UnitedHealthcare

Commercial Business

BULLETIN (5/1/2025)

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
Aimovig, Ajovy, Emgality	Step Therapy	Aimovig® (erenumab), Ajovy® (fremanezumab), Emgality® (galcanezumab)	Added footnote for California specific requirement. Updated list of potential prophylactic therapies. Added oral CGRPs to the required options for Ajovy. Updated references.	5/1/2025
Aimovig, Ajovy, Emgality	Medical Necessity	Aimovig® (erenumab), Ajovy® (fremanezumab), Emgality® (galcanezumab)	Added footnote for California specific requirement. Updated list of potential prophylactic therapies. Added oral CGRP to the list of required options for Ajovy. Updated references.	5/1/2025
Aimovig, Ajovy, Emgality	Notification	Aimovig® (erenumab), Ajovy® (fremanezumab), Emgality® (galcanezumab)	Updated references.	5/1/2025
Alyftrek	Medical Necessity	Alyftrek™ (vanzacaftor/tezacaftor/deutivacaftor)	New program	5/1/2025
Alyftrek	Notification	Alyftrek™ (vanzacaftor/tezacaftor/deutivacaftor)	New program	5/1/2025
Arikayce	Medical Necessity	Arikayce® (amikacin liposome inhalation suspension)	Annual review with no change to coverage criteria. Updated reference.	5/1/2025
Besremi	Step Therapy	Besremi® (ropeginterferon alfa-2b-njft)	Archive program.	5/1/2025
Bosulif	Notification	Bosulif® (bosutinib)	Annual review with no changes to coverage criteria. Updated background and references.	5/1/2025
Braftovi	Notification	Braftovi® (encorafenib)	Updated background and criteria to include new FDA approved use in combination with Erbitux and mFOLFOX6 in BRAF V600E mutated colorectal cancer.	5/1/2025
Brexafemme	Medical Necessity	Brexafemme® (ibrexafungerp)	Annual review. No changes.	5/1/2025
Brukinsa	Step Therapy	Brukinsa® (zanubrutinib)	Updated criteria removing provider attestation.	5/1/2025
Buphenyl, Olpruva, Pheburane, sodium phenylbutyrate	Notification	Buphenyl® (sodium phenylbutyrate), Olpruva® (sodium phenylbutyrate), Pheburane® (sodium phenylbutyrate), sodium phenylbutyrate	Annual review. No changes to clinical coverage criteria.	5/1/2025
Cayston	Notification	Cayston® (aztreonam for inhalation solution)	Annual review. No changes to coverage criteria.	5/1/2025
Cayston	Step Therapy	Cayston® (aztreonam for inhalation solution)	Annual review. No changes to coverage criteria. Updated reference.	5/1/2025
Crexont, Rytary	Step Therapy	Crexont™ (carbidopa/levodopa extended-release), Rytary® (carbidopa/levodopa extended-release)	New program.	5/1/2025
Cuvrior	Medical Necessity	Cuvrior™ (trientine tetrahydrochloride)	Annual review with no changes to coverage criteria. Updated background and references.	5/1/2025
Cuvrior	Notification	Cuvrior™ (trientine tetrahydrochloride)	Annual review with no changes to coverage criteria.	5/1/2025
Diagnostic Agents, Metopirone - Custom Oxford SoNJ and SoNY	Medical Necessity	Diagnostic Agents, Metopirone (metyrapone)	Archive program.	5/1/2025

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
dichlorphenamide, Keveyis, Ormalvi	Notification	dichlorphenamide, Keveyis® (dichlorphenamide), Ormalvi™ (dichlorphenamide)	Updated initial authorization to 12 months. Added generic dichlorphenamide and Ormalvi. Added coverage exclusion statement for brand Keveyis and Ormalvi. Updated references.	5/1/2025
Dupixent	Medical Necessity	Dupixent® (dupilumab)	Increased authorizations for eosinophilic esophagitis to 12 months.	5/1/2025
Dupixent	Notification	Dupixent® (dupilumab)	Increased authorizations for eosinophilic esophagitis to 12 months.	5/1/2025
Ebglyss	Medical Necessity	Ebglyss™ (lebrikizumab-lbkz)	New program	5/1/2025
Ebglyss	Notification	Ebglyss™ (lebrikizumab-lbkz)	New program	5/1/2025
Egrifta SV	Notification	Egrifta SV™ (tesamorelin for injection)	Annual review. Updated initial authorization to 12 months and updated reference.	5/1/2025
Endari	Medical Necessity	Endari® (L-glutamine Powder for Solution)	Annual review. No changes.	5/1/2025
Ensacove	Notification	Ensacove (ensartinib)	New program	5/1/2025
Firazyr, icatibant, Sajazir	Notification	Firazyr® (icatibant), icatibant, Sajazir™ (icatibant)	Annual review with no changes to coverage criteria. Updated reference.	5/1/2025
Forteo	Step Therapy	Forteo® (teriparatide), teriparatide (generic Forteo)	Annual review. Added teriparatide (generic Forteo). Updated background and references.	5/1/2025
Fruzaqla	Notification	Fruzaqla™ (fruquintinib)	Annual review with no changes to coverage criteria. Updated references.	5/1/2025
Harvoni	Notification	Harvoni® (ledipasvir/sofosbuvir)	Annual review with no changes to coverage criteria. Updated references.	5/1/2025
Human Growth Hormone, Growth Stimulating Products	Medical Necessity	Human Growth Hormone: Somatropin (Genotropin®, Humatrope®, Norditropin®, Nutropin AQ NuSpin®, Omnitrope®, Saizen®, Serostim®, Zomacton®, Zorbtive®), Skytrofa™, (lonapegsomatropin-tcgd), Sogroya®(somapacitan-beco), Ngenla™ (somatrogon-ghla) Growth Stimulating Products: Mecasermin (Increlex®)	Annual review. Updated authorization criteria to align with the most current treatment guidelines for all indications. Removed Nordiflex from program which has been discontinued. Updated background and references.	5/1/2025
Human Growth Hormone, Growth Stimulating Products	Notification	Human Growth Hormone: Somatropin (Genotropin®, Humatrope®, Norditropin®, Nutropin AQ NuSpin®, Omnitrope®, Saizen®, Serostim®, Zomacton®, Zorbtive®), Skytrofa™, (lonapegsomatropin-tcgd), Sogroya®(somapacitan-beco), Ngenla™ (somatrogon-ghla) Growth Stimulating Products: Mecasermin (Increlex®)	Updated authorization criteria to align with the most current treatment guidelines for all indications. Removed dosing limitations for all indications. Removed Nordiflex from program which has been discontinued. Updated background and references.	5/1/2025
Ibrance	Notification	Ibrance® (palbociclib)	Annual review. No changes to clinical criteria.	5/1/2025
Inbrija	Medical Necessity	Inbrija® (levodopa inhalation powder)	Annual review with no change in clinical criteria. Updated references.	5/1/2025
Inbrija	Notification	Inbrija® (levodopa inhalation powder)	Annual review with no change to clinical criteria.	5/1/2025
Inqovi	Notification	Inqovi® (decitabine and cedazuridine) tablet	Annual review. Removed CMML as it would fall under MDS. Updated references.	5/1/2025
Invokana - Non-Formulary	Non-Formulary	Invokana® (canagliflozin)	Annual review. Updated background section and references.	5/1/2025
Iwilfin	Notification	Iwilfin™ (eflornithine)	Annual review. No changes to clinical criteria.	5/1/2025
Jaypirca	Notification	Jaypirca® (pirtobrutinib)	Annual review. Added criteria for B-cell lymphomas and Waldenström Macroglobulinemia according to NCCN guidelines. Updated references.	5/1/2025
Juxtapid	Medical Necessity	Juxtapid® (lomitapide)	Updated diet requirement per label. Added requirement to not be used in combination with Evkeeza. Revised HoFH criteria to include more precise genetic terminology to account for genetic test result interpretation complexity as well as digenic mutations.	5/1/2025
Juxtapid	Notification	Juxtapid® (lomitapide)	Annual review with no changes to coverage criteria.	5/1/2025

