UnitedHealthcare

Commercial Business

BULLETIN (9/1/2024)

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.

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Actimmune	Notification	Actimmune® (interferon gamma-1b)	Annual review. No changes to coverage criteria.	9/1/2024
Adalimumab	Notification	Adalimumab - Abrilada (adalimumab-afzb), Adalimumab-adaz (unbranded Hyrimoz), Adalimumab-fkjp (unbranded Hulio), Amjevita™ (adalimumab-atto), Cyltezo® (adalimumab-adbm), Hadlima™ (adalimumab-bwwd), Hulio® (adalimumab-fkjp), Humira® (adalimumab), Hyrimoz® (adalimumab-adaz), Idacio (adalimumab-aacf), Yuflyma (adalimumab-aaty), Yusimry (adalimumab-aqvh)	Annual review. Added Adalimumab-aacf (unbranded Idacio), Adalimumab-adbm (unbranded Cyltezo), and Simlandi (adalimumab-ryvk) to the program. Noted Humira, Hadlima, Amjevita high concentration, Adalimumab-adbm (unbranded Cyltezo), and Adalimumab-adaz (unbranded Hyrimoz) as covered products. All other products are noted as excluded. Updated references.	9/1/2024
Adalimumab	Medical Necessity	Adalimumab - Abrilada™ (adalimumab-afzb), Adalimumab-aacf (unbranded Idacio), Adalimumab-adaz (unbranded Hyrimoz), Adalimumab-adbm (unbranded Cyltezo), Adalimumab-fkjp (unbranded Hulio), Amjevita™ (adalimumab-atto), Cyltezo® (adalimumab-adbm), Hadlima™ (adalimumab-bwwd), Hulio® (adalimumab-fkjp), Humira® (adalimumab), Hyrimoz® (adalimumab-adaz), Idacio® (adalimumab-aacf), Simlandi® (adalimumab-ryvk), Yuflyma® (adalimumab-aaty)*, and Yusimry™ (adalimumab-aqvh)	Annual review. Added Adalimumab-aacf (unbranded Idacio), Adalimumab-adbm (unbranded Cyltezo), and Simlandi (adalimumab-ryvk) to the program. Noted Humira, Hadlima, Amjevita high concentration, Adalimumab-adbm (unbranded Cyltezo), and Adalimumab-adaz (unbranded Hyrimoz) as covered products. All other products are noted as excluded. Updated references and state mandate footnote.	9/1/2024
Aklief	Medical Necessity	Aklief® (trifarotene) cream	Annual review. Updated initial authorization to 12 months and updated references.	9/1/2024
Alecensa	Notification	Alecensa® (alectinib)	Added criteria for adjuvant treatment following tumor resection of ALK-positive NSCLC per FDA label. Updated references.	9/1/2024
Apokyn	Medical Necessity	Apokyn® (apomorphine) injection	Annual review. Updated initial authorization duration to 12 months. Updated references.	9/1/2024
Berinert	Step Therapy	Berinert® (C1 esterase inhibitor [human])	Annual review with no changes to criteria.	9/1/2024
Besremi	Step Therapy	Besremi® (ropeginterferon alfa-2b-njft)	Annual review. Updated references.	9/1/2024
Bimzelx	Medical Necessity	Bimzelx® (bimekizumab-bkzx)	Added requirement for medical record submission for all authorization criteria. Updated trial/failure criteria for Cosentyx. Removed reauthorization criteria.	9/1/2024

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Braftovi	Notification	Braftovi® (encorafenib)	Annual review. Updated language and formatting of criteria for melanoma, colon cancer, and rectal cancer with no change in intent. Added coverage for advanced and recurrent NSCLC per NCCN Compendium. Added reauthorization requirement for NSCLC that Braftovi is used in combination with Mektovi. Updated references.ted language and formatting of criteria for melanoma, colon cancer, and rectal cancer with no change in intent. Added coverage for advanced and recurrent NSCLC per NCCN Compendium. Added reauthorization requirement for NSCLC that Braftovi is used in combination with Mektovi. Updated references.	9/1/2024
Cometriq	Notification	Cometriq® (cabozantinib)	Annual review. Updated references.	9/1/2024
Descovy - Colorado	Medical Necessity	Descovy® (emtricitabine/tenofovir alafenamide)	Updated wording for HIV-1 infection without change to clinical intent. Updated references.	9/1/2024
Descovy - Colorado	Step Therapy	Descovy® (emtricitabine/tenofovir alafenamide)	Annual review. Updated background per Truvada package insert. Updated wording for HIV-1 infection and HIV-1 PrEP without change to clinical intent. Updated references.	9/1/2024
Digital Applications	Medical Necessity	EndeavorRx®, reSET, reSET-O®, Somryst	Annual review with no changes.	9/1/2024
