Commercial Business

BULLETIN (6/1/2024)

Pharmacy Update - Notice of Changes to Prior Authorization Requirements and Coverage Criteria for UnitedHealthcare Commercial

Inclusion in this list does not indicate a drug is covered by a particular plan. Any drug may be subject to other requirements including but not limited to Exclude at Launch and or Review at Launch.

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Adbry	Notification	Adbry™ (tralokinumab-ldrm)	Annual review. Removed age requirement from criteria. Updated background and reference.	6/1/2024
Adbry	Medical Necessity	Adbry™ (tralokinumab-ldrm)	Annual review. Clarified topical steroid potency in atopic dermatitis with no change to clinical intent or coverage criteria. Updated background and reference.	6/1/2024
Afstyla	Notification	Afstyla® (antihemophilic factor [recombinant], single chain)	Annual review with no changes to coverage criteria. Updated reference.	6/1/2024
Afstyla	Medical Necessity	Afstyla® (antihemophilic factor [recombinant], single chain)	Annual review with no changes to coverage criteria.	6/1/2024
Aimovig, Ajovy, Emgality	Notification	Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab)	Annual review. Increased the initial authorization to 12 months. Updated references.	6/1/2024
Aimovig, Ajovy, Emgality	Medical Necessity	Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab)	Annual review. Updated initial authorization to 12 months. Added episodic to cluster headaches in section header. Updated mandate language. Updated references.	6/1/2024
Aimovig, Ajovy, Emgality	Step Therapy	Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab)	Annual review. Updated state mandate language. Updated references.	6/1/2024
Akeega	Step Therapy	Akeega™ (niraparib and abiraterone acetate)	New program.	6/1/2024
Benefit Determination – Mifeprex 200 mg and mifepristone (generic Mifeprex) 200 mg	Misc	Mifeprex 200 mg and mifepristone (generic Mifeprex) 200 mg	Annual review. No updates.	6/1/2024
Benznidazole	Notification	Benznidazole	Annual review. No changes.	6/1/2024
Bronchitol	Notification	Bronchitol® (mannitol)	Annual review. No change to coverage criteria. Updated reference.	6/1/2024
Bronchitol	Step Therapy	Bronchitol® (mannitol)	Annual review with no change to coverage criteria. Updated reference.	6/1/2024
Caplyta	Notification	Caplyta® (lumateperone)	Annual review. Updated reference.	6/1/2024
Cibinqo	Notification	Cibinqo™ (abrocitinib) tablets	Annual review. Removed age requirement from criteria. Updated reference.	6/1/2024
Cibinqo	Medical Necessity	Cibinqo™ (abrocitinib) tablets	Annual review. Clarified topical steroid potency in atopic dermatitis with no change to clinical intent or coverage criteria. Updated state mandate footnote and reference.	6/1/2024
Cinryze	Notification	Cinryze® (C1 esterase inhibitor, human)	Annual review. No changes to coverage criteria.	6/1/2024
Cinryze	Medical Necessity	Cinryze® (C1 esterase inhibitor, human)	Annual review with update to diagnostic criteria for HAE with normal C1 inhibitor levels. Simplified reauthorization criteria. Updated reference.	6/1/2024
Compounds and Bulk Powders	Notification	Compounds and Bulk Powders	Annual review. No changes.	6/1/2024

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Dry Eye Disease - Cequa, Miebo, Restasis MultiDose, Tyrvaya, Vevye, Xiidra	Medical Necessity	Cequa™ (cyclosporine 0.09% ophthalmic solution), Miebo™ (perfluorohexyloctane), Restasis® MultiDose™ (cyclosporine 0.05% ophthalmic emulsion), Tyrvaya™ (varenicline nasal spray), Vevye™ (cyclosporine 0.1%)	Updated the initial authorization to 12 months. Updated references.	6/1/2024
Dry Eye Disease - Cequa, Miebo, Restasis, Restasis MultiDose, Tyrvaya, Vevye, Xiidra	Notification	Cequa™ (cyclosporine 0.09% ophthalmic solution), Miebo™ (perfluorohexyloctane), Restasis® (cyclosporine 0.05% ophthalmic emulsion), Restasis MultiDose™ (cyclosporine 0.05% ophthalmic emulsion), Tyrvaya™ (varenicline nasal spray), Vevye™ (cyclosporine 0.1%), Xiidra® (lifitegrast 5% ophthalmic solution)	Updated initial authorization to 12 months. Updated references.	6/1/2024
Dupixent	Medical Necessity	Dupixent®(dupilumab)	Clarified topical steroid potency in atopic dermatitis with no change to clinical intent or coverage criteria. Removed weight requirement from Eosinophilic Esophagitis criteria. Updated state mandate footnote, background and reference.	6/1/2024
Dupixent	Notification	Dupixent®(dupilumab)	Removed weight requirement from Eosinophilic Esophagitis criteria. Updated background and reference.	6/1/2024
Esbriet, Ofev	Notification	Esbriet® (pirfenidone) and Ofev® (nintedanib)	Annual review. No change in coverage criteria. Updated references.	6/1/2024
Esbriet, Ofev	Medical Necessity	Esbriet® (pirfenidone) and Ofev® (nintedanib)	Annual review. No change in coverage criteria. Updated references.	6/1/2024
