



Commercial Business

BULLETIN (5/1/2024)

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

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Actemra	Medical Necessity	Actemra® (tocilizumab) This program applies to the subcutaneous formulation of tocilizumab.	Removed Olumiant as a preferred product for RA. Updated state mandate footnote to 30-day trial for Connecticut.	5/1/2024
Actemra, Actemra ACTPen	Step Therapy	Actemra® (tocilizumab), Actemra (tocilizumab) ACTPen *This step criteria refers to the subcutaneous formulations of tocilizumab.	Removed Olumiant as a preferred product for RA.	5/1/2024
Afrezza	Medical Necessity	Afrezza® (insulin human)	Annual review. Updated references. Updated state mandate language.	5/1/2024
Anticonvulsants	Notification	Aptiom® (eslicarbazepine acetate), Banzel® (rufinamide), Briviact® (brivaracetam), Diacomit® (stiripentol), Epidiolex® (cannabidiol), Fintepla® (fenfluramine), Fycompa® (perampanel), Nayzilam® (midazolam), Onfi® (clobazam), Sabril® (vigabatrin), Sympazan® (clobazam), Valtoco® (diazepam), Xcopri® (cenobamate), Ztalmý® (ganaxolone)	Removed Vimpat from criteria.	5/1/2024
Arikayce	Medical Necessity	Arikayce® (amikacin liposome inhalation suspension)	Annual review with no change to coverage criteria.	5/1/2024
Bosulif	Notification	Bosulif® (bosutinib)	Annual review with no changes to coverage criteria. Updated background and references.	5/1/2024
Brexafemme	Medical Necessity	Brexafemme® (ibrexafungerp)	Annual review. Updated mandated states.	5/1/2024
Buphenyl, Olpruva, Pheburane	Notification	Buphenyl® (sodium phenylbutyrate), Olpruva™ (sodium phenylbutyrate), Pheburane® (sodium phenylbutyrate), sodium phenylbutyrate	Added Olpruva and Pheburane, including statement that Olpruva and Pheburane are typically excluded from coverage. Updated references	5/1/2024
Cayston	Notification	Cayston® (aztreonam for inhalation solution)	Annual review. Updated background. No changes to coverage criteria.	5/1/2024
Cayston	Step Therapy	Cayston® (aztreonam for inhalation solution)	Annual review with no changes to coverage criteria. Updated background and references.	5/1/2024
Custom Oxford SoNY and SoCT – GLP-1 & Dual GIP/GLP-1 Receptor Agonists - Oxford	Medical Necessity	Bydureon BCise (exenatide extended-release), Byetta (exenatide), Mounjaro (tirzepatide), Ozempic (semaglutide), Rybelsus (semaglutide), Trulicity (dulaglutide), Victoza (liraglutide)	Archive program.	5/1/2024
Cuvrior	Notification	Cuvrior™ (trientine tetrahydrochloride)	Annual review. Added footnote indicating Cuvrior is typically excluded from coverage. Updated authorization durations to 12 months.	5/1/2024
Cuvrior	Medical Necessity	Cuvrior™ (trientine tetrahydrochloride)	New program.	5/1/2024

