supply disruptions with Lantus that are expected to resolve in the Fall, 2026. Lantus is currently the step-preferred basal insulin. The step-therapy PA requirements for three UF non-step preferred insulin glargine biosimilars were lifted as of July 21, 2026, and will remain in place until resolution of the shortage. Rezvoglar and glargine-yfgn are interchangeable with Lantus and can be substituted at the pharmacy window without provider notification.

- insulin glargine-yfgn PFP by Biocon; NDC: 83257-0015-32
- insulin glargine PFP (Rezvoglar); NDC: 00002-8980-05
- insulin glargine-yfgn by Civica; NDCs: 72572-0424-05 and 72572-0422-05

B. TIBs: IL-1/IL-6/CTLA- 4: tocilizumab PA and MN criteria—From the May 2025 P&T Committee meeting, tocilizumab (Actemra) will remain NF, with PA

criteria requiring a trial of tocilizumab-aazg (Tyenne) in all new and current users. In July 2026, supply shortages were noted for Tyenne, which are expected to continue until mid-2027. As a result, the Tyenne step therapy requirements for Actemra and for tocilizumab-anoh (Avtozma), which was reviewed in May 2026, are suspended until supply stabilizes. The Actemra and Avtozma MN criteria were also administratively updated to allow continued use due to the Tyenne shortage. Similar changes were made to the MN criteria for satralizumab (Enspryng) which is moving to NF status on October 28, 2026, where Tyenne is the formulary alternative. Beneficiary notification will occur when there is sufficient supply of the step preferred tocilizumab and the PA is implemented for new and current users.

- C. TIBs: IL-23 Inhibitors: Ustekinumab Summary of Formulary Actions.** The DoW/VA JNC for ustekinumab was awarded to ustekinumab-aaaz (Otulfi) in May 2026. Changes are currently underway. All patients receiving a ustekinumab product other than Otulfi, including Stelara, are required to try Otulfi. Stelara moves to NF status on August 26, 2026. Beneficiaries are receiving notification of the PA and NF changes. There are no changes to the PAs for current users of other IL-23 inhibitors (Skyrizi, Ilumya, Tremfya, Omvoh), other than all new users must try Otulfi first. The PA for Otulfi also expands access for pediatric patients with Crohn's disease and ulcerative colitis. Automated specialist bypass applies to Otulfi for dermatology and gastroenterology physicians; a PA is not required. Refer to Appendix I for a full summary of the actions taken with ustekinumab.
- D. Therapeutic Substitution**—The committee reviewed the documents sent to MTFs in support of therapeutic substitution. There is ongoing coordination with the Department of Veteran's Affairs to develop multi-agency policies for therapeutic substitution. The guidance now recommends therapeutic substitution to tocilizumab-aazg (Tyenne) and unbranded insulin lispro Junior. Unbranded insulin Humalog Junior can be substituted at TMOP without requiring a new prescription. Availability issues allow substitution back to the non-preferred agents. Refer to Appendix J.
- E. Post-implementation review**—Utilization management tools for PAs on newly launched medications that do not fall under the new drug program according to 32 Code of Federal Regulations (CFR) 199.21(g)(5) were reviewed. Overall trends in utilization and expenditure were evaluated.

X. ADJOURNMENT

The meeting adjourned at 1600 hours on August 6th. The next meeting will be in November 2026.

Appendix A—Attendance

Appendix B—Table of Medical Necessity Criteria

Appendix C—Table of Prior Authorization Criteria

Appendix D—Table of Quantity Limits

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

**Appendix F—TRICARE Maintenance Drug List Status of Medications Designated
Formulary or Nonformulary during the August 2026 DoW P&T
Committee Meeting**

Appendix G—Implementation Dates

Appendix H—Drugs with Complete Exclusion Status and Formulary Alternatives

Appendix I—TIBs: IL-23s Ustekinumab Summary of Actions

**Appendix J—Therapeutic Substitution Update for Ustekinumab, Tocilizumab, and
Insulin Lispro Junior KiwkPen**

DECISION ON RECOMMENDATIONS

SUBMITTED BY:

Signed/Signature on file

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

The Director, DHA:

- ☒ concurs with all recommendations.
- ☐ concurs with the recommendations, with the following modifications:

- ☐ concurs with the recommendations, except for the following:

Signed/Signature on file

William "Tex" Walker
Assistant Director
Health Care Administration and
Operations

October 26, 2026

Date

Appendix A—Attendance

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

Appendix A—Attendance

Nonvoting Members Present	
Dennis Dyke, DHA	Attorney Advisor, Contract Law
Megan Gemunder, DHA	Attorney Advisor, Contract Law
Shannon Kilgore, MD	Department of Veteran's Affairs
Eric Dill, PharmD	Department of Veteran's Affairs
Marsha Peterson	DHA Contracting Officer
Dean Valibhai, PharmD	TPharm5 COR, Pharmacy Benefit Integration Branch
Hope Shen	Defense Logistics Agency, CPOC
Guests	
CDR Kendra Jenkins, USPHS	Bureau of Prisons
Hazel Richardson, PharmD	CDC World Trade Center Health Plan
POD Staff Present	
CAPT Scott Raisor, USPHS	Chief, P&T Section, DHA POD Formulary Management Branch
Angela Allerman, PharmD, BCPS	DHA POD Formulary Management Branch
Shana Trice, PharmD	DHA POD Formulary Management Branch
CDR Elizabeth Hall, BCPS, USPHS	DHA POD Formulary Management Branch
Lt Col Pansy Uberoi, MC	DHA POD Formulary Management Branch
Heather Johnson, PharmD, BCCP	DHA POD Formulary Management Branch
Darrilyn Bihm, PharmD	DHA POD Formulary Management Branch
Thinh Ha, PharmD	DHA POD Formulary Management Branch
CDR Bradey Gotto	DHA POD Formulary Management Branch
Maj Mark McGiffin	DHA POD Formulary Management Branch
Mike Lee, MBM, MPharm-Econ	DHA POD Formulary Management Branch
David Folmar, MS, MBA	DHA POD Formulary Management Branch
Helen Feinstein, PharmD, BCPS	DHA POD Formulary Management Branch
Mat Garber, PharmD, MA, PhD	DHA POD Formulary Management Branch

Appendix A—Attendance

DHA Contracting	
Jules Canaley	DHA Contracting
Kirk Heyen	DHA Contracting
Dwight Bonham	DHA Contracting
Julia Trang	DHA Contracting
Stephanie Erpelding	DHA Contracting

Appendix B—Table of Medical Necessity Criteria

Drug / Drug Class	Medical Necessity (MN) Criteria
Drug Class Reviews MN Criteria	
<ul style="list-style-type: none"> lisdexamfetamine dimesylate 10 mg/mL oral solution (Arynta) <p>ADHD Agents: Stimulants</p>	<p>No changes recommended at the August 2026 meeting</p> <ul style="list-style-type: none"> Use of formulary agent is contraindicated Patient has experienced significant adverse effects from formulary agents <p>Formulary alternatives: lisdexamfetamine capsules, lisdexamfetamine chewable tablets, methylphenidate (e.g., Concerta), amphetamine (e.g., Adderall)</p>
<ul style="list-style-type: none"> amphetamine ER orally disintegrating tablet (Adzenys XR-ODT) <p>ADHD Agents: Stimulants</p>	<p>No changes recommended at the August 2026 meeting</p> <ul style="list-style-type: none"> Use of at least TWO formulary ADHD stimulants is contraindicated Patient has experienced significant adverse events from at least TWO formulary ADHD stimulants Use of at least TWO of the formulary ADHD stimulants has resulted in therapeutic failure <p>Formulary Alternatives: mixed amphetamine salts XR (Adderall XR, generic), methylphenidate ER (Ritalin LA), methylphenidate ER oral suspension (Quillivant XR)</p>
<ul style="list-style-type: none"> amphetamine ER oral suspension (Dyanavel XR) <p>ADHD Agents: Stimulants</p>	<p>Changes from the August 2026 meeting are in bold and strikethrough</p> <ul style="list-style-type: none"> Use of at least TWO formulary ADHD stimulants is contraindicated Patient has experienced significant adverse events from at least TWO formulary ADHD stimulants Use of at least TWO of the formulary ADHD stimulants has resulted in therapeutic failure <p>Formulary Alternatives: mixed amphetamine salts XR (Adderall XR, generic), methylphenidate ER (Ritalin LA), methylphenidate ER oral suspension (Quillivant XR), lisdexamfetamine (Vyvanse)</p>
<ul style="list-style-type: none"> dextroamphetamine transdermal system (Xelstryl) <p>ADHD Agents: Stimulants</p>	<p>No changes recommended at the August 2026 meeting</p> <ul style="list-style-type: none"> Use of formulary agents is contraindicated Patient has experienced significant adverse effects from formulary agents Formulary agents resulted in therapeutic failure No alternative formulary agent <p>Formulary alternatives: extended-release methylphenidate (e.g., Concerta, Metadate CD, Ritalin LA), extended-release mixed amphetamine salts (Adderall XR)</p>
<ul style="list-style-type: none"> mixed amphetamine salts ER capsules triphasic release (Mydayis) methylphenidate ER (Relexxii) <p>ADHD Agents: Stimulants</p>	<p>No changes recommended at the August 2026 meeting</p> <ul style="list-style-type: none"> Use of generic mixed amphetamine salts XR (Adderall XR) and generic methylphenidate OROS and other (Concerta) have resulted in therapeutic failure <p>Formulary Alternatives: mixed amphetamine salts XR (Adderall XR, generic), methylphenidate OROS and other (Concerta, generic)</p>

Appendix B—Table of Medical Necessity Criteria

<ul style="list-style-type: none"> • methylphenidate transdermal system (generic) <p>ADHD Agents: Stimulants</p>	<p>No changes recommended at the August 2026 meeting</p> <ul style="list-style-type: none"> • Use of the formulary ADHD stimulants is contraindicated (e.g. due to hypersensitivity) • Patient has experienced significant adverse effects from the formulary ADHD stimulants • Use of the formulary ADHD stimulants have resulted in therapeutic failure • No alternative formulary agent: Patient is unable to take oral medications <p>Formulary Alternatives: mixed amphetamine salts XR (Adderall XR, generic), methylphenidate OROS and other (Concerta, generic), methylphenidate ER (Metadate CD, Ritalin LA, generics)</p>
<ul style="list-style-type: none"> • methylphenidate ER chewable tablet (Quillichew ER) <p>ADHD Agents: Stimulants</p>	<p>No changes recommended at the August 2026 meeting</p> <ul style="list-style-type: none"> • No alternative formulary agent: Patient cannot take methylphenidate ER oral suspension (Quillivant XR) <p>Formulary Alternatives: mixed amphetamine salts (Adderall IR, Adderall XR, generic), methylphenidate OROS (Concerta, generic), methylphenidate ER oral suspension (Quillivant XR),</p>
<ul style="list-style-type: none"> • methylphenidate ER orally disintegrating tablet (Cotempla XR-ODT) <p>ADHD Agents: Stimulants</p>	<p>No changes recommended at the August 2026 meeting</p> <ul style="list-style-type: none"> • Use of generic mixed amphetamine salts XR (Adderall XR) AND generic methylphenidate OROS and other (Concerta) AND Quillivant XR or generic methylphenidate ER (Aptensio XR) have resulted in therapeutic failure <p>Formulary Alternatives: mixed amphetamine salts XR (Adderall XR, generic), methylphenidate OROS and other (Concerta, generic), methylphenidate ER OS (Quillivant XR), methylphenidate ER capsules (Aptensio XR, generic)</p>
New Drugs MN Criteria	
<ul style="list-style-type: none"> • atomoxetine 4 mg/mL oral solution (Atoncy) <p>ADHD Agents: Nonstimulants</p>	<ul style="list-style-type: none"> • Use of formulary agents is contraindicated • Formulary agents resulted in therapeutic failure <p>Formulary alternatives: atomoxetine capsules, amphetamine XR salts (Adderall XR, generics), methylphenidate</p>
<ul style="list-style-type: none"> • baxdrostat (Baxfendy) <p>Diuretics</p>	<ul style="list-style-type: none"> • Use of formulary agent is contraindicated • Patient has experienced significant adverse effects from formulary agents • Formulary agents resulted in therapeutic failure <p>Formulary alternatives: spironolactone, clonidine, alpha blocker (ex. doxazosin), beta blocker (ex. metoprolol succinate, bisoprolol, carvedilol), amiloride, and hydralazine</p>

Appendix B—Table of Medical Necessity Criteria

<ul style="list-style-type: none"> bimatoprost 0.01% ophthalmic gel (Zolymbus) <p>Glaucoma Drugs</p>	<ul style="list-style-type: none"> Use of formulary agents is contraindicated Patient has experienced significant adverse effects from formulary agents Formulary agents resulted in therapeutic failure <p>Formulary alternatives: bimatoprost ophthalmic solution (Lumigan, generics), latanoprost 0.005% ophthalmic solution (generic Xalatan)</p>
<ul style="list-style-type: none"> duloxetine 80-, 90-, 120 mg DR capsules <p>Antidepressants and Non-Opioid Pain Syndrome</p>	<ul style="list-style-type: none"> Patient has experienced significant adverse effects from formulary agents <p>Formulary alternatives: duloxetine capsules</p>
<ul style="list-style-type: none"> finaxofloxacin 0.3% otic suspension (Xtoro) <p>Antibiotics</p>	<ul style="list-style-type: none"> Use of formulary agents is contraindicated Patient has experienced significant adverse effects from formulary agents Formulary agents resulted in therapeutic failure <p>Formulary alternatives ciprofloxacin 0.3%/dexamethasone 1% otic suspension, ciprofloxacin 0.2% and hydrocortisone 1% otic suspension, ciprofloxacin 0.2% otic solution, ofloxacin 0.3% otic solution</p>
<ul style="list-style-type: none"> linexixibat (Lynavoy) <p>GI-2 Agents</p>	<ul style="list-style-type: none"> Use of formulary agents is contraindicated Patient has experienced significant adverse effects from formulary agents Formulary agents resulted in therapeutic failure <p>Formulary alternatives: seladelpar (Livdelzi), cholestyramine, rifampin, naltrexone, sertraline</p>
<ul style="list-style-type: none"> milsaperidone (Bysanti) <p>Antipsychotic Agents</p>	<ul style="list-style-type: none"> Patient has experienced significant adverse effects from formulary agents <p>Formulary alternatives: risperidone, quetiapine, aripiprazole, olanzapine, olanzapine/fluoxetine, ziprasidone, paliperidone, lurasidone</p>
<ul style="list-style-type: none"> tradipitant (Nereus) <p>Antiemetic Antivertigo Agents</p>	<ul style="list-style-type: none"> Use of formulary agents is contraindicated Patient has experienced significant adverse effects from formulary agents Formulary agents resulted in therapeutic failure <p>Formulary alternatives: scopolamine patch, meclizine, dimenhydrinate</p>
Return to NF status from Complete Exclusion Status	
<ul style="list-style-type: none"> clonidine HCl 0.02 mg/ml oral solution (Javadin) <p>Anti-Hypertensive Agents</p>	<p>Updates from August 2026 are in bold</p> <ul style="list-style-type: none"> No alternative formulary agent. Patient cannot swallow tablets due to a documented medical condition and not due to convenience and has significant irritation with the clonidine transdermal system. <p>Formulary alternatives: clonidine tablets, clonidine transdermal system, Onyda XR</p>

Appendix B—Table of Medical Necessity Criteria

Utilization Management MN Criteria	
<ul style="list-style-type: none"> dextromethorphan hydrobromide/bupropion hydrochloride (Auvelity) <p>Antidepressants and Non-Opioid Pain Syndrome Agents</p>	<p>Updates from August 2026 are in bold</p> <p>For Depression</p> <ul style="list-style-type: none"> Use of formulary agents is contraindicated Patient has experienced significant adverse effects from formulary agents Formulary agents resulted in therapeutic failure Patient previously responded to non-formulary agent and changing to a formulary agent would incur unacceptable risk <p>For Alzheimer's Agitation</p> <ul style="list-style-type: none"> No alternative formulary agent: Patient requires Auvelity for Alzheimer's agitation <p>Formulary alternatives for depression: SSRIs, SNRIs, TCAs, mirtazapine (Remeron), bupropion (Wellbutrin), trazodone, nefazodone, MAOIs</p>
<ul style="list-style-type: none"> ropeginterferon alfa-2b-njft (Besremi) <p>Hematological Agents</p>	<p>Updates from August 2026 are in bold</p> <ul style="list-style-type: none"> Use of formulary agents is contraindicated Patient has experienced significant adverse effects from at least 1 formulary agent At least 1 formulary agent has resulted in therapeutic failure <p>Formulary alternatives: hydroxyurea, Pegasys</p>
<ul style="list-style-type: none"> tocilizumab (Actemra) tocilizumab-anoh (Avtozma) 	<p>Updates from August 2026 are in bold</p> <ul style="list-style-type: none"> Use of formulary agents is contraindicated Patient has experienced significant adverse effects from the formulary agent The preferred agent is on shortage and unobtainable <p>Formulary alternatives: adalimumab (Humira), tocilizumab-aazg (Tyenne)</p>

Appendix C—Table of Prior Authorization (PA) Criteria

Drug / Drug Class	Prior Authorization Criteria
Drug Class Review PAs	
<ul style="list-style-type: none"> encorafenib (Braftovi) <p>Oncological Agents: BRAF-MEK Inhibitors</p>	<p>Updates from the August 2026 meeting are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of Braftovi.</p> <p>Automated PA criteria: When prescribed by an oncologist or hematologist, prior authorization is not required</p> <p><u>Manual PA criteria:</u> If automated PA criteria is not met Braftovi is approved if all criteria are met:</p> <ul style="list-style-type: none"> Patient is 18 years of age or older Prescribed by or in consultation with an oncologist Patient has confirmed BRAF V600E or BRAF V600K mutation by an FDA-approved test Patient has a diagnosis of: <ul style="list-style-type: none"> Unresectable or metastatic melanoma Unresectable or metastatic colorectal cancer Metastatic non-small cell lung cancer Braftovi is being taken in combination with Mektovi, Vectibix, or Erbitux Patient is not on concurrent dabrafenib (Tafinlar), trametinib (Mekinist), vemurafenib (Zelboraf), nor cobimetinib (Cotellic) The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. If so, please list the diagnosis: To facilitate approval, please list the diagnosis, guideline version and page number _____. <p>Non-FDA-approved uses are not approved except as noted above</p> <p>PA does not expire</p>
<ul style="list-style-type: none"> binimetinib (Mektovi) <p>Oncological Agents: BRAF MEK Inhibitors</p>	<p>Updates from the August 2026 meeting are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of Mektovi.</p> <p>Automated PA criteria: When prescribed by an oncologist or hematologist, prior authorization is not required</p> <p><u>Manual PA criteria:</u> If automated PA criteria is not met, Mektovi is approved if all criteria are met:</p> <ul style="list-style-type: none"> Patient is 18 years of age or older Prescribed by or in consultation with an oncologist Has unresectable or metastatic melanoma or metastatic non-small cell lung cancer Has confirmed BRAF V600E or BRAF V600K mutation by an FDA-approved test Mektovi is being taken in combination with Braftovi Patient is not on concurrent dabrafenib (Tafinlar), trametinib (Mekinist), vemurafenib (Zelboraf), nor cobimetinib (Cotellic) The diagnosis is not listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. If so, the provider must list the diagnosis:_____. To facilitate approval please list the diagnosis, guidelines version and page number. <p>Non-FDA-approved uses are not approved, except as noted above</p>

Appendix C—Table of Prior Authorization (PA) Criteria

	PA does not expire.
<ul style="list-style-type: none"> cobimetinib (Cotellic) <p>Oncological Agents: BRAF-MEK Inhibitors</p>	<p>Updates from the August 2026 meeting are in bold</p> <p>Manual PA criteria apply to all new users of Cotellic</p> <p>Automated PA criteria: When prescribed by an oncologist or hematologist, prior authorization is not required</p> <p><u>Manual PA criteria:</u> If automated PA criteria is not met, Cotellic is approved if all criteria are met:</p> <ul style="list-style-type: none"> Prescribed by or in consultation with a hematologist or oncologist Patient is 18 years of age or older. Patient has one of the following: <ul style="list-style-type: none"> Unresectable metastatic melanoma AND has confirmed BRAF V600E or V600K mutation by an FDA-approved test AND Cotellic is being taken in combination with vemurafenib (Zelboraf) AND Patient is not on concurrent encorafenib (Braftovi), binimetinib (Mektovi), dabrafenib (Tafinlar), nor trametinib (Mekinist) OR Histiocytic neoplasms The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. To facilitate approval, please list the diagnosis, guideline version, and page number: _____. <p>Non-FDA-approved uses are not approved, except as noted above</p> <p>Prior authorization does not expire</p>
<ul style="list-style-type: none"> vemurafenib (Zelboraf) <p>Oncological Agents: BRAF-MEK Inhibitors</p>	<p>Updates from the August 2026 meeting are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of Zelboraf</p> <p>Automated PA criteria: When prescribed by an oncologist or hematologist, prior authorization is not required</p> <p><u>Manual PA criteria:</u> If automated PA criteria is not met, Zelboraf is approved if all criteria are met:</p> <ul style="list-style-type: none"> Prescribed by or in consultation with a hematologist/oncologist Documented diagnosis of unresectable or metastatic melanoma with BRAF V600E mutation AND melanoma that is not wild-type BRAF Patient has Erdheim-Chester Disease with BRAF V600 mutation Patient is not on concurrent encorafenib (Braftovi), binimetinib (Mektovi), dabrafenib (Tafinlar), nor trametinib (Mekinist) The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. To facilitate approval if so, please list the diagnosis, guideline version, and page number: _____. <p>Non-FDA-approved uses are not approved, except as noted above</p> <p>PA does not expire</p>
<ul style="list-style-type: none"> dabrafenib (Tafinlar) <p>Oncological Agents: BRAF-MEK Inhibitors</p>	<p>Manual PA criteria apply to all new users of Tafinlar.</p> <p>Manual PA criteria: Coverage will be approved if:</p> <ul style="list-style-type: none"> Prescribed by or in consultation with a hematologist/oncologist Single agent for treatment of unresectable or metastatic melanoma with BRAF V600E mutation