Esperoct	Notification	Esperoct®[antihemophilic factor (recombinant), glycopegylated-exei]	Annual review with no changes to coverage criteria.	6/1/2024
Esperoct	Medical Necessity	Esperoct®[antihemophilic factor (recombinant), glycopegylated-exei]	Annual review with no changes to clinical criteria.	6/1/2024
Esperoct	Step Therapy	Esperoct®[antihemophilic factor (recombinant), glycopegylated-exei]	Annual review with no changes to clinical criteria.	6/1/2024
Filsuvez	Notification	Filsuvez® (birch triterpenes) topical gel	New program.	6/1/2024
Filsuvez	Medical Necessity	Filsuvez® (birch triterpenes) topical gel	New program.	6/1/2024
Furoscix	Notification	Furoscix® (furosemide injection)	Annual review. Updated background to include limitations of use. Updated reference.	6/1/2024
Furoscix	Medical Necessity	Furoscix® (furosemide injection)	Annual review. Updated background to include limitations of use. Updated reference.	6/1/2024
Glaucoma Agents - Travatan Z, Vyzulta, Zioptan	Step Therapy	Travatan Z® (travoprost), Vyzulta® (latanoprostene), Zioptan® (tafluprost)	Annual review. Travatan Z added to the step therapy.	6/1/2024
Haegarda	Notification	Haegarda® (C1 esterase inhibitor Subcutaneous, human)	Annual review. No changes to coverage criteria.	6/1/2024
Haegarda	Medical Necessity	Haegarda® (C1 esterase inhibitor Subcutaneous, human)	Annual review with update to diagnostic criteria for HAE with normal C1 inhibitor levels. Updated language for reauthorization criteria.	6/1/2024
Impavido	Notification	Impavido (miltefosine)	Annual review. Updated references.	6/1/2024
Insulin Delivery Devices	Step Therapy	Insulin Delivery Devices	New program.	6/1/2024
Javygtor, Kuvan	Notification	Javygtor™ (sapropterin dihydrochloride), Kuvan® (sapropterin dihydrochloride)	Annual review. Updated authorization approval duration to 12 months. Updated reference.	6/1/2024
Korlym	Notification	Korlym® (mifepristone)	Annual review. Updated approval duration of coverage criteria to 12 months. Updated reauthorization criteria.	6/1/2024
Lyrica CR	Step Therapy	Lyrica® CR tablets (pregabalin ER)	Annual review. Updated references.	6/1/2024
Ninlaro	Notification	Ninlaro® (ixazomib)	Annual review. Updated background and coverage criteria per NCCN guidelines. Updated references.	6/1/2024

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Opioid-containing cough medicines	Medical Necessity	Opioid-containing cough medicines (including but not limited to: Tussicaps®, Tuxarin ERTM, codeine/phenylephrine/promethazine, codeine/promethazine, hydrocodone/homatropine, hydrocodone bitartrate/guaifenesin, hydrocodone polistirex/chlorpheniramine polistirex, hydrocodone bitartrate/chlorpheniramine)	Removed Tuzistra XR as it is no longer on the market. Updated references.	6/1/2024
Orladeyo	Notification	Orladeyo® (berotralstat)	Annual review with no changes to clinical criteria.	6/1/2024
Orladeyo	Medical Necessity	Orladeyo® (berotralstat)	Annual review with update to diagnostic criteria for HAE with normal C1 inhibitor levels.	6/1/2024
Orserdu	Notification	Orserdu™ (elacestrant)	Annual review. Added premenopausal women treated with ovarian ablation/suppression to coverage criteria per NCCN. Updated background and references.	6/1/2024
Osphena	Notification	Osphena® (ospemifene)	Annual review. Updated references.	6/1/2024
Palforzia	Notification	Palforzia [Peanut (Arachis hypogaea) Allergen Powder-dnfp]	Annual review. Updated references.	6/1/2024
Palforzia	Medical Necessity	Palforzia [Peanut (Arachis hypogaea) Allergen Powder-dnfp]	Annual review. Updated references.	6/1/2024
Piqray	Notification	Piqray® (alpelisib)	Updated criteria reflecting new indication for use is adults removing criteria for postmenopausal, premenopausal with ovarian ablation/suppression and male. Updated background and references.	6/1/2024
Prudoxin, Zonalon	Notification	Prudoxin® (doxepin), Zonalon® (doxepin)	Annual review. No changes.	6/1/2024
Prudoxin, Zonalon	Medical Necessity	Prudoxin® (doxepin), Zonalon® (doxepin)	Review with no changes.	6/1/2024
Repository Corticotropins - Acthar Gel, Purified Cortrophin Gel	Notification	Repository Corticotropins - Acthar Gel® (Repository corticotropin injection), Purified Cortrophin Gel™ (Repository corticotropin injection USP)	Annual review with no changes to criteria. Updated references.	6/1/2024
Repository Corticotropins - Acthar Gel, Purified Cortrophin Gel	Medical Necessity	Repository Corticotropins - Acthar Gel® (Repository corticotropin injection), Purified Cortrophin Gel™ (Repository corticotropin injection USP)	Annual review with no change to coverage criteria. Updated references.	6/1/2024
