UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 1522-1
Program	Prior Authorization/Notification
Medication	Lynavoy (linerixibat)
P&T Approval Date	5/2026
Effective Date	8/1/2026

1. Background:

Lynavoy (linerixibat) is an ileal bile acid transporter (IBAT) inhibitor indicated for the treatment of cholestatic pruritus associated with primary biliary cholangitis (PBC) in adult patients.

Limitations of Use:
Avoid use of Lynavoy in patients with decompensated cirrhosis or those with prior or active hepatic decompensation events (e.g. variceal hemorrhage, ascites, hepatic encephalopathy).

2. Coverage Criteria[a]:

A. Initial Authorization

1. **Lynavoy** will be approved based on **all** of the following criteria:

   a. Diagnosis of primary biliary cholangitis (PBC)

   -AND-

   b. Patient is experiencing pruritis associated with PBC

   -AND-

   c. Patient does not have any of the following:

      (1) Decompensated cirrhosis
      (2) Prior or active hepatic decompensation events (e.g. variceal hemorrhage, ascites, hepatic encephalopathy).

Initial authorization will be issued for 12 months

B. Reauthorization

1. **Lynavoy** will be approved based on the following criterion:

   a. Documentation of positive clinical response to Lynavoy therapy

   -AND-

   b. Patient does not have any of the following:

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(1) Decompensated cirrhosis
(2) Prior or active hepatic decompensation events (e.g. variceal hemorrhage, ascites, hepatic encephalopathy).

Reauthorization will be issued for 12 months

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place
- Medical necessity may be in place
- Step Therapy may be in place

4. References:

1. Lynavoy [package insert]. Durham, NC: GlaxoSmithKline; March 2026.

Program	Prior Authorization/Notification – Lynavoy (linerixibat)
Change Control	
Date	Change
5/2026	New program.

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