

# IHCP *bulletin*

INDIANA HEALTH COVERAGE PROGRAMS    BT2025167    NOVEMBER 25, 2025

## Pharmacy updates approved by Drug Utilization Review Board November 2025

The Indiana Health Coverage Programs (IHCP) announces updates to the Point of Sale Quick Check (PSQC) automated prior authorization (PA) system, PA criteria, Statewide Uniform Preferred Drug List (SUPDL), Over-the-Counter (OTC) Drug Formulary, OTC Supplements Formulary and Preferred Brand Drugs List as approved by the Drug Utilization Review (DUR) Board at its Nov. 21, 2025, meeting.



### PSQC PA enhancement

The IHCP has enhanced its automated PA system to update the criteria for the Antipsychotics, Antiseizure Agents, Dry Eye Disease or Keratoconjunctivitis Agents, Opioid Overutilization PA with QL, Sedative Hypnotics and Benzodiazepines with QL, SSRI and SNRI Duplicate Therapy with QL, Stimulants, and Topical Immunomodulators prior authorizations. These PA changes will be effective for PA requests submitted on or after Jan. 1, 2026. The PA criteria are posted on the *Pharmacy Prior Authorization Criteria and Forms* page on the Optum Rx Indiana Medicaid website, accessible from the [Pharmacy Services](#) webpage at [in.gov/medicaid/providers](http://in.gov/medicaid/providers).

### PA changes

PA criteria for Bone Resorption Inhibitors, Growth Hormone, Hetlioz, MASH/MASLD Agents, Menopausal Symptom Suppressants, Narcolepsy, Non-SUPDL Agents PA and Step Therapy, Nuplazid, Opioid Use Disorder Treatments, Testosterones, and Urea Cycle Disorder Agents were established and approved by the DUR Board. PA criteria for MASH/MASLD Agents and Non-SUPDL Agents PA and Step Therapy apply to the fee-for-service (FFS) benefit only. These PA changes will be effective for PA requests submitted on or after Jan. 1, 2026. The PA criteria are posted on the *Pharmacy Prior Authorization Criteria and Forms* page of the [Optum Rx Indiana Medicaid website](#).

### Changes to the SUPDL

Changes to the SUPDL were made at the Nov. 21, 2025, DUR Board meeting. See Table 1 for a summary of SUPDL changes, effective for FFS claims with dates of service (DOS) on or after Jan. 1, 2026, and managed care claims with DOS on or after Feb. 1, 2026.

*Table 1 – SUPDL changes, effective for FFS claims with DOS on or after Jan. 1, 2026, and managed care claims with DOS on or after Feb. 1, 2026*

Drug class	Drug	SUPDL status
Agents for the Treatment of Opioid Use Disorder or Overdose	Brixadi (buprenorphine)	Preferred (previously nonpreferred)
	Zurnai (nalmefene)	Nonpreferred (previously neutral)

*Table 1 – SUPDL changes, effective for FFS claims with DOS on or after Jan. 1, 2026, and managed care claims with DOS on or after Feb. 1, 2026 (Continued)*

<b>Drug class</b>	<b>Drug</b>	<b>SUPDL status</b>
Antiemetic/Antivertigo Agents	Anzemet (dolasetron) tablet; granisetron tablet; granisetron solution for injection, palonosetron injection	Add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have previous trial of ondansetron – any formulation (as supported by claims history or chart documentation) AND provide medical justification for use of the requested agent over ondansetron</li> </ul>
	Sancuso (granisetron) patch	Update step therapy to the following: <ul style="list-style-type: none"> <li>ST – Prescriber has submitted medical justification for use of Sancuso (granisetron) patch over generic granisetron tablet and injectable formulations</li> </ul>
	Sustol (granisetron) injection – prefilled syringe	Add the following step therapy: <ul style="list-style-type: none"> <li>ST – Prescriber has submitted medical justification for use of Sustol (granisetron) injection (prefilled syringe) over generic granisetron tablet and injectable formulations</li> </ul>
Antiseizure Agents	Generic equivalents of antiseizure products on the Preferred Brand Drug List	Generic Medically Necessary PA will be applied unless prescriber submits prescription with a dispense as written (DAW)-1 code
	Depakote DR and ER (divalproex) tablets brand only	Nonpreferred (previously preferred)
	gabapentin solution (generic Neurontin)	Nonpreferred (previously preferred)
	Gabarone (gabapentin) 100 mg and 400 mg tablets	Nonpreferred (previously neutral); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Prescriber has submitted medical justification for use of Gabarone (gabapentin) tablet over preferred gabapentin capsules</li> </ul>
	Lamictal (lamotrigine) chew	Nonpreferred (previously preferred)
	Lamictal (lamotrigine) ODT, IR/XR tablets	Nonpreferred (previously preferred)
	lamotrigine IR kit and ODT kit (generic Lamictal)	Nonpreferred (previously preferred)
	Keppra (levetiracetam) injection, solution, tablet, XR tablet	Nonpreferred (previously preferred)
	midazolam injection	Neutral (previously preferred)
Onfi (clobazam) suspension and tablet brand only	Nonpreferred (previously preferred)	