Repository Corticotropins - Acthar Gel, Purified Cortrophin Gel	Step Therapy	Repository Corticotropins - Acthar Gel® (Repository corticotropin injection), Purified Cortrophin Gel™ (Repository corticotropin injection USP)	Annual review with no changes to criteria. Updated references.	6/1/2024
Reyvow	Notification	Reyvow® (lasmiditan)	Annual review. No changes.	6/1/2024
Reyvow	Medical Necessity	Reyvow® (lasmiditan)	Annual review. No changes.	6/1/2024
Reyvow	Step Therapy	Reyvow® (lasmiditan)	Annual review. No changes.	6/1/2024
Rezdiffra	Notification	Rezdiffra™ (resmetirom)	New program.	6/1/2024
Rezdiffra	Medical Necessity	Rezdiffra™ (resmetirom)	New program.	6/1/2024
Sublingual Immunotherapy (SLIT)	Notification	Sublingual Immunotherapy (SLIT) – Grastek (Timothy grass pollen allergen extract), Odactra (Dermatophagoides farinae/Dermatophagoides pteronyssinus allergen extract), Oralair (Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens allergen extract), Ragwitek (Short Ragweed Pollen allergen extract)	Annual review. Updated references.	6/1/2024

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Sublingual Immunotherapy (SLIT)	Medical Necessity	Sublingual Immunotherapy (SLIT) – Grastek (Timothy grass pollen allergen extract), Odactra (Dermatophagoides farinae/Dermatophagoides pteronyssinus allergen extract), Oralair (Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens allergen extract), Ragwitek (Short Ragweed Pollen allergen extract)	Annual review. Updated references.	6/1/2024
Sunlenca	Notification	Sunlenca® (lenacapavir)	Annual review with no changes to clinical criteria. Updated reference.	6/1/2024
Supply Limits - Greater than 34 day supply for opioids at retail	Misc	Supply Limits - Greater than 34 day supply for opioids at retail - Includes all salt forms, single and combination ingredient products short-acting and long-acting opioid formulations, and all brand and generic formulations	Annual review. No changes.	6/1/2024
Sutent	Notification	Sutent® (sunitinib malate)	Annual review. Updated GIST, neuroendocrine/adrenal tumors, and thyroid carcinoma per NCCN recommendations.	6/1/2024
Takhzyro	Notification	Takhzyro® (lanadelumab-flyo)	Annual review. No changes to coverage criteria.	6/1/2024
Takhzyro	Medical Necessity	Takhzyro® (lanadelumab-flyo)	Annual review. Update to diagnostic criteria for HAE with normal C1 inhibitor levels. Updated and simplified reauthorization criteria.	6/1/2024
Tasmar	Medical Necessity	Tasmar® (tolcapone)	Annual review. No changes.	6/1/2024
Tazorac	Medical Necessity	Tazorac® (tazarotene)	Annual review. Updated initial authorization to 12 months.	6/1/2024
Tazverik	Notification	Tazverik® (tazemetostat)	Annual review. Added NCCN recommendations to background section. Added criteria to relapsed/refractory follicular lymphoma based on NCCN recommendations. Updated references.	6/1/2024
Test Strips - Non-Formulary	Medical Necessity	Abbott Diabetic Meters (e.g. FreeStyle Freedom Lite, FreeStyle InsuLinx, FreeStyle Lite, FreeStyle Neo, Precision Xtra,) Abbott Test Strips (e.g. FreeStyle Insulinx, FreeStyle Lite, FreeStyle, FreeStyle Precision Neo, Precision Xtra), Ascensia Diabetic Meters, excluding Contour Next Meters (e.g. Contour, Contour Next Link), Ascensia Test Strips, excluding Contour Next Test Strips (e.g. Contour), Roche Diabetic Meters, excluding Accu-Chek Guide and Accu-Chek Guide Me (e.g. Accu-Chek Aviva Plus), Roche Test Strips, excluding Accu-Chek Guide (e.g. Accu-Chek Aviva Plus, Accu-Chek Compact, Accu-Chek Smartview)	Annual review. Updated references.	6/1/2024
Tukysa	Notification	Tukysa® (tucatinib)	Annual review. No changes to clinical criteria.	6/1/2024
Vascepa	Notification	Vascepa® (icosapent ethyl)	Annual review. No changes.	6/1/2024
Vascepa	Medical Necessity	Vascepa® (icosapent ethyl)	Annual review. No changes.	6/1/2024
Viberzi	Medical Necessity	Viberzi® (eluxadoline)	Annual review. Increased initial authorization to 12 months.	6/1/2024
Voquezna	Medical Necessity	Voquezna® (vonoprazan)	New program.	6/1/2024
Wakix	Notification	Wakix® (pitolisant)	Annual review. No changes.	6/1/2024
Xphozah	Medical Necessity	Xphozah® (tenapanor)	New program.	6/1/2024
Xtandi	Notification	Xtandi® (enzalutamide)	Annual review. Updated background and criteria with expanded indication in non-metastatic castration-sensitive setting. Updated references.	6/1/2024
Zelboraf	Notification	Zelboraf® (vemurafenib)	Annual review. Updated nomenclature under Thyroid carcinoma from Hurthle cell to oncocytic with no change to clinical intent. Updated reference.	6/1/2024
Zokinvy	Notification	Zokinvy™ (lonafarnib)	Annual review with no change to coverage criteria.	6/1/2024
Altuviiio	Notification	Altuviiio™ [antihemophilic factor (recombinant), Fc-VWF-XTEN fusion protein-ehtl]	Annual review. No changes to clinical criteria. Updated reference.	7/1/2024