Appendix C—Table of Prior Authorization (PA) Criteria

	<ul style="list-style-type: none"> • In combination with trametinib (Mekinist) for the treatment of patients with: <ul style="list-style-type: none"> ▪ Unresectable or metastatic melanoma with BRAF V600E or BRAF V600K mutations OR ▪ Adjuvant treatment of patients of melanoma with BRAF-V600E or BRAF-V600K mutation and involvement of lymph node(s), following complete resection ▪ Metastatic non-small cell lung cancer (NSCLC) with BRAF V600E Mutation ▪ Locally advanced or metastatic anaplastic thyroid cancer with BRAF V600E mutation with no satisfactory locoregional treatment options ▪ Unresectable or metastatic solid tumors with BRAF V600E mutation who have progressed following prior treatment and have no satisfactory alternative treatment options ▪ Low-grade glioma (LGG) with a BRAF V600E mutation who require systemic therapy • Patient is not on concurrent encorafenib (Braftovi), binimetinib (Mektovi), vemurafenib (Zelboraf), nor cobimetinib (Cotellic) • The diagnosis is not listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. To facilitate approval, please list the diagnosis, guideline version, and page number: _____. <p>Non-FDA-approved uses are not approved, except as noted above PA does not expire</p>
<ul style="list-style-type: none"> • trametinib (Mekinist) <p>Oncological Agents: BRAF-MEK Inhibitors</p>	<p>Manual PA criteria apply to all new users of Mekinist.</p> <p><u>Manual PA criteria:</u> Coverage will be approved if:</p> <ul style="list-style-type: none"> • Prescribed by or in consultation with a hematologist/oncologist • Monotherapy for treatment of unresectable or metastatic melanoma with BRAF-V600E or BRAF-V600K mutation in BRAF-inhibitor treatment naïve patients • Combination with dabrafenib (Tafinlar) for the treatment of patients with: <ul style="list-style-type: none"> ▪ Unresectable or metastatic melanoma with BRAF-V600E or BRAF-V600K mutation ▪ Adjuvant treatment of patients of melanoma with BRAF-V600E or BRAF-V600K mutation and involvement of lymph node(s), following complete resection ▪ Metastatic non-small cell lung cancer (NSCLC) with BRAF V600E mutation ▪ Locally advanced or metastatic anaplastic thyroid cancer with BRAF V600E mutation with no satisfactory locoregional treatment options ▪ Unresectable or metastatic solid tumors with BRAF V600E mutation who have progressed following prior treatment and have no satisfactory alternative treatment options ▪ Low-grade glioma (LGG) with a BRAF V600E mutation who require systemic therapy

Appendix C—Table of Prior Authorization (PA) Criteria

	<ul style="list-style-type: none"> Coverage not approved as a single agent in patients who have received prior BRAF inhibitor therapy Patient is not on concurrent encorafenib (Braftovi), binimetinib (Mektovi), vemurafenib (Zelboraf), nor cobimetinib (Cotellic) The diagnosis is not listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. To facilitate approval please list the diagnosis, guideline version, and page number: _____. <p>Non-FDA-approved uses are not approved, except as noted above PA does not expire</p>
<ul style="list-style-type: none"> amphetamine ER ODT tab (Adzenys XR ODT) <p>ADHD Agents: Stimulants</p>	<p>New PA from the August 2026 meeting Manual PA applies to new users <u>Manual PA Criteria:</u> Adzenys XR ODT is approved if all criteria are met:</p> <ul style="list-style-type: none"> Patient is 6 years of age or older Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) that has been documented in the medical record Provider must document why the patient must have Adzenys XR ODT: write-in <ul style="list-style-type: none"> Acceptable reasons include: Patient can't swallow solid dosage forms of both methylphenidate and amphetamine products and can't tolerate chewable or liquid dosage forms as well as sprinkles mixed with food of these products <p>Non-FDA-approved uses are not approved Prior authorization does not expire</p>
<ul style="list-style-type: none"> lisdexamfetamine capsule, chew tab (Vyvanse) <p>ADHD Agents: Stimulants</p>	<p>No changes from the August 2026 meeting Manual PA apply to all new users of Vyvanse <u>Automated PA Criteria:</u> The patient has filled a prescription for one amphetamine and one methylphenidate at any MHS pharmacy point of service (MTFs, Retail pharmacies or TRICARE Mail Order Pharmacy) during the previous 720 days OR <u>Manual PA Criteria:</u> If automated criteria are not met, Vyvanse is approved if all criteria are met: ADHD</p> <ul style="list-style-type: none"> Patient is 6 years of age or older Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) Patient has tried and failed mixed amphetamine salts ER(Adderall XR, generics) or other long-acting amphetamine or amphetamine derivative type drug Patient has tried and failed methylphenidate OROS and other (Concerta, generics) or other long-acting methylphenidate or methylphenidate derivative type drug <p>Binge Eating Disorder</p> <ul style="list-style-type: none"> Note: If patient is an Active Duty Service Member (ADSM), the provider acknowledges the need to consult service specific policy for Binge Eating Disorder (BED) <i>(For ADSM, if the above is acknowledged, continue following remaining criteria; non-ADSM may by-pass this note and go directly to the criteria below)</i> Patient is 18 years of age or older Patient has a diagnosis of moderate to severe Binge Eating Disorder

Appendix C—Table of Prior Authorization (PA) Criteria

	<ul style="list-style-type: none"> • Prescribed by or in consultation with a psychiatrist or other behavioral specialist • Patient has failed, does not have access to, or has had an inadequate response to cognitive behavioral therapy or other psychotherapy • Patient has tried and failed OR has a contraindication to an SSRI (e.g., citalopram, fluoxetine, sertraline) • Patient has tried and failed OR has a contraindication to topiramate or zonisamide • Provider acknowledges that Vyvanse will be discontinued if the patient does not respond by having a positive clinical response of meaningful decrease of binge eating episodes or binge days per week from baseline or improvement in signs and symptoms of binge eating disorder after taking Vyvanse <p>Non-FDA-approved uses are not approved to include weight loss/obesity</p> <p>Prior authorization does not expire</p>
<ul style="list-style-type: none"> • lisdexamfetamine dimesylate 10 mg/mL oral solution (Arynta) <p>ADHD Agents: Stimulant</p>	<p>No changes from the August 2026 meeting</p> <p>Manual PA criteria apply to all new users of lisdexamfetamine dimesylate oral solution (Arynta)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) • Patient is 6 years of age or older • Patient tried and failed mixed amphetamine salts ER (Adderall XR, generics) or another long-acting amphetamine or amphetamine derivative type drug • Patient tried and failed methylphenidate OROS (Concerta, generics) or another long-acting methylphenidate or methylphenidate derivative type drug • Provider must document why the patient cannot take lisdexamfetamine dimesylate capsules or chewable tablets <ul style="list-style-type: none"> ▪ Acceptable responses include: the patient has experienced a serious allergic reaction (i.e., hives/anaphylaxis) to an excipient in lisdexamfetamine dimesylate capsules; OR the patient cannot swallow tablets due to some documented medical condition (e.g., dysphagia, oral candidiasis, systemic sclerosis), and not due to convenience <p>OR</p> <ul style="list-style-type: none"> • Patient has a diagnosis of moderate to severe Binge Eating Disorder (BED) • Patient is 18 years of age or older • Patient tried and failed OR had a contraindication to an SSRI (for example, citalopram, fluoxetine, sertraline) • Patient tried and failed OR had a contraindication to topiramate or zonisamide • Provider must document why the patient cannot take lisdexamfetamine dimesylate capsules or chewable tablets. <ul style="list-style-type: none"> ▪ Acceptable responses include: the patient has experienced a serious allergic reaction (i.e., hives/anaphylaxis) to an excipient in lisdexamfetamine dimesylate capsules; OR the patient cannot swallow tablets due to some documented medical condition (e.g., dysphagia, oral candidiasis, systemic sclerosis), and not due to convenience <p>Non-FDA approved uses are not approved</p>

Appendix C—Table of Prior Authorization (PA) Criteria

	PA does not expire
<ul style="list-style-type: none"> dextroamphetamine transdermal system (Xelstrym) <p>ADHD Agents: Stimulants</p>	<p>No changes from the August 2026 meeting</p> <p>Manual PA criteria apply to all new users of dextroamphetamine transdermal system (Xelstrym)</p> <p><u>Manual PA criteria:</u> Xelstrym is approved if all criteria are met:</p> <ul style="list-style-type: none"> Patient is 6 years of age and older. Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) that has been appropriately documented in the medical record. Provider is aware of the warnings, screening and monitoring precautions for Xelstrym. Patient must have tried and failed or have a contraindication to one medication from each of the following categories: <ul style="list-style-type: none"> amphetamines (single or mixed salt medications) methylphenidate Patient has documented swallowing dysfunction requiring alternative formulation for treatment <p>Non-FDA approved uses are not approved. PA does not expire.</p>
<ul style="list-style-type: none"> methylphenidate orally disintegrating XR tablet (Cotempla XR-ODT) <p>ADHD Agents: Stimulants</p>	<p>No changes from the August 2026 meeting</p> <p><u>Manual PA Criteria:</u> Cotempla XR-ODT is approved if <u>all</u> criteria are met:</p> <ul style="list-style-type: none"> Patient is 6 to 17 years of age Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) Patient has tried and failed OR has a contraindication to generic Adderall XR Patient has tried and failed OR has a contraindication to generic Concerta Patient has tried and failed OR has a contraindication to Quillivant XR (methylphenidate ER oral suspension), or Aptensio XR (methylphenidate ER cap) <p>Non-FDA-approved uses are not approved Prior authorization does not expire</p>
<ul style="list-style-type: none"> methylphenidate extended release tablets (Relexxii) <p>ADHD Agents: Stimulants</p>	<p>No changes from the August 2026 meeting</p> <p>Manual PA criteria apply to all new and current users of methylphenidate extended release tablets (Relexxii).</p> <p><u>Manual PA criteria:</u> Relexxii is approved if <u>all</u> criteria are met:</p> <ul style="list-style-type: none"> Provider is aware and acknowledges that several other long-acting methylphenidate ER formulations, including generic Concerta, generic Metadate CD, generic Methylin ER, generic Aptensio XR, and generic Ritalin, and Quillivant XR are available to Tricare beneficiaries without requiring prior authorization The provider must explain why the patient requires Relexxii 72 mg ER tablets and cannot take the available alternatives. Acceptable reasons the patient cannot swallow multiple tablets/capsules and has documentation of swallowing difficulties <p>Non-FDA-approved uses are not approved.</p>

Appendix C—Table of Prior Authorization (PA) Criteria

	Prior authorization does not expire.
<ul style="list-style-type: none"> methylphenidate XR sprinkle capsules nighttime dosing (Jornay PM) <p>ADHD Agents: Stimulants</p>	<p>Updates from the August 2026 meeting are in bold and strikethrough</p> <p><u>Manual PA Criteria:</u> Jornay PM is approved if <u>all</u> criteria are met:</p> <ul style="list-style-type: none"> Patient is 6 years of age or older Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) that has been documented in the medical record Patient has had at least a 2 month trial and failure of generic methylphenidate ER/CD/LA (Concerta, Metadate, etc) OR has difficulty swallowing pills Patient has had at least a 2 month trial and failure of another long-acting methylphenidate (Methylphenidate ER/CD/LA, Quillivant XR, Aptensio XR) Patient has had at least a 2 month trial and failure of dextroamphetamine/amphetamine (Adderall XR (generic)) OR has a contraindication to dextroamphetamine/amphetamine Adderall XR Patient has tried, for at least two months, an immediate release formulation methylphenidate product in conjunction with generic Concerta or another long-acting methylphenidate Provider will explain why the patient requires Jornay PM: _____ <ul style="list-style-type: none"> Acceptable reasons include: Attempts to titrate with alternative treatments has not managed ADHD symptoms OR patient belongs to the exceptional family member program <p>Non-FDA-approved uses are not approved Prior authorization does not expire</p>
<ul style="list-style-type: none"> serdexmethylphenidate/dexmethylphenidate (Azstarys) <p>ADHD Agents: Stimulants</p>	<p>Updates from the August 2026 meeting are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of Azstarys</p> <p><u>Manual PA Criteria:</u> Azstarys is approved if <u>all</u> criteria are met:</p> <ul style="list-style-type: none"> Patient is 6 years of age or older Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) that has been documented in the medical record Patient has tried for at least two months and failed, had an inadequate response, or has a contraindication to methylphenidate OROS (Concerta, generic) or other long-acting methylphenidate Patient has tried for at least two months and failed, had an inadequate response, or has a contraindication to amphetamine mixed salts XR (Adderall XR generic) or other long-acting amphetamine Patient has tried for at least two months and failed, had an inadequate response, or has a contraindication to another long-acting methylphenidate (methylphenidate ER/CD/LA, Quillivant XR, Aptensio XR) Patient has tried, for at least two months, an immediate release formulation methylphenidate product in conjunction with generic Concerta or another long-acting methylphenidate Please explain why the patient needs Azstarys: <i>(fill-in blank question)</i> <ul style="list-style-type: none"> Acceptable reasons include: an attempt to titrate with alternative treatments has not managed ADHD symptoms or patient belongs to the exceptional family member program

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	<p>Non-FDA-approved uses are not approved Prior authorization does not expire.</p>
<ul style="list-style-type: none"> • mixed amphetamine salts ER capsules triphasic release (Mydayis) <p>ADHD Agents: Stimulants</p>	<p>No changes from the August 2026 meeting</p> <p><u>Manual PA Criteria:</u> Mydayis is approved if <u>all</u> criteria are met:</p> <ul style="list-style-type: none"> • Patient is 13 years of age or older • Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) • Patient has tried and failed generic mixed amphetamine salts ER capsules (Adderall XR) • Patient has tried and failed generic methylphenidate ER tablets (Concerta) <p>Non-FDA-approved uses are not approved Prior authorization does not expire</p>
Newly Approved Drug PAs	
<ul style="list-style-type: none"> • anifrolimab-fnia injection (Saphnelo) <p>Immunosuppressives</p>	<p>Manual PA criteria apply to all new users of anifrolimab-fnia (Saphnelo)</p> <p>Manual PA criteria: Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Patient is 18 years of age or older • Prescribed by or in consultation with a rheumatologist • Patient has a diagnosis of systemic lupus erythematosus (SLE) that is autoantibody-positive as defined by at least one of the following: antinuclear antibodies (ANA), anti-double-strand DNA (anti-dsDNA) antibodies, anti-Smith (anti-Sm) antibodies • Patient had an adequate trial (at least 3 months) of the following with an inadequate response, adverse effect, or contraindication to at least two of the four therapies; hydroxychloroquine, azathioprine, methotrexate, mycophenolate • Patient is concurrently taking standard therapy (e.g., hydroxychloroquine, antimalarials, systemic corticosteroids and/or immunosuppressives either alone or in combination) and will remain on standard therapy with Saphnelo • Patient does not have severe active lupus nephritis or severe active central nervous system lupus • The patient is not taking concurrent rituximab, belimumab, or other biologics including but not limited to, TNF inhibitors, interleukins, JAK inhibitors <p>Non-FDA approved uses are not approved PA expires in 12 months</p> <p><u>Renewal criteria:</u> Note that initial TRICARE PA approval is required for renewal. PA will be approved for an additional 12 months if the following applies:</p> <ul style="list-style-type: none"> • Patient has shown documented clinical benefit (i.e. improvement in number/frequency of flares, improvement in in Safety of Estrogen in Lupus Erythematosus National Assessment - SLE Disease Activity Index (SELENA-modified SLEDAI) score, improvement/stabilization of organ dysfunction, improvement in complement levels/lymphocytopenia, etc.) • Patient is concurrently taking standard therapy (e.g., hydroxychloroquine, antimalarials, systemic corticosteroids and/or immunosuppressives either

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	<p>alone or in combination) and will remain on standard therapy with Saphnelo</p> <ul style="list-style-type: none"> • Patient does not have severe active lupus nephritis or severe active central nervous system lupus • The patient is not taking concurrent rituximab, belimumab, or other biologics including but not limited to, TNF inhibitors, interleukins, JAK inhibitors
<ul style="list-style-type: none"> • atomoxetine 4 mg/mL oral solution (Atoncy and authorized generic) <p>ADHD Agents: Nonstimulants</p>	<p>Manual PA criteria apply to all new users of atomoxetine oral solution (Atoncy)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Patient is 6 years or older • Patient has a diagnosis of Attention Deficit Hyperactivity Disorder (ADHD) • For patients younger than 12, must have tried and failed, had an inadequate response, OR contraindication to one stimulant medication (either amphetamine or methylphenidate product) • For patients 12 and older, must have tried and failed, had an inadequate response, intolerance OR contraindication to all of the following <ul style="list-style-type: none"> ▪ amphetamine XR salts (Adderall XR, generics) or other long-acting amphetamines and their derivatives AND ▪ methylphenidate OROS and other (Concerta, generic) or other long-acting methylphenidate or derivative drug AND ▪ The patient cannot swallow tablets due to some documented medical condition (e.g., dysphagia, oral candidiasis, systemic sclerosis, autism spectrum disorder, etc.), and not due to convenience <p>Non-FDA approved uses are not approved</p> <p>PA does not expire</p>
<ul style="list-style-type: none"> • baxdrostat (Baxfendy) <p>Diuretics</p>	<p>Updates to the August meeting are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of baxdrostat (Baxfendy)</p> <p>Manual PA criteria: Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Patient is 18 years of age or older • The drug is prescribed by a hypertension specialist (for example: internal medicine, cardiologist, nephrologist or prescriber with certification from the American Society of Hypertension) • Patient has systolic blood pressure of greater than 140 mm Hg • The patient has documented evidence of resistant hypertension by all the following: <ul style="list-style-type: none"> ▪ Systolic blood pressure (SBP)/diastolic blood pressure (DBP) $\geq$ 130/80 ▪ Patient is currently taking maximal tolerable doses of 3 or more antihypertensive medications of which one must be a diuretic-taken at maximally tolerated dose <ul style="list-style-type: none"> - diuretics - renin-angiotensin system blockers (e.g., ACE inhibitor or ARB blocker) - calcium channel blockers - Mineralocorticoid receptor blockers (e.g., spironolactone) • The patient has a contraindication to or has failed spironolactone as defined by: <ul style="list-style-type: none"> ▪ potassium (K) level > 5 mmol/mL

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	<ul style="list-style-type: none"> ▪ estimated glomerular filtration rate (eGFR) <30 mL/minute ▪ failure to control blood pressure to $\leq$ 130/80 with spironolactone • If unable to take spironolactone: <ul style="list-style-type: none"> ▪ The patient has a contraindication to amiloride, beta blocker, Alpha-2 Agonist, or vasodilator OR ▪ The patient is unable to achieve blood pressure control with a fourth line agent • Patient has tried at least three antihypertensive medications from the following classes one of which must be a diuretic, taken at maximally tolerated dose (Diuretics, Renin-angiotensin system blockers (e.g., ACE inhibitor or ARB blocker), Calcium channel blockers, Mineralocorticoid receptor blockers (e.g., spironolactone)) • Provider is aware of sodium and potassium monitoring requirements <p>Non-FDA approved uses are not approved</p> <p>PA expires in one year</p> <p><u>Renewal Criteria:</u> Note that initial TRICARE PA approval is required for renewal. Coverage will be approved indefinitely for continuation of therapy if all the criteria are met</p> <ul style="list-style-type: none"> • Baxfendy treatment has controlled blood pressure within goal range
<ul style="list-style-type: none"> • bimatoprost 0.01% ophthalmic gel (Zolymbus) <p>Glaucoma Drugs</p>	<p>Updates to the August meeting are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of bimatoprost 0.01% ophthalmic gel (Zolymbus)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Patient is 16 years of age or older • Patient has elevated intraocular pressure (IOP) due to open angle glaucoma or ocular hypertension • Prescriber is an ophthalmologist or an optometrist • Patient has tried two different formulary options, from any of the following glaucoma drug classes, in combination or separately at an appropriate duration of therapy <ul style="list-style-type: none"> ▪ prostaglandin analogs (e.g., Lumigan, Travatan, Xalatan) ▪ beta blockers (e.g., Timoptic) ▪ alpha2-adrenergic agonists (e.g., Alphagan P) ▪ topical carbonic anhydrase inhibitors (e.g., Azopt, Trusopt, Cosopt) OR • Patient is currently taking bimatoprost and requires a preservative-free formulation because they are experiencing significant adverse events OR • Patient is taking three or more different ocular medications that contain preservatives and accumulation of preservatives is a concern. Must document the drug and date of therapy <ul style="list-style-type: none"> ▪ Drug Name _____ Date _____ ▪ Drug Name _____ Date _____ ▪ Drug Name _____ Date _____ • Provider must document why the patient cannot use generic bimatoprost 0.01% ophthalmic solution. Acceptable responses include

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	<ul style="list-style-type: none"> Generic bimatoprost 0.01% ophthalmic solution agent is contraindicated due to benzalkonium chloride (BAK) or other inactive ingredients, OR The patient has experienced significant adverse effects with generic bimatoprost 0.01% ophthalmic solution. <p>Non-FDA approved uses are not approved PA does not expire</p>
<ul style="list-style-type: none"> bulevirtide-gmod injection (Hepcludex) <p>Hepatitis D Agents</p>	<p>Updates to the August meeting are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of bulevirtide-gmod (Hepcludex)</p> <p>Manual PA criteria: Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> Provider acknowledges that severe acute exacerbations of hepatitis D and hepatitis B may occur after Hepcludex is discontinued, especially in patients with cirrhosis, who may be at increased risk of more severe flares or progression to hepatic decompensation. Refer to Hepcludex package labeling on monitoring recommendations. Patient is 18 years of age or older The drug is prescribed by or in consultation with a gastroenterologist, hepatologist, or infectious disease specialist or a liver transplant physician Patient has laboratory evidence of chronic active hepatitis D virus infection Patient either does not have cirrhosis or has compensated cirrhosis <p>Non-FDA approved uses are not approved PA expires in 12 six months</p> <p><u>Renewal Criteria:</u> Note that initial TRICARE PA approval is required for renewal. Coverage will be approved indefinitely for an additional 12 six months of therapy if all the criteria are met</p> <ul style="list-style-type: none"> The patient continues to have a positive response to treatment as demonstrated by undetectable HDV RNA levels OR decreased HDV RNA levels from baseline Patient has evidence of positive response to treatment defined as achieving a virologic response (undetectable HDV RNA OR a ≥ 2 log₁₀ decline in HDV RNA from baseline) Provider continues to monitor alanine aminotransferase levels as part of the assessment of ongoing clinical benefit
<ul style="list-style-type: none"> duloxetine 80-, 90-, 120 mg DR capsules (no brand name) <p>Antidepressant and Non-Opioid Syndrome Agents</p>	<p>Manual PA criteria apply to all new users of duloxetine 80-, 90-, 120 mg delayed release capsules</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> Provider acknowledges other formulations of duloxetine are available without prior authorization Patient is 7 years of age or older and has a diagnosis of generalized anxiety disorder OR Patient is 18 years of age or older and has a diagnosis of major depression AND The patient cannot take multiples or a combination of existing duloxetine generic product dosage strengths (e.g. 40 mg or 60 mg) _____(write-in)