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Diabetes Medications – GLP-1 & Dual GIP/GLP-1 Receptor Agonists	Notification	Bydureon BCise (exenatide extended-release), Byetta (exenatide), Mounjaro (tirzepatide), Ozempic (semaglutide), Rybelsus (semaglutide), Trulicity (dulaglutide), Victoza (liraglutide)	Added additional laboratory value. Removed that step therapy may be in place. Updated references.	5/1/2024
Diabetes Medications – GLP-1 & Dual GIP/GLP-1 Receptor Agonists	Step Therapy	Bydureon BCise® (exenatide extended-release), Byetta® (exenatide), Mounjaro® (tirzepatide), Ozempic® (semaglutide), Rybelsus® (semaglutide), Trulicity® (dulaglutide), Victoza® (liraglutide)	Archive program.	5/1/2024
Egrifta SV	Notification	Egrifta SV™ (tesamorelin for injection)	Annual review with no changes to coverage criteria.	5/1/2024
Empaveli	Notification	Empaveli® (pegcetacoplan)	Added Fabhalta to list of examples of other complement inhibitors used for the treatment of PNH. Revised initial authorization to 12 months. Included criteria for therapeutic duplication. Updated references.	5/1/2024
Empaveli	Medical Necessity	Empaveli® (pegcetacoplan)	Added Fabhalta to list of examples of other complement inhibitors used for the treatment of PNH. Revised initial authorization to 12 months. Updated references.	5/1/2024
Endari	Medical Necessity	Endari® (L-glutamine Powder for Solution)	Annual review. No changes.	5/1/2024
Fabhalta	Notification	Fabhalta® (iptacopan)	New program.	5/1/2024
Fabhalta	Medical Necessity	Fabhalta® (iptacopan)	New program.	5/1/2024
Firazyr, Sajazir	Notification	Firazyr® (icatibant), icatibant, Sajazir™ (icatibant)	Added coverage exclusion statement for brand Firazyr and Sajazir. Revised wording of criteria without changes to clinical intent.	5/1/2024
Firazyr, Sajazir	Medical Necessity	Firazyr® (icatibant), icatibant, Sajazir™ (icatibant)	Added coverage exclusion statement for brand Firazyr and Sajazir. Added Kalbitor to list of other products indicated for the acute treatment of HAE attacks.	5/1/2024
Forteo	Step Therapy	Forteo® (teriparatide)	Annual review with no changes to step criteria. Updated background and references.	5/1/2024
Fosrenol	Step Therapy	Fosrenol® (lanthanum carbonate)	Annual review. Updated references.	5/1/2024
Fruzaqla	Notification	Fruzaqla™ (fruquintinib)	New program	5/1/2024
Glumetza, Fortamet	Medical Necessity	Glumetza® (metformin extended-release modified release, brand and generic) and metformin osmotic extended-release (generic Fortamet®)	Annual review. Updated references. Updated state mandate language and requirement for C	5/1/2024
Harvoni	Notification	Harvoni® (ledipasvir/sofosbuvir)	Annual review. Added cirrhosis criteria for treatment of chronic hepatitis C - genotype 4, 5 or 6.	5/1/2024
Ibrance	Notification	Ibrance® (palbociclib)	Annual review. Specified type of unresectable WD-DDLS to be retroperitoneal per NCCN recommendation. Updated references to separate out package insert references for Ibrance capsules and tablets.	5/1/2024
Inbrija	Notification	Inbrija® (levodopa inhalation powder)	Revised initial authorization to 12 months.	5/1/2024
Inbrija	Medical Necessity	Inbrija® (levodopa inhalation powder)	Annual review. Revised initial authorization to 12 months. Updated references.	5/1/2024
Inqovi	Notification	Inqovi® (decitabine and cedazuridine) tablet	Annual review with no changes to coverage criteria. Updated references.	5/1/2024
Invokana - Non-Formulary	Non-Formulary	Invokana® (canagliflozin)	Annual review. Updated background section, references and diabetes footnote.	5/1/2024
Iwilfin	Notification	Iwilfin™ (eflornithine)	New program	5/1/2024
Jaypirca	Notification	Jaypirca® (pirtobrutinib)	Added coverage for updated labeled indication for CLL/SLL in patients who have received at least two lines of therapy, including a BTK inhibitor and a BCL-2 inhibitor. Updated references.	5/1/2024
Jivi	Notification	Jivi® (antihemophilic factor [recombinant], PEGylated-aucl)	Annual review with no changes to clinical coverage criteria. Updated references.	5/1/2024
Juxtapid	Notification	Juxtapid® (lomitapide)	Annual review. Changed initial authorization period to 12 months.	5/1/2024
Juxtapid	Medical Necessity	Juxtapid® (lomitapide)	Updated diagnostic criteria per European Atherosclerosis Society guidance. Changed initial authorization period to 12 months. Updated references.	5/1/2024