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Altuviiio	Medical Necessity	Altuviiio™ [antihemophilic factor (recombinant), Fc-VWF-XTEN fusion protein-ehtl]	Annual review. No changes to coverage criteria. Updated reference.	7/1/2024
Austedo, Austedo XR	Notification	Austedo® (deutetrabenazine), Austedo® XR (deutetrabenazine)	Annual review with no change to clinical criteria. Reference updated.	7/1/2024
Austedo, Austedo XR	Medical Necessity	Austedo® (deutetrabenazine), Austedo® XR (deutetrabenazine)	Annual review with no change to clinical criteria. Reference updated.	7/1/2024
Berinert	Medical Necessity	Berinert® (C1 esterase inhibitor [human])	Annual review with update to examples of genetic variant(s) and diagnostic criteria with normal C1 inhibitor levels. Updated language for reauthorization criteria.	7/1/2024
Bimzelx	Notification	Bimzelx® (bimekizumab-bkzx)	New program.	7/1/2024
Bimzelx	Medical Necessity	Bimzelx® (bimekizumab-bkzx)	New program.	7/1/2024
Bimzelx	Step Therapy	Bimzelx® (bimekizumab-bkzx)	New program.	7/1/2024
Bosulif	Step Therapy	Bosulif® (bosutinib)	Annual review with no change to coverage criteria. Updated references.	7/1/2024
Breast Cancer Prevention Zero Dollar Cost-Share - generic tamoxifen, generic raloxifene, generic aromatase inhibitors	Prior Authorization / Regulatory	Breast Cancer Prevention Zero Dollar Cost Share - generic tamoxifen (applies to 20 mg dose only), generic raloxifene, generic aromatase inhibitors (anastrozole, letrozole, or exemestane)	Annual review. Removed requirement that member does not have a prior diagnosis of LCIS. Removed no prior history of thromboembolic events and replaced with low risk for adverse medication effects. Removed 5-year risk assessment and replaced with increased risk of breast cancer. Updated references.	7/1/2024
Cablivi	Notification	Cablivi® (caplacizumab-yhdp)	Annual review with no change to clinical criteria. Updated reference.	7/1/2024
Cipro HC - Essential PDL Only	Step Therapy	Cipro® HC (ciprofloxacin/hydrocortisone)	Annual Review. Updated references.	7/1/2024
Cosentyx	Step Therapy	Cosentyx® (secukinumab) prefilled syringe or Sensoready pen	Annual review with no change to coverage criteria. Updated background and references.	7/1/2024
Diabetes Medications - DPP4 - Januvia, Janumet, Janumet XR - Oxford	Medical Necessity	Januvia® (sitagliptin), Janumet® (sitagliptin/metformin immediate-release), Janumet XR (sitagliptin/metformin extended-release)	Updated products typically excluded from coverage. Updated references.	7/1/2024
Empaveli	Notification	Empaveli® (pegcetacoplan)	Simplified criteria language for converting to new complement inhibitor therapy.	7/1/2024
Empaveli	Medical Necessity	Empaveli® (pegcetacoplan)	Simplified criteria language for converting to new complement inhibitor therapy.	7/1/2024
Entresto	Notification	Entresto® (valsartan-sacubitril)	Annual review with no changes.	7/1/2024
Entyvio	Notification	Entyvio® (vedolizumab) This program applies to the subcutaneous formulation of vedolizumab	New program.	7/1/2024
Entyvio	Medical Necessity	Entyvio® (vedolizumab) This program applies to the subcutaneous formulation of vedolizumab	New program.	7/1/2024
Fabhalta	Notification	Fabhalta® (iptacopan)	Simplified criteria language for converting to new complement inhibitor therapy.	7/1/2024
Fabhalta	Medical Necessity	Fabhalta® (iptacopan)	Simplified criteria language for converting to new complement inhibitor therapy.	7/1/2024
Fentanyl - Actiq, Fentora, and fentanyl citrate	Notification	Actiq® (fentanyl transmucosal lozenge), Fentora® (fentanyl buccal tablet), and fentanyl citrate	Removed Lazanda and Subsys as they are no longer on the market. Added opioid tolerate dose for oral hydrocodone. Updated references.	7/1/2024
Firazyr, Sajazir	Medical Necessity	Firazyr® (icatibant), icatibant, Sajazir™ (icatibant)	Update to examples of genetic variant(s) and diagnostic criteria with normal C1 inhibitor levels. Updated language for reauthorization criteria. Updated references.	7/1/2024
Ilumya	Step Therapy	Ilumya® (tildrakizumab-asmn)	Annual review with no change to coverage criteria. Updated references.	7/1/2024
Ingrezza	Notification	Ingrezza® (valbenazine)	Removed notation that Ingrezza is typically excluded.	7/1/2024
Ingrezza	Medical Necessity	Ingrezza® (valbenazine)	Removed notation that Ingrezza is typically excluded. Removed failure, contraindication, or intolerance to Austedo/Austedo XR from criteria.	7/1/2024
Ingrezza	Step Therapy	Ingrezza® (valbenazine)	Archive program.	7/1/2024
Inrebic	Step Therapy	Inrebic® (fedratinib)	Annual review. Updated background to include NCCN recommendations. Updated coverage criteria to include diagnosis of accelerated/blast phase myeloproliferative neoplasm. Updated references.	7/1/2024
Kisqali	Step Therapy	Kisqali® (ribociclib)	Annual review. Updated step therapy language with no change to clinical intent. Updated background and references.	7/1/2024
