February 2026 DUR Board Meeting Minutes

Date: February 12, 2026

Members Present: Barnhill, Anglim, Blake, Brown, Caldwell, Forster, Harrison, Jost, McGrane, Nauts, Oley, Rask

Members Absent: None

Others Present: Katie Hawkins, Shannon Sexauer, Dani Feist, Josh Surginer (DPHHS); Miranda (Mountain Pacific); and representatives from the pharmaceutical industry.

Members of DPHHS, Mountain-Pacific and the Board introduced themselves as Risik Rask replaced Starla Blank and Dr. Lee Harrison replaced Dr. Robert Putsch.

Public Comment:
1. Royce Cyriac, Neurocrine Biosciences – Ingrezza®

Written public comment was submitted to the Board prior to the meeting. It consisted of one manufacturer letter on behalf of Ingrezza®, which is on the agenda and discussed later in the meeting.

Meeting Minute Review: The November 19, 2025, DUR meeting minutes were approved as written.

Department Update: Shannon Sexauer alerted the Board that effective March 2027 all prescribers will need to be enrolled as a Montana Healthcare Programs provider to have their prescriptions paid for at the pharmacy. This is a CMS mandate that the State of Montana must become compliant with. If a provider is not registered as a Montana Healthcare Programs provider, then the member will end up needing to pay cash for their prescription. Shannon requested all members of the Board share this information with their peers to get this information out in multiple different platforms.

Board Discussion

1. Criteria Changes/Dosing and Age Updates:

A. Fasenra® (benralizumab)

Criteria Updates – the criteria documented below is the updated and current criteria approved by the Board. For all other previously reviewed indications, the criteria remain the same. The updates are as follows:

1. *Eosinophil level language updated to greater than or equal to 150cells/microL within the last 6 weeks or greater than or equal to 300cells/microL within the last year.*
2. *'Compliant' changed to 'adherent' to match current criteria language.*

Initial Coverage Criteria

Member must meet all of the following criteria:
Add-on maintenance treatment of adults and children aged 6 years and older with severe asthma and with an eosinophilic phenotype.

- Be 6 years of age or older.
- Have a diagnosis of severe uncontrolled asthma with an eosinophilic phenotype.
    - Have baseline peripheral blood eosinophil count of ≥150 cells/µL within the last 6 weeks or ≥ 300 cells/µL within the last year.
    - Have a history of severe asthma attacks despite treatment with, and adherence to, an optimized dose of inhaled corticosteroid in combination with a long-acting beta2-agonist (ICS/LABA) for three consecutive months.
- If medication is non-preferred, must have had a trial and inadequate response or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List 19 (mt.gov) (unless preferred product(s) do not have the appropriate indication).

Treatment of adult patients with eosinophilic granulomatosis with polyangiitis (EGPA).

- Be 18 years of age or older.
- Has a diagnosis of EGPA and
    - Is experiencing exacerbations while on a stable dose of oral corticosteroid or during steroid taper.
    - Immunosuppressive therapy has been ineffective, contraindicated, or not tolerated.
- If medication is non-preferred, must have had a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List 19 (mt.gov) (unless preferred product(s) do not have the appropriate indication).

Prescriber requirements:

- Must be prescribed by, or in consult with, a pulmonology, allergy, rheumatology or immunology specialist.
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly reauthorization.
- Attests that member will not use Fasenra® concomitantly with other biologics.

Limitations:

- Fasenra® is not indicated for treatment of other eosinophilic conditions or for the relief of acute bronchospasm or status asthmaticus.
- Dosed per package labeling.

Renewal Coverage Criteria

Add on Treatment of Severe Eosinophilic Asthma:

Member must meet all of the following criteria:

- Have positive clinical response to therapy such as a reduction in frequency and/or severity of symptoms and exacerbations or medication dose reduction.
- Be adherent to Fasenra® **and** ICS/LABA therapy.

