Commercial Business

BULLETIN (1/1/2026)

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.

For fully insured plans sitused in Maryland only: For mental health and immune globulin medications, once a prior authorization is approved, reauthorization will not be denied if the patient has been using the medication consistently without interruption and the provider states that staying on the medication is medically necessary to treat the condition.

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
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)	Added notation Humira is excluded from coverage for the majority of our benefits. Added notation Humira is excluded from coverage for the majority of our benefits. Updated combination examples notating “systemic” with no change to clinical intent.	1/1/2026
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)	Added notation Humira is excluded from coverage for the majority of our benefits. Updated combination examples notating “systemic” with no change to clinical intent.	1/1/2026
Alhemo	Step Therapy	Alhemo® (concizumab-mtci)	New program.	1/1/2026
Alhemo	Medical Necessity	Alhemo® (concizumab-mtci)	Added preferred therapy criteria for hemophilia A or B without inhibitors.	1/1/2026
Andembry	Notification	Andembry® (garadacimab-gxii)	New program.	1/1/2026
Andembry	Medical Necessity	Andembry® (garadacimab-gxii)	New program.	1/1/2026
Caprelsa	Notification	Caprelsa® (vandetanib)	Annual review. Updated criteria for oncocytic, papillary, and follicular carcinoma per NCCN. Updated references.	1/1/2026

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Continuous glucose monitors, sensors and transmitters (all brands)	Medical Necessity	Continuous glucose monitors, sensors and transmitters (all brands)	Added Simplera to program. Added definitions to hypoglycemia criteria. Added section for State of Illinois.	1/1/2026
Egrifta	Notification	Egrifta SV™ (tesamorelin), Egrifta WR™ (tesamorelin)	Added Egrifta WR to program. Updated references.	1/1/2026
Empaveli	Notification	Empaveli® (pegcetacoplan)	Added criteria for new FDA-approved indications C3G and IC-MPGN. Updated background and references.	1/1/2026
Empaveli	Medical Necessity	Empaveli® (pegcetacoplan)	Added criteria for new FDA-approved indications C3G and IC-MPGN. Updated background and references.	1/1/2026
Epclusa	Notification	Epclusa® (sofosbuvir/velpatasvir)	Removed criteria related to decompensated liver disease status. Simplified pangenotypic treatment criteria. Updated authorization to 12 months.	1/1/2026
Epclusa	Medical Necessity	Epclusa® (sofosbuvir/velpatasvir)	Removed criteria for decompensated liver disease status. Simplified pangenotypic treatment criteria. Updated authorization to 12 months. Updated references.	1/1/2026
Harvoni	Notification	Harvoni® (ledipasvir/sofosbuvir)	Reorganized criteria so that chronic HCV infection for treatment-experienced patients as well as other specific populations are addressed in one section. Simplified cirrhosis status criteria. Updated authorization to 12 months. Updated references.	1/1/2026
Harvoni	Medical Necessity	Harvoni® (ledipasvir/sofosbuvir)	Reorganized criteria so that chronic HCV infection for treatment-experienced patients as well as other specific populations are addressed in one section. Simplified cirrhosis status criteria. Updated authorization to 12 months. Updated references.	1/1/2026
Hernexeos	Notification	Hernexeos© (zongertinib)	New program.	1/1/2026
Humira Brand - Non-Formulary	Prior Authorization / Non-Formulary	Humira	New program.	1/1/2026
Imbruvica	Notification	Imbruvica® (ibrutinib)	Annual review. Simplified criteria for non-germinal center diffuse large B-cell lymphoma. Updated references.	1/1/2026