Kisqali Femara Co-Pack	Step Therapy	Kisqali® Femara® Co-Pack (ribociclib/letrozole)	Annual review. Updated background and references.	7/1/2024

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Lonsurf	Notification	Lonsurf® (trifluridine/tipiracil)	Annual review. Removed oncology medications footnote. Updated background for FDA indications and NCCN recommendations. Updated diagnostic criteria for colorectal cancer. Updated gastric/gastroesophageal junction adenocarcinoma diagnostic criteria. Updated references.	7/1/2024
Lorbrena	Step Therapy	Lorbrena® (lorlatinib)	Annual review with no change to coverage criteria. Updated references.	7/1/2024
Mirvaso, Rhofade	Notification	Mirvaso® (brimonidine gel), Rhofade® (oxymetazoline cream)	Annual review. Added medical necessity language and updated references.	7/1/2024
Northera	Medical Necessity	Northera® (droxidopa)	Annual review. Increased authorization periods to 12 month and updated references.	7/1/2024
Proton Pump Inhibitors Nexium for suspension, Prevacid SoluTab, Zegerid for suspension	Step Therapy	Nexium® for suspension (esomeprazole), Prevacid® SoluTab™ (lansoprazole), Zegerid® for suspension (omeprazole and sodium bicarbonate)	Annual review. References updated.	7/1/2024
Rivfloza	Notification	Rivfloza™ (nedosiran) *This program applies to the prefilled syringe formulation	New program.	7/1/2024
Rivfloza	Medical Necessity	Rivfloza™ (nedosiran) *This program applies to the prefilled syringe formulation	New program.	7/1/2024
Rivfloza	Step Therapy	Rivfloza™ (nedosiran)	Archive program	7/1/2024
Rubraca	Notification	Rubraca® (rucaparib)	Annual review with no changes to criteria. Updated references.	7/1/2024
Rubraca	Step Therapy	Rubraca® (rucaparib)	Annual review with no changes to criteria. Updated references.	7/1/2024
Ruconest	Medical Necessity	Ruconest® (C1 esterase inhibitor [recombinant])	Annual review with update to examples of genetic variant(s) and diagnostic criteria with normal C1 inhibitor levels. Updated language for reauthorization criteria.	7/1/2024
Siliq	Step Therapy	Siliq® (brodalumab)	Annual review with no change to coverage criteria. Updated references.	7/1/2024
Sotyktu	Step Therapy	Sotyktu™ (deucravacitinib)	Annual review with no change to coverage criteria. Updated background and references.	7/1/2024
Sprycel	Step Therapy	Sprycel® (dasatinib)	Annual review. Updated Tasigna step therapy wording with no change to clinical intent. Updated references.	7/1/2024
Sucraid	Medical Necessity	Sucraid (sacrosidase) oral solution	Added carbon-13 sucrose breath test as an acceptable confirmatory diagnostic test. Updated references.	7/1/2024
Supply Limits - Greater than 34 day supply for opioids at retail	Misc	Supply Limits - Greater than 34 day supply for opioids at retail - Includes all salt forms, single and combination ingredient products short-acting and long-acting opioid formulations, and all brand and generic formulations	Annual review. No changes.	7/1/2024
Taltz	Step Therapy	Taltz® (ixekizumab)	Annual review with no change to coverage criteria. Updated background and references.	7/1/2024
Talzenna	Step Therapy	Talzenna™ (talazoparib)	Annual review with no change to coverage criteria. Updated references.	7/1/2024
Tasigna	Step Therapy	Tasigna® (nilotinib)	Annual review with no changes to coverage criteria. Updated references.	7/1/2024
Tepmetko	Notification	Tepmetko® (tepotinib)	Annual review with no change to clinical criteria. Updated background and references.	7/1/2024
Velsipity	Notification	Velsipity™ (etrasimod)	New program.	7/1/2024
Velsipity	Medical Necessity	Velsipity™ (etrasimod)	New program.	7/1/2024
Velsipity	Step Therapy	Velsipity™ (etrasimod)	New program.	7/1/2024
Venclexta	Notification	Venclexta® (venetoclax)	Annual review. Updated background on NCCN recommendations. Updated criteria for ALL and AML based on NCCN recommendations. Added criteria for additional indications based on NCCN recommendations for the following: hairy cell leukemia, myeloproliferative neoplasms – accelerated/blast phase myeloproliferative neoplasms, and CMML. Removed oncology medications footnote.	7/1/2024

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Xolair	Notification	Xolair® (omalizumab) *This program applies to the prefilled syringe for subcutaneous use formulation	Added criteria for new indication, IgE-mediated food allergy. Updated background and references.	7/1/2024
Xolair	Medical Necessity	Xolair® (omalizumab) *This program applies to the prefilled syringe for subcutaneous use formulation	Added criteria for new indication, IgE-mediated food allergy. Updated background and references.	7/1/2024
Zeposia	Medical Necessity	Zeposia® (ozanimod)	Annual review. Updated not used in combination examples with no change to clinical intent. Updated reference.	7/1/2024