Gilotrif	Notification	Gilotrif® (afatinib)	Annual review. No changes to clinical criteria.	9/1/2024
Intrarosa	Medical Necessity	Intrarosa® (prasterone)	Annual review. Updated references.	9/1/2024
Iron Chelators - Exjade, Jadenu, Ferriprox	Notification	Exjade® (deferasirox), Jadenu® (deferasirox), and Ferriprox® (deferiprone)	Annual review. No changes to clinical criteria. Updated reference.	9/1/2024
Isturisa	Notification	Isturisa® (osilodrostat)	Annual review with no change to coverage criteria. Updated reference.	9/1/2024
Kalydeco	Notification	Kalydeco® (ivacaftor)	Annual review. Increased initial authorization approval duration to 12 months. Updated reference.	9/1/2024
Kalydeco	Medical Necessity	Kalydeco® (ivacaftor)	Annual review. Increased initial authorization approval duration to 12 months. Removed prescriber requirement from reauthorization criteria. Updated reference.	9/1/2024
Leuprolide acetate	Notification	Leuprolide acetate (bulk powder, 1 mg/0.2 mL injection)	Annual review. Simplified criteria for prostate and salivary gland cancer. Added criteria for uterine sarcoma. Updated reauthorization criteria for CPP. Updated background and references.	9/1/2024
Levemir	Medical Necessity	Levemir® (insulin detemir)	Annual review. No changes.	9/1/2024
Lokelma, Veltassa	Medical Necessity	Lokelma® (sodium zirconium cyclosilicate), Veltassa® (patiromer)	Annual review. Updated references.	9/1/2024
Lupkynis	Medical Necessity	Lupkynis™ (voclosporin)	Annual review. Updated authorization lengths to 12 months.	9/1/2024
Lupkynis	Notification	Lupkynis™ (voclosporin)	Annual review. Updated authorization lengths to 12 months.	9/1/2024
Menopur	Notification	Menopur® (menotropins)	Annual review. Added coverage criteria for fertility preservation for iatrogenic infertility. Updated term "controlled ovarian stimulation" to "ovarian stimulation". Updated references.	9/1/2024
Motegrity	Medical Necessity	Motegrity® (prucalopride)	Annual review. Updated background section and references. Referenced brand Amitiza exclusion.	9/1/2024
Movantik	Medical Necessity	Movantik® (naloxegol)*	Annual review. Updated background section. Added document date tried. Referenced brand Amitiza exclusion. Updated references.	9/1/2024
Myalept	Medical Necessity	Myalept® (metreleptin)	Annual review with no changes to coverage criteria. Updated background.	9/1/2024

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
New and Therapeutic Equivalent Medications - Excluded Drug	Medical Necessity	New and Therapeutic Equivalent Medications - Excluded Drug	Added Amjevita 50mg/mL, Bexagliflozin, Bimzelx, Cyltezo, Floriva Plus, glipizide 2.5mg, Iyuzeh, Kazano, Multi-Vi-Flor, Multivitamin with fluoride chewable (manufactured by Neos Therapeutics), Nesina, nitrofurantoin 50mg/mL oral suspension, Oseni, Pokonza, Poly-Vi-Flor, Velsipity. Revised Abrilada, Adalimumab-fkjp, Bepreve, Fabior, Genotropin, Hulio, Humatrope, Hyrimoz, Idacio, Pataday, Saizen, Travatan Z, Zerviate, Zomacton. Removed Alogliptin (Nesina authorized generic), Alogliptin-Metformin (Kazano authorized generic), Alogliptin-Pioglitazone (Oseni authorized generic).	9/1/2024
New and Therapeutic Equivalent Medications - Prior Authorization	Medical Necessity	New and Therapeutic Equivalent Medications - Prior Authorization	Added Amjevita 50mg/mL, Bexagliflozin, Bimzelx, Cyltezo, Floriva Plus, glipizide 2.5mg, Iyuzeh, Kazano, Multi-Vi-Flor, multivitamin with floruoride chewable (manufactured by Neos Therapeutics), Nesina, nitrofurantoin 50mg/5mL oral suspension, Oseni, Pokonza, Poly-Vi-Flor, Velsipity. Revised Abrilada, Adalimumab-fkjp, Bepreve, Fabior, Genotropin, Hulio, Humatrope, Hyrimoz, Idacio, Saizen, Travatan Z, Zerviate, Zomacton. Removed Alogliptin (Nesina authorized generic, Alogliptin-Metformin (Kazano authorized generic), Alogliptin-Pioglitazone (Oseni authorized generic), Tev-Tropin.	9/1/2024
Nexletol, Nexlizet	Medical Necessity	Nexletol® (bempedoic acid), Nexlizet ® (bempedoic acid/ezetimibe)	Updated indications to include established and high risk for CVD based on updated labeling. Lowered LDL-C threshold for initiation of therapy.	9/1/2024
Ninlaro	Notification	Ninlaro® (ixazomib)	Updated Multiple Myeloma criteria to only diagnosis.	9/1/2024
