Medical benefit specialty drug update bulletin – July 2023

Specialty drug program updates for UnitedHealthcare Commercial, Community Plan, Medicare Advantage and Individual & Family Plans

Specialty medical injectable drugs added to Review at Launch					
Drug Name	**UnitedHealthcare Commercial**	**UnitedHealthcare Community Plan**	**UnitedHealthcare Medicare Advantage**	**UnitedHealthcare Individual & Family**	**Treatment Uses**
Brixadi™ (buprenorphine)		X			Used for the treatment of moderate to severe opioid use disorder.
Elevidys (delandistrogene moxeparvovec-rokl)	X	X		X	Gene therapy used for the treatment of Duchenne muscular dystrophy in ambulatory pediatric patients age 4 through 5.
Vyjuvek™ (beremagene geperpavec-svdt)	X	X	X	X	Used for the treatment of wounds in patients 6 months of age and older with dystrophic epidermolysis bullosa.
Vyvgart® Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)	X	X		X	Used for the treatment of generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) antibody positive.

To view the **UnitedHealthcare Commercial Plan** Review at Launch Medication List, visit UHCprovider.com > Policies and Protocols > Commercial Policies > Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Commercial Plans > *Review at Launch for New to Market Medications* > **Review at Launch Medication List**.

To view the **UnitedHealthcare Community Plan** Review at Launch Drug List Plan, visit UHCprovider.com > Policies and Protocols > Community Plan Policies > Medical & Drug Policies and Coverage Determination Guidelines for Community Plan > *Review at Launch for New to Market Medications* > **Review at Launch Medication List**.

United Healthcare

For **UnitedHealthcare Medicare Advantage**, Review at Launch drugs are added as Review at Launch Part B Medications in the *Medications/Drugs (Outpatient/Part B)* Coverage Summary. To view the summary, visit UHCprovider.com > Policies and Protocols > Medicare Advantage Policies > Coverage Summaries for Medicare Advantage Plans > Medications/Drugs (Outpatient/Part B) – Medicare Advantage Coverage Summary > *Attachment A: Guideline 5 – Other Examples of Specific Drugs/Medications*.

To view the **UnitedHealthcare Individual & Family Plan** Review at Launch Medication List, visit UHCprovider.com > Policies and Protocols > For Exchange Plans > Medical & Drug Policies and Coverage Determination Guidelines for UnitedHealthcare Individual Exchange Plans > *Review at Launch for New to Market Medications* > **Review at Launch Medication List**

Specialty medical injectable drugs added to Medical Benefit Therapeutic Equivalent Medications – Excluded Drugs

Therapeutic Class	Effective Date	Excluded Medication(s)	Other Options	UnitedHealthcare Commercial
VEGF	10/1/2023	Beovu®, Byooviz™ (Lucentis biosimilar)	Avastin®, Eylea®, Lucentis®, Cimerli™ (Lucentis biosimilar), Vabysmo®	X
Immune Globulin	10/1/2023	Cuvitru™	Bivigam®, Carimune®, Flebogamma®, Gammagard®, Gammaked™, Gammaplex®, Gamunex-C®, Hizentra®, Hyqvia™, Octagam®, Privigen®, Xembify®	X

Specialty medical injectable drugs added to Medication Sourcing for Outpatient Hospitals for UnitedHealthcare Commercial

Drug Name	Effective Date	Therapeutic Class	HCPC Code(s)	Specialty Pharmacy
Beovu®	10/1/23	VEGF	Q5124	To be determined
Briumvi™	10/1/23	Multiple Sclerosis	J2329	To be determined
Byooviz™	10/1/23	VEGF	J0179	To be determined
Elevidys*	10/1/23	Gene Therapy	J3490, J3590, C9399	To be determined
Lamzede®	10/1/23	Enzyme Replacement Therapy	J3490, J3590, C9399	Eversana
Qalsody™	10/1/23	CNS Agents	J3490, J3590, C9399	Optum Frontier Pharmacy
Syfovre™	10/1/23	Complement Inhibitors – Ophthalmologic use	C9151	To be determined

Vyjuvek™*	10/1/23	Gene Therapy	J3490, J3590, C9399	To be determined

*Complex and rare disease drug

Outpatient facilities are required to obtain the medications listed in the specialty pharmacy requirements drug list for UnitedHealthcare commercial plans from the indicated specialty pharmacies for distribution of these medications, unless otherwise authorized by us. When the specialty medication is obtained through the specialty pharmacy, the specialty pharmacy will bill us directly for these medications under the member's medical benefit. The facility administering the specialty drug is not to bill us for the medication obtained through the specialty pharmacy but may bill us for the administration of the medication to the member.