Zeposia	Step Therapy	Zeposia® (ozanimod)	Annual review with no change to coverage criteria. Updated references.	7/1/2024
Zileuton extended-release, Zyflo	Step Therapy	Zileuton extended-release, Zyflo® (zileuton)	Annual review. Updated references.	7/1/2024
Zilxi	Step Therapy	Zilxi® (minocycline)	Annual review with no changes.	7/1/2024
Afinitor	Notification	Afinitor® (everolimus)	Updated background to reflect current NCCN guidance. Updated criteria for neuroendocrine tumors, advanced renal cell carcinoma/kidney cancer. Renamed and updated criteria for tuberous sclerosis complex-associated renal cell carcinoma. Renamed and updated criteria for subependymal giant cell astrocytoma section. Updated criteria for breast cancer, soft tissue sarcomas, thymomas and thymic carcinomas, meningiomas, bone cancer - osteosarcoma, and histiocytic neoplasms. Separated and updated criteria for gastrointestingal stromal tumor (GIST) from soft tissue sarcoma. Removed oncology medications footnote.	8/1/2024
Afstyla	Notification	Afstyla® (antihemophilic factor [recombinant], single chain)	Archive program	8/1/2024
Ampyra	Notification	Ampyra® (dalfampridine)	Annual review. Initial Authorization increased to 12 months.	8/1/2024
Arcalyst	Notification	Arcalyst® (rilonacept)	Annual review with no change to coverage criteria.	8/1/2024
Balversa	Notification	Balversa® (erdafitinib)	Annual review. Removed coverage for FGFR2 genetic alterations. Added that first line of prior systemic therapy should contain an immune checkpoint inhibitor, if eligible. Updated background and references.	8/1/2024
Calquence	Notification	Calquence® (acalabrutinib)	Annual review with no change to clinical criteria. Updated reference.	8/1/2024
Cetrotide	Medical Necessity	Cetrotide® (cetrorelix acetate)	Added coverage criteria for fertility preservation for iatrogenic infertility. Updated term "controlled ovarian stimulation" to "ovarian stimulation".	8/1/2024
Cholbam	Notification	Cholbam™ (cholic acid)	Annual review with no change to coverage criteria. Updated reference.	8/1/2024
Copiktra	Notification	Copiktra® (duvelisib)	Annual review with no change to clinical criteria. Updated reference.	8/1/2024
Daraprim	Medical Necessity	Daraprim® (pyrimethamine)	Annual review without change to coverage criteria. Updated references.	8/1/2024
Daybue	Notification	Daybue™ (trofinetide)	Annual review. Updated initial approval duration to 12 months.	8/1/2024
Daybue	Medical Necessity	Daybue™ (trofinetide)	Updated initial approval duration from 6 months to 12 months.	8/1/2024
Descovy	Step Therapy	Descovy® (emtricitabine/tenofovir alafenamide)	Annual review. Updated wording for HIV-1 infection and HIV-1 PrEP without change to clinical intent. Updated references.	8/1/2024
Descovy	Medical Necessity	Descovy® (emtricitabine/tenofovir alafenamide)	Annual review. Updated wording for HIV-1 infection without change to clinical intent. Updated references.	8/1/2024
Dojolvi	Notification	Dojolvi® (triheptanoin)	Revised initial authorization to 12 months. Updated reference.	8/1/2024
Dojolvi	Medical Necessity	Dojolvi® (triheptanoin)	Annual review. Revised listing of genes associated with long-chain fatty acid disorders. Revised initial authorization to 12 months. Updated references.	8/1/2024
Eloctate	Notification	Eloctate® [antihemophilic factor (recombinant), Fc fusion protein]	Archive program	8/1/2024
Eohilia	Medical Necessity	Eohilia™ (budesonide oral suspension)	New program.	8/1/2024
Esbriet, Ofev	Medical Necessity	Esbriet® (pirfenidone) and Ofev® (nintedanib)	Removed prescriber requirement from reauthorization criteria.	8/1/2024

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Esperoct	Notification	Esperoct®[antihemophilic factor (recombinant), glycopegylated-exei]	Archive program	8/1/2024
Follistim AQ, Gonal-f, Gonal-f RFF	Notification	Follistim® AQ (follitropin beta), Gonal-f® (follitropin alfa), Gonal-f RFF® (follitropin alfa)	Added coverage criteria for fertility preservation for iatrogenic infertility. Updated term "controlled ovarian stimulation" to "ovarian stimulation".	8/1/2024
Follistim AQ, Gonal-f, Gonal-f RFF, Menopur - Supported by Fertility Solutions	Medical Necessity	Follistim® AQ (follitropin beta), Gonal-f™ (follitropin alfa), Gonal-f™ RFF (follitropin alfa), Menopur® (menotropins)‡	Added coverage criteria for fertility preservation for iatrogenic infertility. Updated term "controlled ovarian stimulation" to "ovarian stimulation".	8/1/2024
Fotivda	Notification	Fotivda® (tivozanib)	Annual review with no change to clinical criteria. Updated references.	8/1/2024
Fruzaqla	Step Therapy	Fruzaqla™ (fruquintinib)	New program.	8/1/2024
Fuzeon	Notification	Fuzeon® (enfuvirtide)	Annual review. Updated formatting with no change to clinical criteria.	8/1/2024