Prescriber requirements:

- Annual specialist consult provided if prescriber not a specialist.
- Have documentation of positive clinical response to therapy such as a reduction in frequency and/or severity of symptoms and exacerbations or medication dose reduction.
- Verification of compliance will be made via Medicaid paid claims data. If non-compliance is determined, the reauthorization time frame may be reduced to allow time for the provider to address member compliance.
- Attests that member **will not** use Fasenra® concomitantly with other biologics.

Treatment of adult patients with eosinophilic granulomatosis with polyangiitis (EGPA).

Member must meet all of the following criteria:

- Have positive clinical response to therapy such as a reduction in frequency and/or severity of symptoms and exacerbations or corticosteroid dose reduction.

Prescriber requirements:

- Annual specialist consult provided if prescriber not a specialist.
- Have documentation of positive clinical response to therapy such as a reduction in frequency and/or severity of symptoms and exacerbations or corticosteroid dose reduction.
- Attests that member **will not** use Fasenra® concomitantly with other biologics.

Quantity Limits

Maximum Dose:

Add on Treatment of Severe Eosinophilic Asthma:

- Adults and adolescents 12 years of age and older: 30mg SQ every 4 weeks for 3 doses, then 30mg SQ every 8 weeks.
- Children 6 to 11 years of age:
    - Weighing less than 35 kg:10 mg SQ every 4 weeks for the first 3 doses, then 10 mg SQ once every 8 weeks.
    - Weighing 35 kg or more:30 mg SQ every 4 weeks for the first 3 doses, then 30 mg SQ once every 8 weeks.

Treatment of adult patients with eosinophilic granulomatosis with polyangiitis (EGPA).

- Adults 18 years of age and older: 30mg SQ every 4 weeks.

Coverage Duration

Initial approval: 6 months
Renewal approval duration: 12 months

B. Linzess® (linaclotide)

Criteria Updates – the criteria documented below is the updated and current criteria approved by the Board. The updates are as follows:

1. *Change in approved age from 18 years of age or older to 7 years of age or older for patients with irritable bowel syndrome with constipation (IBS-C).*
2. *Boxed warning remains for off-label use in children under 2 years of age for risk of serious dehydration.*

Initial Coverage Criteria

Irritable bowel syndrome with constipation (IBS-C)

Member must meet all of the following criteria:
- Be 7 years of age or older.
- Have had a trial and inadequate response, or contraindication to at least ONE (1) osmotic laxative (i.e., polyethylene glycol, lactulose, etc.) for at least 14 days.
- If medication is non-preferred, must have had a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List 19 (unless preferred product(s) do not have the appropriate indication)

Chronic idiopathic constipation (CIC) in adults

Member must meet all of the following criteria:
- Be 18 years of age or older.
- Have had a trial and inadequate response, or contraindication to at least ONE (1) osmotic laxative (i.e., polyethylene glycol, lactulose, etc.) for at least 14 days.
- If medication is non-preferred, must have had a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List 19 (unless preferred product(s) do not have the appropriate indication)

Functional constipation (FC) in pediatric patients 6 to 17 years of age

Member must meet all of the following criteria:
- Be 6 years of age or older.
- Have had a trial and inadequate response, or contraindication to at least ONE (1) osmotic laxative (i.e., polyethylene glycol, lactulose, etc.) for at least 14 days.
- If medication is non-preferred, must have had a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List 19 (unless preferred product(s) do not have the appropriate indication)

Limitations:
Dosed per package labeling based on indication and age.

Quantity Limits
- Maximum daily dose: 1 capsule daily

Coverage Duration
Initial approval: 12 months
Renewal approval duration: 12 months

C. Austedo®/Austedo XR® (deutetrabenazine) and Ingrezza®/Ingrezza® Sprinkles (valbenazine)

Criteria Updates – the criteria documented below is the updated and current criteria approved by the Board. The updates are as follows:

1. *Instead of attaching the full 14 item AIMS criteria, only items 1-7 apply to the AIMS score on the PA form for TD requests.*
2. *Provider will document how TD is affecting the member's function, quality of life, or socialization on the PA form instead of requiring 6 months of chart notes.*
3. *Initial authorization interval extended from 12 weeks to 6 months.*
4. *Renewal authorization interval extended from 6 months to 1 year.*

Initial Coverage Criteria

Huntington's Chorea

Member must meet all of the following criteria:

- Be 18 years of age or older.
- Have a functional disability resulting from chorea associated with Huntington's disease, confirmed by a neurologist.