Iressa	Notification	Iressa® (gefitinib)	Annual review. Added coverage criteria for recurrent or advanced NSCLC per NCCN recommendations. Updated reauthorization criteria wording. Updated references.	1/1/2026
Leqselvi	Notification	Leqselvi™ (deuruxolitinib) *Leqselvi is excluded from coverage for the majority of our benefits.	New program.	1/1/2026
Leqselvi	Medical Necessity	Leqselvi™ (deuruxolitinib) *Leqselvi is excluded from coverage for the majority of our benefits.	New program.	1/1/2026
Mavyret	Medical Necessity	Mavyret® (glecaprevir/pibrentasvir)	Reorganized criteria so that chronic HCV infection for treatment-experienced patients as well as liver and kidney transplant recipients are addressed in one section. Simplified pangenotypic treatment and cirrhosis status criteria. Updated authorization to 12 months. Updated references.	1/1/2026
Mavyret	Notification	Mavyret® (glecaprevir/pibrentasvir)	Reorganized criteria so that chronic HCV infection for treatment-experienced patients as well as liver and kidney transplant recipients are addressed in one section. Simplified pangenotypic treatment and cirrhosis status criteria. Updated authorization to 12 months. Updated references.	1/1/2026
Modeyso	Notification	Modeyso® (dordaviprone)	New program.	1/1/2026
Nityr	Notification	Nityr® (nitisinone)	Annual review. Added exclusion footnote. Updated reference.	1/1/2026
Orladeyo	Medical Necessity	Orladeyo® (berotralstat)	Updated coverage criteria by adding Andembry to list of required preventive HAE agents. Updated examples of prophylactic HAE drugs to include Andembry and Dawnzera.	1/1/2026

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Sedative Hypnotic Agents	Step Therapy	Sedative Hypnotic Agents: Belsomra® (suvorexant), DayVigo® (lemborexant), Quviviq® (daridorexant), Rozerem® (ramelteon)	Archive program.	1/1/2026
Sovaldi	Notification	Sovaldi® (sofosbuvir)	Simplified criteria so that chronic HCV infection for specific populations are addressed in one section. Updated authorization to 12 months. Updated references.	1/1/2026
Sovaldi	Medical Necessity	Sovaldi® (sofosbuvir)	Simplified criteria so that chronic HCV infection for specific populations are addressed in one section. Updated authorization to 12 months. Updated references.	1/1/2026
Spevigo	Medical Necessity	Spevigo® (spesolimab-sbzo) injection *This program applies to the subcutaneous formulations of Spevigo	Added coverage criteria for self- or caregiver-administered subcutaneous loading dose. Updated references.	1/1/2026
Sprycel	Notification	Sprycel® (dasatinib)	Annual review. Updated background and coverage criteria to include NCCN recommended use in gastrointestinal stromal tumor. Updated references.	1/1/2026
Topical Retinoid Products	Notification	Topical Retinoid Products Altreno® (tretinoin), Arazlo®, (tazarotene), Avita® (tretinoin), Atralin® (tretinoin), Retin-A® (tretinoin) [brand only], Retin-A Micro® (tretinoin microspheres), Differin® (adapalene), Fabior® (tazarotene), Tazorac® (tazarotene), and Aklief® (trifarotene)	Annual review. Updated references. Removed Aklief from the typically- excluded list.	1/1/2026
Topical Steroids	Step Therapy	Topical Steroids: Cloderm® (clocortolone pivalate) cream 0.1%, Halog® (halcinonide) cream 0.1%, desonide gel 0.05%, Ultravate® (halobetasol propionate) lotion 0.05%, Bryhali® (halobetasol propionate) lotion 0.01%	Annual review. Removed Cordran, Halog ointment, Cutivate, and Diprolene AF from policy to reflect product discontinuation. Updated references.	1/1/2026
Triptans-Agents for Migraine - Supply Limits - Oxford	Prior Authorization	Triptans-Agents for Migraine	Removed almotriptan, Frova, Relpax tablets and Zomig tablets as standard supply limits were increased. Updated references.	1/1/2026