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Lenvima	Notification	Lenvima® (lenvatinib)	Annual review. Removed criteria for biliary cancer as it is no longer recommended by NCCN. Removed combination use with Keytruda for endometrial cancer per NCCN. Updated background and references.	5/1/2025
Livtencity	Notification	Livtencity (maribavir)	Annual review. Updated background and reference.	5/1/2025
Lorbrena	Notification	Lorbrena® (lorlatinib)	Annual review. Added Augtyro (repotrectinib) as a first-line therapy option for ROS1 positive NSCLC per NCCN. Updated references.	5/1/2025
Mytesi	Notification	Mytesi™ (crofelemer)	Annual review. Updated initial authorization duration to 12 months.	5/1/2025
New and Therapeutic Equivalent - Excluded Drugs	Prior Authorization	New and Therapeutic Equivalent Medications - Excluded Drugs	Add baclofen 15mg, Clobetasol propionate 0.05% ophthalmic suspension, Cobenfy, brand Daliresp, brand Durezol, brand Keveyis, brand Kiprofen, Levetiracetam 250mg disintegrating soluble, brand Marinol, ondansetron 16mg ODT, Opsynvi, Ormalvi, Oxycodone 10mg abuse deterrent tablet, Promacta tablet, Sovuna, brand Sprycel, Tolectin 600mg, Tolmetin 400mg, Tryvio, Vafseo, brand Victoza, Zituvimet. Revise chlorzoxazone 250mg, Lofena, Lorzone, Mydayis to brand only, Namzaric to brand and generic, Norgesic Forte, Orphengesic Forte, Oxycontin, Roxybond drug status, Safyral to brand only, Scemblix. Remove Generess FE, Nivestym, Rexulti, Stelara 45mg vial, Trintellix.	5/1/2025
New and Therapeutic Equivalent Medications - Prior Authorization	Prior Authorization	New and Therapeutic Equivalent Medications - Prior Authorization	Add baclofen 15mg, Clobetasol propionate 0.05% ophthalmic suspension, brand Daliresp, brand Durezol, brand Keveyis, brand Kiprofen, Levetiracetam 250mg disintegrating soluble, brand Marinol, Norgesic, ondansetron 16mg ODT, Opsynvi, Ormalvi, Oxycodone 10mg abuse deterrent, brand Sprycel, Sovuna, Tolectin 600mg, tolmetin 400mg, brand Victoza, Zituvimet. Revise chlorzoxazone 250mg, Lofena, Lorzone, Mydayis to brand only, Namzaric to brand and generic, Norgesic Forte, Orphengesic Forte, Oxycontin, Promacta tablet, Roxybond drug status, Safyral to brand only, Travatan Z. Remove Generess FE, Nivestym.	5/1/2025
Nocdurna	Medical Necessity	Nocdurna® (desmopressin acetate)	Annual review. No changes.	5/1/2025

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
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), 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 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)	Updated background to note Jylamvo will process automatically for patients under the age of six. Removed Ozobax regular strength and Exservan from criteria as they are no longer on the market.	5/1/2025
Nurtec ODT, Qulipta, Ubrelvy, Zavzpret	Step Therapy	Nurtec® ODT (rimegepant), Qulipta™ (atogepant), Ubrelvy™ (ubrogepant), Zavzpret™ (zavegepant)	Added footnote for California specific requirement.	5/1/2025
Nurtec ODT, Qulipta, Ubrelvy, Zavzpret	Medical Necessity	Nurtec® ODT (rimegepant), Qulipta™ (atogepant), Ubrelvy™ (ubrogepant), Zavzpret™ (zavegepant)	Added footnote for California specific requirement.	5/1/2025
Nurtec ODT, Qulipta, Ubrelvy, Zavzpret	Notification	Nurtec® ODT (rimegepant), Qulipta™ (atogepant), Ubrelvy™ (ubrogepant), Zavzpret™ (zavegepant)	Review. No changes.	5/1/2025
Omvoh	Medical Necessity	Omvoh™ (mirikizumab-mrkz) *This program applies to the subcutaneous formulation of Omvoh.	Added coverage criteria for Crohn's disease. Updated background and references.	5/1/2025
Omvoh	Notification	Omvoh™ (mirikizumab-mrkz) *This program applies to the subcutaneous formulation of Omvoh.	Added coverage criteria for Crohn's disease. Updated background and reference.	5/1/2025
Orgovyx	Notification	Orgovyx™ (relugolix)	Annual review with no changes to coverage criteria. Updated references.	5/1/2025
Oriahnn, MyFembree	Medical Necessity	Oriahnn® (elagolix and estradiol/norethindrone), MyFembree® (relugolix and estradiol hemihydrate/norethindrone)	Annual review. Updated references.	5/1/2025
Orilissa	Medical Necessity	Orilissa® (elagolix)	Annual review. No changes.	5/1/2025
Oxbryta	Medical Necessity	Oxbryta™ (voxelotor)	Archive program.	5/1/2025
Oxbryta	Notification	Oxbryta™ (voxelotor)	Archive program.	5/1/2025
Oxervate	Medical Necessity	Oxervate® (cenegermin-bkbj) ophthalmic solution	Annual review with no change to clinical criteria. Updated reference.	5/1/2025
Oxervate	Notification	Oxervate® (cenegermin-bkbj) ophthalmic solution	Annual review with no change to clinical criteria. Updated reference.	5/1/2025