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Ketodan	Step Therapy	ketoconazole foam (generic Extina®) (ketoconazole), Ketodan® (ketoconazole) foam	Annual review. Updated references. Updated to clarify the generic products and removed brand Extina due to product discontinuation.	5/1/2024
Keveyis	Notification	Keveyis® (dichlorphenamide)	Annual review. Updated reference.	5/1/2024
Kevzara	Medical Necessity	Kevzara® (sarilumab) Injection	Removed Olumiant as a preferred product for RA. Updated state mandate footnote to 30-day trial for Connecticut.	5/1/2024
Kevzara	Step Therapy	Kevzara® (sarilumab) Injection	Removed Olumiant as a preferred product for RA.	5/1/2024
Kineret	Step Therapy	Kineret® (anakinra)	Removed Olumiant as a preferred product for RA.	5/1/2024
Kisqali	Notification	Kisqali® (ribociclib)	Annual review. Updated background and added clinical criteria for endometrial carcinoma per NCCN. Updated reference.	5/1/2024
Kisqali Femara Co-Pack	Notification	Kisqali® Femara® Co-Pack (ribociclib/letrozole)	Annual review. Updated background and added clinical criteria for endometrial carcinoma per NCCN. Updated reference.	5/1/2024
Krazati	Notification	Krazati™ (adagrasib)	Annual review. Added criteria for NCCN recommended use of Krazati in colon cancer, rectal cancer, ampullary adenocarcinoma and pancreatic adenocarcinoma. Updated background and references.	5/1/2024
Kynmobi	Notification	Kynmobi® (apomorphine) sublingual film	Archive program	5/1/2024
Kynmobi	Medical Necessity	Kynmobi® (apomorphine) sublingual film	Archive program	5/1/2024
Lenvima	Notification	Lenvima® (lenvatinib)	Annual review. Updated thyroid cancer criteria based on label and NCCN. Updated hepatobiliary and thymic cancer based on NCCN recommendations. Updated references.	5/1/2024
Livtency	Notification	Livtency (maribavir)	Annual review. Updated background and reference.	5/1/2024
Lorbrena	Notification	Lorbrena® (lorlatinib)	Annual review. Added criteria for NCCN recommended use of Lorbrena in uterine sarcoma, peripheral T-Cell lymphoma and large B-cell lymphoma. Updated background and references.	5/1/2024
Lucemyra	Medical Necessity	Lucemyra® (lofexidine)	Annual review. Nevada footnote added. Updated references.	5/1/2024
Minocycline ER	Medical Necessity	minocycline extended-release tablet (generic Solodyn™), Minolira™ (minocycline extended-release tablet), Solodyn (minocycline extended-release tablet), Ximino® (minocycline extended-release capsule)	Annual review. No changes.	5/1/2024
Multisource Brand/Modified Release Anticonvulsants	Medical Necessity	Multisource Brand/Modified Release Anticonvulsants – Banzel®, Depakote®, Depakote ER®, Felbatol®, Keppra®, Keppra XR®, Lamictal, Lamictal XR, Lamictal ODT (brand and generic), Lyrica®, Motpoly XR, Mysoline®, Neurontin®, Onfi®, Sabril®, Topamax®, Trileptal®, Vimpat®, Zonegran®	Added Motpoly XR to criteria.	5/1/2024
Mytesi	Notification	Mytesi™ (crofelemer)	Annual review with no changes to coverage criteria.	5/1/2024
New and Therapeutic Equivalent Medications - Excluded Drug	Medical Necessity	New and Therapeutic Equivalent Medications - Excluded Drug	Added Imbruvica 140mg and 280mg tablet, methylphenidate extended-release tablet, Millipred, Ogsiveo, Sodium Oxybate, ursodiol 200mg and 400mg capsule, Xdemvy, zolpidem capsule Revised Adhansia XR, Adzeys XR-ODT, Aptensio XR, Cotempla XR-ODT, Daytrana, Dyanavel XR, Evekeo, Focalin XR, Forteo, Pentasa, Quillichew ER, Quillivant XR, Relexxi 72mg, Relexxi/methylphenidate extended-relesae 45mg and 63mg, Ritalin LA, Sogroya, Teriparatide (from brand only to single source brand), Trilipix, Votrient Removed fluoxetine 60mg tablet, Skytrofa, Sympazan Update to Connecticut trial requirement from 60 days to 30 days.	5/1/2024