Tykerb	Notification	Tykerb® (lapatinib)	Annual review. Updated criteria for breast cancer, central nervous system cancer, colon cancer, and rectal cancer per NCCN recommendations.	1/1/2026
Ustekinumab	Notification	Ustekinumab: Imuldosa (ustekinumab-srlf), Otulfi® (ustekinumab-aauz), Pyzchiva® (ustekinumab-ttwe), Selarsdi™ (ustekinumab-aekn), Starjemza™ (ustekinumab-hmny), Stelara® (ustekinumab), Steqeyma® (ustekinumab-stba), Ustekinumab-ttwe, Wezlana™ (ustekinumab-auub), and Yesintek™ (ustekinumab-kfce)	Added Imuldosa and Starjemza to the program as excluded. Updated program name and references.	1/1/2026
Ustekinumab	Medical Necessity	Ustekinumab: Imuldosa (ustekinumab-srlf), Otulfi® (ustekinumab-aauz), Pyzchiva® (ustekinumab-ttwe), Selarsdi™ (ustekinumab-aekn), Starjemza™ (ustekinumab-hmny), Stelara® (ustekinumab), Steqeyma® (ustekinumab-stba), Ustekinumab-ttwe, Wezlana™ (ustekinumab-auub), and Yesintek™ (ustekinumab-kfce)	Added Imuldosa and Starjemza to the program as excluded. Updated program name and references.	1/1/2026
Vosevi	Notification	Vosevi® (sofosbuvir, velpatasvir, and voxilaprevir)	Simplified pangenotypic treatment criteria. Updated authorization to 12 months. Updated references.	1/1/2026
Vosevi	Medical Necessity	Vosevi® (sofosbuvir, velpatasvir, and voxilaprevir)	Simplified pangenotypic treatment criteria. Updated authorization to 12 months. Updated references.	1/1/2026
Zepatier	Notification	Zepatier® (elbasvir/grazoprevir)	Reorganized criteria so that chronic HCV infection for treatment-experienced patients as well as other specific populations are addressed in one section. Updated authorization to 12 months. Updated references.	1/1/2026

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Zepatier	Medical Necessity	Zepatier® (elbasvir/grazoprevir)	Reorganized criteria so that chronic HCV infection for treatment-experienced patients as well as other specific populations are addressed in one section. Updated authorization to 12 months. Updated references.	1/1/2026
Zolinza	Notification	Zolinza® (vorinostat)	Annual review. Updated coverage criteria for cutaneous t-cell lymphoma per NCCN recommendation. Added new criteria for Classic Hodgkin Lymphoma per NCCN recommendation.	1/1/2026
Agamree	Notification	Agamree® (vamorolone)	Annual review with no changes.	1/17/2026
Agamree	Medical Necessity	Agamree® (vamorolone)	Annual review with no changes to criteria. Updated background and references.	1/17/2026
Agamree	Step Therapy	Agamree® (vamorolone)	Archive program.	1/17/2026
Cosentyx	Medical Necessity	Cosentyx® (secukinumab) prefilled syringe or Sensoready pen	Annual review. Updated combination examples and language with no change to clinical intent.	1/17/2026
Dry Eye Disease	Notification	Dry Eye Disease - Cequa™ (cyclosporine 0.09% ophthalmic solution), Miebo™ (perfluorohexyloctane), Restasis® (cyclosporine 0.05% ophthalmic emulsion), Restasis MultiDose® (cyclosporine 0.05% ophthalmic emulsion), Tryptyr® (acoltremon ophthalmic solution), Tyrvaya™ (varenicline nasal spray), Vevye™ (cyclosporine 0.1%), Xiidra® (lifitegrast 5% ophthalmic solution)	Added Tryptyr.	1/17/2026
Emflaza	Notification	Emflaza® (deflazacort)	Annual review with no changes.	1/17/2026
Emflaza	Medical Necessity	Emflaza® (deflazacort)	Annual review with no changes to criteria. Updated background and references.	1/17/2026
Emflaza	Step Therapy	Emflaza® (deflazacort)	Archive program.	1/17/2026
Enbrel	Notification	Enbrel® (etanercept)	Annual review. Updated combination examples and language with no change to clinical intent.	1/17/2026
Enbrel	Medical Necessity	Enbrel® (etanercept)	Annual review. Updated combination examples and language with no change to clinical intent.	1/17/2026