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Praluent	Medical Necessity	Praluent® (alirocumab)	Simplified diagnosis requirements for HeFH, ASCVD, and primary hyperlipidemia. Removed diet requirement. Revised HoFH criteria to include more precise genetic terminology to account for genetic test result interpretation complexity as well as digenic mutations. Lowered LDL-C threshold from 100 to 55 mg/dL. Updated background and references.	5/1/2025
Pulmozyme	Notification	Pulmozyme® (dornase alfa)	Annual review with no changes to coverage criteria.	5/1/2025
Ravicti	Medical Necessity	Ravicti® (glycerol phenylbutyrate oral liquid)	Annual review with no change to clinical coverage. Updated reference.	5/1/2025
Ravicti	Notification	Ravicti® (glycerol phenylbutyrate oral liquid)	Annual review with no change to clinical coverage.	5/1/2025
Ravicti	Step Therapy	Ravicti® (glycerol phenylbutyrate oral liquid)	Annual review with no change to clinical coverage.	5/1/2025
Recorlev	Notification	Recorlev® (levoketoconazole)	Annual review with no changes to coverage criteria. Added exclusion footnote and updated reference.	5/1/2025
Repatha	Medical Necessity	Repatha (evolocumab)	Archive program.	5/1/2025
Repatha	Notification	Repatha (evolocumab)	Archive program.	5/1/2025
Repatha	Step Therapy	Repatha (evolocumab)	Archive program.	5/1/2025
Rezlidhia	Notification	Rezlidhia™ (olutasidenib)	Annual review. Added criteria for Myelodysplastic Syndromes (MDS) per NCCN. Updated background and references.	5/1/2025
Sandostatin	Notification	Sandostatin® (octreotide acetate) Note: Only the subcutaneous formulation of octreotide requires notification. Sandostatin LAR is covered under the medical benefit and therefore addressed in the Somatostatin Analogs drug policy.	Annual review. Updated wording within acromegaly and meningioma coverage criteria without change in clinical intent. Added criteria for well-differentiated grade 3 neuroendocrine tumor. Updated criteria for thymoma or thymic carcinoma. Removed HIV/AIDS-related diarrhea coverage criteria align with current clinical evidence. Added general NCCN recommended review criteria. Updated background and references.	5/1/2025
Spravato	Medical Necessity	Spravato (esketamine)	Revised options for clinical assessments to reflect different item versions of the same scale as well as added BDI. Removed requirement for combination with oral antidepressant for TRD per updated label.	5/1/2025
Spravato	Notification	Spravato (esketamine)	Revised coverage criteria for TRD to remove reference to current depressive episode and remove specific trial length from history of failure of a trial of at least two different antidepressant medications or treatment regimens. Removed requirement for combination with oral antidepressant for TRD per updated label. Updated references.	5/1/2025
Stelara, Steqeyma, Yesintek	Medical Necessity	Stelara® (ustekinumab), Steqeyma (ustekinumab-stba), Yesintek™ (ustekinumab-kfce) *This program applies to the subcutaneous formulation of ustekinumab.	Added Steqeyma and Yesintek to all coverage criteria in parity with Stelara. Updated background and reference.	5/1/2025
Stelara, Steqeyma, Yesintek	Notification	Stelara® (ustekinumab), Steqeyma (ustekinumab-stba), Yesintek™ (ustekinumab-kfce) *This program applies to the subcutaneous formulation of ustekinumab.	Added Steqeyma and Yesintek to all coverage criteria in parity with Stelara. Updated background and reference.	5/1/2025
Tarpeyo	Medical Necessity	Tarpeyo® (budesonide delayed-release capsules)	Annual review. Updated references.	5/1/2025
Testosterone	Medical Necessity	Androderm®, Androgel®, Fortesta®, Jatenzo®, Natesto®, Kyzatrex™, Testim®, testosterone topical solution (generic Axiron®), testosterone transdermal gel (generic Testim), Tlando™, Undecatrex™, Vogelxo®, Xyosted®	Added Undecatrex to program. Updated references.	5/1/2025
Tetrabenazine	Notification	Tetrabenazine (Xenazine®)	Annual review. No changes to clinical coverage criteria.	5/1/2025