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	<ul style="list-style-type: none"> Acceptable reasons include the patient has an allergy to an inactive ingredient in generic duloxetine that is not contained in higher dose strength product <p>Non-FDA approved uses are not approved</p> <p>PA does not expire</p>
<ul style="list-style-type: none"> filgrastim-laha injection (Filkri) <p>White Blood Cell Stimulants: Filgrastims</p>	<p>Updates from the August 2026 meeting are in bold</p> <p>Manual PA criteria apply to all new users of Filkri</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> Provider acknowledges that Filkri will be completely excluded from the TRICARE pharmacy benefit 120 days after the signing of the P&T meeting minutes by the Director, DHA Tbo-filgrastim (Granix) and filgrastim-aafi (Nivestym) are the TRICARE preferred filgrastims and are available without a prior authorization. Please consider changing the prescription to a formulary preferred medication. Note: Granix and Nivestym are available at the generic (Tier 1) copay at the Mail Order and Retail Network Pharmacies Prescribed by or in consultation with a hematologist or oncologist Patient experienced an inadequate treatment response or intolerance to tbo-filgrastim (Granix) and is expected to respond to filgrastim (Neupogen), filgrastim-ayow (Releuko), filgrastim-txid (Nypozi), filgrastim-sndz (Zarxio), or filgrastim-laha (Filkri) <p>Non-FDA approved uses are not approved</p> <p>PA does not expire until after implementation of complete exclusion status</p>
<ul style="list-style-type: none"> finaxofloxacin 0.3% otic suspension (Xtoro) <p>Antibiotics</p>	<p>Manual PA criteria apply to all new users of finaxofloxacin 0.3% otic suspension (Xtoro)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> Patient has a diagnosis of acute otitis externa caused by susceptible strains of <i>Pseudomonas aeruginosa</i> and <i>Staphylococcus aureus</i>. Patient has tried and failed, experienced an adverse reaction, or has a contraindication to two other medications used to treat acute otitis externa (e.g., ciprofloxacin, ofloxacin, ciprofloxacin/dexamethasone, neomycin-polymyxin-hydrocortisone) <p>Non-FDA approved uses are not approved</p> <p>PA expires after each course of therapy. PA renewal is not allowed; no refills allowed; each course of therapy requires a new PA</p>
<ul style="list-style-type: none"> folic acid 0.2 mg/mL (Quiofic and authorized generic) <p>Vitamins</p>	<p>Updates from the August 2026 meeting are in bold</p> <p>Manual PA criteria apply to all new users of folic acid oral solution (Quiofic)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> Provider acknowledges that Quiofic will be completely excluded from the TRICARE pharmacy benefit 120 days after the signing of the P&T meeting minutes by the Director, DHA Patient has a diagnosis of megaloblastic anemia due to folic acid deficiency Provider must document why the patient cannot take folic acid tablets (Write-in) _____ <ul style="list-style-type: none"> Acceptable responses include: the patient cannot swallow tablets due to some documented medical condition (e.g., dysphagia, oral candidiasis, systemic sclerosis), and not due to convenience <p>Non-FDA approved uses are not approved</p> <p>PA does not expire until after implementation of complete exclusion status</p>

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<ul style="list-style-type: none"> linerixibat (Lynavoy) <p>GI-2 Agents</p>	<p>Updates from the August 2026 meeting are in bold</p> <p>Manual PA criteria apply to all new users of linerixibat (Lynavoy)</p> <p>Manual PA criteria: Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> Patient is 18 years of age or older The drug is prescribed by a gastroenterologist, hepatologist, or liver transplant specialist Patient has Primary Biliary Cholangitis (PBC) with severe refractory pruritus Diagnosis of PBC has been confirmed by at least TWO of the following: <ul style="list-style-type: none"> Alkaline phosphatase (ALP) elevated above the upper limit of normal (ULN) as defined by normal laboratory reference values Positive anti-mitochondrial antibodies (AMAs) or PBC-specific antinuclear antibodies (ANA) (e.g., anti-gp210, anti-sp100) Histologic evidence of PBC from a liver biopsy Patient been evaluated for possible orthotopic liver transplant (OLT) Patient is currently receiving or has an intolerance to ursodiol therapy Patient tried and failed or had intolerance to THREE two of the following: <ul style="list-style-type: none"> —ursodiol cholestyramine rifampin naltrexone ONE antihistamine (for example, Atarax, Benadryl, etc.) Provider acknowledges use of this agent with seladelpar (Livdelzi) or elafibranor (Iqirvo) has not been studied <p>Non-FDA approved uses are not approved, including progressive familial intrahepatic cholestasis, Alagille syndrome, metabolic dysfunction-associated steatohepatitis (MASH), metabolic dysfunction-associated liver disease (MASLD), primary sclerosing cholangitis, and other cholestatic diseases</p> <p>PA expires in 6 months</p> <p><u>Renewal Criteria:</u> Note that initial TRICARE PA approval is required for renewal. Coverage will be approved for an additional 6 months if all the criteria are met</p> <ul style="list-style-type: none"> Patient demonstrated significant improvement in pruritus symptoms
<ul style="list-style-type: none"> milsaperidone (Bysanti) <p>Antipsychotic Agents</p>	<p>Updates to the August meeting are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of milsaperidone (Bysanti)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> Patient is 18 years of age or older Provider acknowledges that Bysanti is the active metabolite of Fanapt. FDA approval was based on pharmacokinetic data with Fanapt and no clinical trials were conducted with Bysanti. Prescribed by a psychiatrist <p>Patient has an established, primary diagnosis of schizophrenia AND</p> <ul style="list-style-type: none"> Patient has a history of acute exacerbations OR relapses of psychotic symptoms which failed to respond to ONE at least TWO

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	<p>atypical antipsychotics at maximally tolerated doses (ex. iloperidone (Fanapt), risperidone, quetiapine, aripiprazole, olanzapine, olanzapine/fluoxetine, ziprasidone, paliperidone, lurasidone) OR</p> <ul style="list-style-type: none"> • Patient has a history of acute exacerbations OR relapses of psychotic symptoms which failed to respond to ONE FIRST generation antipsychotics at maximally tolerated doses—OR <p>Patient has a diagnosis of acute treatment of manic or mixed episodes associated with bipolar I disorder in adults AND</p> <ul style="list-style-type: none"> • Patient has tried and failed two formulary atypical antipsychotics (e.g., risperidone, aripiprazole, lurasidone, quetiapine) <p>Non-FDA approved uses are not approved PA does not expire</p>
<ul style="list-style-type: none"> relacorilant (Lifyorli) <p>Oncological Agents: Glucocorticoid Receptor Antagonist</p>	<p>Manual PA criteria apply to all new users of relacorilant (Lifyorli)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Patient is 18 years of age or older • Prescribed by or in consultation with a hematologist or oncologist • Patient has platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer • Patient will be receiving the requested medication in combination with nab-paclitaxel • Patient has tried one to three prior systemic therapies; where one of which is bevacizumab • The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation: to facilitate approval, please list the diagnosis, guideline version, and page number <p>Non-FDA approved uses are not approved except as noted above PA does not expire</p>
<ul style="list-style-type: none"> tradipitant (Nereus) <p>Antiemetic- Antivertigo Agents</p>	<p>Manual PA criteria apply to all new users of tradipitant (Nereus)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Provider acknowledges that scopolamine patch is available without the need of prior authorization • Provider acknowledges that dimenhydrinate and meclizine are readily available over the counter and are effective for prevention of motion sickness • The patient has tried and failed dimenhydrinate, meclizine and scopolamine in the past or had experienced significant adverse effects with these medications • Provider acknowledges safety has not been established for usage exceeding 90 doses <p>Non-FDA approved uses are not approved PA does not expire</p>

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<ul style="list-style-type: none"> • vepdegestrant (Veppanu) <p>Breast Cancer Agents: Estrogen Receptor Antagonist</p>	<p>Manual PA criteria apply to all new users of vepdegestrant (Veppanu)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Patient is 18 years of age or older • Prescribed by or in consultation with a hematologist or oncologist • Patient has ER-positive, HER2-negative, ESR1-mutated advanced or metastatic breast cancer • Patient had disease progression following at least one prior line of endocrine therapy (for example, letrozole, fulvestrant) • Patient had disease progression following at least one CDK4/6 inhibitor (palbociclib, ribociclib, or abemaciclib) • The diagnosis is not listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation: to facilitate approval, please list the diagnosis, guideline version, and page number _____ <p>Non-FDA approved uses are not approved except as noted above</p> <p>PA does not expire</p>
<p>Return to NF status from Complete Exclusion Status</p>	
<ul style="list-style-type: none"> • clonidine HCl 0.02 mg/ml oral solution (Javadin) <p>Antihypertensive Agents</p>	<p>Updates from the August meeting are in bold and strikethrough</p> <p><u>Age edit:</u> PA not required if patient is age 12 years or younger</p> <p>Manual PA criteria apply to all new users of clonidine oral solution (Javadin)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Patient is 18 years of age or older • Patient has hypertension • Provider must document why the patient cannot take clonidine tablets and transdermal system. (write-in) <ul style="list-style-type: none"> ▪ Acceptable responses include the patient cannot swallow tablets due to some documented medical condition (e.g., dysphagia, oral candidiasis, systemic sclerosis) AND ▪ The patient has had significant irritation with the clonidine transdermal system OR the clonidine transdermal system is inappropriate for the indication <p>Non-FDA approved uses are not approved</p> <p>PA does not expire</p>
<p>Utilization Management PAs</p>	
<ul style="list-style-type: none"> • Glycerol phenylbutyrate oral liquid (Ravicti) <p>Gastrointestinal-2 Agents</p>	<p>New PA approved in May 2026 (previously omitted)</p> <p>Manual PA criteria apply to all new users of glycerol phenylbutyrate oral solution (Ravicti)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Provider acknowledges that generic sodium phenylbutyrate powder is available at the lowest copay and doesn't require a PA and can be mixed with liquids and/or specialized formula and common soft foods to improve taste • Patient has a diagnosis of urea cycle disorders (UCDs) involving deficiencies of carbamylphosphate synthetase (CPS), ornithine transcarbamylase (OTC), or argininosuccinic acid synthetase (AS) confirmed through genetic, biochemical or enzymatic test

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	<ul style="list-style-type: none"> • Patient has inadequate response to dietary interventions AND will continue to manage the urea cycle disorder with dietary measures, including protein restriction and/or amino acid supplementation • Ravicti will not be used concomitantly with any sodium phenylbutyrate products (i.e. powders, tablets, or pellets) • Prescription is written by a specialist in diagnosing and treating urea cycle disorders • The patient has tried and failed or has a contraindication to generic sodium phenylbutyrate, Pheburane or Olpruva OR • Patient has experienced one or more of the following adverse effects: intolerance to inactive ingredients in generic sodium phenylbutyrate, Pheburane and Olpruva, vomiting or severe nausea limiting adherence, edema due to sodium content, or worsening CHF or kidney function OR • Patient has a diagnosis of CHF, severe renal insufficiency, or sodium retention accompanied by edema, requiring low sodium version product <p>Non-FDA approved uses are not approved PA does not expire</p>
<ul style="list-style-type: none"> • aprocitentan (Tryvio) <p>Antihypertensive Agents: Endothelin Receptor Agonists</p>	<p>Updates from August 2025 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of Tryvio</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • The patient is 18 years of age or older • The drug is prescribed by a hypertension specialist (for example: internal medicine, cardiologist, nephrologist, or prescriber with certification from the American Society of Hypertension) • Patient has systolic blood pressure of greater than 140 mmHg • Patient has resistant hypertension defined by the following: <ul style="list-style-type: none"> ▪ Systolic Blood Pressure/Diastolic Blood Pressure greater than or equal to 130/80 • Patient has tried at least two three antihypertensive medications from the following classes one of which must be a diuretic, taken at maximally tolerated doses <ul style="list-style-type: none"> ▪ diuretic ▪ renin-angiotensin system blockers (e.g., ACE inhibitor or ARB blocker) ▪ calcium channel blockers ▪ mineralocorticoid receptor blocker (e.g., spironolactone) • The patient has a contraindication to or has failed therapy with spironolactone, defined by <ul style="list-style-type: none"> ▪ potassium level greater than 5 mmol/mL ▪ estimated glomerular filtration rate (eGFR) < 30 mL/minute ▪ failure to control blood pressure to less than or equal to 130/80 • If unable to take spironolactone, the patient has contraindications to a beta blocker, Alpha-2 Agonist, or vasodilator OR the patient is unable to achieve blood pressure control with a fourth line agent • Women of child-bearing age will be tested for pregnancy • Provider is enrolled in the Risk Evaluation and Mitigation System (REMS) program <p>Non-FDA approved uses are not approved, including for pulmonary arterial hypertension.</p> <p>PA expires in one year</p>

Appendix C—Table of Prior Authorization (PA) Criteria

	<p><u>Renewal Criteria:</u> Note that initial TRICARE PA approval is required for renewal. Coverage will be approved indefinitely for continuation of therapy if all the criteria are met</p> <ul style="list-style-type: none"> • Tryvio treatment has controlled blood pressure within goal range • Provider continues to be enrolled in the Risk Evaluation and Mitigation Strategies program
<ul style="list-style-type: none"> • latanoprost 0.005% ophthalmic solution (Iyuzeh) <p>Glaucoma Agents</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of latanoprost ophthalmic solution (Iyuzeh)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Iyuzeh is prescribed by an ophthalmologist or an optometrist • Patient has a diagnosis of ocular hypertension or open-angle glaucoma • Patient has had a trial of appropriate duration with two different formulary options, from any of the following glaucoma drug classes, in combination or separately: <ul style="list-style-type: none"> ▪ prostaglandin analogs (e.g., Lumigan, Travatan, Xalatan) ▪ beta blockers (e.g., Timoptic) ▪ alpha2-adrenergic agonists (e.g., Alphagan P) ▪ topical carbonic anhydrase inhibitors (e.g., Azopt, Trusopt, Cosopt) • Patient has failed to reach intraocular target goals using medications from standard therapy classes (standard therapy classes include prostaglandin analogs, beta blockers, alpha2-adrenergic agonists, topical carbonic anhydrase inhibitors) OR • Patient is currently taking latanoprost and requires a preservative-free formulation due to experiencing adverse events OR • Patient is on three or more different ocular medications that contain preservatives and accumulation of preservatives is a concern. Must document the drug and date of therapy <ul style="list-style-type: none"> ▪ Drug Name_____ Date_____ ▪ Drug Name_____ Date_____ ▪ Drug Name_____ Date_____ <p>Non-FDA-approved uses are not approved</p> <p>PA does not expire</p>
<ul style="list-style-type: none"> • iloperidone (Fanapt) <p>Antipsychotic Agents</p>	<p>Manual PA criteria apply to all new users of iloperidone (Fanapt)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Patient is 18 years of age or older • Prescribed by a psychiatrist • Patient has an established, primary diagnosis of schizophrenia and has tried and failed two formulary atypical antipsychotics OR • Patient has a diagnosis of acute treatment of manic or mixed episodes associated with bipolar I disorder and has tried and failed two formulary atypical antipsychotics <p>Non-FDA approved uses are not approved</p> <p>PA does not expire</p>

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<ul style="list-style-type: none"> gabapentin (Relgaabi) capsules <p>Antidepressants and Non-Opioid Pain Syndrome Agents: Gamma-aminobutyric Acid Analogs</p>	<p>Manual PA criteria apply to all new and current users of gabapentin (Relgaabi) capsules</p> <p><u>Manual PA criteria:</u> gabapentin (Relgaabi) capsules are approved if all criteria are met:</p> <ul style="list-style-type: none"> Provider is aware and acknowledges that other formulations of gabapentin are available to TRICARE beneficiaries without the need for prior authorization. Providers are encouraged to consider changing the prescription to one of these products. Provider must explain why the patient requires gabapentin (Relgaabi) capsules and cannot take cost-effective alternatives (blank write-in) <ul style="list-style-type: none"> Acceptable responses include the patient has experienced a serious allergic reaction (e.g., hives/anaphylaxis) to one or more inactive ingredients in currently available gabapentin capsules. <p>Non-FDA-approved uses are not approved.</p> <p>Prior authorization does not expire.</p>
<ul style="list-style-type: none"> buspirone 2.5 mg and 12.5 mg tablets <p>Antianxiety Agents</p>	<p>Manual PA criteria apply to all new and current users of buspirone 2.5 mg and 12.5 mg tablets.</p> <p><u>Manual PA criteria:</u> buspirone 2.5 mg and 12.5 mg tablets are approved if all criteria are met:</p> <ul style="list-style-type: none"> Provider acknowledges other buspirone formulations, including the 5 mg and 7.5 mg tablets are available without requiring prior authorization. Provider must explain why the patient requires buspirone 2.5 mg and 12.5 mg tablets and cannot take cost-effective alternatives (blank write-in) <ul style="list-style-type: none"> Acceptable responses include the patient has experienced a serious allergic reaction (i.e., hives/anaphylaxis) to one or more inactive ingredients in currently available buspirone tablets. <p>Non-FDA-approved uses are not approved.</p> <p>Prior authorization does not expire.</p>
<ul style="list-style-type: none"> omadacycline (Nuzyra) <p>Antibiotics: Tetracyclines</p>	<p>Manual PA criteria apply to all new users of omadacycline (Nuzyra)</p> <p><u>Automated PA criteria:</u> When prescribed by an infectious disease physician or a pulmonologist, prior authorization is not required.</p> <p><u>Manual PA Criteria:</u> If automated PA criteria is not met, Nuzyra is approved if all criteria are met:</p> <ul style="list-style-type: none"> Patient is 18 years of age or older Patient has a diagnosis of community-acquired bacterial pneumonia (CABP), acute bacterial skin and soft tissue infection (ABSSTI), or non-tuberculous mycobacteria (NTM) AND <ul style="list-style-type: none"> Patient has documented bacterial culture results showing one of the susceptible organisms from the package insert that is resistant to all other oral antibiotics, including doxycycline OR Patient has experienced inadequate treatment response, intolerance, or contraindication to at least two first-line therapies for each approved diagnosis (e.g. CABP—macrolide, doxycycline, amoxicillin, levofloxacin; ABSSTI—vancomycin, linezolid, clindamycin, cephalexin, trimethoprim/sulfa, piperacillin-tazobactam) OR Patient is receiving omadacycline for a documented NTM/<i>Mycobacterium abscessus</i> infection in consultation with an NTM specialist

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	<p>Other indications are not approved unless prescribed by an ID physician or pulmonologist.</p> <p>PA does not expire for NTM indication. For all other indications, PA expires in 14 days.</p> <p>No renewal allowed. A new prescription will require a new PA to be submitted.</p>
<ul style="list-style-type: none"> diclofenac epolamine 1.3% patch (Licart) <p>Pain Agents: Pain Topical</p>	<p>Updates from the August 2026 meeting are in bold and strikethrough</p> <p>Manual PA is required for all new users of Licart.</p> <p><u>Manual PA Criteria:</u> Licart is approved if all criteria are met:</p> <ul style="list-style-type: none"> Patient has acute pain due to minor strains, sprains, and/or contusions Patient is 6 48 years of age or older Patient cannot tolerate an oral NSAID due to renal insufficiency, history of gastrointestinal bleed, or other adverse events OR Patient has tried and failed TWO oral NSAIDs <p>Non-FDA-approved uses are not approved.</p> <p>PA expires after 6 months.</p> <p><u>Renewal PA Criteria:</u> No renewal allowed. When the PA expires, the next fill/refill will require submission of a new PA.</p>
<ul style="list-style-type: none"> marstacimab-hncq (Hypavzi) <p>Antihemophilic Agents: Non-Factor Agents</p>	<p>Updates from the August 2026 meeting are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of Hypavzi.</p> <p><u>Manual PA criteria:</u> Hypavzi is approved if all criteria are met:</p> <ul style="list-style-type: none"> Patient is 6 42 years of age or older Prescribed by or in consultation with a hematologist Patient has hemophilia A with or without factor VIII inhibitors or hemophilia B with or without factor IX inhibitors Patient is not concurrently receiving Factor VIII or IX therapy unless for the treatment of breakthrough bleeding Medication is not being used in combination with Immune Tolerance Induction (ITI) <p>Non-FDA-approved uses are NOT approved.</p> <p>PA does not expire.</p>
<ul style="list-style-type: none"> secukinumab (Cosentyx) <p>Targeted Immunomodulatory Biologics: IL-17</p>	<p>Updates from the August 2026 meeting are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of secukinumab (Cosentyx).</p> <p><u>Manual PA Criteria:</u> Coverage is approved if <u>ALL</u> criteria are met.</p> <ul style="list-style-type: none"> Taltz is the Department of Defense's preferred IL-17. The patient must have tried Humira AND Taltz: The patient had an inadequate response to Humira AND Taltz OR the patient experienced an adverse reaction to Humira AND Taltz that is not expected to occur with the requested agent OR the patient has a contraindication to Humira AND Taltz (Note: Taltz trial not required for GPP, ERA, or HS, or pediatric psoriatic arthritis) Coverage is approved for patients 18 years of age or older with one of the following diagnosis/indications: <ul style="list-style-type: none"> Active psoriatic arthritis (PsA) Generalized pustular psoriasis (GPP) with a history of at least two GPP flares of moderate-to-severe intensity in the past Moderate to severe plaque psoriasis in patients who are candidates for systemic therapy or phototherapy Active non-radiographic axial spondyloarthritis (nr-axSpA) with objective signs of inflammation