Enspryng	Notification	Enspryng™ (satralizumab-mwge)	Annual review. Updated examples of complement inhibitors. Updated statement for concomitant use.	1/17/2026
Enspryng	Medical Necessity	Enspryng™ (satralizumab-mwge)	Annual review. Updated examples of complement inhibitors. Updated statement for concomitant use.	1/17/2026
Entyvio	Medical Necessity	Entyvio® (vedolizumab) *This program applies to the subcutaneous formulation of vedolizumab	Annual review. Updated combination examples and language with no change to clinical intent.	1/17/2026
Kineret	Notification	Kineret® (anakinra)	Annual review. Updated combination examples and language with no change to clinical intent.	1/17/2026

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Long-Acting Opioid Pain Medications	Medical Necessity	Includes both brand and generic versions of the listed products unless otherwise noted: fentanyl transdermal patch (generic Duragesic®) 12, 25, 50, 75, 100 mcg/hr, fentanyl transdermal patch 37.5, 62.5, 87.5 mcg/hr^, hydrocodone extended-release capsules (generic Zohydro ER), hydrocodone extended-release tablets (generic Hysingla ER), hydromorphone extended-release (generic Exalgo®), Hysingla ER^, methadone, morphine sulfate controlled-release capsules (generic Avinza®), morphine sulfate controlled-release tablets (generic MS Contin®), morphine sulfate sustained-release capsules (generic Kadian®), MS Contin^, Nucynta® ER (tapentadol extended-release), oxycodone controlled-release (authorized generic for OxyContin®)^, OxyContin^, oxymorphone extended-release (generic Opana® ER), Xtampza® ER (oxycodone extended-release)	Annual review. Updated references.	1/17/2026
Nexletol, Nexlizet	Medical Necessity	Nexletol® (bempedoic acid), Nexlizet® (bempedoic acid/ezetimibe)	Removed ezetimibe requirement. Updated references.	1/17/2026
Nexletol, Nexlizet	Step Therapy	Nexletol® (bempedoic acid), Nexlizet® (bempedoic acid/ezetimibe)	Removed ezetimibe requirement. Updated references.	1/17/2026
Olumiant	Notification	Olumiant® (baricitinib)	Annual review. Updated combination examples and language with no change to clinical intent.	1/17/2026
Simponi	Notification	Simponi® (golimumab) *This program applies to the subcutaneous formulation of golimumab.	Annual review. Updated combination examples and language with no change to clinical intent. Updated background and criteria to address new pediatric indication for UC. Updated reference.	1/17/2026
Simponi	Medical Necessity	Simponi® (golimumab) *This program applies to the subcutaneous formulation of golimumab.	Annual review. Updated combination examples and language with no change to clinical intent. Updated background and criteria to address new pediatric indication for UC. Updated reference.	1/17/2026
Sotyktu	Medical Necessity	Sotyktu™ (deucravacitinib)	Annual review. Updated combination examples and language with no change to clinical intent.	1/17/2026
Xeljanz, Xeljanx XR, Xeljanz Oral Solution	Notification	Xeljanz®/Xeljanz® XR/Xeljanz® Oral Solution (tofacitinib)	Annual review. Updated combination examples and language with no change to clinical inte	1/17/2026
Xeljanz, Xeljanx XR, Xeljanz Oral Solution	Medical Necessity	Xeljanz®/Xeljanz® XR/Xeljanz® Oral Solution (tofacitinib)	Annual review. Updated combination examples and language with no change to clinical inte	1/17/2026
Zegfrovy	Notification	Zegfrovy® (sunvozertinib)	New program	1/17/2026
Zymfentra	Notification	Zymfentra (infliximab-dyyb) *Zymfentra is excluded from coverage for the majority of our benefits	Annual review. Updated combination examples and language with no change to clinical inte	1/17/2026