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Tremfya	Medical Necessity	Tremfya® (guselkumab) This program applies to the subcutaneous formulations of Tremfya	Added coverage criteria for ulcerative colitis. Updated background.	5/1/2025
Tremfya	Notification	Tremfya® (guselkumab) This program applies to the subcutaneous formulations of Tremfya	Added coverage criteria for ulcerative colitis. Updated background.	5/1/2025
Trikafta	Medical Necessity	Trikafta® (elexacaftor/tezacaftor/ivacaftor)	Updated list of CFTR responsive gene mutations. Updated background and reference.	5/1/2025
Trikafta	Notification	Trikafta® (elexacaftor/tezacaftor/ivacaftor)	Updated list of CFTR responsive gene mutations. Updated background and reference.	5/1/2025
Tryngolza	Medical Necessity	Tryngolza™ (olezarsen)	New program	5/1/2025
Tryngolza	Notification	Tryngolza™ (olezarsen)	New program	5/1/2025
Tryvio	Medical Necessity	Tryvio™ (aprocitentan)	Added lifestyle modification and other causes have been ruled out. Modified prescriber requirement and concomitant medication requirements. Updated reference.	5/1/2025
Viekira Pak	Medical Necessity	Viekira Pak™ (ombitasvir, paritaprevir, and ritonavir tablets; dasabuvir tablets)	Archive program.	5/1/2025
Viekira Pak	Notification	Viekira Pak (ombitasvir, paritaprevir, and ritonavir tablets; dasabuvir tablets)	Archive program.	5/1/2025
Wainua	Medical Necessity	Wainua™ (eplontersen)	Added Attruby to Vyndaqel/Vyndamax and relabeled as transthyretin stabilizer agents not to be used in combination. Updated reference.	5/1/2025
Wainua	Notification	Wainua™ (eplontersen)	Added Attruby to Vyndaqel/Vyndamax and relabeled as transthyretin stabilizer agents not to be used in combination. Updated reference.	5/1/2025
Xalkori	Notification	Xalkori® (crizotinib)	Annual review with no change to clinical criteria. Updated references.	5/1/2025
Xalkori - Non-Formulary	Non-Formulary	Xalkori® (crizotinib)	Annual review with no change to clinical criteria. Updated references	5/1/2025
Xospata	Notification	Xospata® (gilteritinib)	Annual review. Added criteria for treatment of AML based on NCCN recommendations.	5/1/2025
Yonsa	Notification	Yonsa® (abiraterone acetate)	Annual review. No changes to clinical criteria. Updated reference.	5/1/2025
Yonsa	Step Therapy	Yonsa® (abiraterone acetate)	Annual review. No changes to step therapy criteria. Updated reference.	5/1/2025
Zepatier	Medical Necessity	Zepatier® (elbasvir/grazoprevir)	Annual review. Removed liver disease staging criteria that was included for quality purposes rather than part of coverage decision. Updated references.	5/1/2025
Zepatier	Notification	Zepatier® (elbasvir/grazoprevir)	Annual review with no changes to coverage criteria. Updated references.	5/1/2025
Zoryve	Medical Necessity	Zoryve® (roflumilast)	Updated step therapy requirements for atopic dermatitis to one agent and removed Eucrisa as a required step agent. Updated prior authorization footnote.	5/1/2025
Zykadia	Notification	Zykadia® (ceritinib)	Annual review. Removed ROS positive criteria from NSCLC as this is no longer an NCCN recommendation. Removed criteria for IMT which was duplicative as this is covered under soft tissue sarcomas. Updated background and reference.	5/1/2025
Zykadia - Non-Formulary	Non-Formulary	Zykadia® (ceritinib)	Annual review. Removed ROS positive criteria from NSCLC as this is no longer an NCCN recommendation. Removed criteria for IMT which was duplicative as this is covered under soft tissue sarcomas. Updated background and reference.	5/1/2025
Cibinqo	Medical Necessity	Cibinqo™ (abrocitinib) tablets	Annual review. Added Ebglyss as an example of systemic drug product. Updated examples with no change to clinical intent.	5/16/2025
Cibinqo	Notification	Cibinqo™ (abrocitinib) tablets	Annual review with no changes to coverage criteria. Updated examples with no change to clinical intent.	5/16/2025

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Rinvoq, Rinvoq LQ	Medical Necessity	Rinvoq® (upadacitinib) extended-release tablets/ Rinvoq® LQ (upadacitinib) oral solution	Annual review. Added Ebglyss as an example of systemic drug product. Updated examples with no change to clinical intent.	5/16/2025
Actemra	Medical Necessity	Actemra® (tocilizumab) and Tyenne® (tocilizumab-aazg) *This program applies to the subcutaneous formulation of tocilizumab.	Removed examples for adalimumab step therapy. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Actemra, Actermra ACTPen, Tyenne	Step Therapy	Actemra® (tocilizumab), Actemra (tocilizumab) ACTPen, and Tyenne® (tocilizumab-aazg) *This step criteria refers to the subcutaneous formulations of tocilizumab.	Removed examples for adalimumab step therapy. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
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)	Removed notation that only Amjevita (adalimumab-atto) for Nuvaila is covered. All other Amjevita (adalimumab-atto) products are excluded from coverage for the majority of our benefits. Updated Stelara examples to ustekinumab. Added Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Tremfya (guselkumab) as examples of not used in combination for UC and CD.	6/1/2025
Adalimumab	Notification	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)	Removed notation that only Amjevita (adalimumab-atto) for Nuvaila is covered. All other Amjevita (adalimumab-atto) products are excluded from coverage for the majority of our benefits. Updated Stelara examples to ustekinumab. Added Entyvio (vedolizumab), Omvoh (mirikizumab-mrkz), Tremfya (guselkumab) as examples of not used in combination for UC and CD.	6/1/2025
Afstyla	Medical Necessity	Afstyla® (antihemophilic factor [recombinant], single chain)	Annual review with no changes to coverage criteria. Updated references.	6/1/2025
Akeega	Step Therapy	Akeega™ (niraparib and abiraterone acetate)	Annual review with no changes to step criteria. Updated references.	6/1/2025
Alhemo	Medical Necessity	Alhemo® (concizumab-mtci)	New program.	6/1/2025
Alhemo	Notification	Alhemo® (concizumab-mtci)	New program.	6/1/2025
Anticonvulsants	Notification	Aptiom® (eslicarbazepine acetate), Banzel® (rufinamide), Briviact® (brivaracetam), Diacomit® (stiripentol), Epidiolex® (cannabidiol), Fintepla® (fenfluramine), Fycompa® (perampanel), Libervant (diazepam)TM, Nayzilam® (midazolam), Onfi® (clobazam), Sabril® (vigabatrin), Sympazan® (clobazam), Valtoco® (diazepam), Vigafyde™ (vigabatrin), Vigpoder ™ (vigabatrin), Xcopri® (cenobamate), Ztalmy® (ganaxolone)	Added Vigafyde and Vigpoder to criteria. Noted that brand Sabril is typically excluded from coverage.	6/1/2025
Aqneursa	Medical Necessity	Aqneursa™ (levacetylleucine)	Added criteria that Aqneursa taken in combination with miglustat or history of failure, contraindication, or intolerance to miglustat.	6/1/2025
Azilect - Essential PDL Only	Step Therapy	Azilect (rasagiline)	No changes.	6/1/2025
Benznidazole	Notification	Benznidazole	Archive program.	6/1/2025