Ocaliva	Notification	Ocaliva® (obeticholic acid)	Annual review. Updated initial authorization to 12 months.	9/1/2024
Ocaliva	Medical Necessity	Ocaliva® (obeticholic acid)	Annual review. Updated initial authorization to 12 months.	9/1/2024
Ocaliva	Step Therapy	Ocaliva® (obeticholic acid)	Annual review with no changes to coverage criteria.	9/1/2024
Ojemda	Notification	Ojemda ™ (tovorafenib)	New program	9/1/2024
Omnipod 5	Notification	Omnipod® 5	Annual review. Updated references.	9/1/2024
Orkambi	Notification	Orkambi® (lumacaftor/ivacaftor)	Annual review. Increased initial authorization approval duration to 12 months. Updated reference.	9/1/2024
Orkambi	Medical Necessity	Orkambi® (lumacaftor/ivacaftor)	Annual review. Increased initial authorization approval duration to 12 months. Removed prescriber requirement from reauthorization criteria. Updated reference.	9/1/2024
Otezla	Notification	Otezla® (apremilast)	Updated background to reflect new indication for pediatrics with plaque psoriasis. Updated reference.	9/1/2024
Palynziq	Step Therapy	Palynziq™ (pegvaliase-pqpz)	Annual review with no change to coverage criteria. Updated references.	9/1/2024
Procysbi	Notification	Procysbi® (cysteamine bitartrate)	Annual review with no changes to criteria.	9/1/2024
Rydapt	Notification	Rydapt® (midostaurin)	Annual review with no changes to clinical criteria. Updated references.	9/1/2024
Samsca	Notification	Samsca® (tolvaptan)	Annual review with no changes to criteria. Updated formatting of background.	9/1/2024
Sotyktu	Notification	Sotyktu™ (deucravacitinib)	Annual review. No changes.	9/1/2024
Spravato	Notification	Spravato® (esketamine)	Updated wording of coverage criteria without change to clinical intent. Updated approval duration, both initial and reauthorization, to 12 months.	9/1/2024
Spravato	Medical Necessity	Spravato® (esketamine)	Updated wording of coverage criteria without change to clinical intent. Updated approval duration, both initial and reauthorization, to 12 months.	9/1/2024

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Stivarga	Notification	Stivarga® (regorafenib)	Annual review. Added examples to anti-EGFR therapy. Removed "criteria" from all reauthorization sections. Separated gastrointestinal stromal tumor criteria from soft tissue sarcoma criteria and updated criteria per NCCN guideline. Added disease subtype criteria to hepatobiliary cancer section. Changed osteosarcoma section to bone cancer and added Ewing Sarcoma to criteria per NCCN guideline. Updated background and reference.	9/1/2024
Symdeko	Notification	Symdeko® (tezacaftor/ivacaftor)	Annual review. Updated initial authorization approval duration to 12 months. Updated reference.	9/1/2024
Symdeko	Medical Necessity	Symdeko® (tezacaftor/ivacaftor)	Annual review. Updated initial authorization approval duration to 12 months. Simplified reauthorization criteria. Updated reference.	9/1/2024
Syprine	Notification	Syprine® (trientine hydrochloride)*, Trientine hydrochloride	Annual review with no changes to criteria.	9/1/2024
Trikafta	Notification	Trikafta® (elexacaftor/tezacaftor/ivacaftor)	Annual review. Increased initial authorization approval duration to 12 months. Updated reference.	9/1/2024
Trikafta	Medical Necessity	Trikafta® (elexacaftor/tezacaftor/ivacaftor)	Annual review. Increased initial authorization approval duration to 12 months. Removed prescriber requirement from reauthorization criteria. Updated reference.	9/1/2024
Tryvio	Medical Necessity	Tryvio™ (aprocitentan)	New program	9/1/2024
Vijoice	Notification	Vijoice® (alpelisib)	Annual review. Updated initial authorization to 12 months. Updated references.	9/1/2024
Vijoice	Medical Necessity	Vijoice® (alpelisib)	Annual review. Revised criteria for presumptive PROS if unable to confirm PIK3CA gene mutation. Updated initial authorization to 12 months. Updated references.	9/1/2024
Voquezna	Medical Necessity	Voquezna® (vonoprazan)	Updated step one options to include omeprazole and pantoprazole.	9/1/2024
Winrevair	Notification	Winrevair ™ (sotatercept-csrk)	New program	9/1/2024
Winrevair	Medical Necessity	Winrevair ™ (sotatercept-csrk)	New program	9/1/2024
Xermelo	Notification	Xermelo® (telotristat ethyl)	Annual review. Updated initial authorization duration to 12 months.	9/1/2024