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<b>Drug class</b>	<b>Drug</b>	<b>SUPDL status</b>
Antiseizure Agents (Continued)	oxcarbazepine ER tablet (generic Oxtellar XR)	Nonpreferred (previously preferred)
	pregabalin solution (generic Lyrica)	Nonpreferred (previously preferred)
	Subvenite IR tablet (lamotrigine)	Nonpreferred (previously preferred)
	Subvenite (lamotrigine) IR kits	Nonpreferred (previously preferred)
	Sympazan (clobazam)	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of clobazam tablet or suspension (as supported by claims history or chart documentation) AND prescriber has submitted medical justification for the use of Sympazan (clobazam) film over clobazam tablet and suspension</li> </ul>
	Topamax (topiramate) sprinkle capsule and IR tablet	Nonpreferred (previously preferred)
	topiramate ER sprinkle capsule (generic Qudexy)	Add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be 2 years of age or older and less than 12 years of age OR 12 years of age or older and unable to swallow capsules</li> </ul>
	topiramate ER capsule (generic Trokendi)	Nonpreferred (previously preferred)
	topiramate IR solution (generic Eprontia)	Nonpreferred (previously preferred)
Trileptal (oxcarbazepine) IR tablet & suspension	Nonpreferred (previously preferred)	
Gastroprotective Agents	Vyscoxa (celecoxib) oral suspension	Nonpreferred (previously neutral); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be 2 years of age or older and less than 12 years of age OR 12 years of age or older and unable to swallow capsules</li> </ul>
Mental Health Agents: Alzheimer's and Dementia Agents	Brand only: Aricept (donepezil), Exelon (rivastigmine) patch, Namenda (memantine) ER capsule/titration pack	Nonpreferred (previously preferred)

*Table 1 – SUPDL changes, effective for FFS claims with DOS on or after Jan. 1, 2026, and managed care claims with DOS on or after Feb. 1, 2026 (Continued)*

<b>Drug class</b>	<b>Drug</b>	<b>SUPDL status</b>
Mental Health Agents: Alzheimer's and Dementia Agents (Continued)	Adlarity (donepezil)	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Prescriber must provide medical justification for topical formulation OR history of Adlarity for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	galantamine oral solution	Add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be unable to swallow tablet formulation, as supported by chart documentation</li> </ul>
	memantine/donepezil (generic Namzaric)	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Prescriber must provide documentation supporting separate components are not suitable for use</li> </ul>
	Namzaric (memantine/donepezil)	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Prescriber must provide documentation supporting separate components are not suitable for use; OR history of Namzaric (memantine/ donepezil) capsules for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	Zunveyl (benzgalantamine)	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Trial and failure of galantamine (any formulation) AND prescriber has submitted medical justification for use; OR history of Zunveyl (benzgalantamine) for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
Mental Health: Anti-Anxiety and Related Disorders	Brand only: Ativan (lorazepam) injection, Klonopin (clonazepam) tablet, Valium (diazepam) tablet, Xanax (alprazolam) IR/XR tablet	Nonpreferred (previously preferred)

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<b>Drug class</b>	<b>Drug</b>	<b>SUPDL status</b>
Mental Health: Anti-Anxiety and Related Disorders (Continued)	Bucapsol (buspirone)	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have previous trial and failure of buspirone tablet (as supported by claims history or chart documentation) AND prescriber must provide rationale for Bucapsol over buspirone tablet</li> </ul>
	Igalmi (dexmedetomidine)	Nonpreferred (previously preferred)
	Loreev XR (lorazepam)	Nonpreferred (previously preferred)
	meprobamate	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have previous trial and failure of buspirone IR tablet and hydroxyzine (as supported by claims history or chart documentation) AND prescriber must provide rationale for meprobamate use over buspirone IR tablet and hydroxyzine; OR history of meprobamate for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
Mental Health Agents: Antidepressant Agents	Brand only: Celexa (citalopram) tablet, Cymbalta (duloxetine) capsule, Effexor XR (venlafaxine) capsule, Forfivo XL (bupropion) tab, Lexapro (escitalopram) tablet, Paxil (paroxetine) IR tablet/CR tablet/oral suspension, Pristiq ER (desvenlafaxine) tablet, Prozac (fluoxetine) capsule, Viiibryd (vilazodone) tablet, Zoloft (sertraline) concentrate/tablet	Nonpreferred (previously preferred)
	Brand only: Anafranil (clomipramine) tablet, Nardil (phenelzine) tablet, Norpramin (desipramine) tablet, Pamelor (nortriptyline) capsule, Parnate (tranylcypromine) tablet, Remeron (mirtazapine) ODT/tablet, Wellbutrin SR (bupropion) tablet	Nonpreferred (previously preferred)