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Bimzelx	Step Therapy	Bimzelx® (bimekizumab-bkzx)	Removed examples for adalimumab in step therapy. Changed Stelara step therapy to "One of the preferred ustekinumab productsc". Changed Stelara example to Ustekinumab. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Bimzelx	Medical Necessity	Bimzelx® (bimekizumab-bkzx)	Removed examples for adalimumab in step therapy. Changed Stelara step therapy to "One of the preferred ustekinumab productsc". Changed Stelara example to Ustekinumab. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Bonjesta, Diclegis	Medical Necessity	Bonjesta® (doxylamine/pyridoxine extended-release), Diclegis® (doxylamine/pyridoxine delayed-release)	Annual review with no changes.	6/1/2025
Bronchitol	Notification	Bronchitol® (mannitol)	Annual review. No change to coverage criteria. Updated reference.	6/1/2025
Bronchitol	Step Therapy	Bronchitol® (mannitol)	Annual review with no change to coverage criteria. Updated reference.	6/1/2025
Calquence	Notification	Calquence® (acalabrutinib)	Updated criteria to reflect FDA indication for patients with previously untreated MCL who are ineligible for HSCT. Updated background and references.	6/1/2025
Cinryze	Medical Necessity	Cinryze® (C1 esterase inhibitor, human)	Annual review. Updated coverage criteria by adding Takhzyro (lanadelumab) to list of products requiring a history of use. Updated reference.	6/1/2025
Cinryze	Notification	Cinryze® (C1 esterase inhibitor, human)	Annual review. No changes to coverage criteria.	6/1/2025
Contraceptive Medications	Notification	Contraceptive Medications: medroxyprogesterone acetate (Depo-Provera®), etonogestrel/ethinyl estradiol (NuvaRing®), Oral Contraceptives, norelgestromin/ethinyl estradiol (OrthoEvra®), Annovera® (segesterone/ethinyl estradiol), Twirla® (levonorgestrel/ethinyl estradiol)	Annual review. No changes.	6/1/2025
Crenessity	Medical Necessity	Crenessity™(crinecerfont) oral capsule and oral suspension	Added non-solid dosage form criteria for Crenessity oral suspension.	6/1/2025
Elmiron	Step Therapy	Elmiron® (pentosan polysulfate sodium)	Annual review. Updated references.	6/1/2025
Esbriet, Ofev	Notification	Esbriet® (pirfenidone) and Ofev® (nintedanib)	Annual review. No change in coverage criteria. Updated references.	6/1/2025
Esperoct	Medical Necessity	Esperoct® (antihemophilic factor [recombinant], glycopegylated-exei)	Annual review. Revised outline of coverage criteria without change to clinical intent. Updated references.	6/1/2025
Esperoct	Step Therapy	Esperoct® (antihemophilic factor [recombinant], glycopegylated-exei)	Annual review with no changes to clinical criteria. Updated references.	6/1/2025
Evrysdi	Medical Necessity	Evrysdi® (risdiplam)	Revised criteria for patients that have documented decline from pretreatment baseline status following administration of gene replacement therapy.	6/1/2025
Evrysdi	Notification	Evrysdi® (risdiplam)	Revised criteria for patients that have documented decline from pretreatment baseline status following administration of gene replacement therapy.	6/1/2025
Fluticasone propionate HFA - Non-Formulary	Non-Formulary	Fluticasone propionate HFA	Annual review. Updated references.	6/1/2025
Glaucoma Agents - Travatan Z, Vyzulta, Zioptan	Step Therapy	Travatan Z® (travoprost), Vyzulta® (latanoprostene), Zioptan® (tafluprost)	Annual review. Updated references.	6/1/2025
Haegarda	Medical Necessity	Haegarda® (C1 esterase inhibitor Subcutaneous, human)	Annual review. No changes to the clinical criteria.	6/1/2025
Haegarda	Notification	Haegarda® (C1 esterase inhibitor Subcutaneous, human)	Annual review. No changes to coverage criteria.	6/1/2025
Health Care Reform - Cardiovascular Disease Prevention Zero Cost Share	Notification	Health Care Reform - Cardiovascular Disease Prevention Zero Cost Share - atorvastatin (generic Lipitor) 10 mg and 20 mg and simvastatin (generic Zocor) 5 mg, 10 mg, 20 mg, 40 mg	Annual review. Updated references.	6/1/2025
Hetlioz, Hetlioz LQ	Medical Necessity	Hetlioz®, Hetlioz LQ™ (tasimelteon)	Updated initial authorization to 12 months.	6/1/2025
Hetlioz, Hetlioz LQ	Notification	Hetlioz®, Hetlioz LQ™ (tasimelteon)	Increased authorization to 12 months.	6/1/2025

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Ilumya	Step Therapy	Ilumya® (tildrakizumab-asmn)	Removed examples for adalimumab in step therapy. Changed Stelara step therapy to "One of the preferred ustekinumab productsc". Changed Stelara example to Ustekinumab. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Ilumya	Medical Necessity	Ilumya® (tildrakizumab-asmn)	Removed examples for adalimumab in step therapy. Changed Stelara step therapy to "One of the preferred ustekinumab productsc". Changed Stelara example to Ustekinumab. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Impavido	Notification	Impavido (miltefosine)	Annual review. Updated references.	6/1/2025
Javygtor, Kuvan	Notification	Javygtor™ (sapropterin dihydrochloride), Kuvan® (sapropterin dihydrochloride)	Annual review. Updated references.	6/1/2025
Kevzara	Medical Necessity	Kevzara® (sarilumab) Injection	Removed examples for adalimumab step therapy. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Kevzara	Step Therapy	Kevzara® (sarilumab)	Removed examples for adalimumab step therapy. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Korlym	Notification	Korlym® (mifepristone)	Annual review with no changes to coverage criteria. Updated reference.	6/1/2025
Lampit	Notification	Lampit® (nifurtimox)	Archive program.	6/1/2025
minocycline extended-release (generic Solodyn)	Medical Necessity	minocycline extended-release tablet (generic Solodyn™)	Annual review. Removed brand extended-release minocycline products. Updated references.	6/1/2025
Neffy	Medical Necessity	Neffy® (epinephrine nasal spray)	Archive program.	6/1/2025
Nuplazid	Notification	Nuplazid® (pimavanserin)	Annual review. Updated references.	6/1/2025
Olumiant	Step Therapy	Olumiant® (baricitinib)	Removed examples for adalimumab step therapy. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Olumiant	Medical Necessity	Olumiant® (baricitinib)	Removed examples for adalimumab step therapy. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Omnipod 5, Twiist	Medical Necessity	Omnipod® 5, Twiist™	Added Twiist to criteria. Removed requirement for hypoglycemia, unpredictable blood glucose swings, or HbA1C outside of goal.	6/1/2025
Omnipod 5, Twiist	Notification	Omnipod® 5, Twiist™	Added Twiist to criteria.	6/1/2025
Orencia	Medical Necessity	Orencia® (abatacept) *This program applies to the subcutaneous formulation of abatacept	Removed examples for adalimumab in step therapy. Changed Stelara step therapy to "One of the preferred ustekinumab productsc". Changed Stelara example to Ustekinumab. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Orencia	Step Therapy	Orencia® (abatacept) *This step criteria refers to the subcutaneous formulation of abatacept	Removed examples for adalimumab in step therapy. Changed Stelara step therapy to "One of the preferred ustekinumab productsc". Changed Stelara example to Ustekinumab. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Orladeyo	Medical Necessity	Orladeyo® (berotralstat)	Annual review with no changes to clinical criteria. Updated reference.	6/1/2025
Orladeyo	Notification	Orladeyo® (berotralstat)	Annual review with no changes to clinical criteria.	6/1/2025
Orserdu	Notification	Orserdu™ (elacestrant)	Annual review with no changes to coverage criteria.	6/1/2025
Osphena	Notification	Osphena® (ospemifene)	Annual review. Updated references.	6/1/2025
Palforzia	Medical Necessity	Palforzia [Peanut (Arachis hypogaea) Allergen Powder-dnfp]	Annual review. No changes.	6/1/2025
Palforzia	Notification	Palforzia [Peanut (Arachis hypogaea) Allergen Powder-dnfp]	Annual review. No changes.	6/1/2025
Piqray	Notification	Piqray® (alpelisib)	Annual review with no changes to coverage criteria.	6/1/2025