Xtandi	Notification	Xtandi® (enzalutamide)	Updated criteria to reflect that for non-metastatic castration-sensitive prostate cancer concomitant use with GnRH is not required.	9/1/2024
Xuriden	Notification	Xuriden® (uridine triacetate)	Annual review with no change to criteria. Updated reference.	9/1/2024
Therapeutic Duplication – administrative override	Misc	Therapeutic Duplication – administrative override	Added GLP1/DPP4 combinations.	9/15/2024
Abilify MyCite	Medical Necessity	Abilify MyCite® (aripiprazole tablet with sensor)	Annual review. Updated references.	10/1/2024
Agamree	Notification	Agamree® (vamorolone)	New program.	10/1/2024
Agamree	Medical Necessity	Agamree® (vamorolone)	New program.	10/1/2024
Agamree	Step Therapy	Agamree® (vamorolone)	New program.	10/1/2024
Albuterol tablets	Medical Necessity	Albuterol tablets	Annual review. Updated medication examples in criteria.	10/1/2024
Ayvakit	Notification	Ayvakit® (avapritinib)	Annual review. Updated wording of systemic mastocytosis criteria per NCCN without change to clinical intent. Updated references.	10/1/2024
Benlysta	Notification	Benlysta® (belimumab) *This program applies to the subcutaneous formulation of belimumab	Annual review with no changes to coverage criteria. Updated reference.	10/1/2024
Berinert	Notification	Berinert® (C1 esterase inhibitor, human)	Annual review with no changes to coverage criteria.	10/1/2024
Brukinsa	Notification	Brukinsa® (zanubrutinib)	Annual review. Clinical coverage criteria added for follicular lymphoma and hairy cell leukemia. Updated B-cell lymphoma formatting. Updated background and reference.	10/1/2024
Brukinsa	Step Therapy	Brukinsa® (zanubrutinib)	Annual review with no changes to step criteria. Updated background and references.	10/1/2024
Carbaglu	Notification	Carbaglu® (carglumic acid)	Annual review with no changes to coverage criteria. Updated reference.	10/1/2024

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Constipation Agents - Amitiza, Ibsrela, Linzess, Motegrity, Movantik, Symproic, Trulance	Notification	Amitiza® (lubiprostone), Ibsrela® (tenapanor), Linzess® (linaclotide), Motegrity® (prucalopride), Movantik® (naloxegol), Symproic® (naldemedine), Trulance® (plecanatide)	Annual review. Removed criteria for Ibsrela that patient is 18 or older. Updated references.	10/1/2024
Continuous glucose monitors, sensors and transmitters (all brands)	Medical Necessity	Continuous glucose monitors, sensors and transmitters (all brands)	Removed requirement for inadequate glycemic control. Added criteria for hypoglycemia.	10/1/2024
Diabetes Medications - DPP4 Inhibitors - Januvia, Janumet, Janumet XR, Zituvio	Step Therapy	Januvia® (sitagliptin), Janumet® (sitagliptin/metformin immediate-release), Janumet® XR (sitagliptin/metformin extended-release), Zituvio™ (sitagliptin)	Added Zituvio and updated Nesina and Kazano to the authorized generic products. Updated references.	10/1/2024
Diabetes Medications - DPP4 Inhibitors - Januvia, Janumet, Janumet XR, Zituvio - Custom Oxford SoNY and SoCT	Medical Necessity	Januvia® (sitagliptin), Janumet® (sitagliptin/metformin immediate-release), Janumet® XR (sitagliptin/metformin extended-release), Zituvio™ (sitagliptin)	Added Zituvio and updated Nesina and Kazano to the authorized generic products. Updated references.	10/1/2024
Duvyzat	Notification	Duvyzat™ (givinostat) oral suspension	New program.	10/1/2024
Duvyzat	Medical Necessity	Duvyzat™ (givinostat) oral suspension	New program.	10/1/2024
Epclusa	Medical Necessity	Epclusa® (sofosbuvir/velpatasvir)	Annual review. Removed liver disease staging criteria that was included for quality purposes rather than part of coverage decision. Updated references.	10/1/2024
Evrysdi	Notification	Evrysdi® (risdiplam)	Annual review. Updated reference.	10/1/2024
Evrysdi	Medical Necessity	Evrysdi® (risdiplam)	Annual review. Revised prescriber requirement and updated Upper Limb Module to Revised Upper Limb Module test. Updated references.	10/1/2024
Fasenra	Notification	Fasenra® (benralizumab) *This program applies to the prefilled autoinjector formulation.	Annual review. Updated background for ages 6 years and older. Modified criteria for existing prior authorization for under the medical benefit. Updated reference.	10/1/2024