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	<ul style="list-style-type: none"> ▪ Active ankylosing spondylitis (AS, axSpA) ▪ Moderate to severe hidradenitis suppurativa (HS) • Coverage is approved for pediatric patients with one of the following diagnosis/indications: <ul style="list-style-type: none"> ▪ Moderate to severe plaque psoriasis in patients who are candidates for systemic therapy or phototherapy (Age 6+) ▪ Enthesis-related arthritis (ERA) (Age 4+) ▪ Active psoriatic arthritis (PsA) (Age 2+) ▪ Generalized pustular psoriasis (GPP) with a history of at least two GPP flares of moderate-to-severe intensity in the past (Age 12+) ▪ Moderate to severe hidradenitis suppurativa (HS) (Age 12+) ▪ Active ankylosing spondylitis (Age 12+) • Below criteria applies to all patients unless noted: <ul style="list-style-type: none"> ▪ Patient has had an inadequate response, intolerance, or contraindication to non-biologic systemic therapy. (For example - methotrexate, aminosaliclates [e.g., sulfasalazine, mesalamine], corticosteroids, immunosuppressant's [e.g. azathioprine], antibiotics, anti-androgens, etc.) (Note: AS, nr-axSpA, ERA do not apply) ▪ Patient has had an inadequate response to at least two NSAIDs over a period of at least two months (Note: applies to AS and nr-axSpA ONLY) ▪ May not be used concomitantly with other TIBs agents, including but not limited to: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, interleukins, JAK inhibitors <p>Non-FDA-approved uses are not approved, except as noted above. Prior Authorization does not expire.</p>
<ul style="list-style-type: none"> • dupilumab (Dupixent) <p>Atopy: IL-13, IL-31</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA is required for all new users of dupilumab (Dupixent). Manual PA Criteria: Coverage is approved if all criteria are met: For Atopic Dermatitis</p> <ul style="list-style-type: none"> • The patient is at least 6 months of age or older • The drug is prescribed by a dermatologist, allergist, or immunologist • The patient has moderate to severe or uncontrolled atopic dermatitis • The patient has a contraindication to, intolerance to, or has failed treatment with one medication in each of the following categories: <ul style="list-style-type: none"> ▪ Topical Corticosteroids: <ul style="list-style-type: none"> – For patients 18 years of age or older; high potency/class 1 topical corticosteroids (e.g., clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream) – For patients 6 months to 17 years of age: any topical corticosteroid ▪ Topical calcineurin inhibitor (e.g., pimecrolimus, tacrolimus); note: not required for less than 2 years of age • The patient has a contraindication to, intolerance to, inability to access treatment, or has failed treatment with Narrowband UVB phototherapy • The patient is not currently receiving another immunobiologic (e.g., benralizumab [Fasenra], mepolizumab [Nucala], or omalizumab [Xolair]) <p>Non-FDA-approved uses are not approved Prior authorization expires after 12 months</p>

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	<p>Renewal Criteria: (Initial TRICARE PA approval is required for renewal). Coverage will be approved indefinitely for continuation of therapy if the following criteria are met:</p> <ul style="list-style-type: none"> For Atopic Dermatitis: The patient's disease severity has improved and stabilized to warrant continued therapy <p>For Asthma</p> <ul style="list-style-type: none"> The patient is 6 years of age or older The drug is prescribed by an allergist, immunologist, pulmonologist, or asthma specialist The patient has one of the following: <ul style="list-style-type: none"> Moderate to severe asthma with an eosinophilic phenotype, with baseline eosinophils ≥ 150 cells/mcL OR Oral corticosteroid-dependent asthma with at least 1 month of daily oral corticosteroid use within the past 3 months For eosinophilic asthma: <ul style="list-style-type: none"> The patient's asthma must be uncontrolled despite adherence to optimized medication therapy regimen as defined as requiring one of the following; <ul style="list-style-type: none"> Hospitalization for asthma in past year OR Two courses oral corticosteroids in past year OR Daily high-dose inhaled corticosteroids with inability to taper off of the inhaled corticosteroids The patient has tried and failed an adequate course (3months) of two of the following while using a high-dose inhaled corticosteroid: <ul style="list-style-type: none"> Long-acting beta agonist (LABA e.g., Serevent, Striverdi), Long -acting muscarinic antagonist (LAMA e.g. Spiriva, Incruse), or Leukotriene receptor antagonist (e.g., Singulair, Accolate, Zflo) For all indications, the patient is not currently receiving another immunobiologic (e.g., benralizumab [Fasenra], mepolizumab [Nucala], or omalizumab [Xolair]) <p>Non-FDA-approved uses are not approved</p> <p>Prior authorization expires after 12 months</p> <p>Renewal Criteria: (Initial TRICARE PA approval is required for renewal). Coverage will be approved indefinitely for continuation of therapy if the following criteria are met:</p> <ul style="list-style-type: none"> For Asthma: The patient's disease severity has improved and stabilized to warrant continued therapy <p>For Chronic Rhinosinusitis With Nasal Polyposis</p> <ul style="list-style-type: none"> The patient is 18 years of age or older The drug is prescribed by allergist, immunologist, pulmonologist, or otolaryngologist The patient has chronic rhinosinusitis with nasal polyposis defined by all of the following: <ul style="list-style-type: none"> Presence of nasal polyposis is confirmed by imaging or direct visualization At least two of the following: mucopurulent discharge, nasal obstruction and congestion, decreased or absent sense of smell, or facial pressure and pain Dupixent will only be used as add-on therapy to standard treatments, including nasal steroids and nasal saline irrigation
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Appendix C—Table of Prior Authorization (PA) Criteria

	<ul style="list-style-type: none"> The symptoms of chronic rhinosinusitis with nasal polyposis must continue to be inadequately controlled despite all of the following treatments: <ul style="list-style-type: none"> Adequate duration of at least TWO different high-dose intranasal corticosteroids AND Nasal saline irrigation Past surgical history or endoscopic surgical intervention or has a contraindication to surgery Patients with chronic rhinosinusitis with nasal polyposis must use only the 300 mg strength For all indications the patient is not currently receiving another immunobiologic (e.g., benralizumab [Fasenra], mepolizumab [Nucala], or omalizumab [Xolair]) <p>Non-FDA-approved uses are not approved</p> <p>Prior authorization expires after 12 months.</p> <p>Renewal Criteria: (Initial TRICARE PA approval is required for renewal). Coverage will be approved indefinitely for continuation of therapy if the following criteria are met:</p> <ul style="list-style-type: none"> For Chronic rhinosinusitis with nasal polyposis : The patient's disease severity has improved and stabilized to warrant continued therapy <p>For Eosinophilic Esophagitis (EoE)</p> <ul style="list-style-type: none"> The patient is one year of age or older and weighs at least 15 kilograms The drug is prescribed by or in consultation with a gastroenterologist, allergist, or immunologist Patient has a documented diagnosis of Eosinophilic Esophagitis (EoE) by endoscopic biopsy For EoE, the patient has tried and failed an adequate course of both the following: <ul style="list-style-type: none"> Proton pump inhibitor (PPI) at up to maximally indicated doses (adults: 20-40 mg twice daily omeprazole equivalent; children: 1-2mg/kg or equivalent), unless contraindicated or clinically significant adverse effects are experienced AND Topical glucocorticoids [e.g., fluticasone (Flovent), budesonide (Pulmicort)] at up to maximally indicated doses, unless contraindicated, clinically significant adverse effects are experienced For all indications, the patient is not currently receiving another immunobiologic (e.g., benralizumab [Fasenra], mepolizumab [Nucala], or omalizumab [Xolair]) <p>Non-FDA approved uses are not approved</p> <p>Prior authorization expires after 12 months</p> <p>Renewal Criteria: (Initial TRICARE PA approval is required for renewal). Coverage will be approved indefinitely for continuation of therapy if the following criteria are met:</p> <ul style="list-style-type: none"> For Eosinophilic Esophagitis (EoE): The patient's disease severity has improved and stabilized to warrant continued therapy <p>For Prurigo Nodularis</p> <ul style="list-style-type: none"> Patient is 18 years of age or older Dupixent is prescribed by a dermatologist, allergist, or immunologist Patient has a diagnosis of prurigo nodularis
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Appendix C—Table of Prior Authorization (PA) Criteria

	<ul style="list-style-type: none"> • Patient has 20 or more identifiable nodular lesions in total on both arms, and/or both legs, and/or trunk • Patient has experienced pruritus for 6 weeks or longer • Patient's prurigo nodularis is NOT medication-induced or secondary to a nondermatologic condition OR the patient has a secondary cause of prurigo nodularis that has been identified and adequately managed • The patient has a contraindication to, intolerance to, or has failed treatment with one high potency/class 1 topical corticosteroids (e.g., clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream) • The patient has a contraindication to, intolerance to, inability to access treatment, or has failed treatment with phototherapy • For all indications, the patient is not currently receiving another immunobiologic (e.g., benralizumab [Fasenra], mepolizumab [Nucala], or omalizumab [Xolair]) <p>Non-FDA approved uses are not approved</p> <p>Prior authorization expires after 12 months</p> <p>Renewal Criteria: (Initial TRICARE PA approval is required for renewal). Coverage will be approved indefinitely for continuation of therapy if the following criteria are met:</p> <ul style="list-style-type: none"> • For Prurigo Nodularis: The patient's disease severity has improved and stabilized to warrant continued therapy <p>For COPD</p> <ul style="list-style-type: none"> • Patient is 18 years of age or older • Prescribed by a pulmonologist • Patient has moderate to severe COPD with both chronic bronchitis and an eosinophilic phenotype (>300 cells/ul) • Patient has uncontrolled COPD symptoms despite the use of LAMA/LABA/ICS • Medication is being requested for add-on maintenance therapy for management of COPD • For all indications, the patient is not currently receiving another immunobiologic (e.g., benralizumab [Fasenra], mepolizumab [Nucala], or omalizumab [Xolair]) <p>Non-FDA-approved uses are not approved</p> <p>Prior authorization expires after 12 months</p> <p>Renewal Criteria: Note that initial TRICARE PA approval is required for renewal. Coverage will be approved indefinitely for continuation of therapy if all the criteria are met:</p> <ul style="list-style-type: none"> • For COPD: Patient's disease severity has improved and stabilized to warrant continued therapy <p>For Chronic Spontaneous Urticaria</p> <ul style="list-style-type: none"> • Patient is 42 years of age or older • Prescribed by an allergist, immunologist or dermatologist • Patient has a diagnosis of chronic spontaneous urticaria with symptoms lasting greater than 6 weeks • Patient remains symptomatic despite trial of at least 4 weeks with recommended urticarial dosing up to 4 times standard dose of a second generation H1 antihistamine (i.e., cetirizine, levocetirizine, loratadine, desloratadine, fexofenadine)
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Appendix C—Table of Prior Authorization (PA) Criteria

	<ul style="list-style-type: none"> For all indications, the patient is not currently receiving another immunobiologic (e.g., benralizumab [Fasenra], mepolizumab [Nucala], or omalizumab [Xolair]) <p>Non-FDA approved uses are not approved</p> <p>PA expires following 12 months</p> <p>Renewal Criteria: Note that initial TRICARE PA approval is required for renewal. Coverage will be approved indefinitely for continuation of therapy if all the criteria are met:</p> <ul style="list-style-type: none"> For Chronic Spontaneous Urticaria: Patient's disease severity has improved and stabilized to warrant continued therapy <p>For Bullous Pemphigoid</p> <ul style="list-style-type: none"> Patient is 18 years of age or older Prescribed by a dermatologist, allergist, or immunologist Patient has a confirmed diagnosis of bullous pemphigoid Patient has an initial bullous pemphigoid disease area index (BPDAI) score ≥ 24 Patient has an initial Peak Pruritus Numeric Rating Scale score of ≥ 4 The patient has a contraindication to, intolerance to, or has failed treatment with all the following: <ul style="list-style-type: none"> One high potency/class 1 topical corticosteroid (e.g., clobetasol propionate 0.05% ointment/cream) One oral corticosteroid (e.g., prednisone, prednisolone) Two additional adjuncts (e.g., methotrexate, azathioprine, mycophenolate, cyclophosphamide, doxycycline) For all indications, the patient is not currently receiving another immunobiologic (e.g., benralizumab [Fasenra], mepolizumab [Nucala], or omalizumab [Xolair]) <p>Non-FDA approved uses are not approved</p> <p>PA expires following 12 months</p> <p>Renewal Criteria: (Note that initial TRICARE PA approval is required for renewal.) Coverage will be approved indefinitely for continuation of therapy if all the criteria are met:</p> <ul style="list-style-type: none"> For Bullous Pemphigoid: Patient's disease severity has improved and stabilized to warrant continued therapy
<ul style="list-style-type: none"> efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo) <p>Neurologic Agents Miscellaneous</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of efgartigimod alfa and hyaluronidase-qvfc (Vyvgart Hytrulo)</p> <p><u>Manual PA Criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> Patient is 18 years of age or older Prescribed by a neurologist Patient is being treated for chronic inflammatory demyelinating polyneuropathy OR Patient is being treated for generalized myasthenia gravis (gMG) that is anti-acetylcholine receptor (AChR) antibody positive For patients being treated for generalized myasthenia gravis: <ul style="list-style-type: none"> Patient had insufficient response or intolerance to pyridostigmine AND

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	<ul style="list-style-type: none"> ▪ Patient had insufficient response or intolerance to glucocorticoid sparing therapy such as azathioprine, mycophenolate, cyclosporine, or tacrolimus AND • Patient is not receiving concomitant neonatal Fc receptor antagonists or other C5 inhibitors with Vyvgart Hytrulo including but not limited to the following: efgartigimod injection for intravenous use (Vyvgart), eculizumab (Soliris), ravulizumab (Ultomiris), rozanolixizumab (Rystiggo), zilucoplan (Zilbrysq) <p>Non-FDA approved uses are not approved</p> <p>PA expires in 6 months</p> <p><u>Renewal Criteria:</u> (Initial TRICARE PA approval required for renewal) Coverage will be approved indefinitely if the following applies:</p> <ul style="list-style-type: none"> • The patient's disease severity has improved and stabilized to warrant continued therapy.
<ul style="list-style-type: none"> • ustekinumab-aaaz (unbranded) • ustekinumab-hmny (Starjemza) • ustekinumab-srlf (Imuldosa) <p>Targeted Immunomodulatory Biologics: IL-23</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of ustekinumab-aaaz (unbranded Otulfi); ustekinumab-hmny (Starjemza); ustekinumab-srlf (Imuldosa)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • The provider acknowledges that the step-preferred product branded Otulfi is TRICARE's preferred ustekinumab product • The patient had an inadequate response to Humira OR the patient experienced an adverse reaction to Humira that is not expected to occur with ustekinumab OR the patient has a contraindication to Humira • Please provide a patient-specific justification as to why the step-preferred branded Otulfi cannot be used in this patient. <ul style="list-style-type: none"> ▪ Acceptable reasons include the patient has an allergy to an inactive ingredient found in the step-preferred product that is not in the non-step-preferred product • Patients may have used infliximab in lieu of Humira for UC and CD • Coverage approved for patients 18 years of age or older with: <ul style="list-style-type: none"> ▪ Active psoriatic arthritis ▪ Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy ▪ Moderately to severely active Crohn's disease (CD) ▪ Moderately to severely ulcerative colitis (UC) • Coverage approved for pediatric patients ages 6 to 17 years with: <ul style="list-style-type: none"> ▪ Active psoriatic arthritis (ages 6 and older) ▪ Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy (ages 6 and older) ▪ Moderately to severely active Crohn's disease (ages 2 and older) • The criteria below apply to all patients unless noted: <ul style="list-style-type: none"> ▪ Patient has had an inadequate response, intolerance, or contraindication to nonbiologic systemic therapy (for example – methotrexate, aminosaliclates (e.g., sulfasalazine, mesalamine), corticosteroids, immunosuppressants (e.g., azathioprine). (Note: Does not apply to CD, UC) ▪ Coverage is NOT provided for concomitant use with other TIBs including, but not limited to TNF inhibitors, interleukins, JAK inhibitors

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	<p>Non-FDA approved uses are not approved</p> <p>PA does not expire</p>
<ul style="list-style-type: none"> ustekinumab-ttwe (Pyzchiva) ustekinumab-aekn (Selarsdi) ustekinumab (Stelara) ustekinumab (unbranded Stelara) ustekinumab-stba (Steqeyma) ustekinumab-auub (Wezlana) ustekinumab-kfce (Yesintek) <p>Targeted Immunomodulatory Biologics: IL-23</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of (NF non-step-preferred products)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> The provider acknowledges that the step-preferred product branded Otulfi is TRICARE's preferred ustekinumab product, and ustekinumab-aauz (unbranded Otulfi); ustekinumab-hmny (Starjemza); ustekinumab-srlf (Imuldosa) are also Uniform Formulary The patient had an inadequate response to Humira OR the patient experienced an adverse reaction to Humira that is not expected to occur with ustekinumab OR The patient has a contraindication to Humira Please provide a patient-specific justification as to why the step-preferred product branded Otulfi and the UF non-step-preferred products ustekinumab-aauz (unbranded Otulfi); ustekinumab-hmny (Starjemza); ustekinumab-srlf (Imuldosa) cannot be used in this patient. <ul style="list-style-type: none"> Acceptable reasons include the patient has an allergy to an inactive ingredient found in the Otulfi and ustekinumab-aauz (unbranded Otulfi); ustekinumab-hmny (Starjemza); ustekinumab-srlf (Imuldosa) that is not in the nonformulary non-step-preferred product Patients may have used infliximab in lieu of Humira for UC and CD Coverage approved for patients 18 years of age or older with: <ul style="list-style-type: none"> Active psoriatic arthritis Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy Moderately to severely active Crohn's disease (CD) Moderately to severely ulcerative colitis (UC) Coverage approved for pediatric patients ages 6 to 17 years with: <ul style="list-style-type: none"> Active psoriatic arthritis (ages 6 and older) Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy (ages 6 and older) Moderately to severely active Crohn's disease (ages 2 and older) The criteria below apply to all patients unless noted: <ul style="list-style-type: none"> Patient has had an inadequate response, intolerance, or contraindication to nonbiologic systemic therapy (for example – methotrexate, aminosaliclates (e.g., sulfasalazine, mesalamine), corticosteroids, immunosuppressants (e.g., azathioprine). (Note: Does not apply to CD, UC) Coverage is NOT provided for concomitant use with other TIBs including, but not limited to TNF inhibitors, interleukins, JAK inhibitors <p>Non-FDA approved uses are not approved</p> <p>PA does not expire</p>

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<ul style="list-style-type: none"> risankizumab (Skyrizi) pens, syringes <p>Targeted Immunomodulatory Biologics: IL-23</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of risankizumab (Skyrizi)</p> <p><u>Manual PA Criteria:</u> Coverage is approved if ALL criteria are met:</p> <ul style="list-style-type: none"> Provider acknowledges that ustekinumab-aauz (Otulfi) is TRICARE's step-preferred IL-23 The patient has a contraindication or has had an inadequate response to Otulfi OR has had an adverse reaction to Otulfi that is not expected with the requested non-step-preferred TIB AND The patient has a contraindication or has had an inadequate response to Humira OR has had an adverse reaction to Humira that is not expected with the requested non-step-preferred TIB AND Patient is 18 6 years or older with the following diagnosis/indication: <ul style="list-style-type: none"> Active psoriatic arthritis (PsA) Moderate to severe plaque psoriasis (PsO) who are candidates for systemic therapy or phototherapy Patient has tried and had an inadequate response, intolerance, or contraindication to non-biologic systemic therapy (e.g., methotrexate, aminosaliclates [e.g., sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. azathioprine]) Coverage NOT provided for concomitant use with other TIBs, including but not limited to the following: TNF inhibitors, interleukins, JAK inhibitors <p>Providers should fill out the PA for Skyrizi pen and syringes for plaque psoriasis or psoriatic arthritis. Use of the on-body injector is limited to Crohn's disease or ulcerative colitis.</p> <p>Non-FDA approved uses are not approved.</p> <p>PA does not expire.</p>
<ul style="list-style-type: none"> sparsentan (Filspari) <p>Nephrology Agents Miscellaneous</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of sparsentan (Filspari)</p> <p><u>Manual PA Criteria:</u> Coverage is approved if ALL criteria are met:</p> <ul style="list-style-type: none"> Filspari is prescribed by a nephrologist, a physician specializing in nephrology Provider acknowledges that Filspari is only available through a REMS program due to the risk of hepatotoxicity and embryo-fetal toxicity, and will follow the monitoring requirements The patient is not receiving concomitant renin-angiotensin-aldosterone system inhibitors (for example ACE-inhibitors or ARBs such as irbesartan, telmisartan, losartan; or spironolactone), endothelin receptors antagonists (for example ambrisentan or bosentan) or aliskiren) The medication will not be used concurrently with iptacopan (Fabhalta) or (atrasentan) Vanrafia Patient is not currently receiving dialysis or has not undergone kidney transplant • Patient is 18 years of age or older The patient has a diagnosis of biopsy-verified primary immunoglobulin A nephropathy (IgAN) without cellular crescents in more than 25% of sampled glomeruli <ul style="list-style-type: none"> Patient is 18 years of age or older Patient has a UPCR greater than or equal to 1.0 g/gram Patient has an eGFR greater than or equal to 30 mL/min

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	<ul style="list-style-type: none"> • Patient is not currently receiving dialysis or has not undergone kidney transplant ▪ Patient has not received immunosuppressants, including corticosteroids, in the past 2 weeks and is not expected to need immunosuppressants in the next 6 months ▪ Patient has continued to have proteinuria despite maximal ACE-inhibitor or ARB therapy for at least six months prior to the start of therapy and is at high risk for disease progression • OR The patient has a diagnosis of focal segmental glomerulosclerosis (FSGS) <ul style="list-style-type: none"> ▪ Patient is 8 years of age or older ▪ Disease is biopsy confirmed OR ▪ Patient has a genetic variant associated with the disease AND ▪ Patient does not have nephrotic syndrome (as defined by a current proteinuria > 3.5 g/day for adults or ≥ 2 g/g for patients < 18 years of age and serum albumin < 30 g/L with or without edema) AND ▪ Patient has a UPCR greater than or equal to 1.5 g/gram AND ▪ Patient has an eGFR greater than or equal to 30 mL/min ▪ Patient has continued to have proteinuria despite maximal ACE-inhibitor or ARB therapy for at least six months prior to the start of therapy and is at high risk for disease progression • The patient's baseline liver aminotransferase (AST and ALT) levels are not elevated to greater than 3 times the upper limit of normal • If patient is a female of child-bearing age, the patient must be tested for pregnancy before, during and 1 month after treatment discontinuation • If patient can become pregnant, they will use effective contraception before starting treatment, during and for month after treatment <p>Non-FDA approved uses are not approved, including IgAN due to systemic lupus erythematosus, liver cirrhosis, Henoch-Schonlein purpura, or pulmonary arterial hypertension or FSGS</p> <p>PA expires in 9 months</p> <p><u>Renewal Criteria:</u> Coverage will be approved indefinitely if all the following apply</p> <ul style="list-style-type: none"> • Patient has had a response to Filspari defined by: <ul style="list-style-type: none"> ▪ reduction in urine protein-to-creatinine ratio from baseline OR ▪ reduction in proteinuria from baseline. • Patient's eGFR rate is greater than or equal to 30 mL/min/1.73 m² • Filspari is not being used in combination with any RAAS blocker (e.g., ACE-Is, ARB), endothelin receptor antagonist, or aliskiren, atrasentan (Vanrafia), or iptacopan (Fabhalta)
<ul style="list-style-type: none"> • olezarsen (Tryngolza) <p>Antilipidemics-2 Agents</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of olezarsen</p> <p><u>Manual PA Criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Patient is 18 years of age or older

