



CareOregon (OHP) Formulary Changes

Abbreviations: PA = Prior Authorization Required; QL = Quantity Limit; ST = Step Therapy Required; AR = Age Restriction

EFFECTIVE DATE	FORMULARY CHANGE	DRUG NAME	STRENGTH	DOSAGE FORM	DESCRIPTION
10/1/2026	Added QL	GLIPIZIDE	15MG	TAB	QL 2 per day
10/1/2026	Removed	NEULASTA	4/0.4ML	INJ	
10/1/2026	Added with PA & QL	BESREMI	500MCG	INJ PEN	PA Required. See PA criteria document for details. QL 0.04 Per day
10/1/2026	Added with PA & QL	NILOTINIB HCL			PA Required. See PA criteria document for details. QL 4 Per day
10/1/2026	Added QL	GRANISOL	2MG/10ML	SOL	QL 10ML per day
10/1/2026	Added with PA & QL	JAKAFI XR	11MG, 22MG, 33MG, 44MG, 55MG	TAB	PA Required. See PA criteria document for details. QL 1 Per day
10/1/2026	Added with PA & QL	VEPPANU	100MG, 200MG	TAB	PA Required. See PA criteria document for details. QL 1 Per day
10/1/2026	Added with PA & QL	XDEMVY	0.25%	DRO	PA Required. See PA criteria document for details. QL 10MLS Per 180 days
10/1/2026	Removed	ZEPBOUND	15/0.5ml, 12.5/0.5ml, 10/0.5ml, 7.5/0.5ml, 5/0.5ml, 2.5/0.5ml	INJ	
10/1/2026	Removed	ADAPALENE	0.3%	GEL	
10/1/2026	Removed	CLINDAMYCIN PHOSPHATE	0.1%	Gel	
10/1/2026	Added with PA & QL	HEPCLUDEX	8.5MG	INJ	PA Required. See PA criteria document for details. QL 1 per day
10/1/2026	Added with PA	PEGASYS	180MCG	INJ	PA Required. See PA criteria document for details.
10/1/2026	Removed	STEGLATRO	5MG, 15MG	TAB	
10/1/2026	PA Removed	DAPAGLIFLOZIN	5MG, 10MG	TAB	
10/1/2026	Added to Medical Benefit	Wainua	45mg/0.8ml	INJ	PA Required. See PA criteria document for details.
10/1/2026	Criteria Updated	Tziel	2mg/2ml	INJ	Criteria updated to criteria to reflect FDA approved age minimum
10/1/2026	Added to Medical Benefit	Contepo		INJ	PA Required. See PA criteria document for details.
10/1/2026	Criteria Updated	Alyftrek	10-50-125 MG & 4-20-50 MG	TAB	Update OHP PA criteria to include new indication (update initial criteria to reflect all mutations that will allow for coverage of Alyftrek).
10/1/2026	Criteria Updated	Trikafta	50-25-37.5 MG/75MG, 100-50-75 MG/150MG, 80-40-60 MG/59.5MG, 100-50-75MG/75MG	tablets, oral granules	Update OHP PA criteria to include new indication. The initial criteria will need updated to reflect all mutations that will allow for coverage of Trikafta

10/1/2026	Criteria Updated	Fasenra	30 MG/ML & 10 MG/0.5ML	SQ injection	Update OHP PA criteria to include new. Follow Nucala criteria for the indication including failure of hydroxyurea first. Remove the requirement of disease duration of at least 6 months as this was a requirement for the Nucala FDA approval, but not for Fasenra. Change criteria to prefer Fasenra over Nucala.
10/1/2026	Criteria Updated	Filspari	200mg & 400mg	TAB	Update OHP PA Criteria to add this indication. Criteria based on 1) nephrologist, 2) REMS contraindication, 3) confirmed FSGS (biopsy or genetic) without nephrotic syndrome, 3) labs based on a) study inclusion criteria, and b) exclusion of nephrotic syndrome (by study definition), and 4) therapeutic failure of a) primary disease management with immunosuppression and b) less costly ACEi/ARB alts at maximized dose.
10/1/2026	Criteria Updated	Vyvgart			Update OHP PA criteria (expand to seronegative population, remove IVIG requirement, require IV formulation over SQ Hytrulo).
10/1/2026	Criteria Updated	Vyvgart Hytrulo			Update OHP PA criteria (expand to seronegative population, remove IVIG requirement, require IV formulation over SQ Hytrulo).
10/1/2026	Added to Medical Benefit	Sarclisa			PA Required. See PA criteria document for details.