Fasenra	Medical Necessity	Fasenra® (benralizumab) *This program applies to the prefilled autoinjector formulation.	Annual review. Modified criteria for existing prior authorization for under the medical benefit. Updated background for expanded indication for ages 6 years and older. Updated references.	10/1/2024
Fentanyl Transmucosal - Actiq, Fentora, fentanyl citrate bulk powder	Medical Necessity	Actiq® (brand only) (fentanyl transmucosal lozenge), Fentora® (fentanyl buccal tablet), and fentanyl citrate bulk powder	Removed Lazanda and Subsys as they are no longer on the market. Added opioid tolerate dose for oral hydrocodone. Updated references.	10/1/2024
Hepatitis C Direct Acting Antivirals - Epclusa, Harvoni, Mavyret, Sovaldi, Viekira Pak, Zepatier	Step Therapy	Hepatitis C Direct Acting Antivirals - Epclusa® (sofosbuvir/velpatasvir), Harvoni® (ledipasvir/sofosbuvir), Mavyret® (glecaprevir/pibrentasvir), Sovaldi® (sofosbuvir), Viekira Pak™ (ombitasvir, paritaprevir, and ritonavir tablets; dasabuvir tablets), Zepatier® (elbasvir/grazoprevir)	Annual review. Updated background and references.	10/1/2024
Ibsrela, Trulance	Medical Necessity	Ibsrela® (tenapanor), Trulance® (plecanatide)	Review. Added documentation requirement. Updated references.	10/1/2024
Ibsrela, Trulance	Step Therapy	Ibsrela® (tenapanor), Trulance® (plecanatide)	Review. Added documentation requirement. Updated references.	10/1/2024
Juxtapid	Step Therapy	Juxtapid® (lomitapide)	Annual review with no change to clinical criteria. Updated background.	10/1/2024
Lithobid	Medical Necessity	Lithobid® (brand only)	Removed therapeutic levels requirement for generic trial and stability duration.	10/1/2024
Lokelma, Veltassa	Medical Necessity	Lokelma® (sodium zirconium cyclosilicate), Veltassa® (patiromer)	Removed requirement to adjust medications.	10/1/2024
Lumakras	Notification	Lumakras™ (sotorasib)	Annual review. Added criteria for ampullary adenocarcinoma, colon cancer, and rectal cancer per NCCN guidelines. Updated background and references.	10/1/2024
Lybalvi	Medical Necessity	Lybalvi™ (olanzapine/samidorphan)	Updated to require a trial of three medications and removed weight gain requirement.	10/1/2024
Lynparza	Notification	Lynparza® (olaparib)	Annual review. Updated formatting for ovarian cancer without change in clinical intent. Updated references.	10/1/2024
Mavyret	Medical Necessity	Mavyret® (glecaprevir/pibrentasvir)	Annual review. Removed liver disease staging criteria that was included for quality purposes rather than part of coverage decision. Updated references.	10/1/2024
Mirvaso, Rhofade	Notification	Mirvaso® (brimonidine gel), Rhofade® (oxymetazoline cream)	Removed step and medical necessity language.	10/1/2024

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Nerlynx	Notification	Nerlynx® (neratinib)	Annual review. Formatting changes to criteria without change to clinical intent. Updated background and references.	10/1/2024
Nucala	Medical Necessity	Nucala® (mepolizumab) *This program applies to the prefilled autoinjector and prefilled syringe formulations.	Annual review. Updated background with modified indication for CRSwNP. Specified existing prior authorization for under the medical benefit. Updated references.	10/1/2024
Nucala	Notification	Nucala® (mepolizumab) *This program applies to the prefilled autoinjector and prefilled syringe formulations.	Annual review. Updated background with modified indication for CRSwNP. Removed nasal corticosteroid requirement in CRSwNP criteria. Added Tezspire to list of drugs not allowed for concomitant use. Updated reference.	10/1/2024
Nuedexta	Notification	Nuedexta® (dextromethorphan/quinidine)	Annual review. Updated initial authorization.	10/1/2024
Nuedexta	Medical Necessity	Nuedexta® (dextromethorphan/quinidine)	Annual review. Updated initial authorization to 12 months.	10/1/2024
Palynziq	Notification	Palynziq™ (pegvaliase-pqpz)	Annual review. Simplified reauthorization criteria to standard documentation of positive clinical response language.	10/1/2024
Palynziq	Medical Necessity	Palynziq™ (pegvaliase-pqpz)	Annual review. Updated authorization durations to 12 months. Updated references.	10/1/2024