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Radicava ORS	Medical Necessity	Radicava ORS® (edaravone)	Updated reference to Radicava IV to reflect that edaravone IV is available generically. Simplified diagnosis requirement. Updated invasive ventilation requirement with no change to clinical intent. Updated references.	6/1/2025
Regranex	Notification	Regranex® (becaplermin gel)	Annual review. No changes.	6/1/2025
Repository Corticotropins - Acthar Gel, Purified Cortrophin Gel	Medical Necessity	Repository Corticotropins - Acthar Gel® (repository corticotropin injection), Purified Cortrophin Gel™ (Rrepository corticotropin injection USP)	Annual review. Removed references to OptumRx throughout criteria without changes to intent of criteria. Updated background and references.	6/1/2025
Repository Corticotropins - Acthar Gel, Purified Cortrophin Gel	Notification	Repository Corticotropins - Acthar Gel® (repository corticotropin injection), Purified Cortrophin Gel™ (Rrepository corticotropin injection USP)	Annual review. Removed references to OptumRx throughout criteria without changes to intent of criteria. Updated background and references.	6/1/2025
Repository Corticotropins - Acthar Gel, Purified Cortrophin Gel	Step Therapy	Repository Corticotropins - Acthar Gel® (repository corticotropin injection), Purified Cortrophin Gel™ (Rrepository corticotropin injection USP)	Annual review with no changes to step criteria. Updated background and references.	6/1/2025
Reyvow	Medical Necessity	Reyvow® (lasmiditan)	Annual review. Updated list of prophylactic agents and removed prescriber requirement.	6/1/2025
Reyvow	Notification	Reyvow® (lasmiditan)	Annual review. No changes.	6/1/2025
Reyvow	Step Therapy	Reyvow® (lasmiditan)	Annual review. No changes.	6/1/2025
Savaysa	Step Therapy	Savaysa® (edoxaban)	Added cancer state mandate footnote.	6/1/2025
Scemblix	Step Therapy	Scemblix® (asciminib)	New program.	6/1/2025
Sedative Hypnotic Agents: Belsomra, DayVigo, Quviviq, Rozerem	Step Therapy	Sedative Hypnotic Agents: Belsomra® (suvorexant), DayVigo® (lemborexant), Quviviq® (daridorexant), Rozerem® (ramelteon)	Annual review. Updated references.	6/1/2025
Siliq	Medical Necessity	Siliq (brodalumab)	Removed examples for adalimumab in step therapy. Changed Stelara step therapy to "One of the preferred ustekinumab productsc". Changed Stelara example to Ustekinumab. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Siliq	Step Therapy	Siliq® (brodalumab)	Removed examples for adalimumab in step therapy. Changed Stelara step therapy to "One of the preferred ustekinumab productsc". Changed Stelara example to Ustekinumab. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Sprycel	Step Therapy	Sprycel® (dasatinib)	Archive program.	6/1/2025
Statins - Lescol XL, Livalo, Zypitamag	Step Therapy	Lescol® XL (brand and generic fluvastatin extended-release), Livalo® (brand and generic pitavastatin calcium), Zypitamag® (pitavastatin magnesium)	Annual review. Updated references.	6/1/2025
Stromectol (ivermectin)	Notification	Stromectol® (ivermectin) oral dosage form	Annual review. Updated references and background with FDA reference.	6/1/2025
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. No changes.	6/1/2025

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
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. No changes.	6/1/2025
Sunlenca	Notification	Sunlenca® (lenacapavir)	Annual review with no changes to clinical criteria. Updated reference.	6/1/2025
Sutent	Notification	Sutent® (sunitinib malate)	Annual review. Updated soft tissue sarcoma to include coverage for extraskeletal myxoid chondrosarcoma per NCCN guidelines. Updated references.	6/1/2025
Takhzyro	Medical Necessity	Takhzyro® (lanadelumab-flyo)	Annual review. No changes to clinical criteria.	6/1/2025
Takhzyro	Notification	Takhzyro® (lanadelumab-flyo)	Annual review. No changes to coverage criteria.	6/1/2025
Taltz	Medical Necessity	Taltz (ixekizumab)	Removed examples for adalimumab in step therapy. Changed Stelara step therapy to "One of the preferred ustekinumab productsc". Changed Stelara example to Ustekinumab. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Taltz	Step Therapy	Taltz® (ixekizumab)	Removed examples for adalimumab in step therapy. Changed Stelara step therapy to "One of the preferred ustekinumab productsc". Changed Stelara example to Ustekinumab. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Tasmar	Medical Necessity	Tasmar® (tolcapone)	Archive program.	6/1/2025
Tazorac	Medical Necessity	Tazorac® (tazarotene)	Annual review. Updated references.	6/1/2025
Tazverik	Notification	Tazverik® (tazemetostat)	Annual review with no changes to coverage criteria. Updated references.	6/1/2025
Tobacco Cessation - Health Care Reform	Medical Necessity	Varenicline (generic Chantix®), Nicotrol Inhaler® (nicotine inhalation system), and Nicotrol NS® (nicotine nasal spray)	Removed reference to Zyban due to product becoming obsolete. Updated references.	6/1/2025
Tobacco Cessation – Health Care Reform - New Jersey Fully Insured	Misc	Varenicline (generic Chantix®), Nicotrol Inhaler® (nicotine inhalation system), and Nicotrol NS® (nicotine nasal spray)	Annual review. Removed reference to Zyban due to product becoming obsolete. Updated references.	6/1/2025
Tobacco Cessation – Health Care Reform - Supply Limit (Therapy Duration) Override – Kentucky Fully Insured	Misc	Varenicline (generic Chantix®), Nicotrol Inhaler® (nicotine inhalation system), and Nicotrol NS® (nicotine nasal spray)	Removed reference to Zyban due to product becoming obsolete. Updated references.	6/1/2025
Topical Products - New Jersey and New York	Notification	Topical Products	Annual review. No changes.	6/1/2025
Tukysa	Notification	Tukysa® (tucatinib)	Annual review. Added criteria for NCCN recommended use of Tukysa in biliary tract cancers. Updated background and references.	6/1/2025
Vascepa	Medical Necessity	Vascepa® (icosapent ethyl)	Annual review. No changes.	6/1/2025
Vascepa	Notification	Vascepa® (icosapent ethyl)	Annual review. No changes.	6/1/2025
Velsipity	Medical Necessity	Velsipity™ (etrasimod)	Removed examples for adalimumab in step therapy. Changed Stelara step therapy to "One of the preferred ustekinumab productsc". Changed Stelara example to Ustekinumab. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Velsipity	Step Therapy	Velsipity™ (etrasimod)	Removed examples for adalimumab in step therapy. Changed Stelara step therapy to "One of the preferred ustekinumab productsc". Changed Stelara example to Ustekinumab. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Zelboraf	Notification	Zelboraf® (vemurafenib)	Annual review with no change to coverage criteria.	6/1/2025