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
New and Therapeutic Equivalent Medications - Prior Authorization	Medical Necessity	New and Therapeutic Equivalent Medications - Prior Authorization	Added Imbruvica 140mg and 280mg tablet, methylphenidate extended-release tablet, Millipred, Ogsiveo, ursodiol 200mg and 400mg capsule, Xdemvy, zolpidem capsule Revised Adhansia XR, Adzenys XR-ODT, Aptensio XR, Cotempla XR-ODT, Daytrana, Dyanavel XR, darifenacin, Evekeo (to brand only), Focalin XR, Forteo (to brand and generic), Mydayis, Pentasa, Quillichew ER, Quillivant XR, Relexxi 72mg, Relexxi/methylphenidate extended-release 45mg and 63mg, Ritalin LA, Sodium Oxybate, Sogroya, Trilipix (to brand only), Votrient Removed fluoxetine 60mg tablet, Hемangeol, Skytrofa, Sohonos, Sympazan Update to Connecticut trial requirement from 60 days to 30 days.	5/1/2024
Nocdurna	Medical Necessity	Nocdurna® (desmopressin acetate)	Annual review. Increased initial authorization to 12 months. Updated references.	5/1/2024
Ojjaara	Step Therapy	Ojjaara™ (momelotinib)	New program	5/1/2024
Olumiant	Medical Necessity	Olumiant® (baricitinib)	Updated criteria to require a failure, contraindication or intolerance to two preferred products for RA removing failure of TNF or needle-phobia. Added adalimumab preferred product footnote.	5/1/2024
Olumiant	Step Therapy	Olumiant® (baricitinib)	New program.	5/1/2024
Orencia	Medical Necessity	Orencia® (abatacept) *This program applies to the subcutaneous formulation of abatacept	Removed Olumiant as a preferred product for RA.	5/1/2024
Orencia	Step Therapy	Orencia® (abatacept) *This program applies to the subcutaneous formulation of abatacept	Removed Olumiant as a preferred product for RA.	5/1/2024
Orgovyx	Notification	Orgovyx™ (relugolix)	Annual review with no changes to coverage criteria. Updated references.	5/1/2024
Oriahnn, MyFembree	Medical Necessity	Oriahnn® (elagolix and estradiol/norethindrone), MyFembree® (relugolix and estradiol hemihydrate/norethindrone)	Annual review. Updated failure language. Updated state mandate language. Updated authorization duration. Updated references.	5/1/2024
Orilissa	Medical Necessity	Orilissa® (elagolix)	Annual review. Updated failure language. Updated state mandate language. Updated authorization duration. Updated references.	5/1/2024
Oxbryta	Notification	Oxbryta™ (voxelotor)	Annual review. Simplified reauthorization criteria and updated authorization durations to 12 months. Updated reference.	5/1/2024
Oxbryta	Medical Necessity	Oxbryta™ (voxelotor)	Annual review. Updated initial authorization duration to 12 months. Updated references.	5/1/2024
Oxervate	Notification	Oxervate® (cenegermin-bkbj) ophthalmic solution	Annual review with no change to clinical criteria. Updated reference.	5/1/2024
Oxervate	Medical Necessity	Oxervate® (cenegermin-bkbj) ophthalmic solution	Annual review with no change to clinical criteria. Updated reference.	5/1/2024
PAH Agents	Notification	Adcirca® (tadalafil), Adempas® (riociguat), Alyq™ (tadalafil), Letairis® (ambrisentan), Liqrev® (sildenafil) oral suspension, Opsumit® (macitentan), Orenitram™ (treprostinil), Revatio® (sildenafil citrate) oral powder for suspension, Tadliq® (tadalafil) oral suspension, Tracleer® (bosentan), Tyvaso® (treprostinil), Tyvaso DPI™ (treprostinil), Uptravi® (selexipag), Ventavis® (iloprost)	Annual review. Added Liqrev oral suspension for PAH and updated exclusion footnote. Updated background and references.	5/1/2024