Pancreaze, Pertzye, Viokace	Step Therapy	Pancreaze®, Pertzye®, Viokace®	Annual review. Updated references.	10/1/2024
Prevymis	Notification	Prevymis™ (letermovir)	Annual review with no changes to coverage criteria. Updated reference.	10/1/2024
Qelbree	Medical Necessity	Qelbree® (viloxazine)	Annual review. No changes.	10/1/2024
Qinlock	Notification	Qinlock™ (ripretinib)	Annual review. Updated disease type for GIST based on NCCN recommendations. Reformatted sections for GIST and cutaneous melanoma. Updated references.	10/1/2024
Radicava ORS	Notification	Radicava ORS® (edaravone)	Annual review. Updated initial authorization and reauthorization to 12 months.	10/1/2024
Radicava ORS	Medical Necessity	Radicava ORS® (edaravone)	Annual review. Clarified criteria for existing prior authorization for under the medical benefit. Updated initial authorization and reauthorization to 12 months.	10/1/2024
Relistor	Medical Necessity	Relistor® (methylnaltrexone bromide)	Annual review. Updated references.	10/1/2024
Ruconest	Notification	Ruconest® (C1 esterase inhibitor [recombinant])	Annual review. No changes to coverage criteria.	10/1/2024
SGLT2 Inhibitors - Brenzavvy, Farxiga, Glyxambi, Inpefa, Invokana, Invokamet, Invokamet XR, Qtern, Segluromet, Steglatro, Steglujan, Xigduo XR	Step Therapy	Brenzavvy® (bexagliflozin), Farxiga® (dapagliflozin), Glyxambi® (empagliflozin/linagliptan), Inpefa® (sotagliflozin), Invokana® (canagliflozin), Invokamet (canagliflozin/metformin), Invokamet XR (canagliflozin/metformin extended-release), Qtern® (dapagliflozin/saxagliptin), Segluromet® (ertugliflozin/metformin), Steglatro® (ertugliflozin), Steglujan® (ertugliflozin/sitagliptin), Xigduo® XR (dapagliflozin/metformin extended-release)	Annual review. Updated excluded products – removed Brenzavvy, added Bexagliflozin. Updated regulatory requirement. Updated references.	10/1/2024
SGLT2 Inhibitors - Brenzavvy, Farxiga, Glyxambi, Inpefa, Invokana, Invokamet, Invokamet XR, Qtern, Segluromet, Steglatro, Steglujan, Xigduo XR - Custom Oxford SoNY and SoCT	Medical Necessity	Brenzavvy® (bexagliflozin), Farxiga® (dapagliflozin), Glyxambi® (empagliflozin/linagliptan), Inpefa® (sotagliflozin), Invokana® (canagliflozin), Invokamet (canagliflozin/metformin), Invokamet XR (canagliflozin/metformin extended-release), Qtern® (dapagliflozin/saxagliptin), Segluromet® (ertugliflozin/metformin), Steglatro® (ertugliflozin), Steglujan® (ertugliflozin/sitagliptin), Xigduo® XR (dapagliflozin/metformin extended-release)	Annual review. Updated excluded products – removed Brenzavvy, added Bexagliflozin. Updated regulatory requirement. Updated references.	10/1/2024
Skyrizi	Notification	Skyrizi® (risankizumab-rzaa) injection *This program applies to the subcutaneous formulations of Skyrizi	Updated clinical coverage criteria and background to add ulcerative colitis. Updated reference.	10/1/2024
Skyrizi	Medical Necessity	Skyrizi® (risankizumab-rzaa) injection *This program applies to the subcutaneous formulations of Skyrizi	Updated clinical coverage criteria and background to add ulcerative colitis. Updated active prior authorization verbiage under Crohn's disease with no change to clinical intent. Updated reference.	10/1/2024
Solaraze	Notification	Solaraze (diclofenac 3% gel)	Annual review. Updated references.	10/1/2024

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Somavert	Notification	Somavert® (pegvisomant)	Annual review with no changes to coverage criteria. Updated reference.	10/1/2024
Somavert	Medical Necessity	Somavert® (pegvisomant)	Annual review with no changes to coverage criteria. Updated references.	10/1/2024
Stendra	Medical Necessity	Stendra® (avanafil)	Annual review. Updated references.	10/1/2024
Tabrecta	Notification	Tabrecta® (capmatinib)	Annual review. Updated references.	10/1/2024
Tezspire	Notification	Tezspire™ (tezepelumab-ekko) *This program applies to the prefilled pen for self-administration.	Annual review. Specified existing prior authorization for under the medical benefit. Updated reference.	10/1/2024