Gonadotropin-releasing hormone (GnRH) antagonist - Cetrotide, ganirelix acetate	Notification	Cetrotide® (cetrorelix acetate) and ganirelix acetate	Added coverage criteria for fertility preservation for iatrogenic infertility. Updated term "controlled ovarian stimulation" to "ovarian stimulation".	8/1/2024
Harvoni	Medical Necessity	Harvoni® (ledipasvir/sofosbuvir)	Annual review. Removed liver disease staging criteria that was included for quality purposes rather than part of coverage decision. Updated references.	8/1/2024
human chorionic gonadotropin (hCG) - Novarel, Ovidrel, Pregnyl	Notification	Novarel® (chorionic gonadotropin), Ovidrel® (choriogonadotropin alfa), and Pregnyl® (chorionic gonadotropin)	Added coverage criteria for fertility preservation for iatrogenic infertility. Updated term "controlled ovarian hyperstimulation" to "ovarian stimulation".	8/1/2024
Jivi	Notification	Jivi® (antihemophilic factor [recombinant], PEGylated-aucl)	Archive program	8/1/2024
Joenja	Notification	Joenja® (leniolisib)	Annual review. Updated initial authorization duration to 12 months.	8/1/2024
Joenja	Medical Necessity	Joenja® (leniolisib)	Annual review. Updated initial authorization duration to 12 months. Updated references.	8/1/2024
Livmarli	Notification	Livmarli™ (maralixibat)	Annual review. Added coverage criteria for new PFIC indication. Updated initial authorization duration to 12 months for ALGS indication. Updated background and reference.	8/1/2024
Livmarli	Medical Necessity	Livmarli™ (maralixibat)	Annual review. Added coverage criteria for new PFIC indication. Updated authorization durations to 12 months for ALGS indication. Updated background and references.	8/1/2024
Mekinist	Notification	Mekinist® (trametinib)	Added coverage criteria for hairy cell leukemia, salivary gland tumor, and GIST per NCCN. Updated background and references.	8/1/2024
Methyldopa	Medical Necessity	Methyldopa	Annual review with no changes.	8/1/2024
Methyldopa	Step Therapy	Methyldopa	Annual review with no changes.	8/1/2024

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Multiple Sclerosis	Notification	Multiple Sclerosis - Aubagio® (teriflunomide), Avonex® (interferon β-1a), Bafiertam™ (monomethyl fumarate), Betaseron® (interferon β-1b), Copaxone® (glatiramer acetate), dimethyl fumarate, Extavia® (interferon β-1b), fingolimod, Gilenya® (fingolimod)*, Glatopa™ (glatiramer acetate), glatiramer acetate, Kesimpta (ofatumumab), Mayzent (siponimod)®, Plegridy™ (peginterferon β-1a), Ponvory™ (Ponesimod)*, Rebif® (interferon β-1a), Tascenso ODT™ (fingolimod), Tecfidera™ (dimethyl fumarate), teriflunomide, Vumerity™ (diroximel fumarate) *Aubagio (brand), Copaxone (brand), Extavia, Gilenya (brand), Ponvory, Rebif, Tascenso ODT, Tecfidera (brand), and Vumerity are excluded from coverage for the majority of our benefits. Mavenclad® (cladribine) coverage is provided according to the product specific Mavenclad Prior Authorization/Notification program Zeposia® (ozanimod) coverage is provided according to the product specific Zeposia Prior Authorization/Notification program	Annual review with no change to clinical criteria. Updated references.	8/1/2024
Myalept	Notification	Myalept® (metreleptin)	Annual review with no changes to coverage criteria.	8/1/2024
Non-Solid Oral and Suppository Dosage Forms	Medical Necessity	Alkindi® Sprinkle (hydrocortisone), Aspruzyo Sprinkle™ (ranolazine), Atorvaliq® (atorvastatin), Carafate® (sucralfate) suspension, Carospir® (spironolactone), chlorpromazine oral solution, Epaned® (enalapril), Eprontia® (topiramate), Ermeza™ (levothyroxine), Exservan™ (riluzole), Ezallor Sprinkle™ (rosuvastatin), Fleqsuvy® (baclofen), Flolipid (simvastatin), Indocin® (indomethacin) suspension, Indocin (indomethacin) suppository, Jylamvo (methotrexate), Katerzia® (amlodipine), Lyvispah® (baclofen), Meloxicam (meloxicam) suspension, Naprosyn® (naproxen) suspension, Nexium® for suspension (esomeprazole), Norliqva® (amlodipine), Ozobax® (baclofen), Ozobax DS (baclofen), Pradaxa® (dabigatran) oral pellets, Prevacid® SoluTab™ (lansoprazole), Prograf® Granules (tacrolimus), Qbrelis® (lisinopril), Qdolo™ (tramadol), Renvela® (sevelamer carbonate) powder for suspension, Sotylize® (sotalol), Sympazan (clobazam)®, Syndros® (dronabinol), Tiglutik® (riluzole), Tirosint®-Sol (levothyroxine), Valsartan oral solution, Xatmep® (methotrexate), Xelstrym™ (dextroamphetamine), Zegerid® for suspension (omeprazole and sodium bicarbonate), Zonisade® (zonisamide)	Jylamvo added to criteria.	8/1/2024
Orfadin	Notification	Orfadin® (nitisinone)	Annual review. No changes to clinical criteria.	8/1/2024
Phexxi	Medical Necessity	Phexxi® (lactic acid, citric acid, and potassium bitartrate) vaginal gel	Annual review. Updated references.	8/1/2024