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<b>Drug class</b>	<b>Drug</b>	<b>SUPDL status</b>
Health Agents: Antidepressant Agents (Continued)	MAO-I subclass: Emsam (selegiline), Marplan (isocarboxazid), phenelzine, tranylcypromine	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have previous trial and failure of one SSRI and one SNRI agent for at least 4 weeks each (as supported by claims history or chart documentation) AND prescriber has submitted medical justification for use; OR history of requested agent for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	bupropion ER (generic Forfivo XL) 450 mg tablet	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Prescriber has submitted medical justification for use of bupropion ER 450 mg tablet over preferred bupropion agents; OR history of bupropion ER 450 mg tablet for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	citalopram capsule	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have previous trial and failure of citalopram tablet (as supported by claims history or chart documentation) AND prescriber has submitted medical justification for the use of citalopram capsule over citalopram tablet; OR history of citalopram capsule for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	citalopram, escitalopram, fluoxetine oral solutions	Add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be under 12 years of age OR 12 years of age or older and unable to swallow capsule/tablet formulation, as supported by chart documentation; OR history of respective oral solution for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	Drizalma (duloxetine) sprinkle	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be under 12 years of age OR 12 years of age or older and unable to swallow capsule formulation, as supported by chart documentation; OR history of Drizalma sprinkle capsules for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>

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<b>Drug class</b>	<b>Drug</b>	<b>SUPDL status</b>
Health Agents: Antidepressant Agents (Continued)	escitalopram capsule	Nonpreferred (previously preferred); add the following quantity limit and step therapy: <ul style="list-style-type: none"> <li>• QL – 1 capsule/day</li> <li>• ST – Must have previous trial and failure of escitalopram tablet (as supported by claims history or chart documentation) AND prescriber has submitted medical justification for the use of escitalopram capsule over escitalopram tablet; OR history of escitalopram capsule for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	Exxua (gepirone) tablet	Nonpreferred (previously preferred); add the following quantity limits, age limit, and step therapy: <ul style="list-style-type: none"> <li>• QL – 1 tablet/day; 1 titration pack/90 days</li> <li>• AL – 18 years of age or older</li> <li>• ST – Must have trial and failure of two preferred antidepressant agents for at least 4 weeks each; OR history of requested agent for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	fluvoxamine ER capsule	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>• ST – Must have previous trial and failure of fluvoxamine IR tablet formulation (as supported by claims history or chart documentation) AND prescriber has submitted medical justification for the use of fluvoxamine ER capsule over fluvoxamine IR tablet; OR history of fluvoxamine ER capsule for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	nortriptyline oral solution	Add the following step therapy: <ul style="list-style-type: none"> <li>• ST – Must be under 12 years of age OR 12 years of age or older and unable to swallow capsule formulation, as supported by chart documentation; OR history of nortriptyline oral solution for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	paroxetine oral suspension	Add the following step therapy: <ul style="list-style-type: none"> <li>• ST – Must be unable to swallow tablet formulation, as supported by chart documentation; OR history of paroxetine oral suspension for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>

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Drug class	Drug	SUPDL status
Health Agents: Antidepressant Agents (Continued)	Raldesy (trazodone) oral solution	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be under 12 years of age OR 12 years of age or older and unable to swallow tablet formulation, as supported by chart documentation; OR history of Raldesy oral solution for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	sertraline capsule	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of sertraline tablet (as supported by claims history or chart documentation) AND prescriber has submitted medical justification for the use of sertraline capsule over sertraline tablet; OR history of sertraline capsule for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	sertraline oral concentrate (generic Zoloft)	Add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be under 12 years of age OR 12 years of age or older and unable to swallow tablet formulation, as supported by chart documentation; OR history of sertraline oral concentrate for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	Spravato (esketamine)	Nonpreferred (previously preferred)
	trimipramine capsule	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of all preferred tricyclic antidepressants OR medical justification for the use of trimipramine over all preferred tricyclic antidepressants</li> </ul>
Mental Health: Antipsychotic and Antimanic Agents	Brand only: Abilify (aripiprazole) tablet, Clozaril (clozapine) tablet, Geodon (ziprasidone) capsule/IM solution, Haldol Decanoate (haloperidol) IM solution, Invega (paliperidone) tablet, Latuda (lurasidone) tablet, Risperdal (risperidone) oral solution/tablet, Saphris (asenapine) SL tablet, Seroquel (quetiapine) IR/XR tablet, Symbyax (olanzapine/fluoxetine) capsule, Zyprexa (olanzapine) IM solution/tablet, Zyprexa Zydis (olanzapine) ODT	Nonpreferred (previously preferred)