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Zeposia	Medical Necessity	Zeposia® (ozanimod)	Removed examples for adalimumab in step therapy. Changed Stelara step therapy to "One of the preferred ustekinumab productsc". Changed Stelara example to Ustekinumab. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Zeposia	Step Therapy	Zeposia® (ozanimod)	Removed examples for adalimumab in step therapy. Changed Stelara step therapy to "One of the preferred ustekinumab productsc". Changed Stelara example to Ustekinumab. Added the footnote "For a list of preferred products please reference drug coverage tools."	6/1/2025
Zokinvy	Notification	Zokinvy™ (lonafarnib)	Annual review with no change to coverage criteria. Updated background and reference.	6/1/2025
Adbry	Medical Necessity	Adbry™ (tralokinumab-ldrm)	Annual review with no changes to coverage criteria. Updated examples with no change to clinical intent. Updated references.	7/1/2025
Adbry	Notification	Adbry™ (tralokinumab-ldrm)	Annual review with no changes to coverage criteria. Updated examples with no change to clinical intent. Updated reference.	7/1/2025
Afrezza	Medical Necessity	Afrezza® (insulin human)	Annual review with no changes.	7/1/2025
Altuviiio	Medical Necessity	Altuviiio® [antihemophilic factor (recombinant), Fc-VWF-XTEN fusion protein-ehtl]	Annual review. No changes to coverage criteria. Updated reference.	7/1/2025
Alyftrek	Medical Necessity	Alyftrek™ (vanzacaftor/tezacaftor/deutivacaftor)	Updated criteria to require history, contraindication, or intolerance to Trikafta, or member is currently on Alyftrek therapy.	7/1/2025
Austedo, Austedo XR	Notification	Austedo® (deutetrabenazine), Austedo® XR (deutetrabenazine)	Annual review with no change to clinical criteria. Reference updated.	7/1/2025
Austedo, Austedo XR	Medical Necessity	Austedo® (deutetrabenazine), Austedo® XR (deutetrabenazine)	Annual review with no change to clinical criteria. References updated.	7/1/2025
Berinert	Medical Necessity	Berinert® (C1 esterase inhibitor [human])	Annual review. No changes to coverage criteria.	7/1/2025
Bosulif	Step Therapy	Bosulif® (bosutinib)	Annual review with no change to coverage criteria. Updated references.	7/1/2025
Cablivi	Notification	Cablivi® (caplacizumab-yhdp)	Annual review with no change to clinical criteria. Updated reference.	7/1/2025
Caplyta	Notification	Caplyta® (lumateperone)	Annual review with no changes.	7/1/2025
Compounds and Bulk Powders	Notification	Compounds and Bulk Powders	Annual review. Updated references.	7/1/2025
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)	Annual review – updated background and references.	7/1/2025
Diabetic Meters, Test Strips	Non-Formulary	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 Smartview)	Removed Accu-Chek Compact as this product is off the market. Removed section for Omnipod EROS/Classic insulin pump as this product is off the market.	7/1/2025
Empaveli	Notification	Empaveli® (pegcetacoplan)	Annual review. No changes to coverage criteria. Updated examples of alternate complement inhibitors.	7/1/2025
Empaveli	Medical Necessity	Empaveli® (pegcetacoplan)	Annual review. No changes to coverage criteria. Updated examples of alternate complement inhibitors.	7/1/2025
Filsuvez	Medical Necessity	Filsuvez® (birch triterpenes) topical gel	Annual review with no changes to criteria. Updated references.	7/1/2025