Brekiya, Migranal, Ergomar, Trudhesa	Step Therapy	Brekiya® (dihydroergotamine), Dihyroergotamine nasal spray (Migranal®), Ergomar® (ergotamine), Trudhesa® (dihydroergotamine nasal spray)	New program.	2/1/2026
Brinsupri	Notification	Brinsupri™ (brensocatib)	New program.	2/1/2026
Brinsupri	Medical Necessity	Brinsupri™ (brensocatib)	New program.	2/1/2026
Cotellic	Notification	Cotellic® (cobimetinib)	Updated coverage criteria for central nervous system cancers and histiocytic neoplasms based on NCCN recommendations.	2/1/2026
Danziten	Notification	Danziten™ (nilotinib)	Archive program.	2/1/2026
Danziten, nilotinib d-tartrate, Tasigna	Notification	Danziten™ (nilotinib), nilotinib d-tartrate (nilotinib), Tasigna® (nilotinib)	Annual review. Added Danziten and nilotinib d-tartrate as typically excluded from coverage. Updated references.	2/1/2026

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Dry Eye Disease	Medical Necessity	Cequa™ (cyclosporine 0.09% ophthalmic solution), Restasis MultiDose® (cyclosporine 0.05% ophthalmic emulsion), Tyrvaya™ (varenicline nasal spray), Vevye™ (cyclosporine 0.1%)	Added Tryptyr as a step 1 option.	2/1/2026
Duvyzat	Medical Necessity	Duvyzat™ (givinostat) oral suspension	Added criterion for initial authorization addressing previous treatment with gene therapy for DMD. Removed criterion from reauthorization addressing previous treatment with gene therapy for DMD.	2/1/2026
Ekterly	Medical Necessity	Ekterly® (sebetralstat)	Added criteria requiring trial, failure, or contraindication to other HAE products based on age.	2/1/2026
Ekterly	Step Therapy	Ekterly® (sebetralstat)	New program.	2/1/2026
Firdapse	Notification	Firdapse® (amifampridine)	Annual review. Removed requirement for no concomitant use with similar potassium channel blockers from initial authorization criteria. Updated reference formatting.	2/1/2026
Firdapse	Medical Necessity	Firdapse® (amifampridine)	Annual review. Within initial authorization criteria, added confirmation of diagnosis and removed requirement for no concomitant use with similar potassium channel blockers. Added examples of positive clinical response within reauthorization criteria. Updated references.	2/1/2026
Gavreto	Notification	Gavreto® (pralsetinib)	Annual review. Updated criteria under hepatobiliary cancers for gallbladder cancer and cholangiocarcinoma and renamed section to biliary tract cancers per NCCN alignment. Updated background and references.	2/1/2026
Harliku	Medical Necessity	Harliku™ (nitisinone)	New program.	2/1/2026
Hycamtin	Notification	Hycamtin® (topotecan hydrochloride)	Annual review. Updated Merkel cell carcinoma criteria based on current NCCN recommendations. Updated background.	2/1/2026
Ibtrozi	Step Therapy	Ibtrozi® (taletrectinib)	New program.	2/1/2026
Iclusig	Notification	Iclusig® (ponatinib)	Annual review. Updated CML criteria based on NCCN recommendations. Updated background and references.	2/1/2026
Inluriyo	Notification	Inluriyo (imlunestrant)	New program.	2/1/2026
Insulin	Step Therapy	Apidra® (insulin glulisine), Apidra SoloStar® (insulin glulisine), Fiasp® (insulin aspart), KirstyTM (insulin aspart-xjhz), MerilogTM (insulin aspart-szjj), Novolin® N (NPH, human insulin isophane), Novolin R (regular, human insulin), Novolin 70/30 (70% NPH, human insulin isophane and 30% regular, human insulin), Novolog® (insulin aspart), Novolog Mix 70/30 (70% insulin aspart protamine and 30% insulin aspart)	Added Kirsty and Merilog. Updated references.	2/1/2026
Jakafi	Notification	Jakafi® (ruxolitinib)	Annual review. Updated coverage criteria for myelofibrosis, polycythemia vera, immunotherapy-related toxicities, and T-cell lymphoma based on NCCN recommendations. Added reauthorization criteria for pediatric acute lymphocytic leukemia. Updated references.	2/1/2026