Tezspire	Medical Necessity	Tezspire™ (tezepelumab-ekko) *This program applies to the prefilled pen for self-administration.	Annual review. Modified criteria for existing prior authorization for under the medical benefit. Removed footnote disclaimer for step therapy. Updated references.	10/1/2024
Vonjo	Notification	Vonjo (pacritinib)	Annual review. Added accelerated/blast phase myeloproliferative neoplasm to list of MF subtypes. Updated criteria for low- and high-risk MF, MF-associated anemia, and splenomegaly and other disease-related symptoms per NCCN guidelines. Updated approval durations to 12 months. Updated background.	10/1/2024
Voquezna Dual Pak, Voquezna Triple Pak	Step Therapy	Voquezna Dual Pak® (vonoprazan and amoxicillin), Voquezna Triple® Pak (vonoprazan, amoxicillin and clarithromycin)	Annual review. Updated references.	10/1/2024
Vowst	Notification	Vowst™ (fecal microbiota spores, live-brpk)	Annual review with no changes.	10/1/2024
Welireg	Notification	Welireg™ (belzutifan)	Updated examples of PD-L1 checkpoint inhibitors and VEGF-TKIs within advanced RCC criteria.	10/1/2024
Winlevi	Medical Necessity	Winlevi® (clascoterone)	Annual review. Updated references.	10/1/2024
Xifaxan	Medical Necessity	Xifaxan® (rifaximin)	Annual review. Updated references.	10/1/2024
Zileuton extended-release, Zyflo	Step Therapy	Zileuton extended-release, Zyflo® (zileuton)	Archive program.	10/1/2024
Nurtec ODT, Qulipta, Ubrelvy, Zavzpret	Step Therapy	Nurtec® ODT (rimegepant), Qulipta™ (atogepant), Ubrelvy™ (ubrogepant), Zavzpret™ (zavegepant)	Updated Zavzpret step and list of potential prophylactic therapies.	10/15/2024
Nurtec ODT, Qulipta, Ubrelvy, Zavzpret	Medical Necessity	Nurtec® ODT (rimegepant), Qulipta™ (atogepant), Ubrelvy™ (ubrogepant), Zavzpret™ (zavegepant)	Updated Zavzpret step and list of potential prophylactic therapies.	10/15/2024
PAH Agents	Notification	Adcirca® (tadalafil), Adempas® (riociguat), Alyq™ (tadalafil), Letairis® (ambrisentan), Liqrev® (sildenafil) oral suspension, Opsumit® (macitentan), Opsynvi® (macitentan/tadalafil), Orenitram™ (treprostinil), Revatio® (sildenafil citrate) oral powder for suspension, Tadliq® (tadalafil) oral suspension, Tracleer® (bosentan), Tyvaso® (treprostinil), Tyvaso DPI™ (treprostinil), Uptravi® (selexipag), Ventavis® (iloprost)	Added Opsynvi tablets to criteria for PAH. Added Opsynvi to additional information section. Updated background and references.	10/15/2024
PAH Agents	Medical Necessity	Adcirca® (tadalafil), Adempas® (riociguat), Alyq™ (tadalafil), Letairis® (ambrisentan), Liqrev® (sildenafil) oral suspension, Opsumit® (macitentan), Opsynvi® (macitentan/tadalafil), Orenitram™ (treprostinil), Revatio® (sildenafil citrate) oral powder for suspension, Tadliq® (tadalafil) oral suspension, Tracleer® (bosentan), Tyvaso® (treprostinil), Tyvaso DPI™ (treprostinil), Uptravi® (selexipag), Ventavis® (iloprost)	Added coverage criteria for Opsynvi tablets for PAH. Added Opsynvi to additional information section. Updated background and references.	10/15/2024
Xolremdi	Notification	Xolremdi™ (mavorixafor)	New program	10/15/2024
Xolremdi	Medical Necessity	Xolremdi™ (mavorixafor)	New program	10/15/2024
Albenza, Emverm	Medical Necessity	Albenza (albendazole), Emverm (mebendazole)	Annual review. Clarified spelling of Opisthorchiasis.	11/1/2024
Augtyro	Notification	Augtyro™ (repotrectinib)	Updated background and coverage criteria to include new indication for solid tumors with NTRK gene fusion per package insert. Updated references.	11/1/2024

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Braftovi	Step Therapy	Braftovi® (encorafenib)	Annual review. Added non-small cell lung cancer section, updated background with new indications. Updated references.	11/1/2024
Bylvay	Notification	Bylvay™ (odevixibat)	Annual review. Updated initial authorization durations to 12 months. Updated background and reference.	11/1/2024
Bylvay	Medical Necessity	Bylvay™ (odevixibat)	Annual review. Updated examples of conventional treatment and initial authorization durations. Updated background and references.	11/1/2024
Camzyos	Notification	Camzyos® (mavacamten)	Annual review. Added Med Nec may be in place under additional clinical rules. Updated reference.	11/1/2024
Camzyos	Medical Necessity	Camzyos® (mavacamten)	Annual review. Updated references.	11/1/2024