Prescriber requirements:

- Attests to the following:
  - They are aware of the black box warning of increased risk of depression and suicidal ideation and behavior in patients with Huntington's Disease.
  - Member is not at significant risk of suicidal behavior.
  - Member will be counseled on, and monitored for, depression and suicidal thoughts and behaviors.
  - Member is not currently and will not be prescribed any MAOI or reserpine.
  - Member will not use Austedo®, Austedo XR®, Ingrezza®, or Ingrezza® Sprinkles concomitantly with any other vesicular monoamine transporter 2 (VMAT2) inhibitors.

Limitations:
Dosed per package labeling.

Tardive Dyskinesia

Member must meet all of the following criteria:

- Be 18 years of age or older.
- Have a diagnosis of moderate to severe tardive dyskinesia (TD).
- Have had symptoms for at least 2 months prior to prescription.

- Have had an inadequate response to the following treatment modalities, unless all are contraindicated, not tolerated or are inappropriate to maintain stable psychiatric function:
    - Discontinuation or dose modification of the offending medication
    - Switching from a first-generation antipsychotic to a second-generation antipsychotic.
- If non-preferred, must have had a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List 19 (mt.gov).

Prescriber requirements:

- Diagnosis of moderate to severe Tardive Dyskinesia was made by or in consult with one of the following:
    - Psychiatrist
    - Neurologist
    - Psychiatric Nurse Practitioner
- Has determined that Tardive Dyskinesia is antipsychotic (dopamine receptor blocker) induced.
- Attests to the following:
    - They have ruled out other potential causes of movement disorder, including, but not limited to, stimulants, stimulant use disorder, metoclopramide, etc.
    - Member is not currently and will not be prescribed any MAOI or reserpine.
    - Member will not use Austedo®, Austedo XR®, Ingrezza®, or Ingrezza® Sprinkles concomitantly with any other vesicular monoamine transporter 2 (VMAT2) inhibitors.
- Provide the following Abnormal Involuntary Movement Scale (AIMS) questions 1-7 **prior** to Austedo®, Austedo XR®, Ingrezza®, or Ingrezza® Sprinkles **initiation**. Minimum score must be greater than 6 (six).

Scoring: 0=None 1=Minimal, may be extreme normal 2=Mild 3=Moderate 4=Severe

Facial and Oral Movements

1. Muscles of Facial Expression: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
e.g., movements of forehead, eyebrows, periorbital area, cheeks, including frowning, blinking, smiling, grimacing

2. Lips and Perioral Area: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
e.g., puckering, pouting, smacking

3. Jaw: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
e.g., biting, clenching, chewing, mouth opening, lateral movement

4. Tongue: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Rate only increase in movement both in and out of mouth, NOT inability to sustain movement. Darting in and out of mouth.

Extremity Movements

5. Upper (arms, wrists, hands, fingers): ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Include choreic movements (i.e., rapid, objectively purposeless, irregular, spontaneous) athetoid movements (i.e., slow, irregular, complex, serpentine). DO NOT INCLUDE TREMOR (i.e., repetitive, regular, rhythmic)

6. Lower (legs, knees, ankles, toes): ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot.

Trunk Movements

7. Neck, shoulders, hips: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
e.g., rocking, twisting, squirming, pelvic gyrations

TOTAL SCORE: _____

DATE of AIMS assessment prior to beginning treatment: _____

- Document BELOW how TD is affecting the member's function, quality of life, or socialization **(must be answered for approval)**:

Limitations:
Dosed per package labeling.

Renewal Coverage Criteria

Huntington's Chorea

Member must meet all the following criteria:
- Has shown symptom improvement as evidenced by a decrease in the Total Maximal Chorea Score.
- Is not at significant risk for suicidal behavior.

