Mountain Pacific DUR PROGRAM NEWS

WINTER 2025-2026

Montana Healthcare Pharmacy Programs Link (Current Montana Healthcare Programs Preferred Drug List, Provider Notices, DUR Board/Meeting Information, Resources)
http://medicaidprovider.mt.gov/19

For current drug prior authorization criteria:
https://mpqhf.org/resources/pharmacy-resources/#drug-prior-authorization

The Drug Utilization Review (DUR) Program, administered by Mountain Pacific through a contract with the Allied Health Services Bureau of the Montana Department of Public Health and Human Services, is the quality assurance body seeking to assure the quality of pharmaceutical care and to help provide rational, cost-effective medication therapy for Montana Healthcare Programs members.

Updates and Reminders

PHARMACIST-ADMINISTERED VACCINES

This is a reminder that pharmacist-administered vaccines **are not covered for Medicaid enrolled children**. These members are eligible under the Vaccines for Children (VFC) program.

Pharmacist-administered vaccines and vaccine administration **are covered for members enrolled in Medicaid and Medicaid expansion who are 19 years of age and older** and for all members enrolled in Healthy Montana Kids (HMK).

Find a Montana VFC provider:
https://dphhs.mt.gov/assets/publichealth/Immunization/PhilProviderList.pdf

ANTIVIRALS: INFLUENZA

Oseltamivir suspension and capsules, and Xofluza® are the preferred agents on the Montana Healthcare Programs Preferred Drug List (PDL) dated December 12, 2025. To be sure these are the current preferred products, check the PDL at medicaidprovider.mt.gov/19.

PDL REMINDER

Remember, the PDL changes multiple times during the year but most frequently when PDL meetings are held in the spring. The meetings are open to the public, and dates and times can be found at medicaidprovider.mt.gov/19 then going to the "Drug Use Review (DUR) Board" tab, then choosing "Drug Use Review (DUR) Board/Formulary Committee." This will give you an option for "DUR Board Meeting Agendas" where you will find the agenda for the upcoming meeting.

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Montana Healthcare Programs Drug Prior Authorization Unit 1-800-395-7961

This information is brought to you by:
Mountain Pacific
P.O. Box 5119 | Helena, MT 59604
www.mpqhf.org

Updates and Reminders (cont.)

VETERANS AFFAIRS REPORTING DIFFERENCE

At the last Montana Healthcare Programs drug utilization board meeting, Tamara Jost, PharmD, Chief of Pharmacy Service, at Fort Harrison, Montana Veterans Affairs Pharmacy, informed the board that, because gabapentin is classified as a controlled substance at the state level but not at the federal level, Veterans Affairs pharmacies **are prohibited from reporting gabapentin dispensing** to the Montana Prescription Drug Registry (MPDR) or any other state drug monitoring program.

This is a concern for prescribers and pharmacists who depend on the MPDR to get this important information. Feel free to share this information with your colleagues.

Overview of Guideline Updates

As we wrap up another year and look ahead to 2026, it is a great time to pause, regroup and ensure our pharmacy practices remain aligned with the most up-to-date evidence. The past year has brought significant updates across many major disease states. The following sections highlight key resources with guidelines and updates, organized by disease state for quick reference.

Anticoagulation

American College of Chest Physicians (CHEST) Journal article Antithrombotic Therapy for VTE Disease: Second Update of the CHEST Guideline and Expert Panel Report, published December 2021.
https://journal.chestnet.org/article/S0012-3692(21)01506-3/fulltext

Highlights:

- **Venous thromboembolism (VTE) treatment:** Prefer the use of direct oral anticoagulants (DOACs) over warfarin for the first three months in most patients with a deep vein thrombosis (DVT) or pulmonary embolism (PE).
- **Cancer-associated thrombosis:** Use oral Xa inhibitors (e.g., apixaban [Eliquis], rivaroxaban [Xarelto], edoxaban [Savaysa]) over low molecular weight heparin (LMWH). Apixaban or LMWH preferred in luminal gastrointestinal cancers due to lower bleeding risk.
- **Superficial venous thrombosis (SVT):** Treat high-risk SVT with fondaparinux (Arixtra) using a dosage of 2.5mg daily for 45 days **or** with rivaroxaban (Xarelto) using a dosage of 10mg daily as a reasonable alternative.