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	<ul style="list-style-type: none"> • Prescribed by cardiologist, an endocrinologist, or an internal medicine physician experienced in treating disorders related to severe hypertriglyceridemia • Patient has Familial Chylomicronemia Syndrome (FCS) <ul style="list-style-type: none"> ▪ Patient has undergone genetic testing to confirm the diagnosis of familial chylomicronemia syndrome or patient has evidence of symptomatic persistent chylomicronemia with recurrent pancreatitis ▪ Patient has fasting triglyceride level of 880 mg/dL or greater • OR Patient has severe hypertriglyceridemia at high risk of acute pancreatitis <ul style="list-style-type: none"> ▪ Patient has a triglyceride level of 500 mg/dL or greater despite being on maximally tolerated lipid-lowering therapy (i.e. high intensity statin, fibrate, PCSK9, omega-3 fatty acid) ▪ Patient does not have Familial Chylomicronemia Syndrome (FCS) • Patient will adhere to a low fat-diet (less than or equal to 20 g fat per day) while receiving Tryngolza • Patient has tried and failed therapy with plogasiran (Redemplo) • Patient will not take concurrently with plogasiran (Redemplo) <p>Non-FDA approved uses are not approved PA does not expire</p>
<ul style="list-style-type: none"> • setmelanotide (Imcivree) <p>Metabolic Agents: Miscellaneous</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of Imcivree</p> <p><u>Manual PA criteria:</u> Imcivree is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Patient is 2 years of age or older <ul style="list-style-type: none"> ▪ Patient has a confirmed diagnosis (via genetic testing) of POMC-, PCSK1-, or LEPR-deficiency that are interpreted as pathogenic, likely pathogenic, or of uncertain significance (VUS) Patient has monogenic or syndromic obesity due to Bardet-Beidl syndrome (BBS) <p>OR</p> <ul style="list-style-type: none"> • Patient is 4 years of age or older <ul style="list-style-type: none"> ▪ Patient has Acquired Hypothalamic Obesity following a hypothalamic tumor, hypothalamic lesion, or hypothalamic damage or injury • Patient and provider agree to evaluate weight loss after 12-16 weeks of treatment. NOTE - Imcivree should be discontinued if a patient has not lost at least 5% of baseline body weight, or 5% of baseline BMI for patients with continued growth potential <p>Non-FDA approved uses are not approved including Alström Syndrome, POMC-, PCSK1-, or LEPR-deficiency with POMC, PCSK1, or LEPR variants classified as benign or likely benign, other types of obesity not related to POMC, PCSK1 or LEPR deficiency, BBS, including obesity associated with other genetic syndromes and general (polygenic) obesity</p> <p>Initial prior authorization expires in 4 months</p> <p><u>Renewal criteria:</u> Note that initial TRICARE PA approval is required for renewal. Imcivree is approved for 1 year for continuation of therapy for POMC-, PCSK1-, or LEPR deficiency, BBS, or acquired hypothalamic obesity if all criteria are met:</p>

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	<ul style="list-style-type: none"> The patient has a documented improvement (a decrease from baseline) in at least 5% of baseline body weight, or 5% of baseline BMI for patients with continued growth potential
<ul style="list-style-type: none"> capivasertib (Truqap) <p>Breast Cancer Agents PIK3CA</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of capivasertib (Truqap)</p> <p><u>Manual PA Criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> Patient is 18 years of age or older The drug is prescribed by or in consultation with hematologist or oncologist Patient has advanced or metastatic HR-positive, HER2-negative breast cancer Patient has PIK3CA/AKT1/PTEN-alterations as detected by an FDA-approved test Patient has tried and failed, or is not a candidate for, adjuvant or neoadjuvant chemotherapy Patient had disease progression while on or after endocrine therapy Patient will be receiving fulvestrant injection (Faslodex) therapy along with capivasertib (Truqap) OR Patient has metastatic prostate cancer with PTEN-deficiency AND Truqap will be given with abiraterone and prednisone The diagnosis is NOT listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. To facilitate approval please list the diagnosis, guidelines version and page number _____. The diagnosis must be listed. Provider is aware of all monitoring requirements and screening precautions <p>Other non-FDA approved uses are NOT approved except as noted above</p> <p>PA does not expire</p>
<ul style="list-style-type: none"> dextromethorphan/ bupropion (Auvelity) <p>Antidepressants and Non-Opioid Pain Syndrome Agents</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA is required for all new users of Auvelity</p> <p><u>Manual PA Criteria:</u> Auvelity is approved if all criteria are met:</p> <ul style="list-style-type: none"> The patient is 18 years of age or older The patient does not have a history of seizure disorder or conditions that increase the risk of seizure (for example; bulimia, anorexia nervosa, severe head injury) The patient is being treated for depression or Alzheimer's disease agitation If used for depression, the following applies: <ul style="list-style-type: none"> The provider acknowledges that they discussed with the patient that non-pharmacologic interventions (for example: CBT, sleep hygiene) are encouraged to be used in conjunction with this medication The patient tried and failed generic extended-release bupropion HCL at maximally tolerated dose The patient have a contraindication to, intolerance to, or have they failed a trial of TWO other formulary antidepressant medications [for example: for selective serotonin reuptake inhibitor (SSRI) (citalopram, escitalopram, fluoxetine), for serotonin-norepinephrine reuptake inhibitor (SNRI) (venlafaxine IR,

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	<p>venlafaxine ER, desvenlafaxine succinate ER)] (note: failure of medication is defined as a minimum treatment duration of 4-6 weeks at maximally tolerated dose</p> <ul style="list-style-type: none"> • If used for agitation due to Alzheimer's disease or dementia the following applies: <ul style="list-style-type: none"> ▪ Other causes of agitation have been ruled out or treated ▪ Non-pharmacological management of agitation has failed ▪ The provider acknowledges that this medication will not be prescribed for prn use ▪ Concomitant use with brexpiprazole (Rexulti) is not allowed <p>Non-FDA-approved uses are not approved Prior authorization does not expire</p>
<ul style="list-style-type: none"> • selinexor (Xpovio) <p>Oncological Agents: Multiple Myeloma</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of selinexor (Xpovio). <u>Manual PA criteria:</u> Xpovio is approved if <u>ALL</u> criteria are met:</p> <ul style="list-style-type: none"> • Patient is greater than or equal to 18 years of age • Prescribed by or in consultation with an oncologist/hematologist • Patient has: <ul style="list-style-type: none"> ▪ Relapsed or refractory multiple myeloma (RRMM) who have received at least four prior therapies and whose disease is refractory to at least two proteasome inhibitors, at least two immunomodulatory agents, and an anti-CD38 monoclonal antibody AND patient will use Xpovio in combination with dexamethasone OR ▪ Relapsed or refractory diffuse large B-cell lymphoma (DLBCL), not otherwise specified, including DLBCL arising from follicular lymphoma, after at least 2 lines of systemic therapy OR ▪ Multiple myeloma who have received at least one prior therapy AND patient will use Xpovio in combination with bortezomib (Velcade) and dexamethasone OR • The diagnosis is NOT listed above but IS cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation: to facilitate approval, please list the diagnosis, guideline version, and page number_____. <p>Non-FDA approved uses are not approved, except as noted above PA does not expire</p>
<ul style="list-style-type: none"> • meclizine 25 mg chewable tablet (Antivert) <p>Antiemetic- Antivertigo Agents</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to new and current users of meclizine 25 mg chewable tablet (Antivert). <u>Manual PA Criteria:</u> Meclizine 25 mg chewable tablet (Antivert) is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Provider is aware and acknowledges that meclizine 25 mg tablet is available to Tricare beneficiaries without the need of prior authorization, and is encouraged to consider changing the prescription to the preferred meclizine 25 mg tablet • The provider must explain why the patient requires meclizine 25 mg chewable tablet (Antivert) and cannot take the cost-effective meclizine 25 mg tablet (fill-in blank) <ul style="list-style-type: none"> ▪ Acceptable responses include the following the patient's medical history includes trial and failure of the tablet form of meclizine 25 mg patient has documented swallowing

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	<p>dysfunction requiring an alternative formulation for treatment AND the patient has experienced a serious allergic reaction (i.e., hives/anaphylaxis) to one or more inactive ingredients in currently available OTC meclizine 25 mg chewable tablets.</p> <p>Non-FDA-approved uses are not approved.</p> <p>Prior authorization does not expire</p>
<ul style="list-style-type: none"> nemolizumab (Nemluvio) <p>Atopy: IL-13, 31</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of nemolizumab (Nemluvio)</p> <p><u>Manual PA Criteria:</u> Nemluvio is approved if all criteria are met:</p> <p>For Prurigo Nodularis:</p> <ul style="list-style-type: none"> Patient is 18 years of age or older Nemluvio is prescribed by an allergist, immunologist, or dermatologist Patient has a diagnosis of prurigo nodularis Patient has 20 or more identifiable nodular lesions in total on both arms, and/or both legs, and/or trunk Patient has experienced pruritus for 6 weeks or longer Patient's prurigo nodularis is not medication induced or secondary to a non-dermatologic condition OR the patient has a secondary cause of prurigo nodularis that has been identified and adequately managed The patient has a contraindication to, intolerability to, or has failed treatment with one high potency/class 1 topical corticosteroids (e.g., clobetasol propionate 0.05% ointment/cream, fluocinonide 0.05% ointment/cream) The patient has a contraindication to, intolerability to, inability to access treatment, or has failed treatment with phototherapy For all indications, the patient is not currently receiving another immunobiologic (e.g., benralizumab [Fasenra], mepolizumab [Nucala], or omalizumab [Xolair]) <p>Non-FDA approved uses are not approved</p> <p>PA expires in 12 months</p> <p><u>Renewal Criteria:</u> (Initial TRICARE PA approval is required for renewal). Coverage will be approved indefinitely for continuation of therapy if the following criteria are met:</p> <ul style="list-style-type: none"> For Prurigo Nodularis: The patient's disease severity has improved and stabilized to warrant continued therapy
<ul style="list-style-type: none"> plozasiran (Redemplo) <p>Antilipidemics-2 Agents</p>	<p>Updates from August 2026 are in bold</p> <p>Manual PA criteria apply to all new users of plozasiran</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> Patient is 18 years of age or older Prescribed by cardiologist, an endocrinologist, or an internal medicine physician experienced in disorders related to severe hypertriglyceridemia Patient has undergone genetic testing to confirm the diagnosis of familial chylomicronemia syndrome OR Patient has evidence of symptomatic persistent chylomicronemia with recurrent pancreatitis Patient has a fasting triglyceride level of 880 or greater

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	<ul style="list-style-type: none"> • Patient will adhere to a low fat-diet (less than or equal to 20 g fat per day) while receiving Redemplo • Patient will not take concurrently with olesarsen (Tryngolza) <p>Non-FDA approved uses are not approved</p> <p>PA does treating not expire</p>
<ul style="list-style-type: none"> • prucalopride (Motegrity) <p>Gastrointestinal-2 Agents CIC and IBS-C</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new and current users of Motegrity</p> <p><u>Manual PA Criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Patient is 18 years of age or older • Patient has tried and failed all formulary agents including Amitiza, Linzess, and Trulance • Patient has documented symptoms for ≥ 3 months • Patient has diagnosis of chronic idiopathic constipation (CIC) • Patient does not have a GI obstruction • Patient has no history of suicidal ideation • Patient has low cardiovascular risk • Patient has documentation of failure of an increase in dietary fiber/dietary modification • Patient has tried at least 2 standard laxative classes or has an intolerance or FDA-labeled contraindication to at least 2 standard laxative classes defined as <ul style="list-style-type: none"> ▪ Osmotic laxative (e.g., lactulose, sorbitol, magnesium [Mg] citrate, Mg hydroxide, glycerin rectal suppositories) ▪ Bulk forming laxative (e.g., psyllium, oxidized cellulose, calcium polycarbophil) with fluids; ▪ Stool softener (e.g., docusate); ▪ Stimulant laxative (e.g., bisacodyl, sennosides) • Patient is not taking any of these agents secretagogues or peripherally acting mu-opioid receptor antagonists concomitantly (Amitiza, Linzess, Trulance, Ibsrela, Symproic, Relistor, Movantik) <p>Non-FDA-approved uses are not approved.</p> <p>Initial Expiration date: 1 year; Renewal PA (continuation): 1 year</p> <p>Prior authorization expires after 12 months.</p> <p><u>Renewal PA Criteria:</u> Renewal PA criteria will be approved indefinitely Motegrity will be approved for an additional 12 months if the following are met:</p> <ul style="list-style-type: none"> • Patient has had improvement in constipation symptoms • Patient is not taking any of these agents secretagogues or peripherally acting mu-opioid receptor antagonists concomitantly (Amitiza, Linzess, Trulance, Ibsrela, Symproic, Relistor, Movantik) • Patients are monitored for suicidal risk
<ul style="list-style-type: none"> • plecanatide (Trulance) <p>Gastrointestinal-2 Agents CIC and IBS-C</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of Trulance</p> <p><u>Manual PA Criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Patient is 18 years of age or older • Patient has documented symptoms for ≥ 3 months

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	<ul style="list-style-type: none"> • Patient has diagnosis of IBS-C or CIC • Patient has absence of GI obstruction • Patient has documentation of failure of an increase in dietary fiber/dietary modification • Patient has tried at least 2 standard laxative classes or has an intolerance or FDA-labeled contraindication to at least 2 standard laxative classes, defined as <ul style="list-style-type: none"> ▪ Osmotic laxative (e.g., lactulose, sorbitol, magnesium [Mg] citrate, Mg hydroxide, glycerin rectal suppositories) ▪ Bulk forming laxative (e.g., psyllium, oxidized cellulose, calcium polycarbophil) with fluids ▪ Stool softener (e.g., docusate) ▪ Stimulant laxative (e.g., bisacodyl, sennosides) • Patient is not taking any of these agents other prokinetics, secretagogues or peripherally acting mu-opioid receptor antagonists concomitantly (Trulance, Amitiza, Linzess, Symproic, Relistor, or Movantik) <p>Non-FDA-approved uses are NOT approved.</p> <p>Prior authorization expires after 1 year.</p> <p><u>Renewal PA Criteria:</u> Renewal PA criteria will be approved indefinitely if the following are met:</p> <p>Coverage will be approved for 1 year for continuation of therapy if:</p> <ul style="list-style-type: none"> • Patient has had improvement in constipation symptoms and • Patient is not taking other prokinetics, secretagogues or peripherally acting mu-opioid receptor antagonists any of these agents concomitantly (Amitiza, Linzess, Symproic, Trulance, Relistor, or Movantik)
<ul style="list-style-type: none"> • Tenapanor (Ibsrela) <p>Gastrointestinal-2 Agents CIC and IBS-C</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of Ibsrela.</p> <p><u>Manual PA criteria:</u> Ibsrela is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Patient is 18 years of age or older • Patient has had documented symptoms for ≥ 3 months • Patient has diagnosis of IBS-C • Patient has tried and failed all formulary agents including Linzess, Amitiza, and Trulance • Patient does not have GI obstruction • Patient has documentation of failure of an increase in dietary fiber/dietary modification • Patient has tried at least 2 standard laxative classes or has an intolerance or FDA labeled contraindication to at least 2 standard laxative classes defined as: <ul style="list-style-type: none"> ▪ Osmotic laxative (e.g., lactulose, sorbitol, magnesium [Mg] citrate, Mg hydroxide, glycerin rectal suppositories) ▪ Bulk forming laxative (e.g., psyllium, oxidized cellulose, calcium polycarbophil) with fluids; ▪ Stool softener (e.g., docusate) ▪ Stimulant laxative (e.g., bisacodyl, sennosides) • Patient is not taking other prokinetics, secretagogues or peripherally acting mu-opioid receptor antagonists concomitantly any of these

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	<p>agents concomitantly (Amitiza, Linzess, Trulance, Zelnorm, Motegrity, Symproic, Relistor, or Movantik)</p> <p>Non-FDA-approved uses are not approved including opioid-induced constipation (OIC), chronic idiopathic constipation (CIC), and hyperphosphatemia.</p> <p>Prior authorization expires in 1 year.</p> <p>Renewal criteria: (Initial TRICARE PA approval required for renewal)</p> <p>Coverage will be approved for an additional year if both of the following applies:</p> <ul style="list-style-type: none"> • Patient has had improvement in constipation symptoms • Patient is not taking other prokinetics, secretagogues or peripherally acting mu-opioid receptor antagonists concomitantly any of these agents concomitantly (Amitiza, Linzess, Trulance, Zelnorm, Motegrity, Symproic, Relistor, or Movantik)
<ul style="list-style-type: none"> • naloxegol (Movantik) <p>Gastrointestinal-2 Agents Opioid Induced Constipation</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to new users of Movantik</p> <p><u>Manual PA Criteria:</u> Approved if all criteria are met:</p> <ul style="list-style-type: none"> • The patient is 18 years of age or older with a diagnosis of opioid-induced constipation (OIC) AND • The patient is currently taking an opioid agonist AND • The patient is not on other opioid antagonists (naloxone not including rescue agents, naltrexone, etc.) AND • The patient has either failed or not tolerated two or more of the following: <ul style="list-style-type: none"> ▪ At least one stimulant laxative (sennosides or bisacodyl) AND ▪ At least one osmotic laxative (Miralax, lactulose, or magnesium citrate) AND • The patient does not have a known or suspected gastrointestinal obstruction or is not at increased risk of recurrent obstruction AND • The patient is not currently on strong CYP3A4 inducers/inhibitors (e.g., clarithromycin, ketoconazole) AND • The patient is not taking other prokinetics, secretagogues or peripherally acting mu-opioid receptor antagonists concomitantly <p>Non-FDA-approved uses are not approved</p> <p>Prior authorization expires in 1 year</p> <p><u>Renewal PA Criteria:</u> Coverage will be approved for an additional year if all of the following apply:</p> <ul style="list-style-type: none"> • The patient continues to take opioids AND • The patient continues lifestyle modifications including regular use of a stimulant laxative (e.g. bisacodyl, senna), a high fiber diet, increased fluid intake, moderate exercise and opioid dose de-escalation to minimum effective dose AND • The patient is responding in a meaningful manner (e.g. improvement of at least 1 additional spontaneous bowel movement per week over baseline) AND • The patient is not taking other prokinetics, secretagogues or peripherally acting mu-opioid receptor antagonists concomitantly

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<ul style="list-style-type: none"> • naldemedine (Symproic) <p>Gastrointestinal-2 Agents Opioid Induced Constipation</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to new users of Symproic</p> <p><u>Manual PA Criteria:</u> Approved if all criteria are met:</p> <ul style="list-style-type: none"> • The patient is 18 years of age or older with a diagnosis of opioid-induced constipation (OIC) AND • The patient is currently taking an opioid agonist AND • The patient is not on other opioid antagonists (naloxone not including rescue agents, naltrexone, etc.) AND • The patient has either failed or not tolerated two or more of the following: <ul style="list-style-type: none"> ▪ At least one stimulant laxative (sennosides or bisacodyl) AND ▪ At least one osmotic laxative (Miralax, lactulose, or magnesium citrate) AND • The patient does not have a known or suspected gastrointestinal obstruction or is not at increased risk of recurrent obstruction AND • The patient is not currently on strong CYP3A4 inducers/inhibitors (e.g., clarithromycin, ketoconazole) AND • The patient is not taking other prokinetics, secretagogues or peripherally acting mu-opioid receptor antagonists concomitantly • Non-FDA-approved uses are not approved. Prior authorization expires in 1 year <p><u>Renewal PA Criteria:</u> Coverage will be approved for an additional year if all of the following apply:</p> <ul style="list-style-type: none"> • The patient continues to take opioids AND • The patient continues lifestyle modifications including regular use of a stimulant laxative (e.g. bisacodyl, senna), a high fiber diet, increased fluid intake, moderate exercise and opioid dose de-escalation to minimum effective dose AND • The patient is responding in a meaningful manner (e.g. improvement of at least 1 additional spontaneous bowel movement per week over baseline) AND • The patient is not taking other prokinetics, secretagogues or peripherally acting mu-opioid receptor antagonists concomitantly
<ul style="list-style-type: none"> • methylnaltrexone (Relistor) <p>Gastrointestinal-2 Agents Opioid Induced Constipation</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to new users of Relistor tablets. PA is not required for Relistor injection.</p> <p><u>Manual PA Criteria:</u> Approved if all criteria are met:</p> <ul style="list-style-type: none"> • The patient is 18 years of age or older with a diagnosis of opioid-induced constipation (OIC) AND • The patient is currently taking an opioid agonist AND the patient is not on other opioid antagonists (naloxone not including rescue agents, naltrexone, etc.) AND • The patient has either failed or not tolerated two or more of the following: <ul style="list-style-type: none"> ▪ At least one stimulant laxative (sennosides or bisacodyl) AND ▪ At least one osmotic laxative (Miralax, lactulose, or magnesium citrate) AND • The patient has tried and failed naloxegol (Movantik) AND • The patient has tried and failed naldemedine (Symproic) AND • The patient has tried and failed lubiprostone (Amitiza) AND