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Pomalyst	Notification	Pomalyst® (pomalidomide)	Annual review. Updated criteria for multiple myeloma and kaposi sarcoma. Updated background and references.	8/1/2024
Praluent	Notification	Praluent® (alirocumab)	Updated background to align with new label for pediatric patients aged 8 years and older with HeFH. Updated reference.	8/1/2024
Praluent	Medical Necessity	Praluent® (alirocumab)	Added criterion for patients less than 10 years of age to align with new label for pediatric patients aged 8 years and older with HeFH. Updated background and reference.	8/1/2024
Praluent	Step Therapy	Praluent® (alirocumab)	Added criterion for patients less than 10 years of age to align with new label for pediatric patients aged 8 years and older with HeFH. Updated background and reference.	8/1/2024
Pyrukynd	Medical Necessity	Pyrukynd® (mitapivat)	Updated initial approval duration from 6 months to 12 months. Simplified reauthorization criteria.	8/1/2024
Pyrukynd	Notification	Pyrukynd® (mitapivat)	Annual review. Updated initial criteria approval to 12 months.	8/1/2024
Revlimid	Notification	Revlimid® (lenalidomide)	Annual review. Updated background to reflect current NCCN guidance and updated the lenalidomide REMS program information. Removed footnote for state mandate for oncology medications. Updated criteria per NCCN for myelodysplastic syndrome, b-cell lymphomas, myelofibrosis-associated anemia, Hodgkin lymphoma, systemic light chain amyloidosis, chronic lymphocytic leukemia/small lymphocytic lymphoma, t-cell lymphoma, and kaposi sarcoma. Renamed and updated criteria for histiocytic neoplasms. Moved castleman disease from b-cell lymphoma into its own criteria. Updated references.	8/1/2024
Skyclarys	Notification	Skyclarys™ (omaveloxolone)	Annual review with no changes to coverage criteria. Updated references.	8/1/2024
Skyclarys	Medical Necessity	Skyclarys™ (omaveloxolone)	Annual review with no updates to coverage criteria. Updated references.	8/1/2024
Skyrizi	Notification	Skyrizi® (risankizumab-rzaa) injection	Annual review with no changes to coverage criteria. Updated reference.	8/1/2024
Skyrizi	Medical Necessity	Skyrizi® (risankizumab-rzaa) injection	Annual review with no changes to coverage criteria. Updated state mandate footnote and references.	8/1/2024
Sovaldi	Notification	Sovaldi® (sofosbuvir)	Annual review. Updated background and references.	8/1/2024
Sovaldi	Medical Necessity	Sovaldi® (sofosbuvir)	Annual review. Removed liver disease staging criteria that was included for quality purposes rather than part of coverage decision. Updated references.	8/1/2024
Spevigo	Notification	Spevigo® (spesolimab-sbzo) injection	New program.	8/1/2024
Spevigo	Medical Necessity	Spevigo® (spesolimab-sbzo) injection	New program.	8/1/2024
Tafinlar	Notification	Tafinlar® (dabrafenib)	Added coverage criteria for hairy cell leukemia, salivary gland tumor, and GIST per NCCN. Updated background and references.	8/1/2024
Thalomid	Notification	Thalomid® (thalidomide)	Annual review. Removed criteria for myelofibrosis-associated anemia and updated background based on NCCN recommendations. Renamed section D from b-cell lymphoma to castleman disease. Updated criteria for Kaposi sarcoma per NCCN guidance. Updated references.	8/1/2024
Vemlidy	Medical Necessity	Vemlidy® (tenofovir alafenamide)	Updated background with expanded indication in patients 6 to 11 years of age weighing at least 25 kg. Updated reference.	8/1/2024
Verkazia	Medical Necessity	Verkazia® (cyclosporine 0.1% ophthalmic emulsion)	Annual review. No changes.	8/1/2024
Verzenio	Notification	Verzenio® (abemaciclib)	Annual review. Updated background and added clinical criteria for endometrial carcinoma per NCCN. Updated references.	8/1/2024

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Viekira Pak	Medical Necessity	Viekira Pak™ (ombitasvir, paritaprevir, and ritonavir tablets; dasabuvir tablets)	Annual review. Removed liver disease staging criteria that was included for quality purposes rather than part of coverage decision. Updated references.	8/1/2024
Voydeya	Notification	Voydeya™ (danicopan)	New program.	8/1/2024
Voydeya	Medical Necessity	Voydeya™ (danicopan)	New program.	8/1/2024
Vumerity	Medical Necessity	Vumerity® (diroximel fumarate)	Annual review. Updated the listing of the brand names of step therapy medications. Updated references.	8/1/2024
Vumerity	Step Therapy	Vumerity® (diroximel fumarate)	Annual review. Updated the listing of the brand names of step therapy medications. Updated references.	8/1/2024
Zydelig	Notification	Zydelig® (idelalisib)	Annual review. Updated references.	8/1/2024
Zytiga	Notification	Zytiga® (abiraterone acetate)	Annual review. Added criteria for salivary gland tumor per NCCN. Updated reference.	8/1/2024