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Guideline Updates (cont.)

Asthma

Global Initiative for Asthma (GINA) 2025 Summary Guide for Asthma Management and Prevention, published May 2025. https://ginasthma.org/2025-gina-summary-guide/

Highlights:

- **Use an inhaled corticosteroid (ICS) for all.** No patient should be treated with a short-acting beta agonist (SABA) alone. All regimens should include an ICS-containing inhaler.
- **Anti-Inflammatory reliever (AIR) approach:** The guide promotes ICS-formoterol as both the asthma controller and reliever in a single inhaler across most severity levels. If ICS-formoterol is not available, use ICS-SABA as an alternative.

National Asthma Education and Prevention Program (NAEPP) 2020 Focused Updates to the Asthma Management Guidelines, published December 2020. https://www.nhlbi.nih.gov/resources/2020-focused-updates-asthma-management-guidelines

Highlights:

- **ICS-formoterol:** Updates strongly recommend ICS-formoterol in a single inhaler for dual use as both daily controller and reliever therapy for patients four years of age or older with moderate-to-severe persistent asthma. ICS-formoterol provides both rapid bronchodilation and ongoing anti-inflammatory control.
- **Long-acting muscarinic agents (LAMAs) add-on therapy:** The use of LAMAs may be added to ICS-based regiments for patients needing additional long-term asthma control. LAMAs help maintain airway relaxation and can reduce symptoms and exacerbations.
- **Step therapy adjustments:** The updates support short courses of daily ICS at onset of viral infections in children zero to four years of age, allowing ICS/SABA as needed for mild persistent asthma in adults.
- **Allergen and immunotherapy guidance:** Updates shift toward targeted, multicomponent allergen mitigation and conditionally support subcutaneous immunotherapy (SCIT) as an adjunct for controlled allergic asthma.

Chronic Obstructive Pulmonary Disease (COPD)

2025 GOLD Report: Global Initiative for Chronic Obstructive Lung Disease, published November 2024. https://goldcopd.org/wp-content/uploads/2024/11/GOLD-2025-Report-v1.0-15Nov2024_WMV.pdf

- **Recommendation of two novel classes of medication:**
  - Ensifentrine (Ohtuvayre®), a dual PDE3/PDE4 inhibitor, is an anti-inflammatory and bronchodilator that may be added for patients with persistent dyspnea despite dual bronchodilator therapy.

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  - Dupilumab (Dupixent®), a biologic that targets IL-4/IL-13 pathways, has been shown to reduce exacerbations and improve lung function. Consider adding this for patients on triple therapy who continue to exacerbate.
- **Additional 2025 considerations:** Expanded guidance on cardiovascular risk, pulmonary hypertension, climate impacts and hydration status in COPD management.

Chronic Kidney Disease (CKD)

Kidney Disease Improving Global Outcomes (KDIGO) Guidelines, published April 2024. https://kdigo.org/guidelines/ckd-evaluation-and-management/

- **Expanded therapy focus:** Guidelines recommend sodium-glucose cotransporter-2 inhibitors (SGLT2 inhibitors), nonsteroidal mineralocorticoid receptor antagonists (MRAs) and glucose-like peptide-1 (GLP-1) receptor agonists for kidney and cardiovascular protection in eligible patients, along with optimized blood pressure, glucose and lipid management.
- **Personalized care approach:** Guidelines emphasize a multifactorial management plan, targeting systolic blood pressure (SBP) at less than 120 mmHg, the use of statins for atherosclerotic cardiovascular disease (ASCVD) protection and tailoring interventions based on age, comorbidities and CKD stage.
- **Medication safety and stewardship:** The guidelines introduce guidance on dose adjustment by glomerular filtration rate (GFR), avoidance of nephrotoxic drugs and periodic medication reviews to reduce polypharmacy and adverse effects.