Appendix C—Table of Prior Authorization (PA) Criteria

	<ul style="list-style-type: none"> The patient does not have a known or suspected gastrointestinal obstruction or is not at increased risk of recurrent obstruction AND The patient is not currently on strong CYP3A4 inducers/inhibitors (e.g., clarithromycin, ketoconazole) AND The patient is not taking other prokinetics, secretagogues or peripherally acting mu-opioid receptor antagonists concomitantly <p>Non-FDA-approved uses are not approved</p> <p>Prior authorization expires in 1 year</p> <p><u>Renewal PA Criteria:</u> Coverage will be approved for an additional year if <u>all</u> of the following apply:</p> <ul style="list-style-type: none"> The patient continues to take opioids AND The patient continues lifestyle modifications including regular use of a stimulant laxative (e.g. bisacodyl, senna), a high fiber diet, increased fluid intake, moderate exercise and opioid dose de-escalation to minimum effective dose AND The patient is responding in a meaningful manner (e.g. improvement of at least 1 additional spontaneous bowel movement per week over baseline) AND The patient is not taking other prokinetics, secretagogues or peripherally acting mu-opioid receptor antagonists concomitantly
<ul style="list-style-type: none"> sotatercept-csrk (Winrevair) <p>Pulmonary Arterial Hypertension</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p><u>Automated PA Criteria:</u> When the patient is 18 years or older and when prescribed by a pulmonologist, cardiologist, cardiac transplant surgeon, or cardiothoracic transplant surgeon prior authorization is not required</p> <p>Manual PA criteria apply to all new users of sotatercept-csrk (Winrevair)</p> <p><u>Manual PA criteria :</u> Coverage is approved if</p> <ul style="list-style-type: none"> Patient is 18 years of age or older Prescribed by or in consultation with cardiologist or pulmonologist Patient has documented diagnosis of WHO group 1 PAH Patient has WHO functional class II, or III PAH, or IV PAH Patient has had right heart catheterization Documentation provided to confirm patient has had right heart catheterization and confirms diagnosis of WHO Group 1 PAH Documentation is provided to confirm the patient is on stable background therapy for PAH (i.e., monotherapy, double therapy, triple therapy) Females of childbearing potential must use contraception up to 4 months after the last dose <p>Non-FDA approved uses are not approved</p> <p>PA does not expire</p>
<ul style="list-style-type: none"> niraparib (Zejula) <p>Breast Cancer Agents Polyadenosine Diphosphate-Ribose Polymerase (PARP) Inhibitors</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of Zejula.</p> <p><u>Manual PA Criteria:</u> Coverage will be approved if all criteria are met:</p> <ul style="list-style-type: none"> Zejula is prescribed by or in consultation with a hematologist/oncologist Patient is 18 years of age or older Niraparib will be prescribed as a maintenance therapy for one of the following diagnoses: <ul style="list-style-type: none"> The patient has a diagnosis of advanced epithelial ovarian, fallopian tube, or primary peritoneal cancer and whose cancer is

Appendix C—Table of Prior Authorization (PA) Criteria

	<p>associated with homologous recombination deficiency (HRD)-positive status defined by either AND</p> <ul style="list-style-type: none"> • A deleterious or suspected deleterious BRCA mutation OR Genetic instability • Deleterious or suspected deleterious germline BRCA mutated recurrent epithelial ovarian, fallopian tube, or primary peritoneal cancer <ul style="list-style-type: none"> • Zejula is being prescribed as first-line maintenance therapy and was in objective response (partial or complete) to the first-line platinum-based therapy OR • Zejula is being prescribed as maintenance therapy and the patient has received 2 or more lines of platinum-based chemotherapy AND the patient was in objective response (either complete or partial) to the most recent first-line platinum-based chemotherapy <p>OR</p> <ul style="list-style-type: none"> • The diagnosis is NOT listed above but is cited in the National Comprehensive Cancer Network (NCCN) guidelines as a category 1, 2A, or 2B recommendation. To facilitate approval, please list the diagnosis, guideline version, and page number:_____. <p>Other non-FDA-approved uses are not approved PA does not expire.</p>
<ul style="list-style-type: none"> • tocilizumab (Actemra) • tocilizumab- injection (Avtozma) <p>TIBs: IL-6 Inhibitor Actemra biosimilar</p>	<p>Note from the August meeting: The requirement for current users to try Tyenne is temporarily suspended until resolution of the Tyenne shortage.</p> <p>Manual PA criteria apply to all new and current users of tocilizumab (Actemra) and tocilizumab-anoh (Avtozma)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Provider acknowledges the Department of Defense TRICARE benefit requires a trial of Humira. Has the patient tried Humira? (Note: Applies to RA and pJIA) <ul style="list-style-type: none"> ▪ Patient had inadequate response OR experienced an adverse reaction OR has a contraindication to Humira • Provider acknowledges the Department of Defense TRICARE's preferred IL-1, IL-6, CTLA4-Ig is Tyenne. Has the patient tried Tyenne? (Note: Applies to all indications) <ul style="list-style-type: none"> ▪ Patient had an inadequate response OR experienced an adverse reaction OR has a contraindication to Tyenne • Patient has: tried Humira: <ul style="list-style-type: none"> ▪ Moderate to severely active RA and has had an inadequate response to at least 1 or more DMARDs ▪ Active polyarticular Juvenile Idiopathic Arthritis (pJIA) • Patient has not tried Humira and has an indication for which adalimumab is not approved: <ul style="list-style-type: none"> ▪ Giant cell arteritis ▪ Systemic sclerosis-associated lung disease ▪ Systemic Juvenile Idiopathic Arthritis (sJIA) • Patient will not be receiving any other targeted immunomodulatory biologics with the requested agent, including but not limited to the following: TNF inhibitors, IL-1, IL-6, IL-17, IL-23, IL-36, JAK inhibitors, rituximab <p>Non-FDA approved uses are not approved, except as noted above PA does not expire</p>

Appendix C—Table of Prior Authorization (PA) Criteria

Appendix D—Table of Quantity Limits (QL)

Drug / Drug Class	Quantity Limits
<ul style="list-style-type: none"> encorafenib (Braftovi) binimetinib (Mektovi) dabrafenib (Tafinlar) trametinib (Mekinist) vemurafenib (Zelboraf) <p>Oncological Agents: BRAF-MEK Inhibitors</p>	<ul style="list-style-type: none"> MTF/TMOP/Retail: 60-day supply
<ul style="list-style-type: none"> cobimetinib (Cotellic) <p>Oncological Agents: BRAF-MEK Inhibitors</p>	<ul style="list-style-type: none"> MTF/TMOP/Retail: 56-day supply
<ul style="list-style-type: none"> anifrolimab-fnia (Saphnelo) <p>Immunosuppressives</p>	<ul style="list-style-type: none"> MTF/TMOP/Retail: 56-day supply
<ul style="list-style-type: none"> ensitrelvir (Xocova) <p>Antivirals: FDA-approved COVID Therapeutics</p>	<ul style="list-style-type: none"> MTF/TMOP/Retail: 7 tablets or 1 blister pack per prescription fill with no refills allowed and max of 4 fills per year at all points per service
<ul style="list-style-type: none"> linexibat (Lynavoy) <p>GI-2 Agents</p>	<ul style="list-style-type: none"> MTF/TMOP/Retail: 30-day supply
<ul style="list-style-type: none"> tradipitant (Nereus) <p>Antiemetic-Antivertigo Agents</p>	<ul style="list-style-type: none"> MTF/TMOP/Retail: 36 caps per 90 days supply, 180 caps per 720 days
<ul style="list-style-type: none"> vepedegestrant (Veppanu) <p>Breast Cancer Agents: Estrogen Receptor Antagonist</p>	<ul style="list-style-type: none"> MTF/TMOP/Retail: 60-day supply
<ul style="list-style-type: none"> tedizolid (Sivextro) <p>Anti-infectives: Miscellaneous</p>	<ul style="list-style-type: none"> MTF/TMOP/Retail: 6 tablets per fill <p>Specialist bypass of QL allowed for Infectious Disease physicians and pulmonologists</p>
<ul style="list-style-type: none"> ruxolitinib (Jakafi) XR tablets <p>Oncological Agents: Myelofibrosis</p>	<ul style="list-style-type: none"> MTF/TMOP/Retail: 60-day supply

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

Generic (Trade) UF Class	Comparators	Strength/ Form/ Dosing	Indications	Adverse Events	Clinical Summary	Recommendation
<ul style="list-style-type: none"> anifrolimab-fnia injection (Saphnelo) <p>Immuno suppressives</p>	<ul style="list-style-type: none"> belimumab (Benlysta) 	<ul style="list-style-type: none"> 120 mg/ 0.8 mL prefilled syringe or autoinjector 	<ul style="list-style-type: none"> Moderate to severe systemic lupus erythematosus (SLE) 	<ul style="list-style-type: none"> Nasopharyngitis Upper respiratory tract infections Herpes zoster Injection site reaction 	<ul style="list-style-type: none"> Type I interferon (INF) receptor antagonist Currently available as medical benefit Phase 3 study demonstrated BICLA response at Week 52 of 56.2% vs 37.1% for placebo Alternative therapy, Benlysta, has a warning for progressive multifocal leukoencephalopathy that is not listed for Saphnelo Represents an alternative to Benlysta for selected patients with SLE 	<ul style="list-style-type: none"> UF PA QL: 56-day supply TRICARE Maintenance Drug List: Add to contingent list Specialty
<ul style="list-style-type: none"> atomoxetine 4 mg/mL oral solution (Atoncy) <p>ADHD Agents: Non-stimulants</p>	<ul style="list-style-type: none"> atomoxetine capsules 	<ul style="list-style-type: none"> 4 mg/mL Oral solution 1.2 mg/kg/day in children under 70 kg Children 70 kg and above and adults: max dose is 80 mg/day 	<ul style="list-style-type: none"> Treatment of ADHD in adults and pediatric patients 6 years of age and older 	<ul style="list-style-type: none"> liver injury cardiovascular reactions increased blood pressure and heart rate new psychotic or manic symptoms activation of mania aggressive behavior priapism growth effect in pediatric patients 	<ul style="list-style-type: none"> Oral solution formulation of atomoxetine No new clinical efficacy studies; approved via 505(b)(2) pathway using data from Strattera Atomoxetine capsules cannot be opened and must be swallowed whole Atoncy must be discarded 45 days after first opening Also available as an authorized generic While current formulary options cover 90-95% of patients, Atoncy provides a liquid, non-stimulant ADHD treatment for patients who require an alternate dosage form due to swallowing, systemic, or sensory barriers 	<ul style="list-style-type: none"> NF PA MN TRICARE Maintenance Drug List:

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

Generic (Trade) UF Class	Comparators	Strength/ Form/ Dosing	Indications	Adverse Events	Clinical Summary	Recommendation
<ul style="list-style-type: none"> baxdrostat (Baxfendy) <p>Diuretics</p>	<ul style="list-style-type: none"> spironolactone clonidine aprocitentan (Tryvio) 	<ul style="list-style-type: none"> 1 mg, 2 mg tabs 	<ul style="list-style-type: none"> Hypertension (HTN) treatment in combo with other drugs, to lower blood pressure in adults who are not adequately controlled on other agents. Lowering blood pressure reduces the risk of fatal and nonfatal cardiovascular events, primarily strokes and MI 	<ul style="list-style-type: none"> hyperkalemia hyponatremia hypotension 	<ul style="list-style-type: none"> Aldosterone synthase inhibitor Phase 3 study demonstrated blood pressure reductions when combined with background therapy vs. placebo in uncontrolled and resistant hypertension No outcomes studies are available, but under investigation for heart failure and CKD Guidelines for resistant hypertension list spironolactone as the preferred fourth-line drug (after RAAS, CCB, diuretic) Spironolactone has additional indications for heart failure and has demonstrated reduction in cardiovascular outcomes Baxfendy is associated with an increased risk of hyperkalemia, hyponatremia and hypotension, similar to the MRAs Other aldosterone synthetase inhibitors are in the pipeline The current place in therapy and long-term safety remain to be determined More established therapies, including an MRA or a more potent diuretic (indapamide or chlorthalidone), should be tried first as add-in therapy for resistant HTN 	<ul style="list-style-type: none"> NF PA MN

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Generic (Trade) UF Class	Comparators	Strength/ Form/ Dosing	Indications	Adverse Events	Clinical Summary	Recommendation
<ul style="list-style-type: none"> bimatoprost (Zolymbus) 0.01% ophthalmic gel Glaucoma Drugs	<ul style="list-style-type: none"> bimatoprost soln lyuzeh tafluprost 	<ul style="list-style-type: none"> 0.01% ophthalmic gel in single-dose container One drop in the affected eye(s) once daily in the evening 	<ul style="list-style-type: none"> Reduction of elevated intraocular pressure in patients with open-angle glaucoma or ocular hypertension 	<ul style="list-style-type: none"> conjunctival hyperemia eye irritation 	<ul style="list-style-type: none"> Preservative free ophthalmic gel formulation of bimatoprost Approved via 505(b)(2) pathway. Single study demonstrated non-inferiority to preserved bimatoprost ophthalmic solution 0.01% After pouch is opened the single-dose containers may be stored in the foil pouch up to 14 days at room temperature then discarded Zolymbus is preservative free while Lumigan contains 0.2 mg/mL of benzalkonium chloride, which is thought to cause corneal irritation Latanoprost (lyuzeh) and tafuprost are preservative free ophthalmic solutions lyuzeh brand only; tafluprost available in a generic While current formulary options cover 90-95% of patients, Zolymbus provides a gel formulation, and may be beneficial for patients requiring greater IOP reduction 	<ul style="list-style-type: none"> NF PA MN TRICARE Maintenance Drug List:

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

Generic (Trade) UF Class	Comparators	Strength/ Form/ Dosing	Indications	Adverse Events	Clinical Summary	Recommendation
<ul style="list-style-type: none"> bulevirtide-gmod injection (Hepcludex) <p>Hepatitis D Agents</p>	<ul style="list-style-type: none"> peginterferon alfa-2a (Pegasys) 	<ul style="list-style-type: none"> 8.5 mg/vial SC once daily 	<ul style="list-style-type: none"> Treatment of chronic HDV infection in adults without cirrhosis or with compensated cirrhosis. This indication is approved under accelerated approval based on participants who achieved a ↓ in HDV RNA and ALT normalization. Continued approval may be contingent upon verification and description of clinical benefit in a confirmatory trial. 	<ul style="list-style-type: none"> Injection site reactions headache abdominal pain fatigue pruritus 	<ul style="list-style-type: none"> Sodium taurocholate co-transporting polypeptide (NTCP)-directed HDV attachment inhibitor for treatment of chronic HDV infection in adults without cirrhosis or with compensated cirrhosis Ongoing phase 3 study demonstrated higher virologic and biochemical responses vs. control group Declines in virologic and biochemical responses upon discontinuation indicate that prolonged or indefinite therapy may be required to sustain benefits Safety profile of Hepcludex appears favorable relative to pegylated interferon alfa when used off-label for chronic HDV Guidelines support consideration of Hepcludex in patients with chronic HDV and compensated liver disease despite uncertainty in the optimal duration of therapy Long-term observational study ongoing to confirm clinical benefit Provides a long-term disease-modifying strategy rather than a finite curative approach for chronic HDV; which is a condition with no other approved treatment options 	<ul style="list-style-type: none"> UF PA Specialty Adherence safety net

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Generic (Trade) UF Class	Comparators	Strength/ Form/ Dosing	Indications	Adverse Events	Clinical Summary	Recommendation
<ul style="list-style-type: none"> doravirine/ islatravir (Idvynso) <p>Antiretrovirals</p>	<ul style="list-style-type: none"> bictegravir/ emtricitabine/ tenofovir alafenamide (Biktarvy) 	<ul style="list-style-type: none"> 100 mg doravirine/ 0.25 mg islatravir tablets 	<ul style="list-style-type: none"> Complete regimen for the treatment of HIV-1 infection in adults to replace the current antiretroviral regimen in those who are virologically-suppressed (HIV-1 RNA less than 50 copies per mL) on a stable antiretroviral regimen with no history of virologic treatment failure and no known substitutions associated with resistance to doravirine 	<ul style="list-style-type: none"> diarrhea dizziness fatigue abdominal distension headache weight gain 	<ul style="list-style-type: none"> Two-drug combination of doravirine, a Non-Nucleoside Reverse Transcriptase Inhibitor (NNRTI) and islatravir, a Nucleoside Reverse Transcriptase Inhibitor (NRTI) Two phase 3 studies demonstrated noninferiority to background antiretroviral therapy and Biktarvy in virologically suppressed adults Non-Integrase Strand Transfer Inhibitors (INSTI)-based two-drug regimen approved for HIV-1 treatment Alternative to complete oral Integrase Strand Transfer Inhibitors regimens (INSTI) and long-acting injectable Integrase Strand Transfer Inhibitors (INSTI)-based regimens, as well as other HIV products containing Non-Nucleoside Reverse Transcriptase Inhibitors (NNRTIs) and Nucleoside Reverse Transcriptase Inhibitors (NRTIs) for patients who are virally suppressed on their current antiretroviral therapy and desire to switch to another suppressive regimen 	<ul style="list-style-type: none"> UF

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

Generic (Trade) UF Class	Comparators	Strength/ Form/ Dosing	Indications	Adverse Events	Clinical Summary	Recommendation
<ul style="list-style-type: none"> duloxetine 80-, 90-, 120 mg DR capsules (no brand name) <p>Antidepressant and Non-Opioid Syndrome Agents</p>	<ul style="list-style-type: none"> duloxetine generic capsules 	<ul style="list-style-type: none"> 80 mg, 90 mg, 120 mg 	<p>Major depression disorder Generalized anxiety disorder</p>	<ul style="list-style-type: none"> suicidal thoughts and Behaviors hepatotoxicity orthostatic hypotension serotonin syndrome increased risk of bleeding severe skin reactions activation of mania/hypomania angle-closure glaucoma seizures increases in blood pressure hyponatremia urinary hesitation and retention sexual dysfunction 	<ul style="list-style-type: none"> Higher dosage branded formulation of existing duloxetine generic product No new clinical efficacy studies; approved via 505(b)(2) pathway using Cymbalta data Duloxetine capsules cannot be opened and must be swallowed whole for any strength Prescribing information states that doses higher than 60 mg/day for any approved indication do not have evidence of benefit from clinical trials Higher dosage strength product has fewer FDA-approved indications than standard generic products There is no compelling clinical advantage to using higher dosage strength product when multiples or combination of existing generic duloxetine can be used 	<ul style="list-style-type: none"> NF PA MN TRICARE Maintenance Drug List:

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Generic (Trade) UF Class	Comparators	Strength/ Form/ Dosing	Indications	Adverse Events	Clinical Summary	Recommendation
<ul style="list-style-type: none"> ensitrelvir (Xocova) Antivirals: FDA Approved COVID Therapeutics	<ul style="list-style-type: none"> nirmatrelvir/ ritonavir (Paxlovid) 	<ul style="list-style-type: none"> 125 mg tablets blister pack of 7 tablets 	<ul style="list-style-type: none"> Post-exposure prophylaxis of coronavirus disease 2019 (COVID-19) in adults and adolescents 12 years of age and older following contact with an individual who has COVID-19 	<ul style="list-style-type: none"> headache diarrhea cough 	<ul style="list-style-type: none"> Oral SARS-CoV-2 main protease inhibitor indicated for Post-Exposure Prophylaxis (PEP) of COVID-19 following contact with an individual who has COVID-19 Phase 3 study demonstrated Xocova reduced the risk of confirmed symptomatic COVID-19 by 67% compared with placebo among household contacts of infected individuals Individuals at high risk who have not been recently vaccinated against COVID-19 are likely to derive the most benefit from Xocova Paxlovid, Veklury, and Lagevrio are approved for treatment of established infection, and prior PEP studies with Paxlovid and Lagevrio failed to demonstrate significant reductions in symptomatic COVID-19 among household contacts Use is not expected to be universal to all exposed individuals, but may be more common in patients at higher risk of severe disease 	<ul style="list-style-type: none"> UF QL: 7 tablets or 1 blister pack per fill; 4 fills per year

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Generic (Trade) UF Class	Comparators	Strength/ Form/ Dosing	Indications	Adverse Events	Clinical Summary	Recommendation
<ul style="list-style-type: none"> filgrastim-laha injection (Filkri) White Blood Cell Stimulants: Filgrastims	<ul style="list-style-type: none"> tbo filgrastim (Granix) filgrastim-aafi (Nivestym) filgrastim-sndz (Zarxio) 	<ul style="list-style-type: none"> 300 mcg/0.5 mL, 480 mcg/0.8 mL single-dose prefilled syringe 	<ul style="list-style-type: none"> decrease infection in non-myeloid malignancies receiving myelosuppressive drugs associated with significant severe neutropenia with fever decrease time to neutrophil recovery & duration of fever, following induction or consolidation chemotherapy in AML decrease duration of neutropenia and neutropenia-related sequelae in non-myeloid malignancies undergoing chemotherapy followed by BMT decrease incidence and duration of severe neutropenia in congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia increase survival in patients acutely exposed to myelosuppressive doses of radiation (Hematopoietic Syndrome of Acute Radiation Syndrome) 	<ul style="list-style-type: none"> pyrexia pain rash cough dyspnea pain epistaxis anemia diarrhea hypoesthesia alopecia 	<ul style="list-style-type: none"> 7th filgrastim; another biosimilar to Neupogen No new clinical data Available as a prefilled syringe Syringe contains latex unlike other biosimilars that are latex-free Provides no compelling advantages over other filgrastims 	<ul style="list-style-type: none"> Complete Exclusion Temporary PA until implementation

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

Generic (Trade) UF Class	Comparators	Strength/ Form/ Dosing	Indications	Adverse Events	Clinical Summary	Recommendation
<ul style="list-style-type: none"> folic acid 0.2 mg/mL (Quiofic and authorized generic) Vitamins	<ul style="list-style-type: none"> folic acid tablets 	<ul style="list-style-type: none"> Oral suspension: 0.2 mg/mL in 75 mL bottle 	<ul style="list-style-type: none"> Treatment of megaloblastic anemias due to folic acid deficiency in adult and pediatric patients 	<ul style="list-style-type: none"> nausea anorexia bloating 	<ul style="list-style-type: none"> Oral solution formulation of folic acid No new clinical efficacy studies; approved via 505(b)(2) Unused Quiofic must be discarded 30 days after first opening Folic acid tablets are available without a PA, and a liquid formulation of folic acid is available OTC Also available as an authorized generic Provides no compelling clinical advantage over existing agents 	<ul style="list-style-type: none"> Complete Exclusion Temporary PA until implementation
<ul style="list-style-type: none"> finaxofloxacin 0.3% otic suspension (Xtoro) Antibiotics	<ul style="list-style-type: none"> ofloxacin 0.3% otic solution ciprofloxacin 0.2% otic solution 	<ul style="list-style-type: none"> 5 mL otic suspension, 0.3% in 8 mL bottle Four drops in the affected ear(s) BID for 7 days 	<ul style="list-style-type: none"> Treatment of acute otitis externa (AOE) caused by susceptible strains of <i>Pseudomonas aeruginosa</i> and <i>Staphylococcus aureus</i> 	<ul style="list-style-type: none"> pruritus nausea 	<ul style="list-style-type: none"> Otic fluoroquinolone indicated specifically for AOE Two phase 3 studies demonstrated higher clinical cure rates in the Xtoro group vs. patients given vehicle, with a treatment difference of around 34% Guidelines do not prefer one topical antimicrobial agent over the others, but selection should consider patient specific factors No data directly comparing Xtoro with other FDA-approved otic fluoroquinolones; however, the cure rates with Xtoro is similar to other otic quinolone products Xtoro provides another fluoroquinolone for the treatment of AOE, without advantages in efficacy or safety 	<ul style="list-style-type: none"> NF PA MN

