

UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2026 P 2299-5
Program	Prior Authorization/Medical Necessity
Medication	Enbumyst™ (bumetanide nasal spray), Furoscix® (furosemide injection)*, Lasix® ONYU (furosemide injection)
P&T Approval Date	3/2023, 3/2024, 10/2024, 5/2025, 2/2026
Effective Date	5/1/2026

1. Background:

Enbumyst (bumetanide nasal spray), Furoscix (furosemide injection) and Lasix ONYU (furosemide injection) are loop diuretics.

Enbumyst is indicated for the treatment of edema associated with congestive heart failure, hepatic and renal disease, including the nephrotic syndrome in adults.

Furoscix (furosemide injection) is indicated for the treatment of edema in pediatric patients weighing 43 kg and above and in adult patients with chronic heart failure or chronic kidney disease, including the nephrotic syndrome.

Lasix ONYU (furosemide injection) is indicated for the treatment of edema in adult patients with chronic heart failure.

2. Coverage Criteria ^a:

A. Authorization

1. **Enbumyst** or **Lasix ONYU** will be approved based on **all** of the following criteria:

a. **Edema associated with one** of the following:

- (1) Congestive heart failure
- (2) Renal disease, including nephrotic syndrome
- (3) Hepatic disease

-AND-

b. Submission of medical records confirming that the patient is established on background loop diuretic therapy (e.g., bumetanide, furosemide, torsemide) for the treatment of edema

-AND-

c. **Both** of the following:

- (1) Patient does not require ongoing emergency care or hospitalization

-AND-

- (2) Patient is currently a candidate for parenteral or nasal diuresis outside of the hospital

-AND-

- d. Prescribed by or in consultation with **one** of the following:

- (1) cardiologist
- (2) nephrologist
- (3) hepatologist
- (4) gastroenterologist

-AND-

- e. For **Lasix ONYU** only:

- (1) Trial, failure or contraindication to Enbumyst

Authorization will be issued for 1 month

2. **Furoscix*** will be approved based on the following criterion:

- a. Patient is less than 18 years of age

Authorization will be issued for 1 month

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

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply Limits may be in place.
- *Furoscix is typically excluded. Coverage will only be provided for pediatric patients.

4. References:

1. Furoscix [package insert]. Burlington, MA: scPharmaceuticals, Inc.; March 2025.
2. Heidenreich PA, Bozkurt, B, et al. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. *Circulation*. 2022;145(18):e895-e1032.
3. Enbumyst [package insert]. Henderson, NV: Corstasis USA LLC; November 2025.
4. Lasix ONYU [package insert]. Burlington, MA: SQ Innovation, Inc.; October 2025.

Program	Prior Authorization/Medical Necessity – Enbumyst, Furoscix, Lasix ONYU
Change Control	
3/2023	New program.
3/2024	Annual review. Updated background to include limitations of use. Updated reference.
10/2024	Updated background and removed criteria for NYHA Class II and Class III chronic heart failure per updated indication that includes NYHA Class IV chronic heart failure. Updated references.
5/2025	Updated background and added criteria for CKD per updated indication. Removed creatinine clearance requirements. Updated references.
2/2026	Added Enbumyst and Lasix ONYU to criteria. Updated Furoscix to note typically excluded.