Congestive Heart Failure (CHF)

2024 American College of Cardiology (ACC) Expert Consensus Decision Pathway for Treatment of Heart Failure with Reduced Ejection Fraction: A Report of the ACC Solution Set Oversight Committee, published March 2024. https://www.jacc.org/doi/10.1016/j.jacc.2023.12.024

- **Early guideline-directed medical therapy (GDMT) initiation:** Start all GDMT therapies (e.g., angiotensin receptor-neprilysin inhibitor (ARNI), beta-blocker, sodium-glucose cotransporter 2 (SGLT2) inhibitor, an MRA) as early as possible, preferably during hospitalization if safe.
  - SGLT2 inhibitors can be initiated anytime, including inpatient, regardless of ejection fraction.
  - Updates highlight refined diuretic/decongestion strategies, individualized medication titration and stronger focus on care coordination and equity.

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Guideline Updates (cont.)

Diabetes

American Diabetes Association (ADA) Standards of Care in Diabetes 2025, published January 2025. https://diabetesjournals.org/care/issue/48/Supplement_1

- **Expanded pharmacologic guidance:** Prioritize agents improving cardiovascular, renal and weight outcomes with a broader use of GLP-1, dual glucose-dependent insulinotropic polypeptide (GIP)/glucagon-like peptide-1 (GLP-1), SGLT2 inhibitors and pioglitazone for patients with comorbid CKD, heart failure with preserved ejection fraction (HFpEF) or metabolic liver disease.
- **Medication adjustments:** Reassess insulin and sulfonylurea dosing when adding new agents to reduce hypoglycemia risk. Standards of care advise against combining dipeptidyl peptidase-4 (DPP-4) inhibitors with any GLP-1 due to limited benefit.

American Association of Clinical Endocrinology (AACE) Consensus Statement: Comprehensive Type 2 Diabetes Management Algorithm, published May 2023. https://www.endocrinepractice.org/article/S1530-891X(23)00034-4/fulltext

- **Comorbidity-centered therapy:** Select agents based on comorbidities. For example, use GLP-1 receptor agonists or SGLT2 inhibitors with proven ASCVD, heart failure or CKD benefit, independent of glycated hemoglobin (A1C).
- **A1C goal:** Target A1C is safe when less than or equal to 6.5%. Individualize target to 7-8% for patients at higher hypoglycemia risk or with advanced disease.
- **Preferred agents:** Choose therapies with low hypoglycemia risk and avoid sulfonylureas or insulin unless clinically necessary.
- **Timely adjustment:** Reassess every three months and escalate therapy promptly to reach goals and reduce complications.

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Guideline Updates (cont.)

Hepatitis C

American Association for the Study of Liver Diseases and Infectious Diseases Society of America Guidance, latest update published March 2025. https://www.hcvguidelines.org/

- **Same-day initiation:** In settings with point-of-care Hepatitis C virus (HCV) RNA testing, start antiviral therapy on the day of diagnosis if the criteria has been met.
- **Simplified regimen access extended:** The guidance emphasizes the broader eligibility for simplified pangenotypic direct-acting antivirals (DAAs) in adults with treatment-naïve HCV, even in community or non-specialist settings.
- **Prioritizing vulnerable populations:** The algorithm emphasizes minimizing loss-to-follow-up in high-risk groups by reducing time from test to treatment.

Hereditary Angioedema (HAE) with Normal C1

Clinical Reviews in Allergy & Immunology article Hereditary Angioedema with Normal C1 Inhibitor: an Updated International Consensus Paper on Diagnosis, Pathophysiology and Treatment, published March 2025. https://link.springer.com/article/10.1007/s12016-025-09027-4

- **Diagnosis is challenging:** Physicians may hesitate to initiate treatment because C1 inhibitor (C1INH) tests are normal. The consensus emphasizes the importance of a diagnosis made by an expert physician, even without an identified genetic mutation.
- **Treatment is critical:** The document states that patients with HAE-nC1INH are at risk of serious morbidity and mortality, similar to those with C1INH deficiency. Proactive management is crucial.
- **Avoid certain medications:** Patients should be advised to avoid certain drugs, including angiotensin-converting enzyme inhibitors (ACEi), hormone replacement therapy and estrogen-based oral contraceptives, as they may worsen HAE attacks.