Cetrotide	Step Therapy	Cetrotide® (cetrorelix acetate)	Annual review. Updated background and references.	11/1/2024
Duopa	Medical Necessity	Duopa™ (carbidopa/levodopa)	Annual review. No changes.	11/1/2024
Epclusa	Notification	Epclusa® (sofosbuvir/velpatasvir)	Annual review with no changes to coverage criteria.	11/1/2024
Epsolay	Medical Necessity	Epsolay® (benzoyl peroxide)	Annual review. Removed that step therapy may be in place.	11/1/2024
Jynarque	Notification	Jynarque® (tolvaptan)	Annual review with no changes to coverage criteria.	11/1/2024
Kevzara	Notification	Kevzara® (sarilumab) Injection	Added clinical coverage criteria for pJIA. Updated background and reference. Alphabetized targeted immunomodulator examples with no change to intent.	11/1/2024
Kevzara	Medical Necessity	Kevzara® (sarilumab) Injection	Added clinical coverage criteria for pJIA. Updated background and reference. Alphabetized preferred products and targeted immunomodulator examples with no change to intent.	11/1/2024
Klisyri	Step Therapy	Klisyri® (tirbanibulin)	Annual review. Removed Cerac from examples, as this product is typically excluded from benefit coverage. Updated references.	11/1/2024
Krazati	Notification	Krazati™ (adagrasib)	Combined criteria for colon and rectal cancer in one section – Colorectal Cancer. Added criteria for NCCN recommended use of Krazati in biliary tract cancer. Updated background and references.	11/1/2024
Mavyret	Notification	Mavyret® (glecaprevir/pibrentasvir)	Annual review with no changes to coverage criteria. Updated references.	11/1/2024
Mekinist	Step Therapy	Mekinist® (trametinib)	Annual review. No changes to clinical criteria. Updated background and references.	11/1/2024
Mektovi	Step Therapy	Mektovi® (binimetinib)	Annual review. Added non-small cell lung cancer section, updated background with new indications. Updated references.	11/1/2024
Nurtec ODT, Qulipta, Ubrelvy, Zavzpret	Notification	Nurtec® ODT (rimegepant), Qulipta™ (atogepant), Ubrelvy™ (ubrogepant), Zavzpret™ (zavegepant)	Review. No changes.	11/1/2024
Solosec	Step Therapy	Solosec® (secnidazole)	Annual review. No changes.	11/1/2024
Sprix	Step Therapy	Sprix® (ketorolac)	Annual review, updated reference.	11/1/2024
Tafinlar	Step Therapy	Tafinlar® (dabrafenib)	Annual review. No changes to clinical criteria. Updated background and references.	11/1/2024
Talzenna	Notification	Talzenna® (talazoparib)	Annual review. Updated references.	11/1/2024
Veozah	Medical Necessity	Veozah™ (fezolinetant)	Annual review. Updated references.	11/1/2024
Vivjoa	Medical Necessity	Vivjoa® (oteseconazole)	Annual review. Updated regulatory statement.	11/1/2024
Vosevi	Medical Necessity	Vosevi™ (sofosbuvir, velpatasvir, and voxilaprevir)	Annual review with no changes to the criteria.	11/1/2024
Vosevi	Notification	Vosevi™ (sofosbuvir, velpatasvir, and voxilaprevir)	Annual review with no changes to the criteria.	11/1/2024
Demser	Notification	Demser® (metyrosine)	New program.	1/1/2025
Mulpleta	Medical Necessity	Mulpleta® (lusutrombopag)	New program.	1/1/2025
Phosphate Binders - Fosrenol, Velhoro	Step Therapy	Fosrenol® (lanthanum carbonate), Velphoro® (sucroferric oxyhydroxide)	Added Velphoro to program.	1/1/2025

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Plans with Weight Loss Medication Coverage	Notification	Weight Loss – phentermine (all brand products including Adipex-P® and Lomaira™), benzphetamine, Contrave® (naltrexone HCl and bupropion HCl, diethylpropion, Imcivree® (setmelanotide), phendimetrazine, orlistat (Xenical®), Qsymia® (phentermine and topiramate extended-release), Saxenda® (liraglutide) Wegovy® (semaglutide) and Zepbound™ (tirzepatide)	Added coverage requirements for North Dakota.	1/1/2025
Promacta for oral suspension	Medical Necessity	Promacta® (eltrombopag) for oral suspension *This program applies to the formulation for oral suspension	New program.	1/1/2025
Promacta, Alvaiz	Notification	Promacta® and Alvaiz™ (eltrombopag) *Promacta tablet formulation is excluded from coverage for the majority of our benefits.	Added statement that the Promacta tablet formulation is excluded from coverage for the majority of our benefits.	1/1/2025
Xhance	Step Therapy	Xhance® (fluticasone propionate)	New program.	1/1/2025