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<b>Drug class</b>	<b>Drug</b>	<b>SUPDL status</b>
Mental Health: Antipsychotic and Antimanic Agents (Continued)	Lithobid (lithium carbonate) ER tablet brand only	Nonpreferred (previously preferred)
	Abilify Mycite (aripiprazole) starter and maintenance kit	Remove from coverage
	aripiprazole ODT	Add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be under 12 years of age OR 12 years of age or older and unable to swallow tablet formulation (as supported by chart documentation); OR history of aripiprazole ODT for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	aripiprazole solution	Add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be under 12 years of age OR 12 years of age or older and unable to swallow tablet formulation (as supported by chart documentation); OR history of aripiprazole solution for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	clozapine ODT	Add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of clozapine tablet (as supported by claims history or chart documentation) AND prescriber has submitted medical justification for the use of clozapine ODT over clozapine tablet; OR history of clozapine ODT for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	Cobenfy (xanomeline/trospium)	Nonpreferred (previously preferred)
	Fanapt (iloperidone) tablet/titration packs	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of one preferred antipsychotic agent OR medical justification for the use of Fanapt over all preferred agents; OR history of the requested agent for 90 of the past 120 days</li> </ul>
	lithium solution	Add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be under 12 years of age OR 12 years of age or older and unable to swallow capsule/tablet formulation, as supported by chart documentation</li> </ul>
	Nuplazid (pimavanserin)	Nonpreferred (previously preferred)

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<b>Drug class</b>	<b>Drug</b>	<b>SUPDL status</b>
Mental Health: Antipsychotic and Antimanic Agents (Continued)	Opipza (aripiprazole) film	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of aripiprazole tablet (as supported by claims history or chart documentation) AND prescriber has submitted medical justification for the use of Opipza over aripiprazole tablet; OR history of Opipza for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	Perseris (risperidone) IM inj	Remove from coverage
	pimozide	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Member has tried and failed two of the following for 4 weeks each: aripiprazole, haloperidol, risperidone, as supported by claims history or chart documentation; OR history of pimozide for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	risperidone microspheres inj solution (generic Risperdal Consta)	Nonpreferred (previously preferred)
	risperidone ODT	Add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be under 12 years of age OR unable to swallow tablet formulation (as supported by chart documentation); OR history of risperidone ODT for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	risperidone solution (generic Risperdal)	Add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be under 12 years of age OR 12 years of age or older and unable to swallow tablet formulation (as supported by chart documentation); OR history of risperidone solution for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>
	Rykindo (risperidone) IM inj	Remove from coverage
	Secuado (asenapine) patch	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of asenapine SL (as supported by claims history or chart documentation) AND prescriber has submitted medical justification for the use of Secuado patch over asenapine SL; OR history of Secuado patch for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>

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<b>Drug class</b>	<b>Drug</b>	<b>SUPDL status</b>
Mental Health: Antipsychotic and Antimanic Agents (Continued)	Versacloz (clozapine) oral suspension	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be unable to swallow tablet formulation, as supported by chart documentation</li> </ul>
Mental Health: Insomnia Agents	Brand only: Ambien (zolpidem) CR/IR, Doral (quazepam) tablet, Halcion (triazolam) tablet, Restoril (temazepam) capsule	Nonpreferred (previously preferred)
	Brand only: Rozerem (ramelteon) tablet, Silenor (doxepin) tablet	Nonpreferred (previously preferred)
	Dayvigo (lemborexant)	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of Belsomra (as supported by claims history or chart documentation) OR prescriber has submitted medical justification for the use of Dayvigo over Belsomra</li> </ul>
	Edluar (zolpidem) 5 mg and 10 mg sublingual tabs	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of zolpidem tablet (as supported by claims history or chart documentation) AND prescriber has submitted medical justification for the use of Edluar SL over zolpidem tablet</li> </ul>
	flurazepam	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of all preferred benzodiazepine agents for insomnia (as supported by claims history or chart documentation) OR medical justification for use over preferred benzodiazepine agents for insomnia</li> </ul>
	Hetlioz/Hetlioz LQ (tasimelteon)	Nonpreferred (previously preferred)
	quazepam	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of all preferred benzodiazepine agents for insomnia (as supported by claims history or chart documentation) OR medical justification for use over preferred benzodiazepine agents for insomnia</li> </ul>