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Filsuvez	Notification	Filsuvez® (birch triterpenes) topical gel	Annual review with no changes to criteria. Updated references.	7/1/2025
Firazyr, icatibant, Sajazir	Medical Necessity	Firazyr® (icatibant), icatibant, Sajazir™ (icatibant)	Annual review. No changes to coverage criteria. Updated reference.	7/1/2025
Gleevec	Notification	Gleevec® (imatinib mesylate)	Archive program.	7/1/2025
Glumetza, Fortamet	Medical Necessity	Glumetza® (metformin extended-release modified release, brand and generic) and metformin osmotic extended-release (generic Fortamet®)	Annual review. Updated references.	7/1/2025
Gomekli	Notification	Gomekli™ (mirdametinib)	New program.	7/1/2025
Hympavzi	Notification	Hympavzi™ (marstacimab-hncq)	New program.	7/1/2025
Hympavzi	Medical Necessity	Hympavzi™ (marstacimab-hncq)	New program.	7/1/2025
Ingrezza	Medical Necessity	Ingrezza® (valbenazine)	Annual review with no change to clinical criteria. References updated.	7/1/2025
Ingrezza	Notification	Ingrezza® (valbenazine)	Annual review. No changes to clinical coverage criteria. Updated reference.	7/1/2025
Inrebic	Step Therapy	Inrebic® (fedratinib)	Annual review. Removed superscripts for references. No changes to clinical criteria. Updated references.	7/1/2025
Kisqali	Step Therapy	Kisqali® (ribociclib)	Updated criteria in early-stage breast cancer to reflect current NCCN guidelines.	7/1/2025
Kisqali Femara Co-Pack	Step Therapy	Kisqali® Femara® Co-Pack (ribociclib/letrozole)	Updated criteria in early-stage breast cancer to reflect current NCCN guidelines.	7/1/2025
Lonsurf	Notification	Lonsurf® (trifluridine/tipiracil)	Annual review. No changes to clinical criteria. Updated references.	7/1/2025
Lorbrena	Step Therapy	Lorbrena® (lorlatinib)	Annual review with no change to coverage criteria. Updated references.	7/1/2025
Lucemyra	Medical Necessity	Lucemyra® (lofexidine)	Annual review with no changes.	7/1/2025
Lyrica CR	Step Therapy	Lyrica® CR tablets (pregabalin ER)	Annual review. Updated reference.	7/1/2025
Mavenclad	Notification	Mavenclad® (cladribine)	Added statement to initial criteria "Patient has not already received the FDA-recommended limit of 2 lifetime treatment courses (4 treatment cycles) of Mavenclad" and revised similar statement in reauthorization criteria to clarify maximum recommended lifetime treatment.	7/1/2025
Mavenclad	Step Therapy	Mavenclad® (cladribine)	Revised criteria to clarify maximum recommended lifetime treatment.	7/1/2025
Multisource Brand/Modified Release Anticonvulsants	Medical Necessity	Multisource Brand/Modified Release Anticonvulsants – Banzel®, Depakote®, Depakote ER®, Felbatol®, Fycompa® (brand and generic), Keppra®, Keppra XR®, Lamictal, Lamictal XR, Lamictal ODT (brand and generic), Lyrica®, Motpoly XR, Mysoline®, Neurontin®, Onfi®, Sabril®*, Topamax®, Trileptal®, Vimpat®, Zonegran®	Added footnote that brand Sabril is typically excluded from coverage. Added Fycompa to criteria.	7/1/2025
Northera	Medical Necessity	Northera® (droxidopa)	Annual review. Brands of Forinef and ProAmatine are no longer available – updated to list generic only.	7/1/2025
Palforzia	Notification	Palforzia [Peanut (Arachis hypogaea) Allergen Powder-dnfp]	Updated age range based on update to prescribing information.	7/1/2025
Palforzia	Medical Necessity	Palforzia [Peanut (Arachis hypogaea) Allergen Powder-dnfp]	Updated age range based on update to prescribing information.	7/1/2025
Prudoxin, Zonalon	Medical Necessity	Prudoxin® (doxepin), Zonalon® (doxepin)	Annual review with no changes.	7/1/2025
Prudoxin, Zonalon	Notification	Prudoxin® (doxepin), Zonalon® (doxepin)	Annual review with no changes.	7/1/2025
Rezdiffra	Notification	Rezdiffra™ (resmetirom)	Annual review with no changes to criteria.	7/1/2025
Rivfloza	Notification	Rivfloza™ (nedosiran)	Annual review. No changes to coverage criteria.	7/1/2025
Romvimza	Notification	Romvimza™ (vimseltinib)	New program.	7/1/2025
Rubraca	Notification	Rubraca® (rucaparib)	Annual review. Updated background and criteria to remove requirement for taxane-based chemotherapy for prostate cancer per NCCN. Updated references.	7/1/2025
Rubraca	Step Therapy	Rubraca® (rucaparib)	Annual review. Revised wording without change to clinical intent. Updated references.	7/1/2025
Ruconest	Medical Necessity	Ruconest® (C1 esterase inhibitor [recombinant])	Annual review. No changes to coverage criteria.	7/1/2025

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Sensipar	Medical Necessity	Sensipar® (cinacalcet)	Archive program.	7/1/2025
Single Source Brand Anticonvulsants	Medical Necessity	Single Source Brand Anticonvulsants – Aptiom® (eslicarbazepine), Briviact® (brivaracetam), Epidiolex® (cannabidiol), Fintepla® (fenfluramine), Xcopri® (cenobamate) and Ztalmy® (ganaxolone)	Moved Fycompa to Multi-Source Brand Anticonvulsants criteria due to a generic launch. Aligned trial/failure language for consistency.	7/1/2025
Suboxone	Medical Necessity	Suboxone® (Brand Only)	Annual review. Updated background and references.	7/1/2025
Talzenna	Step Therapy	Talzenna® (talazoparib)	Annual review. Revised wording without change to clinical intent. Updated references.	7/1/2025
Tasigna	Step Therapy	Tasigna® (nilotinib)	Annual review with no changes to coverage criteria. Updated references.	7/1/2025
Temodar	Notification	Temodar® (temozolomide)	Archive program.	7/1/2025
Tepmetko	Notification	Tepmetko® (tepotinib)	Annual review with no change to clinical criteria. Updated references.	7/1/2025
Velsipity	Notification	Velsipity™ (etrasimod)	Annual review. Updated examples with no change to clinical intent. Updated reference.	7/1/2025
Venclexta	Notification	Venclexta® (venetoclax)	Annual review. Updated background and criteria to include Myelodysplastic Syndromes based on NCCN recommendations. Updated multiple myeloma criteria to include additional drugs to be given in combinations with. Updated references.	7/1/2025
Verquvo	Medical Necessity	Verquvo® (vericiguat)	Annual review. Updated references.	7/1/2025
Viberzi	Medical Necessity	Viberzi® (eluxadoline)	Annual review. Updated references.	7/1/2025
Xolair	Medical Necessity	Xolair® (omalizumab) *This program applies to the prefilled syringe and prefilled autoinjector formulations for self-administered subcutaneous use	Annual review. No changes to coverage criteria.	7/1/2025
Xolair	Notification	Xolair® (omalizumab) *This program applies to the prefilled syringe and prefilled autoinjector formulations for self-administered subcutaneous use	Annual review. No changes to coverage criteria.	7/1/2025
Yonsa	Step Therapy	Yonsa® (abiraterone acetate)	Archive program.	7/1/2025
Yonsa	Notification	Yonsa® (abiraterone acetate)	Archive program.	7/1/2025
Zytiga	Notification	Zytiga® (abiraterone acetate)	Archive program.	7/1/2025