



AmeriHealth Caritas[™]
New Hampshire

To: AmeriHealth Caritas New Hampshire Medicaid Providers

Date: June 10th, 2026

Subject: AmeriHealth Caritas New Hampshire Formulary Changes

Summary: Effective July 6, 2026, the changes below will be made to the AmeriHealth Caritas New Hampshire formulary.

Medications added to the formulary:

- Daybue Stix Oral Packet 5000 MG w/PA
- Daybue Stix Oral Packet 6000 MG w/PA
- Daybue Stix Oral Packet 8000 MG w/PA
- Metoprolol Tartrate Oral Tablet 12.5 MG
- Shingrix Intramuscular Suspension Prefilled Syringe 50 MCG/0.5ML w/PA,
- Lopressor Oral Tablet 12.5 MG w/PA
- levetiracetam Oral Tablet Disintegrating Soluble 500 MG w/PA
- Ustekinumab-ttwe Subcutaneous Solution 45 MG/0.5ML w/PA
- Orladeyo Oral Packet 72 MG w/PA
- Orladeyo Oral Packet 96 MG w/PA
- Orladeyo Oral Packet 108 MG w/PA
- Orladeyo Oral Packet 132 MG w/PA
- Neulasta Subcutaneous Solution 4 MG/0.4ML w/PA

Medications removed from the formulary:

- Roctavian
- Synagis

Quantity limit (QL) additions:

- Epinephrine (Adrenaclick[®]) 0.15 mg auto-injector QL of #4/30
- Auvi-Q[®] (epinephrine) 0.15 mg auto-injector QL of #4/30
- Auvi-Q[®] (epinephrine) 0.1 mg auto-injector QL of #4/30
- Neffy[®] (epinephrine) 2 mg/0.1 ml nasal spray QL of #4/30
- Neffy[®] (epinephrine) 1 mg/0.1 ml, adding a QL of #4/30
- Estazolam (Prosom[®]) 1 mg tablet QL(30/30)
- Estazolam (Prosom[®]) 2 mg tablet QL(30/30)
- Flurazepam (Dalmane[®]) 30 mg capsule QL(30/30)
- Flurazepam (Dalmane[®]) 15 mg capsule QL(30/30)
- Temazepam (Restoril[®]) 7.5mg capsule QL(30/30)

- Temazepam (Restoril®) 15 mg capsule QL(30/30)
- Temazepam (Restoril®) 22.5 mg capsule QL(30/30)
- Temazepam (Restoril®) 30 mg capsule QL(30/30)

New clinical prior authorization criteria additions:

- Aqvesme
- Zycubo
- Loargys
- Yartemlea
- Redemplo

Clinical prior authorization revisions:

- Hypertrophic Cardiomyopathy
- Itvisma
- SMN2 Splicing Modifiers for the Treatment of Spinal Muscular Atrophy (SMA)
- Somatostatin Analogs and Growth Hormone Receptor Antagonists
- Systemic Immunomodulators
- Injectable/Infusible Bone-Modifying Agents for Oncology Indications
- Agents to Treat Gaucher Disease prior authorization criteria

Prior authorization revisions with no clinical changes:

- N/A

The following criteria will be retired:

- Roctavian
- Synagis

Age limit (AL) additions (in years of age):

- N/A

Questions: If you have questions about this communication, please contact AmeriHealth Caritas New Hampshire Provider Pharmacy Services at **1-888-765-6394 (TTY 1-855-809-9206)**.