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<b>Drug class</b>	<b>Drug</b>	<b>SUPDL status</b>
Mental Health: Insomnia Agents	Quviviq (daridorexant)	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of Belsomra (as supported by claims history or chart documentation) OR prescriber has submitted medical justification for the use of Quviviq over Belsomra</li> </ul>
	tasimelteon capsule (generic Hetlioz)	Nonpreferred (previously preferred)
	zolpidem 7.5 mg capsule	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of zolpidem IR 5 mg (as supported by claims history or chart documentation)</li> </ul>
	Zolpidem 1.75 mg and 3 mg sublingual tablets	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Prescriber has submitted medical justification for the use of zolpidem sublingual tablets AND member is not using concomitantly with other zolpidem strengths/formulations</li> </ul>
Mental Health Agents: Narcolepsy and Cataplexy Agents	Brand only: Nuvigil (armodafinil) tablet, Provigil (modafinil) tablet	Nonpreferred (previously preferred)
	sodium oxybate (generic Xyrem)	Nonpreferred (previously preferred)
	Sunosi (solriamfetol)	Nonpreferred (previously preferred)
	Wakix (pitolisant)	Nonpreferred (previously preferred)
	Xywav (calcium/magnesium/potassium/sodium oxybate)	Nonpreferred (previously preferred)
Mental Health Agents: Non-Stimulant ADHD Agents	Brand only: Catapres-TTS (clonidine) patch, Intuniv ER (guanfacine) tablet, Strattera (atomoxetine) capsule	Nonpreferred (previously preferred)
	Qelbree (viloxazine)	Add the following step therapy: <ul style="list-style-type: none"> <li>ST – Previous trial and failure of a preferred ADHD agent (stimulant or non-stimulant); OR history of Qelbree (viloxazine) for 90 of the past 120 days (as supported by claims history or chart documentation)</li> </ul>

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Drug class	Drug	SUPDL status
Mental Health Agents: Stimulants	Brand only: Adderall IR (amphetamine/dextroamphetamine) tablet, Adderall ER/XR (amphetamine/dextroamphetamine) capsule, Aptensio XR (methylphenidate) capsule; Concerta ER (methylphenidate) tablet, Desoxyn (methamphetamine) tablet, Dexedrine ER (dextroamphetamine) capsule, Evekeo (amphetamine) tablet, Focalin IR (dexmethylphenidate) tablet, Focalin XR (dexmethylphenidate) capsule, Metadate CD (methylphenidate) capsule, Methylin (methylphenidate) solution, Mydayis (amphetamine/dextroamphetamine), Ritalin (methylphenidate) tablet, Ritalin LA (methylphenidate) capsule	Nonpreferred (previously preferred)
	Non-preferred agents	Add the following step therapy unless otherwise specified: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of two preferred stimulants (different chemical entities) OR medical justification for the use of the non-preferred agent over all preferred agents; OR history of the requested agent for 90 of the past 120 days</li> </ul>
	Adzenys XR ODT (amphetamine)	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of Dyanavel XR (amphetamine) chew or suspension OR medical justification for the use of Adzenys XR (amphetamine) over Dyanavel XR (amphetamine); OR history of the requested agent for 90 of the past 120 days</li> </ul>
	amphetamine ER ODT (generic Adzenys XR-ODT)	Nonpreferred (previously preferred)
	amphetamine/dextroamphetamine (generic Mydayis) ER capsule	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of amphetamine/dextroamphetamine ER capsules (generic Adderall XR) or medical justification for use of generic Mydayis over generic Adderall XR; OR history of the requested agent for 90 of the past 120 days</li> </ul>

*Table 1 – SUPDL changes, effective for FFS claims with DOS on or after Jan. 1, 2026, and managed care claims with DOS on or after Feb. 1, 2026 (Continued)*