Tardive Dyskinesia

Prescriber requirements:

- Provide documented and current **updated** evaluation of the condition. Use the Abnormal Involuntary Movement Scale (AIMS) questions 1-7.

Scoring: 0=None 1=Minimal, may be extreme normal 2=Mild 3=Moderate 4=Severe

Facial and Oral Movements

1. Muscles of Facial Expression: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
e.g., movements of forehead, eyebrows, periorbital area, cheeks, including frowning, blinking, smiling, grimacing

2. Lips and Perioral Area: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
e.g., puckering, pouting, smacking

3. Jaw: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
e.g., biting, clenching, chewing, mouth opening, lateral movement

4. Tongue: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Rate only increase in movement both in and out of mouth, NOT inability to sustain movement. Darting in and out of mouth.

Extremity Movements

5. Upper (arms, wrists, hands, fingers): ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
Include choreic movements (i.e., rapid, objectively purposeless, irregular, spontaneous) athetoid movements (i.e., slow, irregular, complex, serpentine). DO NOT INCLUDE TREMOR (i.e., repetitive, regular, rhythmic)

6. Lower (legs, knees, ankles, toes): ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
e.g., lateral knee movement, foot tapping, heel dropping, foot squirming, inversion and eversion of foot.

Trunk Movements

7. Neck, shoulders, hips: ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4
e.g., rocking, twisting, squirming, pelvic gyrations

TOTAL SCORE: _____

DATE of most recent AIMS assessment: _____

- Document BELOW how Austedo®, Austedo XR®, Ingrezza®, or Ingrezza® Sprinkles has improved the member's function, quality of life, or socialization **(must be answered for approval)**:

_____

_____

Quantity Limits

Maximum Daily Dose:
- Austedo® formulations: 48mg daily (dose optimization required)
- Ingrezza® formulations: 80mg daily (dose optimization required)

Coverage Duration

Huntington's Chorea
- Initial approval duration: 6 months.
- Renewal approval duration: 12 months

Tardive Dyskinesia
- Initial approval duration: 6 months
- Renewal approval duration: 12 months

2. New Indication/Formulation:

A. Wegovy® (semaglutide injection and oral tablets)

Criteria Updates – the criteria documented below is the updated and current criteria approved by the Board. The updates are as follows:

1. *New tablet formulation that is **only** covered for the following indication:*
   To reduce the risk of major adverse cardiovascular events (cardiovascular death, non-fatal myocardial infarction, or non-fatal stroke), MACE, in adults with established cardiovascular disease and either obesity or overweight.

Initial Coverage Criteria

Reduction of risk of MACE in adults with established CVD and obesity or overweight

Member must meet all of the following criteria:
- Be 18 years of age or older.
- Have established cardiovascular disease with a history of prior myocardial infarction, prior stroke, or peripheral arterial disease.
- A BMI of greater than 27 kg/m^2.
- Does not have Type 2 diabetes. Members with type 2 diabetes must be managed with a GLP-1 agonist U.S. Food and Drug Administration (FDA)-approved for that indication from the Montana Healthcare Programs preferred drug list.
- Agreed to adhere to a reduced calorie diet and increased physical activity plan.

- If medication is non-preferred, must have had a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List 19 (unless preferred product(s) do not have the appropriate indication).

Prescriber requirements:

- Must be prescribed by, or in consult with, an appropriate cardiac specialist.
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly reauthorization.
- Attests to the following:
    - The provider is aware Wegovy® is contraindicated in members with a personal or family history of medullary thyroid cancer or multiple endocrine neoplasia 2.
    - The provider is aware of boxed warning about the risk of thyroid C-cell tumors.
    - The provider is aware of the risk of pancreatitis, gallbladder disease, hypoglycemia, acute kidney injury and diabetic retinopathy complications.
    - The provider is aware Wegovy® may increase the risk of suicidal behavior and ideation.
- Attests that member will be placed on a reduced calorie diet and increased physical activity plan.