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

Generic (Trade) UF Class	Comparators	Strength/ Form/ Dosing	Indications	Adverse Events	Clinical Summary	Recommendation
<ul style="list-style-type: none"> • linerixibat (Lynavoy) GI-2 Agents	<ul style="list-style-type: none"> • Iqirvo • seladelpar (Livdelzi) • cholestyramine 	<ul style="list-style-type: none"> • 40 mg tablets • 40 mg PO BID 	<ul style="list-style-type: none"> • Treatment of cholestatic pruritus associated with primary biliary cholangitis (PBC) in adult patients 	<ul style="list-style-type: none"> • diarrhea • nausea • increased ALT, hemorrhage • increased AST • dyspepsia 	<ul style="list-style-type: none"> • IBAT inhibitor approved to treat the cholestatic pruritus associated with Primary Biliary Cholangitis (PBC) • Phase 3 study demonstrated improvement in pruritus compared with placebo • Longer-term follow-up is ongoing which will evaluate durability of treatment response • No significant differences in the change in ALP and total bilirubin from baseline were observed between the treatment groups • AASLD guidelines for the management of pruritus in PBC recommend bile acid binding resins as first-line therapy • Ursodiol (UDCA) remains the current standard of care for the treatment of PBC; however, it is not effective for managing pruritus. Second line therapies for PBC include Iqirvo and Livdelzi • There is no data available to support combining Lynavoy with Iqirvo or Livdelzi in patients with PBC • Livdelzi demonstrated improvement in pruritus as secondary endpoint compared with placebo in the pivotal study. Iqirvo demonstrated improvement in pruritus in the 3-year extension study. • Provides an alternative to other agents, including Iqirvo and Livdelzi, for the management of cholestatic pruritus in adults with Primary Biliary Cholangitis, but is not disease-modifying 	<ul style="list-style-type: none"> • NF • PA • MN • QL: 30-day supply • Specialty • TRICARE Maintenance Drug List: Add to contingent list

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

Generic (Trade) UF Class	Comparators	Strength/ Form/ Dosing	Indications	Adverse Events	Clinical Summary	Recommendation
<ul style="list-style-type: none"> milsaperidone (Bysanti) Antipsychotic Agents	<ul style="list-style-type: none"> lloperidone (Fanapt) 	<ul style="list-style-type: none"> 1 mg, 2 mg, 4mg, 6 mg, 8 mg, 10 mg, 12 mg tablets; 6 mg-12 mg twice daily 	<ul style="list-style-type: none"> Treatment of schizophrenia in adults. Acute treatment of manic or mixed episodes associated with bipolar I disorder in adults 	<ul style="list-style-type: none"> dry mouth dizziness fatigue tachycardia hypotension somnolence hepatic enzyme elevation nasal congestion weight gain 	<ul style="list-style-type: none"> Bysanti is the active metabolite of Fanapt Approved via two unpublished pharmacokinetic studies demonstrating pharmacokinetic bioequivalence to Fanapt Bysanti and Fanapt rapidly interconvert in vivo. Bysanti has an in vitro receptor binding profile like Fanapt Based on bioequivalence data, Bysanti offers a similar clinical efficacy and tolerability profile as its parent drug, Fanapt Bysanti offers no compelling clinical advantage over existing agents 	<ul style="list-style-type: none"> NF PA MN Adherence safety net
<ul style="list-style-type: none"> relacorilant (Lifyorli) Oncological Agents: Glucocorticoid Receptor Antagonist	<ul style="list-style-type: none"> N/A 	<ul style="list-style-type: none"> 25 mg capsules 100mg capsules 	<ul style="list-style-type: none"> In combination with nab-paclitaxel for treatment of platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer for patients who have received prior treatment including bevacizumab 	<ul style="list-style-type: none"> decreased hemoglobin, neutrophils, platelets fatigue nausea diarrhea rash decreased appetite 	<ul style="list-style-type: none"> First in class glucocorticoid receptor antagonist Open label study demonstrated addition of Lifyorli to nab-paclitaxel demonstrated improvement in progression free survival and overall survival NCCN guidelines recommend Lifyorli and nab-paclitaxel for patients as a preferred cytotoxic therapy (category 2A) Lifyorli plus nab-paclitaxel is a treatment option for patients previously treated with bevacizumab 	<ul style="list-style-type: none"> UF PA TRICARE Maintenance Drug List:: Add to contingent list Specialty

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

Generic (Trade) UF Class	Comparators	Strength/ Form/ Dosing	Indications	Adverse Events	Clinical Summary	Recommendation
<ul style="list-style-type: none"> telmisartan / amlodipine / indapamide (Widaplik) <p>Renin Angiotensin Anti-Hypertensives</p>	<ul style="list-style-type: none"> telmisartan/ amlodipine and indapamide amlodipine/ valsartan and HCTZ; telmisartan, amlodipine and indapamide; valsartan, amlodipine, and indapamide 	<ul style="list-style-type: none"> 10 mg/1.25 mg/0.625 mg 20 mg/2.5 mg/1.25 mg 40 mg/5 mg/2.5 mg tabs 	<ul style="list-style-type: none"> Treatment of hypertension, including as initial treatment, to lower blood pressure. Lowering blood pressure reduces the risk of fatal and nonfatal cardiovascular events, primarily strokes and myocardial infarctions 	<ul style="list-style-type: none"> hypotension hyponatremia hypokalemia 	<ul style="list-style-type: none"> Triple fixed-dose combination product May be used as initial therapy in patients likely requiring multiple agents Contains an ARB/CCB/thiazide diuretic – all three components are recommended as 1st line therapy in HTN guidelines Indapamide component has advantages over HCTZ Two studies demonstrated greater systolic blood pressure reduction with triple therapy vs. placebo or dual therapy for hypertension Widaplik is only indicated for HTN; there are no studies demonstrating reductions in CV risk in patients with HTN; however, previous studies with amlodipine, indapamide, and several ARBs have demonstrated such benefits and this is mentioned in the label Single pill combination medications are now recommended in an AHA Scientific Statement Product is non-Trade Agreements Act compliant; the individual components are available separately; however fixed dose combinations are recommended in the guidelines 	<ul style="list-style-type: none"> UF Do not add to the TRICARE Maintenance Drug List – Non-Trade Agreements Act compliant

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

Generic (Trade) UF Class	Comparators	Strength/ Form/ Dosing	Indications	Adverse Events	Clinical Summary	Recommendation
<ul style="list-style-type: none"> tradipitant (Nereus) Antiemetic-Antivertigo Agents	<ul style="list-style-type: none"> scopolamine patch aprepitant meclizine 	<ul style="list-style-type: none"> 85 mg capsules 85 mg or 170 mg one time prior to triggering event 	<ul style="list-style-type: none"> Prevention of vomiting induced by motion in adults. Safety for more than 90 doses has not been established 	<ul style="list-style-type: none"> somnolence headache fatigue 	<ul style="list-style-type: none"> Substance P/NK-1 receptor antagonist that is a prescription oral product for motion sickness Three phase 3 studies demonstrated a decrease in vomiting incidence vs placebo following single-dose administration. Treatment effects were statistically significant in rough-sea environment. The trips were only of short duration and do not reflect conditions similar to military deployment Selection of healthy individuals with history of motion sickness may limit applicability No mention if other medications might have been used prior to anticipated trips No head-to-head comparison studies were done with standard of care treatments, such as scopolamine patch, meclizine or dimenhydrinate. 	<ul style="list-style-type: none"> NF PA MN QL of 36/90 days
<ul style="list-style-type: none"> vepedegestrant (Veppanu) Breast Cancer Agents: Estrogen Receptor Antagonist	<ul style="list-style-type: none"> Inluriyo Orserdu 	<ul style="list-style-type: none"> 100 mg, 200mg tablets 	<ul style="list-style-type: none"> Estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative, estrogen receptor-1 (ESR1)-mutated advanced or metastatic breast cancer following progression on at least one line of endocrine therapy 	<ul style="list-style-type: none"> Hematologic abnormalities Liver disfunction Decreased appetite QT prolongation Constipation 	<ul style="list-style-type: none"> PROTAC ER degraded for ER-positive, HER2-negative, ESR1-mutated advanced or metastatic breast cancer Open label study demonstrated improved progression-free survival in patients by reducing risk of progression or death by 43% compared with fulvestrant Recommended by NCCN as other recommended regimen Veppanu is uniquely associated with QTc prolongation compared to other SERDs New therapeutic option to existing SERDs 	<ul style="list-style-type: none"> UF PA QL: 60-day supply TRICARE Maintenance Drug List:: Add to contingent list Specialty

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

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

ADD to the TRICARE Maintenance Drug List (if Formulary, Add; if NF, NOT Exempted from NF TMOP Requirement)	Do NOT Add to the TRICARE Maintenance Drug List (if Formulary, Do Not Add; if NF, Exempted from NF TMOP Requirement)
<p>Drug Class Reviews</p> <p>Oncological Agents: BRAF MEK Inhibitors Subclass</p> <p>Designated UF</p> <p><i>Retain current status (currently on the TMDL)</i></p> <ul style="list-style-type: none"> • binimetinib (Mektovi) • encorafenib (Braftovi) • cobimetinib (Cotellic) • dabrafenib (Tafinlar) • trametinib (Mekinist) • vemurafenib (Zelboraf) <p>Newly Approved Pharmaceutical Agents per 32 CFR 199.21(g)(5)</p> <p>Designated NF (no reason to exempt from NF TMOP requirement)</p> <ul style="list-style-type: none"> • atomoxetine 4 mg/mL solution (Atoncy) • bimatoprost 0.01% ophthalmic gel (Zolymbus) • duloxetine DR 80, 90, 120 mg capsules (unbranded) 	<p>Drug Class Reviews</p> <p>ADHD Agents: Stimulants</p> <p><i>Do not add any agents to the TMDL (for NF agents, the general exclusion for C-II agents applies)</i></p> <p>Newly Approved Pharmaceutical Agents per 32 CFR 199.21(g)(5)</p> <p>Designated UF</p> <p><i>Do not add</i></p> <ul style="list-style-type: none"> • ensitrelvir fumarate (Xocova) • bulevirtide-gmod (Hepcludex) • doravirine /islatravir (Idynso) • telmisartan/amlodipine/indapamide (Widaplik) <p>Designated NF</p> <p><i>Do not add (not cost advantageous)</i></p> <ul style="list-style-type: none"> • baxdrostat (Baxfendy) <p><i>Do not add (limited duration of use)</i></p> <ul style="list-style-type: none"> • finafloxacin (Xtoro) • tradipitant (Nereus) <p><i>Do not add (antipsychotic exclusion)</i></p> <ul style="list-style-type: none"> • milsaperidone (Bysanti)

*Legal/Regulatory Authorities

- 10 USC 1074g(a)(9) requires beneficiaries generally to refill non-generic prescription maintenance medications at MTFs or TMOP. Medications subject to these requirements are listed on the TRICARE Maintenance Drug List (TMDL).
- 32 CFR 199.21(r) implements 10 USC 1074g(a)(9) and sets out operation of the TMDL in detail.
- 32 CFR 199.21(h)(3)(i) states that non-formulary pharmaceutical agents “are generally not available in military treatment facilities or in the retail point of service. They are available in the mail order program.” 32 CFR 199.21(g)(5) covers formulary status and review of newly approved drugs (other than generics), which are added to the UF unless the P&T Committee recommends NF/Tier 3 status within 120 days of approval. In the meantime, newly approved drugs are considered to be in a classification pending status and available under the same terms as NF/Tier 3 medications.

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

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

ADD to the TRICARE Maintenance Drug List (if Formulary, Add; if NF, NOT Exempted from NF TMOP Requirement)	Do NOT Add to the TRICARE Maintenance Drug List (if Formulary, Do Not Add; if NF, Exempted from NF TMOP Requirement)
<p>Newly Approved Pharmaceutical Agents per 32 CFR 199.21(g)(5))</p> <p><i>Designated UF</i></p> <ul style="list-style-type: none"> • anifrolimab (Saphnelo) • relacorilant (Lifyorli) • vepdegestrant (Veppanu) <p><i>Designated NF</i></p> <ul style="list-style-type: none"> • linerixibat (Lynavoy) 	

Appendix G—Implementation Dates for UF Recommendations/Decisions

Implementation Dates for UF Recommendations/Decisions*

Upon signing: October 26, 2026

Two weeks after signing: November 11, 2026

30 days after Signing: December 2nd, 2026 (due to Thanksgiving holiday)

60 days after signing: December 30th, 2026 (due to Christmas holiday)

90 days after signing: January 27, 2027

120 days after signing: February 24, 2027

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

Appendix H—Complete Exclusion Drugs and Therapeutic Alternatives*

P&T Committee Meeting Date	Drug Class	Completely Excluded Products	Formulary Alternatives	Implementation
August 2026	White Blood Cell Stimulants: Filgrastims	<ul style="list-style-type: none"> • filgrastim-laha injection (Filkri) 	<ul style="list-style-type: none"> • tbo-filgrastim (Granix) • filgrastim-aafi (Nivestym) • filgrastim-sndz (Zarxio) 	<ul style="list-style-type: none"> • 120 days
August 2026	Vitamins	<ul style="list-style-type: none"> • folic acid 0.2 mg/mL oral solution (Quiofic and authorized generic) 	<ul style="list-style-type: none"> • folic acid tablets 	<ul style="list-style-type: none"> • 120 days

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

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

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

APPENDIX I: TIBs: IL-23 INHIBITORS: USTEKINUMAB SUMMARY OF FORMULARY ACTIONS

Background: The TIBs IL-23 subclass was reviewed in November 2024, in anticipation of a JNC with the VA. Since that time, numerous actions have occurred within the subclass. This section summarizes the final recommendations for the IL-23 subclass, including formulary status, PA, and MN criteria. These changes were signed by the Director on January 27, 2025 (for the November 2024 P&T Committee meeting, and on July 20 2026 for the remaining recommendations.)

The P&T Committee actions for the TIBs: IL-23 subclass are as follows:

- The IL-23 inhibitor subclass was reviewed at the November 2024 P&T Committee meeting. The UF step-preferred IL-23 agent was selected as the future ustekinumab biosimilar JNC awardee, pending selection. The expected 2025 ustekinumab JNC solicitation was postponed until 2026.
- Biosimilars for ustekinumab were reviewed at the February, May, August, and November 2025 P&T Committee meetings. The ustekinumab products evaluated included ustekinumab (Stelara), ustekinumab (unbranded), ustekinumab-auub (Wezlana), ustekinumab-kfce (Yesintek), ustekinumab-ttwe (Pyzchiva), ustekinumab-stba (Steqeyma), ustekinumab-aekn (Selarsdi), ustekinumab-aaaz (Otulfi), ustekinumab-aaaz (unbranded), ustekinumab-hmny (Starjemza), and ustekinumab-srlf (Imuldosa). These biosimilars are all considered equally safe and efficacious to each other and the originator Stelara, regardless of therapeutic interchangeability status granted by the FDA. Private label products that are not intended for TRICARE patients are excluded from the TRICARE pharmacy benefit, as outlined in the November 2025 P&T Committee meeting minutes.
- Formulary status changes to the ustekinumab biosimilars were not made during the time frame of the BAP pause, which lasted from March 2025 until June 21, 2026.
- The ustekinumab JNC was awarded to ustekinumab-aaaz (Otulfi) on May 4, 2026 and Otulfi moved to UF step-preferred status on May 8, 2026.
 - Notably, ustekinumab-aaaz is available in both a branded product (Otulfi) and unbranded biologic formulation. Branded Otulfi is the sole step-preferred product, based on the awarded JNC. Ustekinumab-aaaz (unbranded), is non-step-preferred.
- As voted on during the November 2024 class review, the Otulfi step therapy requirement was applied to new users of the non-step-preferred ustekinumabs on May 20, 2026 and to the other IL-23 agents (Skyrizi, Tremfya, Ilumya, Omvoh, Icotyde) on June 3, 2026. Current users of a non-Otulfi ustekinumab product were subject to the Otulfi step therapy requirement (“no-grandfathering”) on July 15, 2026 as per the condition set. Beneficiary notification occurred prior to July 15th.

- Stelara will move to NF status on August 26, 2026, with beneficiary notification occurring prior to the change.
- To ensure high quality, effective operation of the TRICARE Pharmacy benefit and to optimize drug selection and maximize cost avoidance, standardized therapeutic substitution was approved by the P&T Committee for ustekinumab. Therapeutic substitution was implemented on June 22, 2026 for the ustekinumab products to assist with conversion to the UF step-preferred Otulfi.

The actions taken on the IL-23 subclass regarding formulary status, PAs, medical necessity criteria, and implementation of therapeutic substitution to the JNC awardee ustekinumab-aaaz (Otulfi) are outlined below

1. *UF RECOMMENDATION*

- UF and step-preferred
 - ustekinumab-aaaz (Otulfi)
- UF and non-step-preferred
 - ustekinumab-aaaz (unbranded)
 - ustekinumab-hmny (Starjemza)
 - ustekinumab-srlf (Imuldosa)
- NF and non-step-preferred
 - ustekinumab-ttwe (Pyzchiva)
 - ustekinumab-aekn (Selarsdi)
 - ustekinumab (unbranded)
 - ustekinumab-stba (Steqeyma)
 - ustekinumab (Stelara)
 - ustekinumab-auub (Wezlana)
 - ustekinumab-kfce (Yesintek)

2. *MANUAL PA CRITERIA*

- For the UF step-preferred ustekinumab (Otulfi), if the prescribing physician specialist is identified as a dermatologist or gastroenterologist during adjudication, no PA will be required (“automated specialist bypass.”) An automated drug-lookback will also apply for adalimumab (Humira) and all ustekinumab products to allow for PA approval if the patient has received either of these medications in the last 720 days. The current age restrictions were removed, allowing utilization of Otulfi in patients of any age for the

treatment of plaque psoriasis, psoriatic arthritis, ulcerative colitis, and Crohn's disease.

- For the UF non-step-preferred agents, a trial of the UF step-preferred agent Otulfi is required in all new and current users. No changes were made to the current automation. Age restrictions will match the FDA labeling for ustekinumab.
 - For the NF non-step-preferred ustekinumab agents, a trial of all UF agents is now required in all new and current users. No changes were made to automation. Age restrictions will match the FDA labeling for ustekinumab.
 - For the UF non-step-preferred non-ustekinumab IL-23 inhibitors, including Skyrizi, Tremfya, and Ilumya, a trial of the UF step-preferred IL-23 Otulfi is required in all new users. Current users are allowed to continue therapy.
 - For the NF non-step-preferred non-ustekinumab IL-23 inhibitors, including Omvoh and Icotyde, a trial of the UF step-preferred IL-23 Otulfi will be required in all new users. Additionally, a trial of the UF non-step-preferred agents is required. Current users are allowed to continue therapy.
3. ***MN CRITERIA***—MN criteria for Pyzchiva, Selarsdi, Stelara, ustekinumab (unbranded), Steqeyma, Wezlana, and Yesintek were previously recommended when the products were reviewed as innovators. A trial of all the formulary alternatives is required, including the Tumor Necrosis Factor (TNF)-inhibitor Humira, the IL-23 inhibitor Taltz, the JNC-awarded product (Otulfi), ustekinumab-aauz (unbranded), Starjemza, and Imuldosa. For the non-ustekinumabs Icotyde and Omvoh, their MN were updated to include Otulfi.
 4. ***QLs***— The QL is 1 syringe/vial at Retail pharmacies and 3 syringes/vials at MTFs and TMOP for all ustekinumab products.
 5. ***SPECIALTY AND TRICARE MAINTENANCE DRUG LIST***—The ustekinumab products are subject to the TRICARE Maintenance Drug List requirements, with the exception of ustekinumab-hmny (Starjemza) and ustekinumab-aauz (unbranded). Skyrizi, Tremfya, Ilumya, Omvoh and Icotyde are also on the TRICARE Maintenance Drug List.
 6. ***ADHERENCE SAFETY NET***—All ustekinumab formulations will remain on the Adherence Safety Net program managed by the TRICARE pharmacy contractor. The program identifies beneficiaries who have not received a prescription fill for either a step-preferred or non-step-preferred drug, after the initial reject.

7. **THERAPEUTIC SUBSTITUTION**—The ustekinumab products are subject to therapeutic substitution to Otulfi. The MTF pharmacist will convert utilizing the same (1:1) dose conversion and the same dosing frequency from a non-preferred ustekinumab to Otulfi for all orders and prescriptions written by an MTF provider for dispensing at an MTF pharmacy. The committee approved the therapeutic substitution for ustekinumabs during the February 2026 meeting and reviewed and confirmed the process for therapeutic substitution at the MTF as part of the May 2026 meeting. Pharmacists may convert between dosage forms (pen, vial, syringe). New ustekinumab products will be added to the non-preferred list. Therapeutic substitution of ustekinumab began on June 22, 2026. See Appendix J.