Javygtor, Kuvan, sapropterin dihydrochloride, Zelvysia	Notification	Javygtor™ (sapropterin dihydrochloride), Kuvan® (sapropterin dihydrochloride), sapropterin dihydrochloride, Zelvysia (sapropterin dihydrochloride)	Added Zelvysia to program. Added Sephience to combination use criteria. Updated references.	2/1/2026
Leqembi IQLIK	Medical Necessity	Leqembi® IQLIK™ (lecanemab-irmb) injection *This program applies to the subcutaneous formulations of Leqembi	Removed criteria for staging of dementia due to Alzheimer's disease.	2/1/2026
Lorbrena	Step Therapy	Lorbrena® (lorlatinib)	Added Ensacove to step requirement. Updated references.	2/1/2026

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Migranal, Ergomar, Trudhesa	Medical Necessity	Dihyroergotamine nasal spray (Migranal®), Ergomar® (ergotamine), Trudhesa® (dihydroergotamine nasal spray)	Archive program.	2/1/2026
Non-Solid Oral and Suppository Dosage Forms	Medical Necessity	Alkindi® Sprinkle (hydrocortisone), Arbli™ (losartan), Aspruzyo Sprinkle™ (ranolazine), Atorvaliq® (atorvastatin), Brynovin™ (sitagliptin), Carospir® (spironolactone), chlorpromazine oral solution, Epaned® (enalapril), Eprontia® (topiramate), Ermeza™ (levothyroxine), Ezallor Sprinkle™ (rosuvastatin), Fleqsuvy® (baclofen), Flolipid (simvastatin), Imkeldi (imatinib), Indocin® (indomethacin) suspension, Indocin (indomethacin) suppository, Inzirqo™ (hydrochlorothiazide), Jylamvo (methotrexate), Katerzia® (amlodipine), Khindivi (hydrocortisone), Lopressor® (metoprolol) oral solution, 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), Raldesy™ (trazodone), Renvela® (sevelamer carbonate) powder for suspension, Sotylize® (sotalol), Sympazan (clobazam)®, Syndros® (dronabinol), Tezruly™ (terazosin), Tiglutik® (riluzole), Tirosint®-Sol (levothyroxine), Valsartan oral solution, Xatmep® (methotrexate), Xelstrym™ (dextroamphetamine), Xromi® (hydroxyurea), Zegerid® for suspension (omeprazole and sodium bicarbonate), Zonisade® (zonisamide)	Lyvispah and Qdolo removed as they are off the market. Carafate removed from criteria. Updated to note brand only Epaned, Feqsuvy, Indocin Suspension, Indocin Suppositories and Nexium Suspension are typically excluded. Brynovin added to criteria.	2/1/2026
Ojjaara	Notification	Ojjaara™ (momelotinib)	Annual review. Updated coverage criteria for higher-risk myelofibrosis per NCCN recommendations.	2/1/2026
Ojjaara	Step Therapy	Ojjaara™ (momelotinib)	Annual review. Updated criteria for myelofibrosis-associated anemia and for higher-risk myelofibrosis per NCCN recommendations. Separated approved uses into different sections without changing clinical intent.	2/1/2026
Otezla, Otezla XR	Notification	Otezla® (apremilast) / Otezla XR™ (apremilast)	Added Otezla XR to the program with same clinical criteria as Otezla. Removed candidates for phototherapy or systemic therapy from PsO criteria. Updated background and reference.	2/1/2026
Palynziq	Notification	Palynziq™ (pegvaliase-pqpz)	Added Sephience to combination use criteria. Updated references.	2/1/2026
Palynziq	Medical Necessity	Palynziq™ (pegvaliase-pqpz)	Added Sephience to combination use criteria. Revised requirement for trial of sapropterin therapy to remove specified length of trial and to exclude patients with two null mutations in trans. Updated references.	2/1/2026
Palynziq	Step Therapy	Palynziq™ (pegvaliase-pqpz)	Revised requirement for trial of sapropterin therapy to exclude patients with two null mutations in trans.	2/1/2026
Rezdiffra	Medical Necessity	Rezdiffra™ (resmetirom)	Added combination use language and added endocrinologist to prescriber requirement. Added medical record submission requirement to initial authorization criteria for confirming fibrosis stage F2 or F3. Updated references.	2/1/2026