Hypertension

American Heart Association (AHA) Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults: A Report of the ACC/American Heart Association (AHA) Joint Committee on Clinical Practice Guidelines, published August 2025. https://www.ahajournals.org/doi/10.1161/CIR.0000000000001356

- **Resistant hypertension:** All patients with resistant hypertension should be screened for primary aldosteronism regardless of potassium level. Most antihypertensives (except MRAs) should be continued prior to screening.
- **Diabetes, CKD or a greater than or equal to 7.5% 10-year CVD risk:** Patients with any one of these diagnoses should start therapy if their blood pressure is greater than or equal to 130/80. For low-risk CVD patients (less than 7.5% 10-year CVD risk), initiate medications if blood pressure remains greater than or equal to 130/80 after three to six months of lifestyle changes.
- **CKD or diabetes:** In patients with CKD or diabetes, ACEi or angiotensin receptor blockers (ARBs) are recommended if estimated glomerular filtration rate (eGFR) is less than 60 or albuminuria is greater than or equal to 30mg/g.

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Guideline Updates (cont.)

- **Pregnancy-related hypertension:** Treat severe elevations of blood pressure (e.g., a blood pressure greater than or equal to 160/110) within 30-60 minutes. Manage chronic hypertension to a blood pressure less than 140/90 and use low-dose aspirin to prevent preeclampsia. Avoid atenolol, ACEi, ARBs, direct renin inhibitors (DRIs), nitroprusside and MRAs.
- **Other updates** include new guidance on potassium-based salt substitutes, blood pressure targets for cognitive protection and revised stroke management strategies.

Opioid Use Disorder (OUD) Management

American Society of Addiction Medication (ASAM) National Practice Guideline for the Treatment of OUD 2020 Focused Update, published March 2020. https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2

- **Medications for Opioid Use Disorder (MOUD):** Methadone, buprenorphine and extended-release naltrexone are recommended as a first line of treatment for all patients with OUD. Treatment should not be withheld because of concurrent substance use (i.e., benzodiazepines, alcohol, stimulants, cannabis).
- **OUD withdrawal and maintenance:** Buprenorphine and methadone are preferred for withdrawal and maintenance treatment. Buprenorphine is initiated once objective withdrawal is present. Most patients require greater than or equal to 16mg per day of buprenorphine or 60-120 mg per day of methadone for stabilization.
- **Extended-release naloxone:** Extended-release naloxone is an option only after full opioid detoxification (typically 7-14 days opioid free, longer if transitioning from methadone). The dose for extended-release naloxone is 380mg intramuscularly (IM) every four weeks.
- **Avoid abrupt discontinuation:** There is no maximum duration of treatment for OUD with MOUD. Long-term therapy reduces mortality and relapse risk.
- **Naloxone for all:** Naloxone should be provided to all patients. Include counseling on overdose risks during initiation, dose changes or transitions between medications.

Benzodiazepine Tapering

The Joint Clinical Practice Guideline on Benzodiazepine Tapering: Considerations when Benzodiazepine Risks Outweigh Benefits, published by ASAM in March 2025. https://www.asam.org/quality-care/clinical-guidelines/benzodiazepine-tapering

- **Avoid abrupt discontinuation:** Patients who are physically dependent on benzodiazepine should have gradual, supervised tapers to minimize withdrawal. Abrupt cessation is not recommended.

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- **Tapering strategy:** Start with 5-10% dose reductions every two to four weeks, not exceeding 25% every two weeks. Slow or pause taper if withdrawal symptoms emerge. Consider switching to a longer-acting benzodiazepine for stabilization.
- **Support and safety:** Integrate cognitive behavior therapy (CBT), manage co-occurring conditions and provide naloxone when opioids are co-prescribed.