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
PAH Agents	Medical Necessity	Adcirca® (tadalafil), Adempas® (riociguat), Alyq™ (tadalafil), Letairis® (ambrisentan), Liqrev® (sildenafil) oral suspension, Opsumit® (macitentan), Orenitram™ (treprostinil), Revatio® (sildenafil citrate) oral powder for suspension, Tadiq® (tadalafil) oral suspension, Tracleer® (bosentan), Tyvaso® (treprostinil), Tyvaso DPI™ (treprostinil), Upravi® (selexipag), Ventavis® (iloprost)	Annual review. Added Liqrev oral suspension for PAH and updated exclusion footnote. Updated background and references.	5/1/2024
Praluent	Medical Necessity	Praluent® (alirocumab)	Updated diagnostic criteria per European Atherosclerosis Society guidance. Updated references.	5/1/2024
Praluent	Notification	Praluent® (alirocumab)	Simplified reauthorization criteria.	5/1/2024
Pulmozyme	Notification	Pulmozyme® (dornase alfa)	Annual review with no changes to coverage criteria.	5/1/2024
Ravicti	Notification	Ravicti® (glycerol phenylbutyrate oral liquid)	Annual review with no change to clinical coverage.	5/1/2024
Ravicti	Medical Necessity	Ravicti® (glycerol phenylbutyrate oral liquid)	Annual review with no change to clinical coverage.	5/1/2024
Ravicti	Step Therapy	Ravicti® (glycerol phenylbutyrate oral liquid)	Annual review with no change to clinical coverage. Updated reference.	5/1/2024
Recorlev	Notification	Recorlev® (levoketoconazole)	Annual review with no changes to coverage criteria. Updated reference.	5/1/2024
Repatha	Notification	Repatha® (evolocumab)	Simplified reauthorization criteria.	5/1/2024
Repatha	Medical Necessity	Repatha® (evolocumab)	Updated diagnostic criteria per European Atherosclerosis Society guidance. Simplified reauthorization criteria. Updated references.	5/1/2024
Rezlidhia	Notification	Rezlidhia™ (olutasidenib)	Annual review with no change to coverage criteria. Updated reference.	5/1/2024
Slynd	Medical Necessity	Slynd® (drospirenone)	Annual review. Updated criteria to note a progesterone-only contraceptive due to the approval of the over-the-counter contraceptive.	5/1/2024
Slynd	Step Therapy	Slynd® (drospirenone)	Annual review. Updated progestin only contraceptive to e.g. due to the over the counter product.	5/1/2024
Suboxone	Medical Necessity	Suboxone® (Brand Only)	Removed Bunavail from program, it is off the market. Added Nevada mandate. Updated references.	5/1/2024
Tarpeyo	Medical Necessity	Tarpeyo® (budesonide delayed-release capsules)	Updated indication and references.	5/1/2024
Testosterone	Medical Necessity	Androderm®, Androgel®, Fortesta®, Jatenzo®, Natesto®, Kyzatrex™, Testim®, testosterone topical solution (generic Axiron®), testosterone transdermal gel (generic Testim), Tlando™, Vogelxo®, Xyosted®	Annual review. Updated references.	5/1/2024
Tetrabenazine	Notification	Tetrabenazine (Xenazine®)	Annual review. No changes to clinical coverage criteria.	5/1/2024
Vemlidy	Medical Necessity	Vemlidy® (tenofovir alafenamide)	Added Nevada footnote.	5/1/2024
Verquvo	Medical Necessity	Verquvo® (vericiguat)	Annual review. Updated references.	5/1/2024
Viekira Pak	Notification	Viekira Pak (ombitasvir, paritaprevir, and ritonavir tablets; dasabuvir tablets)	Annual review with no changes to coverage criteria.	5/1/2024
Wainua	Notification	Wainua™ (eplontersen)	New program	5/1/2024
Wainua	Medical Necessity	Wainua™ (eplontersen)	New program	5/1/2024
Welireg	Notification	Welireg™ (belzutifan)	Added criteria for advanced renal cell carcinoma. Updated background and references.	5/1/2024
Xalkori	Notification	Xalkori® (crizotinib)	Annual review. Updated background and coverage criteria for cutaneous melanoma per NCCN. Updated references.	5/1/2024
Xalkori - Non-Formulary	Non-Formulary	Xalkori® (crizotinib)	Annual review. Updated background and coverage criteria for cutaneous melanoma per NCCN. Updated references.	5/1/2024

