



DATE: December 13, 2024

This is an update to the Meridian Medicaid Plan (Meridian) Preferred Drug List.

Coverage of the medications listed below has changed, **effective [11/01/2024]**, for all members. Please reference the table for changes.

Note: Active prior authorizations for the medication(s) listed will not be affected.

If you have any questions, please call the pharmacy help desk at **855-580-1688**.

Impacted Medication	Change	Preferred Agents or New Limits
ENDARI POW 5GM	Coverage	Preferred
L-GLUTAMINE POW 5GM	Coverage	Non-preferred
VICTOZA INJ 18MG/3ML	Coverage	Preferred
LIRAGLUTIDE INJ 18MG/3ML	Coverage	Preferred
MYRBETRIQ TAB 25MG and 50 mg	Coverage	Non-Preferred
MIRABEGRON TAB 25MG ER and 50 MG ER	Coverage	Preferred
MYRBETRIQ SUS 8MG/ML	Coverage	Non-Preferred
EMFLAZA TAB 6MG, 18 MG, 30 MG, 36 MG	Coverage	Non-Preferred
DEFLAZACORT TAB 6MG, 18 MG, 30 MG, 36 MG	Coverage	Non-Preferred
EMFLAZA SUS 22.75/ML	Coverage	Non-Preferred
DEFLAZACORT SUS 22.75MG	Coverage	Non-Preferred