Updates to drug program requirements and drug policies

Drug Name	Effective Date	UnitedHealthcare Commercial	UnitedHealthcare Community Plan	UnitedHealthcare Medicare Advantage	UnitedHealthcare Individual & Family	Treatment Uses	Summary of Changes
Altuviiio™ (antihemophilic factor (recombinant), Fc-VWF-XTEN fusion protein-ehtl)	10/1/23	X				Used for routine prophylaxis and on-demand treatment to control bleeding episodes, as well as perioperative management (surgery) for adults and children with hemophilia A.	• FDA approved 2/22/23 • Add Prior Authorization/ Notification
Briumvi™ (ublituximab-xiiy)	10/1/23	X	X	X	X	Used for the treatment of adults with relapsing forms of multiple sclerosis (MS).	• FDA approved 12/28/22 • Add Prior Authorization/ Notification
Byooviz™ (ranibizumab-nuna)	10/1/23				X	Used for the treatment of ophthalmologic conditions that include but is not limited to: neovascular (wet) age-related macular degeneration (AMD), diabetic macular edema (DME), diabetic retinopathy (DR)	• Add Prior Authorization/ Notification
Cimerli™ (ranibizumab-eqrn)	10/1/23				X	Used for the treatment of ophthalmologic conditions that include but is not limited to: neovascular (wet) age-related macular	• Add Prior Authorization/ Notification

						degeneration (AMD), Diabetic macular edema (DME), Diabetic retinopathy (DR)	
Elevidys (delandistrogene moxeparvovec-rokl)	10/1/23	X	X	X	X	Gene therapy used for the treatment of Duchenne muscular dystrophy in ambulatory pediatric patients age 4 through 5	• FDA approved 06/21/23 • Add Prior Authorization/ Notification
Elfabrio® (pegunigalsidase alfa-iwxj)	10/1/23		X		X	Used for the treatment of Fabry disease in adults.	• Add Prior Authorization/ Notification • Add to the Site of Care program for Community Plan only
Gonadotropin Releasing Hormone Analogs (Eligard®, Firmagon®, Leuprolide, Lupron®, Lupron Depot®, Lupron Depot-PED®, Supprelin® LA, Trelstar®, Zoladex®)	10/1/23		X Hawaii Only			Used for the treatment of central precocious puberty (CPP), and the management of conditions such as endometriosis and fibroids	• Add Prior Authorization/ Notification
Lamzede® (velmanase alfa-tycv)	10/1/23	X	X		X	Used for the treatment of non-central nervous system manifestations of alpha-mannosidosis in adult and pediatric patients.	• FDA approved 2/16/23 • Add Prior Authorization/ Notification in Outpatient Hospital place of service • Add to Site of Care for Commercial and Community Plans only
Lanreotide	10/1/23				X	Used for the treatment of acromegaly, carcinoid syndrome, and gastroenteropancreatic neuroendrocrine tumors in adults.	• Add Prior Authorization/ Notification
Qalsody™ (tofersen)	10/1/23	X	X	X	X	Used for the treatment of amyotrophic lateral sclerosis (ALS) in adults who have a mutation in the superoxide dismutase 1 (*SOD1*) gene.	• FDA approved 4/25/23 • Add Prior Authorization/ Notification

Rituximab (Riabni®, Rituxan®, Rituxan Hycela®, Ruxience®, Truxima®)	10/1/23		X Hawaii Only			Used for the treatment of non-oncologic conditions such as immune thrombocytopenic purpura (ITP), pemphigus vulgaris, rheumatoid arthritis, and neuromyelitis optica.	• Add Prior Authorization/ Notification
Somatostatin Analogs (Lanreotide, Octreotide, Sandostatin® LAR, Somatuline® Depot)	10/1/23		X Hawaii Only			Used for the treatment of acromegaly and Cushing's disease.	• Add Prior Authorization/ Notification
Syfovre™ (pegcetacoplan injection)	10/1/23	X			X	Used for the treatment of geographic atrophy (GA) secondary to age-related macular degeneration (AMD).	• FDA approved 2/17/23 • Add Prior Authorization/ Notification
Synagis® (palivizumab)	10/1/23		X Arizona Only			Used for the prevention of serious lower respiratory tract disease caused by RSV in children at high risk of RSV disease.	• Add Prior Authorization/ Notification to the medical benefit
Vyepti® (eptinezumab-jjmr)	10/1/23			X		Used for the preventive treatment of chronic migraines.	• Add Prior Authorization/ Notification
Vyjuvek™ (beremagene geperpavec-svdt)	10/1/23	X	X	X	X	Used for the treatment of dystrophic epidermolysis bullosa (DEB) in pediatric and adult patients.	• FDA approved 5/19/23 • Add Prior Authorization/ Notification • Add to Site of Care for Commercial only

Upon prior authorization renewal, the updated policy will apply. UnitedHealthcare will honor all approved prior authorizations on file until the end date on the authorization or the date the member's eligibility changes. You don't need to submit a new notification/prior authorization request for members who already have an authorization for these medications on the effective date noted above.

Note: Certain specialty medical injectable drug programs and updates will not be implemented at this time for providers practicing in Rhode Island, with respect to certain commercial members, pursuant to the Rhode Island regulation: 230 -RICR-20-30-14. UnitedHealthcare encourages providers practicing in Rhode Island to call in to confirm if prior authorization is required. This exception does not apply to Medicaid and Medicare.

Specialty pharmacy requirement for some commercial plan members to apply in Louisiana

Effective for dates of service on or after October 1, 2023, the requirement for care providers who participate in UnitedHealthcare commercial plans to use a specialty pharmacy when obtaining certain specialty medications for some commercial plan members will also apply in the following state/territory:

- Louisiana

The requirement will continue to not apply to care providers who treat members of plans in the following states/territories.

- Alaska, Kentucky, Maryland, and Rhode Island

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