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Xospata	Notification	Xospata®(gilteritinib)	Annual review. Updated treatment criteria for AML to include additional NCCN recommendations.	5/1/2024
Yonsa	Notification	Yonsa® (abiraterone acetate)	Annual review. Updated background.	5/1/2024
Yonsa	Step Therapy	Yonsa® (abiraterone acetate)	Annual review. No changes to step therapy criteria. Updated reference.	5/1/2024
Zepatier	Notification	Zepatier® (elbasvir/grazoprevir)	Annual review. Updated polymorphism criteria for treatment of chronic hepatitis C genotype 1a infection in treatment-naïve, PegIFN/RBV-experienced patients with baseline NSSA polymorphisms to include “one or more”. Added treatment - naïve requirement in criteria for Chronic Hepatitis C - Genotype 4 -Treatment-naïve patients.	5/1/2024
Zepatier	Medical Necessity	Zepatier® (elbasvir/grazoprevir)	Annual review. Updated polymorphism criteria for treatment of chronic hepatitis C genotype 1a infection in treatment-naïve, PegIFN/RBV-experienced, or PegIFN/RBV/protease inhibitor-experienced patients with baseline NSSA polymorphisms to include “one or more”.	5/1/2024
Zykadia	Notification	Zykadia® (ceritinib)	Annual review. Updated background and coverage criteria for inoperable inflammatory myofibroblastic tumor and anaplastic large cell lymphoma per NCCN. Updated reference.	5/1/2024
Zykadia - Non-Formulary	Non-Formulary	Zykadia® (ceritinib)	Annual review. Updated background and coverage criteria for inoperable inflammatory myofibroblastic tumor and anaplastic large cell lymphoma per NCCN. Updated reference.	5/1/2024
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

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Compounds and Bulk Powders	Notification	Compounds and Bulk Powders	Annual review. No changes.	6/1/2024
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

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Altuviio	Medical Necessity	Altuviio™ [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) *This program applies to the prefilled syringe formulation	New 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 Tassigna 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
Tassigna	Step Therapy	Tassigna® (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

	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
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
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, Zylflo	Step Therapy	Zileuton extended-release, Zylflo® (zileuton)	Annual review. Updated references.	7/1/2024
Zilxi	Step Therapy	Zilxi® (minocycline)	Annual review with no changes.	7/1/2024
Rhofade	Medical Necessity	Rhofade® (oxymetazoline)	New program.	9/1/2024