Pain Management

Center for Disease Control and Prevention (CDC) Clinical Practice Guideline for Prescribing Opioids for Pain, published November 2022.
https://www.cdc.gov/mmwr/volumes/71/rr/rr7103a1.htm#recommendations

- **Morphine milligram equivalents (MME) thresholds:** Use caution before increasing total opioid dosage to greater than or equal to 50 MME per day and reassess benefits and risks. Avoid increasing to greater than or equal to 90 MME per day unless carefully justified based on individualized clinical assessment.
- **Initiation and duration:** When starting opioid therapy for acute pain, prescribe the lowest effective dose for no longer than the expected duration of severe pain. Many acute pain episodes require only a few days or less of opioids.
- **Opioids versus non-opioids:** For most acute, subacute and chronic pain, non-opioid therapies are preferred. Opioids should be used only when expected benefits outweigh the risks. Continue opioids only if they provide meaningful improvements in pain and function.

Department of Veteran Affairs (VA)/Department of Defense (DOD) Clinical Practice Guidelines: Use of Opioids in the Management of Chronic Pain, published May 2022.
https://www.healthquality.va.gov/guidelines/pain/cot/

- **Buprenorphine:** Buprenorphine products with the brand names Butrans® and Belbuca® are preferred over full opioid agonists when opioid therapy is being considered due to a better safety profile (i.e., lower overdose and respiratory depression risk).
- **Avoid long-term opioids:** Avoiding initiating long-term, full-agonist opioids for chronic pain except in highly select cases.
- **Structured approach:** Use a structured opioid trial approach starting low, titrating cautiously, reassessing early and discontinuing if there is no functional improvement.
- **Reassess regularly:** Reassess at least every three months and consider tapering when the risks outweigh the benefits, being sure to avoid abrupt discontinuation.

As pharmacy professionals, staying current with evolving clinical evidence is essential to delivering safe and effective care for our Montana communities. These resources and guidelines highlight meaningful changes across disease management, and many directly impact our day-to-day dispensing, counseling and clinical decision making. By integrating these recommendations into our workflow, medication reviews and patient education, pharmacists across the state can continue advancing evidence-based practices and improving outcomes.

February 2025 - November 2025 Criteria Changes

FEBRUARY 2025

NEW Criteria	Criteria UPDATE	Criteria REMOVED
Erzofri®	Auvelity®	Vyndamax™
Nemluvio®	Cimzia®	Vyndaqel®
Zepbound® (OSA)	Otezla®	
	Qelbree®	
	Skyrizi®	
	Vtama®	
	Invega Sustenna®	
	Invega Trinza®	
	Invega Hafyera®	

JUNE 2025

NEW Criteria	Criteria UPDATE	Criteria REMOVED
Alyftrek®	Dupixent®	Xarelto® 2.5mg
Journavx®	Fasenra®	
Spevigo®	Odactra®	
	Omvoh®	
	Palforzia®	
	Rinvoq®	
	Spravato®	
	Sublocade®	
	Tremfya®	
	Valtoco®	
	Yorvipath®	

SEPTEMBER 2025

NEW Criteria	Criteria UPDATE	Criteria REMOVED
Anzupgo®	Dupixent®	Clobazam®
Andembry®	Doptelet®	
Dawnzera®	Kerendia®	
Ekterly®	Motpoly XR®	
Vykat XR®	Nucala®	
Yutrepia®	Otezla®	
	Zoryve®	
	CGRP migraine criteria	
	HAE category criteria	

NOVEMBER 2025

NEW Criteria	Criteria UPDATE	Criteria REMOVED
Jascayd®	Ajovy®	
Rhapsido®	Leqembi SQ®	
Sephience®	Opzelura®	
Wayrilz®	Repatha®	
Zymfentra®	Tezspire®	
	Tremfya®	
	Wegovy®	
	Zoryve® cream	
	Interstitial lung disease category update	

For More Information

Scan the QR code to the left or use the link for the current Montana **DPHHS PDL**.

Scan the QR code to the right or use the link for Mountain Pacific **drug PA resources**.

Wishing you a safe, healthy and successful

Mountain Pacific
INNOVATING BETTER HEALTH