<b>Drug class</b>	<b>Drug</b>	<b>SUPDL status</b>
Mental Health Agents: Stimulants (Continued)	Cotempla XR ODT (methylphenidate)	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of two preferred stimulants (different chemical entities) OR medical justification for the use of the non-preferred agent over all preferred agents; OR history of the requested agent for 90 of the past 120 days</li> </ul>
	dextroamphetamine solution	Add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be under 12 years of age OR 12 years of age or older and unable to swallow capsule/tablet formulation, as supported by chart documentation</li> </ul>
	Jornay PM (methylphenidate)	Add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of at least one preferred long-acting methylphenidate product OR medical justification for use of Jornay PM; OR history of the requested agent for 90 of the past 120 days</li> </ul>
	lisdexamfetamine capsule (generic Vyvanse)	Nonpreferred (previously preferred)
	lisdexamfetamine chewable tablet (generic Vyvanse)	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be under 12 years of age OR 12 years of age or older and unable to swallow capsule formulation, as supported by chart documentation</li> </ul>
	methylphenidate ER capsule (generic Aptensio XR)	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of at least one preferred long-acting methylphenidate product OR medical justification for use of methylphenidate ER capsule (generic Aptensio XR); OR history of the requested agent for 90 of the past 120 days</li> </ul>
	methylphenidate patch (generic Daytrana)	Nonpreferred (previously preferred); Note: temporarily maintaining preferred status and bypassing GMN criteria due to ongoing product shortage
	Procentra (dextroamphetamine) solution	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of two preferred stimulants (different chemical entities) OR medical justification for the use of the non-preferred agent over all preferred agents; OR history of the requested agent for 90 of the past 120 days</li> </ul>

*Table 1 – SUPDL changes, effective for FFS claims with DOS on or after Jan. 1, 2026, and managed care claims with DOS on or after Feb. 1, 2026 (Continued)*

<b>Drug class</b>	<b>Drug</b>	<b>SUPDL status</b>
Mental Health Agents: Stimulants (Continued)	Relexxi (methylphenidate)	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of two preferred stimulants (different chemical entities) OR medical justification for the use of the non-preferred agent over all preferred agents; OR history of the requested agent for 90 of the past 120 days</li> </ul>
	Vyvanse (lisdexamfetamine) chewable tablet	Add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be under 12 years of age OR 12 years of age or older and unable to swallow capsule formulation, as supported by chart documentation</li> </ul>
	Xelstrym (dextroamphetamine) patch	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must provide medical justification for topical formulation</li> </ul>
	Zenzedi IR (dextroamphetamine) tablet	Nonpreferred (previously preferred); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must have trial and failure of two preferred stimulants (different chemical entities) OR medical justification for the use of the non-preferred agent over all preferred agents; OR history of the requested agent for 90 of the past 120 days</li> </ul>
Skeletal Muscle Relaxants	Tonmya (cyclobenzaprine) sublingual tablet	Nonpreferred (previously neutral); add the following quantity limit and step therapy: <ul style="list-style-type: none"> <li>QL – 2 SL tablets/day</li> <li>ST – Must trial cyclobenzaprine IR (tablets) within the past 30 days</li> </ul>
Acne Agents	Erygel (erythromycin) 2% gel	Remove from SUPDL
Antipsoriatics	Vtama (tapinarof)	Preferred (previously nonpreferred)
Bone Resorption Inhibitors	Bildyos (denosumab-nxxp)	Nonpreferred (previously neutral)
	Bilprevda (denosumab-nxxp)	Nonpreferred (previously neutral)
	Bomynta (denosumab-bnht)	Nonpreferred (previously neutral)
	Osenvelt (denosumab-bmwo)	Nonpreferred (previously neutral)
	Conexence (denosumab-bnht)	Nonpreferred (previously neutral)
	Stoboclo (denosumab-bmwo)	Nonpreferred (previously neutral)

*Table 1 – SUPDL changes, effective for FFS claims with DOS on or after Jan. 1, 2026, and managed care claims with DOS on or after Feb. 1, 2026 (Continued)*