MASH in Adults with moderate to advanced liver fibrosis

Member must meet all of the following criteria:

- Be 18 years of age or older.
- Have a diagnosis of noncirrhotic metabolic dysfunction associated steatohepatitis (MASH) with moderate to advanced liver fibrosis (consistent with stages F2 to F3 fibrosis) diagnosed by one of the following:
    - Specialized ultrasound (such as FibroScan®) measuring fat, inflammation, and scarring in the liver.
    - Liver biopsy.
- Does not have Type 2 diabetes. Members with type 2 diabetes must be managed with a GLP-1 agonist U.S. Food and Drug Administration (FDA)-approved for that indication from the Montana Healthcare Programs preferred drug list.
- Have had a trial of diet, exercise, and lifestyle modification.
- Continue with diet, exercise, and lifestyle modifications.
- If medication is non-preferred, must have had a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List 19 (unless preferred product(s) do not have the appropriate indication).

Prescriber requirements:

- Must be prescribed by, or in consult with, a gastroenterology or hepatology specialist.
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly reauthorization.
- Comorbid conditions (including, but not limited to, those listed below) are being managed with maximumly tolerated medications:

    - Hypertension
    - Dyslipidemia
    - Type 2 Diabetes
- Attests to the following:
    - The provider is aware Wegovy® is contraindicated in members with a personal or family history of medullary thyroid cancer or multiple endocrine neoplasia 2.
    - The provider is aware of boxed warning about the risk of thyroid C-cell tumors.
    - The provider is aware of the risk of pancreatitis, gallbladder disease, hypoglycemia, acute kidney injury and diabetic retinopathy complications.
    - The provider is aware Wegovy® may increase the risk of suicidal behavior and ideation.
- Attests that member will continue on a reduced calorie diet and increased physical activity plan.

Limitations:
Dosed per package labeling titration schedule.

Renewal Coverage Criteria

Reduction of risk of MACE in adults with established CVD and obesity or overweight

Prescriber requirements:
- Annual specialist consult provided if prescriber not a specialist.
- Has documentation of positive clinical measures of cardiovascular disease risk reduction (weight reduction, reduced waist circumference, blood pressure improvement, improved cholesterol profile).
- Attests member has maintained a reduced calorie diet and increased physical activity plan.

MASH in Adults with moderate to advanced liver fibrosis

Prescriber requirements:
- Annual specialist consult provided if prescriber not a specialist.
- At initial 12-month review, and every 4 years thereafter at minimum, provide documentation of improvement in MASH with no worsening of fibrosis OR improvement of fibrosis with no worsening of MASH documented by one (1) of the following:
    - Specialized ultrasound (such as FibroScan®) measuring fat, inflammation, and scarring in the liver.
    - Liver biopsy.
      ***Date and score of last measurement will be required at annual renewal*
- Attests member has maintained a reduced calorie diet and increased physical activity plan.
- Continued maximumly tolerated medications for hypertension, dyslipidemia, and Type 2 diabetes if appropriate.

Quantity Limits
Maximum dose = one injection weekly OR one tablet daily.

- 2.4mg subcutaneous injection weekly for MACE or MASH
- 25mg oral tablet daily for MACE only

Coverage Duration
Initial approval duration: 12 months
Renewal approval duration: 12 months

3. New Drug Criteria:

A. Exdensur® (depemokimab-ulaa)

Initial Coverage Criteria

Member must meet all of the following criteria:

- Be 12 years of age or older.
- Have a diagnosis of severe asthma characterized by an eosinophilic phenotype.
- Have a baseline peripheral blood eosinophil count of greater than or equal to 150 cells/μL within the last 6 weeks or greater than or equal to 300 cells/μL within the last year.
- Have a history of severe asthma attacks despite treatment with, and adherence to, an optimized dose of inhaled corticosteroid in combination with a long-acting beta2-agonist (ICS/LABA) for three consecutive months.
- If medication is non-preferred, must have had a trial and inadequate response, or contraindication to a preferred drug with the same indication from the Montana Healthcare Programs Preferred Drug List 19 (unless preferred product(s) do not have the appropriate indication).