TIBs MN Criteria	
<ul style="list-style-type: none"> ustekinumab (Stelara) ustekinumab (unbranded Stelara) ustekinumab-ttwe (Pyzchiva) ustekinumab-auub (Wezlana) ustekinumab-aekn (Selardsi) ustekinumab-stba (Steqeyma) ustekinumab-kfce (Yesintek) <p>Targeted Immunomodulatory Biologics: IL-23</p>	<ul style="list-style-type: none"> Patient has experienced significant adverse effects from formulary agents <p>Formulary alternatives: adalimumab (Humira), ixekizumab (Taltz), ustekinumab-aaaz (Otulfi), ustekinumab-aaaz (unbranded), ustekinumab-hmny (Starjemza), ustekinumab-srlf (Imuldosa)</p>
<ul style="list-style-type: none"> mirikizumab (Omvoh) <p>Targeted Immunomodulatory Biologics: IL-23</p>	<ul style="list-style-type: none"> Use of all formulary agents is contraindicated Patient has experienced significant adverse effects from all formulary agents Formulary agents resulted in therapeutic failure <p>Formulary alternatives: adalimumab (Humira), ustekinumab-aaaz (Otulfi), guselkumab (Tremfya), risankizumab (Skyrizi)</p>
<ul style="list-style-type: none"> icotrokinra (Icotyde) <p>Targeted Immunomodulatory Biologics: IL-23</p>	<ul style="list-style-type: none"> Use of all formulary agents is contraindicated Patient has experienced significant adverse effects from all formulary agents Formulary agents resulted in therapeutic failure <p>Formulary alternatives: adalimumab (Humira), ustekinumab-aaaz (Otulfi), ixekizumab (Taltz), apremilast (Otezla)</p>

TIBs: Interleukin-23 PA Criteria	
<ul style="list-style-type: none"> ustekinumab-aaaz (Otulfi) <p>Targeted Immunomodulatory Biologics: IL-23</p>	<p><u>Automated PA Criteria:</u> When prescribed by a dermatologist or gastroenterologist a prior authorization is not required. Once therapy is initiated by a dermatologist or gastroenterologist, an automated drug look back will apply, allowing continuation of coverage by any other prescriber if the patient has received the requested medication in the past 720 days.</p> <p><u>Automated PA Criteria:</u> The patient has filled a prescription for adalimumab (Humira) or another ustekinumab product at any MHS pharmacy point of service (MTFs, retail network pharmacies, or TRICARE mail order pharmacy) during the previous 180 days.</p> <p>Manual PA criteria apply to all new users of ustekinumab-aaaz (Otulfi)</p> <p><u>Manual PA Criteria:</u> If automated PA criteria are not met, coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> The patient had an inadequate response to Humira OR the patient experienced an adverse reaction to Humira that is not expected to occur with ustekinumab OR the patient has a contraindication to Humira Patients may have used infliximab in lieu of Humira for UC and CD Coverage is approved for patients with: <ul style="list-style-type: none"> Active psoriatic arthritis Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy Moderately to severely active Crohn's Disease (CD) Moderately to severely active ulcerative colitis (UC) The criteria below apply to all patients unless noted: <ul style="list-style-type: none"> Patient has had an inadequate response, intolerance, or contraindication to nonbiologic systemic therapy (for example – methotrexate, aminosaliclates (e.g. sulfasalazine, mesalamine) corticosteroids, or immunosuppressants (e.g. azathioprine). (Note: Does not apply to CD, UC) Coverage is not provided for concomitant use with other targeted immunobiologics including but not limited to, TNF inhibitors, interleukins, JAK inhibitors <p>Non-FDA approved uses are not approved</p> <p>PA does not expire</p>
<ul style="list-style-type: none"> ustekinumab-aaaz (unbranded) ustekinumab-hmny (Starjemza) ustekinumab-srlf (Imuldosa) 	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of ustekinumab-aaaz (unbranded Otulfi); ustekinumab-hmny (Starjemza); ustekinumab-srlf (Imuldosa)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> The provider acknowledges that the step-preferred product branded Otulfi is TRICARE's preferred ustekinumab product

<p>Targeted Immunomodulatory Biologics: IL-23</p>	<ul style="list-style-type: none"> The patient had an inadequate response to Humira OR the patient experienced an adverse reaction to Humira that is not expected to occur with ustekinumab OR the patient has a contraindication to Humira Please provide a patient-specific justification as to why the step-preferred branded Otulfi cannot be used in this patient. <ul style="list-style-type: none"> Acceptable reasons include the patient has an allergy to an inactive ingredient found in the step-preferred product that is not in the non-step-preferred product Patients may have used infliximab in lieu of Humira for UC and CD Coverage approved for patients 18 years of age or older with: <ul style="list-style-type: none"> Active psoriatic arthritis Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy Moderately to severely active Crohn's disease (CD) Moderately to severely ulcerative colitis (UC) Coverage approved for pediatric patients ages 6 to 17 years with: <ul style="list-style-type: none"> Active psoriatic arthritis (ages 6 and older) Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy (ages 6 and older) Moderately to severely active Crohn's disease (ages 2 and older) The criteria below apply to all patients unless noted: <ul style="list-style-type: none"> Patient has had an inadequate response, intolerance, or contraindication to nonbiologic systemic therapy (for example – methotrexate, aminosaliclates (e.g., sulfasalazine, mesalamine), corticosteroids, immunosuppressants (e.g., azathioprine). (Note: Does not apply to CD, UC) Coverage is NOT provided for concomitant use with other TIBs including, but not limited to TNF inhibitors, interleukins, JAK inhibitors <p>Non-FDA approved uses are not approved</p> <p>PA does not expire</p>
<ul style="list-style-type: none"> ustekinumab-ttwe (Pyzchiva) ustekinumab-aekn (Selarsdi) ustekinumab (Stelara) ustekinumab (unbranded Stelara) ustekinumab-stba (Steqeyma) ustekinumab-auub (Wezlana) ustekinumab-kfce (Yesintek) 	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of (NF non-step-preferred products)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> The provider acknowledges that the step-preferred product branded Otulfi is TRICARE's preferred ustekinumab product, and ustekinumab-aauz (unbranded brand Otulfi); ustekinumab-hmny (Starjemza); ustekinumab-srlf (Imuldosa) are also Uniform Formulary The patient had an inadequate response to Humira OR the patient experienced an adverse reaction to Humira that is not expected to occur with ustekinumab OR The patient has a contraindication to Humira Please provide a patient-specific justification as to why the step-preferred product branded Otulfi and the UF non-step-preferred products ustekinumab-aauz (unbranded brand Otulfi); ustekinumab-hmny (Starjemza); ustekinumab-srlf (Imuldosa) cannot be used in this patient. <ul style="list-style-type: none"> Acceptable reasons include the patient has an allergy to an inactive ingredient found in the Otulfi and ustekinumab-aauz

<p>Targeted Immunomodulatory Biologics: IL-23</p>	<p>(unbranded Otulf); ustekinumab-hmny (Starjemza); ustekinumab-srlf (Imuldosa) that is not in the nonformulary non-step-preferred product</p> <ul style="list-style-type: none"> • Patients may have used infliximab in lieu of Humira for UC and CD • Coverage approved for patients 18 years of age or older with: <ul style="list-style-type: none"> ▪ Active psoriatic arthritis ▪ Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy ▪ Moderately to severely active Crohn's disease (CD) ▪ Moderately to severely ulcerative colitis (UC) • Coverage approved for pediatric patients ages 6 to 17 years with: <ul style="list-style-type: none"> ▪ Active psoriatic arthritis (ages 6 and older) ▪ Moderate to severe plaque psoriasis who are candidates for phototherapy or systemic therapy (ages 6 and older) ▪ Moderately to severely active Crohn's disease (ages 2 and older) • The criteria below apply to all patients unless noted: <ul style="list-style-type: none"> ▪ Patient has had an inadequate response, intolerance, or contraindication to nonbiologic systemic therapy (for example – methotrexate, aminosaliclates (e.g., sulfasalazine, mesalamine), corticosteroids, immunosuppressants (e.g., azathioprine). (Note: Does not apply to CD, UC) ▪ Coverage is NOT provided for concomitant use with other TIBs including, but not limited to TNF inhibitors, interleukins, JAK inhibitors <p>Non-FDA approved uses are not approved</p> <p>PA does not expire</p>
<ul style="list-style-type: none"> • risankizumab on-body injector (Skyrizi OBI) <p>Targeted Immunomodulatory Biologics: IL-23</p>	<p>Step therapy and Manual PA Criteria apply to all new users of risankizumab On-Body Injector (Skyrizi OBI) (No change from previous PA)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Provider acknowledges that ustekinumab-aaaz (Otulf) is TRICARE's preferred IL-23 product <ul style="list-style-type: none"> ▪ Patient had an inadequate response to ustekinumab OR ▪ Patient experienced an adverse reaction to ustekinumab that is not expected to occur with Skyrizi OR ▪ Patient has a contraindication to ustekinumab • Provider acknowledges that adalimumab is TRICARE's preferred biologic product <ul style="list-style-type: none"> ▪ Patient had an inadequate response to adalimumab OR ▪ Patient experienced an adverse reaction to adalimumab that is not expected to occur with Skyrizi OR ▪ Patient has a contraindication to adalimumab OR ▪ A trial of IV infliximab may be used in lieu of Humira for ulcerative colitis and Crohn's disease • Patient is 18 years of age or older with the following indication/diagnosis: <ul style="list-style-type: none"> ▪ Moderately to severely active ulcerative colitis (UC)

	<ul style="list-style-type: none"> ▪ Moderately to severely active Crohn's Disease (CD) • Patient will not be receiving any other targeted immunomodulatory biologics concurrently, including but not limited to the following: TNF inhibitors, interleukins, JAK inhibitors <p>Use of the on-body injector for non-FDA-approved indications, plaque psoriasis, or psoriatic arthritis is not approved. Providers should fill out the PA for Skyrizi pen and syringes for indications other than Crohn's disease or ulcerative colitis.</p> <p>Non-FDA approved uses are not approved.</p> <p>PA does not expire</p>
<ul style="list-style-type: none"> • risankizumab (Skyrizi) pens, syringes <p>Targeted Immunomodulatory Biologics: IL-23</p>	<p>Updates from August 2026 are in bold and strikethrough</p> <p>Manual PA criteria apply to all new users of risankizumab (Skyrizi)</p> <p><u>Manual PA Criteria:</u> Coverage is approved if ALL criteria are met:</p> <ul style="list-style-type: none"> • Provider acknowledges that ustekinumab-aauz (Otulfi) is TRICARE's step-preferred IL-23 • The patient has a contraindication or has had an inadequate response to Otulfi OR has had an adverse reaction to Otulfi that is not expected with the requested non-step-preferred TIB AND • The patient has a contraindication or has had an inadequate response to Humira OR has had an adverse reaction to Humira that is not expected with the requested non-step-preferred TIB AND • Patient is 18 6 years or older with the following diagnosis/indication: <ul style="list-style-type: none"> ▪ Active psoriatic arthritis (PsA) ▪ Moderate to severe plaque psoriasis (PsO) who are candidates for systemic therapy or phototherapy • Patient has tried and had an inadequate response, intolerance, or contraindication to non-biologic systemic therapy (e.g., methotrexate, aminosaliclates [e.g., sulfasalazine, mesalamine], corticosteroids, immunosuppressants [e.g. azathioprine]) • Coverage NOT provided for concomitant use with other TIBs, including but not limited to the following: TNF inhibitors, interleukins, JAK inhibitors <p>Providers should fill out the PA for Skyrizi pen and syringes for plaque psoriasis or psoriatic arthritis. Use of the on-body injector is limited to Crohn's disease or ulcerative colitis.</p> <p>Non-FDA approved uses are not approved.</p> <p>PA does not expire.</p>
<ul style="list-style-type: none"> • guselkumab (Tremfya) <p>Targeted Immunomodulatory Biologics: IL-23</p>	<p>Step therapy and Manual PA Criteria apply to all new users of guselkumab (Tremfya)</p> <p>Manual PA criteria apply to all new users of guselkumab (Tremfya)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Provider acknowledges that ustekinumab-aauz (Otulfi) is TRICARE's preferred IL-23 product <ul style="list-style-type: none"> ▪ Patient had an inadequate response to ustekinumab or the patient experienced an adverse reaction to ustekinumab that is not expected to occur with Tremfya or the patient has a contraindication to ustekinumab

	<ul style="list-style-type: none"> • Provider acknowledges that adalimumab is TRICARE's preferred biologic product <ul style="list-style-type: none"> ▪ Patient had an inadequate response to adalimumab or the patient experienced an adverse reaction to adalimumab that is not expected to occur with Tremfya or the patient has a contraindication to adalimumab ▪ A trial of IV infliximab may be used in lieu of Humira for ulcerative colitis and Crohn's disease • Patient is 18 years of age or older with the following indication/diagnosis: <ul style="list-style-type: none"> ▪ Active psoriatic arthritis (PsA) ▪ Moderate to severe plaque psoriasis (PsO) who are candidates for phototherapy or systemic therapy ▪ Moderately to severely active ulcerative colitis (UC) ▪ Moderately to severely active Crohn's Disease (CD) • Patient is 6 years of age or older and weighs at least 40 kg with the following indication/diagnosis: <ul style="list-style-type: none"> ▪ Active psoriatic arthritis (PsA) ▪ Moderate to severe plaque psoriasis (PsO) who are candidates for phototherapy or systemic therapy • Patient had inadequate response, intolerance, or contraindication to non-biologic systemic therapy (For example: methotrexate, aminosalicylates, corticosteroids, immunosuppressants etc.) (Note: Does not apply to CD, UC) • Patient will not be receiving any other targeted immunomodulatory biologics concurrently, including but not limited to the following: TNF inhibitors, interleukins, JAK inhibitors <p>Non-FDA approved uses are not approved.</p> <p>PA does not expire.</p>
<ul style="list-style-type: none"> • tildrakizumab (Ilumya) <p>Targeted Immunomodulatory Biologics: IL-23</p>	<p>Automated PA Criteria: When prescribed by a dermatologist prior authorization is not required. Once therapy is initiated by a dermatologist an automated drug look back will apply, allowing continuation of coverage by any other prescriber if the patient has received the requested medication in the past 720 days. OR</p> <p><u>Manual PA criteria:</u> If automated criteria are not met, coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Provider acknowledges that ustekinumab-aauz (Otufla) is TRICARE's preferred IL-23 product <ul style="list-style-type: none"> ▪ Patient had an inadequate response to ustekinumab or the patient experienced an adverse reaction to ustekinumab that is not expected to occur with Ilumya or the patient has a contraindication to ustekinumab • Provider acknowledges that adalimumab is TRICARE's preferred biologic product <ul style="list-style-type: none"> ▪ Patient had an inadequate response to adalimumab or the patient experienced an adverse reaction to adalimumab that is not expected to occur with Ilumya or the patient has a contraindication to adalimumab • Patient is 18 years of age or older with the following indication/diagnosis:

	<ul style="list-style-type: none"> ▪ Moderate to severe plaque psoriasis and is a candidate for phototherapy or systemic therapy • Patient had inadequate response, intolerance, or contraindication to non-biologic systemic therapy (For example: methotrexate, aminosaliclates, corticosteroids, immunosuppressants etc.) • Patient will not be receiving any other targeted immunomodulatory biologics concurrently, including but not limited to the following: TNF inhibitors, interleukins, JAK inhibitors <p>Non-FDA approved uses are not approved. PA does not expire.</p>
<ul style="list-style-type: none"> • mirikizumab (Omvoh) <p>Targeted Immunomodulatory Biologics: IL-23</p>	<p>Step therapy and Manual PA Criteria apply to all new users of mirikizumab-mrkz (Omvoh)</p> <p><u>Manual PA criteria:</u> Coverage is approved if all criteria are met:</p> <ul style="list-style-type: none"> • Provider acknowledges that ustekinumab-aauz (Otufti) is TRICARE's preferred IL-23 product <ul style="list-style-type: none"> ▪ Patient had an inadequate response to ustekinumab or the patient experienced an adverse reaction to ustekinumab that is not expected to occur with Omvoh or the patient has a contraindication to ustekinumab • Provider acknowledges that adalimumab is TRICARE's preferred biologic product <ul style="list-style-type: none"> ▪ Patient had an inadequate response to adalimumab or the patient experienced an adverse reaction to adalimumab that is not expected to occur with Omvoh or the patient has a contraindication to adalimumab ▪ A trial of IV infliximab may be used in lieu of Humira • Patient had an inadequate response to Tremfya and Skyrizi, or the patient experienced an adverse reaction to Tremfya and Skyrizi that is not expected to occur with Omvoh or the patient has a contraindication to Tremfya and Skyrizi • Patient is 18 years of age or older with the following indication/diagnosis: <ul style="list-style-type: none"> ▪ Moderately to severely active ulcerative colitis (UC) ▪ Moderately to severely active Crohn's Disease (CD) • Patient will not be receiving any other targeted immunomodulatory biologics concurrently, including but not limited to the following: TNF inhibitors, interleukins, JAK inhibitors <p>Non-FDA approved uses are not approved. PA does not expire</p>

Appendix J – Therapeutic Substitution Update for ustekinumab, tocilizumab, and insulin lispro Junior KwikPen

Guideline Statement:

Pharmacists are empowered to change products to the preferred biosimilar product when orders for non-preferred biologics are placed. The DoW P&T Committee voted on the interchangeability of biosimilar products to the reference biological product, and between biosimilar products of the same reference product, at the August 2024 P&T meeting. This authority saves providers administrative time and improves timeliness of care for the patient.

A decision paper on the establishment of an efficient and effective procedure was signed by the DHA Director in September 2025. This confirmed the authority of the DHA P&T Committee to create national level therapeutic substitutions with implementation immediately after approval by the DHA Director. The P&T Committee may add therapeutic substitution as part of a new drug review, class review, or UM actions. Local MTF facilities may add a substitution or interchange, but not deviate, from Therapeutic Substitutions included on this list.

Note: This policy applies to prescriptions or orders for the medications listed below that were written by providers at MTF facilities and dispensed from MTF pharmacies for inpatient or outpatient use unless specified.

Definitions:

- **Therapeutic substitution (TS) or Therapeutic interchange (TI):** the dispensing of a drug that is therapeutically equivalent to the drug originally prescribed by an authorized provider with prescribing privileges. Although usually of the same pharmacologic class, drugs appropriate for therapeutic substitution may differ in chemistry or pharmacokinetic properties, and may possess different mechanism of action, adverse-reaction, toxicity, and drug interaction profiles. The substituted drugs have close similarity in efficacy and safety profiles when administered to patients in therapeutically equivalent doses.
- **Target Drug:** the medication being evaluated for therapeutic substitution. A target drug may be a traditional medication or biological product.
- **Biological Product:** large, complex molecules produced through biotechnology in a living cell used to diagnose, prevent, treat, and cure diseases and medical conditions.
- **Biosimilar Product:** biological product that is highly similar and has no clinically meaningful differences from an existing Food and Drug Administration approved reference product.
- **Non-Preferred Product:** A non-preferred product is a less cost-effective variation of a medication. For a biological product; it may be a reference or biosimilar. These products can be interchanged automatically by pharmacists to the preferred product when a TS or TI authorization exists. Non-preferred products will be utilized only in cases where the

prescriber provides justification for medical necessity and after appropriate additional criteria (Criteria For Use, PA, MN, etc.) have been met.

- **Preferred Product:** A preferred product is the formulary selected or most cost-effective option to the system. For a biological product, a preferred product may be the reference or biosimilar.
- **Dosing Conversion:** Any required dosing conversions will be clearly included within the approved protocol. This will include dose, route, form, and concentration. All dosing is a one-to-one conversion among biosimilar products and their reference product.
- **Shortage Management:** When the preferred product is unavailable due to shortage, the pharmacist may substitute the next most cost-effective formulary agent to avoid delays in care.

Table of Therapeutic Substitution for Ustekinumab Products

ustekinumab	
Approved for Inpatient, Clinic, and Outpatient use for MTF providers only	
Non-Preferred Products	Preferred Products
All orders and prescriptions written by an MTF provider for dispensing at an MTF pharmacy for a non-preferred product will be therapeutically substituted by the MTF pharmacy to the preferred product unless the provider indicates dispense as written; additional PA and MN criteria apply in these situations	
ustekinumab-srlf (Imuldosa) ustekinumab-aaaz (unbranded Otulfi) ustekinumab-ttwe (Pyzchiva) ustekinumab-aekn (Selarsdi) ustekinumab-hmny (Starjemza) ustekinumab (Stelara) ustekinumab (unbranded Stelara) ustekinumab-stab (Steqeyma) ustekinumab-auub (Wezlana) ustekinumab-kfce (Yesintek)	ustekinumab-aaaz (Otulfi)
Orders will be converted with the same (1:1) dosage, frequency, and route between products Orders may be converted between dosage forms (i.e. prefilled syringe, prefilled pen, vials) Newly approved products will be added to the Non-preferred list When the preferred biologic product is unavailable due to national shortage, the pharmacist may substitute to the next most cost-effective agent to avoid delays in care	

Table of Therapeutic Substitution for Tocilizumab Products

tocilizumab Approved for Inpatient, Clinic, and Outpatient use for MTF providers only	
Non-Preferred Products	Preferred Products
All orders and prescriptions written by an MTF provider for dispensing at an MTF pharmacy for a non-preferred product will be therapeutically substituted by the MTF pharmacy to the preferred product unless the provider indicates dispense as written; additional PA and MN criteria apply in these situations	
tocilizumab (Actemra) tocilizumab-anoh (Avtozma) tocilizumab-bavi (Tofidence)	tocilizumab-aazg (Tyenne)
Orders will be converted with the same (1:1) dosage, frequency, and route between products Orders may be converted between dosage forms (i.e. prefilled syringe, prefilled pen, vials) Newly approved products will be added to the Non-preferred list When the preferred biologic product is unavailable due to national shortage, the pharmacist may substitute to the next most cost-effective agent to avoid delays in care	

Table of Therapeutic Substitution for Insulin Lispro Junior Kwik Pen

Insulin Lispro Junior KwikPen Approved for Inpatient, Clinic, and Outpatient use for MTF providers only	
Non-Preferred Products	Preferred Products
All orders and prescriptions written by an MTF provider for dispensing at an MTF pharmacy for a non-preferred product will be therapeutically substituted by the MTF pharmacy to the preferred product unless the provider indicates dispense as written; additional PA and MN criteria apply in these situations	
Insulin lispro Junior KwikPen (Humalog Jr)	Insulin lispro Junior KwikPen (unbranded Jr)
Orders will be converted with the same (1:1) dosage, frequency, and route between products Orders may only be converted between the Junior KwikPen for half unit dosing accuracy Newly approved products will be added to the Non-preferred list When the preferred biologic product is unavailable due to national shortage, the pharmacist may substitute to the next most cost-effective agent to avoid delays in care	