<b>Drug class</b>	<b>Drug</b>	<b>SUPDL status</b>
DPP-4 Inhibitors and Combination Agents	Brynovin (sitagliptin) oral solution	Nonpreferred (previously neutral); add the following step therapy: <ul style="list-style-type: none"> <li>ST – Must be 18 years of age or older and unable to swallow (supported by chart documentation)</li> </ul>
	Janumet XR (sitagliptin/metformin)	Nonpreferred (previously preferred); update step therapy to the following: <ul style="list-style-type: none"> <li>ST – Must have tried a preferred combination agent for 90 of the past 120 days or provide medical justification for use</li> </ul>
	sitagliptin free base/metformin ER (generic Zituvimet XR)	Preferred (previously nonpreferred); update step therapy to the following: <ul style="list-style-type: none"> <li>ST – Must have tried metformin for 90 of the past 120 days or provide medical justification for use</li> </ul>
Growth Hormones	Sogroya (somapacitan-beco)	Nonpreferred (previously preferred)
Insulins – Intermediate Acting	Humulin N KwikPen (insulin NPH)	Preferred (previously nonpreferred)
	Novolog Mix 70/30 (insulin aspart) FlexPen and vial	Preferred (previously nonpreferred)
Insulins – Rapid Acting	Humalog (insulin lispro) vial	Preferred (previously nonpreferred)
	insulin lispro (vial)	Nonpreferred (previously preferred)
	Merilog (insulin aspart-szjj) pen and vial	Nonpreferred (previously neutral)
	Novolog (all formulations)	Preferred (previously nonpreferred)
SGLT Inhibitors and Combinations	Glyxambi (empagliflozin/linagliptin)	Preferred (previously nonpreferred); remove step therapy requirement
	Qtern (dapagliflozin/saxagliptin)	Update step therapy to the following: <ul style="list-style-type: none"> <li>ST – Must have tried and failed Glyxambi or combination therapy with preferred agents of the same classes OR prescriber has submitted medical justification for use over preferred agents</li> </ul>
	Steglujan (ertugliflozin/sitagliptin)	Update step therapy to the following: <ul style="list-style-type: none"> <li>ST – Must have tried and failed Glyxambi or combination therapy with preferred agents of the same classes OR prescriber has submitted medical justification for use over preferred agents</li> </ul>
Testosterones	Androderm (testosterone) patch	Remove from SUPDL
Estrogen and Related Agents	Estrace (estradiol) tablet	Remove from SUPDL
	Lynkuet (elinzanetant)	Nonpreferred (previously neutral)

*Table 1 – SUPDL changes, effective for FFS claims with DOS on or after Jan. 1, 2026, and managed care claims with DOS on or after Feb. 1, 2026 (Continued)*

<b>Drug class</b>	<b>Drug</b>	<b>SUPDL status</b>
Direct Oral Anticoagulants	Eliquis (apixaban) sprinkle capsule	Preferred (previously neutral); add the following quantity limits and step therapy: <ul style="list-style-type: none"> <li>• QL – 4 capsules/day for 7 days; then 2 capsules/day</li> <li>• ST – Member is less than 18 years of age and weighs 2.6 kg to less than 4 kg</li> </ul>
	Eliquis (apixaban) soluble tablet	Preferred (previously neutral); add the following quantity limits and step therapy: <ul style="list-style-type: none"> <li>• QL – Up to 32 tablets/day for 7 days; then up to 16 tablets/day</li> <li>• ST – Member is less than 18 years of age and weighs 4 kg to less than 35 kg</li> </ul>
Hereditary Angioedema Agents	Andembry (garadacimab-gxii)	Nonpreferred (previously neutral)
	Cinryze (C1 esterase inhibitor (human))	Preferred (previously neutral)
	Dawnzera (donidalorsen)	Nonpreferred (previously neutral)
	Haegarda (C1 esterase inhibitor (human))	Nonpreferred (previously neutral)
	Orladeyo (berotralstat)	Preferred (previously neutral)
	Takhzyro (lanadelumab-flyo)	Preferred (previously neutral)
Leukocyte Stimulants	Nypozi (filgrastim)	Nonpreferred (previously excluded); add to short-acting agents
	Ryzneuta (efbemalenograstim alfa-vuxw)	Nonpreferred (previously neutral); add to long-acting agents
Dry Eye Disease or Keratoconjunctivitis	Tryptyr (acoltremon)	Nonpreferred (previously neutral)
Topical Antiparasitics	Natroba (spinosad) brand only	Nonpreferred (previously preferred)
	Pruradik (crotamiton) 10% lotion	Nonpreferred (previously neutral); add class specific quantity limit of one bottle or one tube per claim
	spinosad (generic Natroba)	Preferred (previously nonpreferred)
Topical Immunomodulators	Anzupgo (delgocitinib)	Nonpreferred (previously neutral)
	Zoryve (roflumilast) 0.05% cream	Nonpreferred (previously neutral)

### OTC Drug Formulary

Changes to the OTC Drug Formulary will be effective for FFS claims with DOS on or after Jan. 1, 2026, and managed care claims with DOS on or after Feb. 1, 2026. See Table 2 for a summary of OTC Drug Formulary changes.