Prescriber requirements:

- Must be prescribed by, or in consult with, a pulmonology, allergy, or immunology specialist.
- If not prescribed by an appropriate specialist, a copy of the specialty consult is required. Annual consult required for yearly reauthorization.
- Attests that member will not use Exdensur® concomitantly with other biologics.

Limitations:
Exdensur® should be administered by a healthcare provider. Currently approved only under the Physicians Administered Drug program.

Renewal Coverage Criteria

Member must meet all of the following criteria:

- Has been adherent to Exdensur® **and** ICS/LABA therapy
- Verification of adherence will be made via Medicaid paid claims data. If non-compliance is determined, the reauthorization time frame may be reduced to allow time for the provider to address member compliance.

Prescriber requirements:

- Annual specialist consult provided if prescriber not a specialist.
- Has documentation of positive clinical response to therapy (e.g., reduction in the frequency and/or severity of asthma symptoms and exacerbations, decrease in emergency healthcare visits, reduction of rescue oral corticosteroids, etc.).
- Attests that member will not use Exdensur® concomitantly with other biologics.

Quantity Limits
Maximum Dose = 100mg subcutaneous injection every 26 weeks.

Coverage Duration

Initial approval: 12 months (2 doses)
Renewal approval duration: 12 months (2 doses)

B. Itvisma® (onasemnogene abeparvovec-brve)
The Board discussed concerns related to member contraception related to Itvisma® treatment. It was decided to add a provider attestation.

The criteria was approved as follows:

Initial Coverage Criteria

Member must meet all of the following criteria:
- Be two (2) years of age or older.
- Has a diagnosis of SMA with:
  - Confirmed bi-allelic SMN1 gene deletions or dysfunctional point mutations confirming a diagnosis of SMA **AND**
  - Less than or equal to 4 copies of the SMN2 gene.
- Has baseline anti-AAV9 antibody titer of less than or equal to 1:50.
- Does not require:
  - invasive ventilation **OR**
  - awake noninvasive ventilation for > 6 hours during a 24-hour period **OR**
  - noninvasive ventilation for > 12 hours during a 24-hour period **OR**
  - requiring tracheostomy

Prescriber requirements:

- Must be prescribed by a neurologist.
- Must submit documentation of a baseline motor function milestone evaluation test using an age-appropriate screening tool (e.g., Revised Hammersmith).
- Attests to the following:
  - Liver function tests, platelet counts, and troponin-1 have been, and will continue to be performed per label.
  - Vaccination status has been assessed.
  - Knowledge of boxed warning of serious liver injury and acute liver failure with Itvisma®.

- The prescriber will administer systemic corticosteroids beginning one day prior to Itvisma® injection and continuing per labeling depending on liver function and then tapered gradually.
- The pregnancy status of females of reproductive potential should be verified prior to treatment.
- Females of reproductive potential should use effective contraception (methods that result in less than 1% pregnancy rates) and should refrain from egg donation for 6 months after administration.
- Men capable of fathering a child should use a barrier method of contraception and should refrain from sperm donation for 3 months following administration.

- Attests that member will not use Itvisma® if they have been treated with Zolgensma®.
- Attests member will not use Itvisma® concurrently with Spinraza®(nusinersen) OR Evrysdi® (risdiplam).

Limitations:
Dosed per package labeling

Renewal Coverage Criteria
Itvisma® is only indicated for one (1) intrathecal injection per lifetime.

Quantity Limits
A single dose of Itvisma® 1.2 x 10^{14} vector genomes is administered intrathecally via lumbar puncture.

Coverage Duration

Initial approval: One (1) single injection.
Renewal approval duration: None.

4. Board Discussion:

Board reminded they will be receiving their annual DUR Board agreement via DocuSign®.

The next 3 meetings are Preferred Drug List (PDL) meetings. Dates were provided to the Board and are as follows: 3/18/26, 4/22/26, and 5/20/26. These are also posted on the Board portal page.

The meeting was adjourned at 2:00 p.m.