*Table 2 – OTC Drug Formulary, effective for FFS DOS on or after Jan. 1, 2026, and managed care DOS on or after Feb. 1, 2026*

Category	Product	Status/criteria
Analgesics	acetaminophen 650 mg ER tablet	Covered product
Non-Sedating Antihistamines	fexofenadine 30 mg/5 mL suspension	Update step therapy to the following: <ul style="list-style-type: none"> <li>Age – Under 12 years or unable to swallow tablet formulation, max age 18 years</li> </ul>
Topical Analgesics	lidocaine 4% patch	Covered product; add the following age and quantity limits: <ul style="list-style-type: none"> <li>Age – 12 years and older</li> <li>QL – 1 patch/day</li> </ul>
Topical Products	chlorhexidine gluconate 4% solution	Covered product

### OTC Supplements Formulary

Changes to the OTC Supplements Formulary will be effective for FFS claims with DOS on or after Jan. 1, 2026, and managed care claims with DOS on or after Feb. 1, 2026. See Table 3 for a summary of OTC Supplements Formulary changes.

*Table 3 – OTC Supplements Formulary, effective for FFS DOS on or after Jan. 1, 2026, and managed care DOS on or after Feb. 1, 2026*

Category	Product	Status/criteria
Iron	ferrous gluconate 240 mg tablet	Covered product
	ferrous gluconate 324 mg tablet	Covered product
	polysaccharide iron 150 mg caplet	Remove from coverage
	polysaccharide iron 150 mg tablet	Remove from coverage
Magnesium	magnesium carbonate 54 mg/5 mL liquid	Remove from coverage
Vitamins	ascorbic acid 250 mg tablet	Remove age limit
	ascorbic acid 500 mg tablet	Remove age limit
	ascorbic acid 1000 mg tablet	Remove age limit
	B-complex vitamin tablet	Covered product

*Table 3 – OTC Supplements Formulary, effective for FFS DOS on or after Jan. 1, 2026, and managed care DOS on or after Feb. 1, 2026 (Continued)*

<b>Category</b>	<b>Product</b>	<b>Status/criteria</b>
Vitamins (Continued)	folic acid 400 mcg tablet	Covered product
	folic acid 800 mcg tablet	Covered product
	vitamin B complex with minerals liquid	Remove from coverage
Zinc	zinc sulfate 220 mg capsule	Remove from coverage
	zinc sulfate 220 mg tablet	Covered product
Miscellaneous	artificial saliva solution	Covered product
	lactobacillus tablet	Covered product
	sodium chloride 1 gm tablet	Covered product

### Changes to the Preferred Brand Drug List

Changes to the Preferred Brand Drug List were made at the Nov. 21, 2025, DUR Board meeting. See Table 4 for a summary of Preferred Brand Drug List changes. Preferred Brand Drug List changes will be effective for FFS claims with DOS on or after Jan. 1, 2026, and managed care claims with DOS on or after Feb.1, 2026.

*Table 4 – Updates to Preferred Brand Drug List, effective for FFS DOS on or after Jan. 1, 2026, and managed care DOS on or after Feb. 1, 2026*

<b>Name of medication</b>	<b>Preferred Brand Drug List status</b>
Lamictal (lamotrigine) IR kit and ODT kit	Add to Preferred Brand Drug List
Lyrica (pregabalin) solution	Add to Preferred Brand Drug List
Neurontin (gabapentin) solution	Add to Preferred Brand Drug List
Premarin (conjugated estrogens) tablet	Add to Preferred Brand Drug List
Ravicti (glycerol phenylbutyrate) oral liquid	Add to Preferred Brand Drug List
Rytary (carbidopa/levodopa) ER capsules	Add to Preferred Brand Drug List
Tegretol IR (carbamazepine) tablet	Add to Preferred Brand Drug List
Xyrem (sodium oxybate) solution	Add to Preferred Brand Drug List
Natroba (spinosad) topical suspension	Remove from Preferred Brand Drug List

**For more information**

The PSQC criteria, PA criteria, SUPDL, OTC Drug Formulary, OTC Supplements Formulary and Preferred Brand Drug List can be found on the [Optum Rx Indiana Medicaid website](#). Notices of the DUR Board meetings and agendas are posted on the [Indiana Family and Social Services Administration \(FSSA\) website](#) at in.gov/fssa. Click **FSSA Calendar** on the left side of the page to access the events calendar.

Please direct FFS pharmacy PA requests and questions about the SUPDL under the FFS pharmacy benefit or about this bulletin to the Optum Rx Clinical and Technical Help Desk by calling toll-free 855-577-6317.

Individual managed care entities (MCEs) establish and publish PA criteria within the managed care delivery system. Questions about managed care PA should be directed to the MCE with which the member is enrolled.

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