Rezdiffra	Notification	Rezdiffra™ (resmetirom)	Added examples of positive clinical response to therapy. Added criterion that patient has not progressed to cirrhosis.	2/1/2026

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Rinvoq, Rinvoq LQ	Notification	Rinvoq® (upadacitinib) extended-release tablets/ Rinvoq® LQ (upadacitinib) oral solution	Updated criteria to reflect updated UC and CD indication regarding TNF blockers. Updated background and reference. Updated combination examples and language with no change to clinical intent.	2/1/2026
Rinvoq, Rinvoq LQ	Medical Necessity	Rinvoq® (upadacitinib) extended-release tablets/ Rinvoq® LQ (upadacitinib) oral solution	Updated criteria to reflect updated UC and CD indication regarding TNF blockers. Updated background and reference. Updated combination examples and language with no change to clinical intent.	2/1/2026
Sephience	Step Therapy	Sephience™ (sepiapterin)	New program.	2/1/2026
Sephience	Notification	Sephience™ (sepiapterin)	New program.	2/1/2026
Sephience	Medical Necessity	Sephience™ (sepiapterin)	New program.	2/1/2026
Tarceva	Notification	Tarceva® (erlotinib)	Archive program.	2/1/2026
Tegsedi	Notification	Tegsedi® (inotersen)	Archive program.	2/1/2026
Tegsedi	Medical Necessity	Tegsedi® (inotersen)	Archive program.	2/1/2026
Testosterone	Medical Necessity	Androgel®, Jatenzo®, Natesto®, Kyzatrex™, Testim®, testosterone gel (generic Fortesta) ®, testosterone topical solution (generic Axiron®), testosterone transdermal gel (generic Testim)*, Tlando™, Undecatrex™, Vogelxo®, Xyosted®	Added requirement male at birth to orchiectomy, panhypopituitarism and genetic disorders requirement section. Added step through topical products for Xyosted. Removed Androderm and brand Fortesta as they are off the market.	2/1/2026
Votrient	Notification	Votrient® (pazopanib)	Annual review. Added additional soft tissue sarcomas to align with NCCN and reformatted soft tissue sarcoma criteria. Updated oncocytic carcinoma criteria to remove radioactive iodine criteria. Removed staging system criteria for Merkel Cell Carcinoma. Updated references.	2/1/2026
Zoryve	Notification	Zoryve® (roflumilast)	Added Zoryve 0.05% cream to atopic dermatitis criteria. Updated background and reference.	2/1/2026
Zoryve	Medical Necessity	Zoryve® (roflumilast)	Added Zoryve 0.05% cream to atopic dermatitis criteria. Updated background and reference.	2/1/2026
Akeega	Notification	Akeega™ (niraparib and abiraterone acetate)	Annual review. No changes to clinical criteria. Updated references.	2/15/2026
Arikayce	Notification	Arikayce® (amikacin liposome inhalation suspension)	Annual review with no change to clinical criteria. Updated reference.	2/15/2026
Caplyta	Medical Necessity	Caplyta® (lumateperone)	Annual review with no changes.	2/15/2026
Caplyta	Step Therapy	Caplyta® (lumateperone)	Annual review with no changes.	2/15/2026
Cimzia	Notification	Cimzia® (certolizumab)	Annual review. Updated examples with no change to clinical intent. Updated references.	2/15/2026
Cimzia	Medical Necessity	Cimzia® (certolizumab)	Annual review. Updated examples with no change to clinical intent. Updated references.	2/15/2026
Continuous glucose monitors, sensors and transmitters (all brands)	Notification	Continuous glucose monitors, sensors and transmitters (all brands)	Annual review. Updated references.	2/15/2026
Cystaran, Cystadrops	Notification	Cystaran® (cysteamine) ophthalmic solution, Cystadrops® (cysteamine) ophthalmic solution	Annual review. Updated references.	2/15/2026

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Devices	Medical Necessity	Alevicyn, Alevicyn Dermal Spray, Alevicyn SG, Aquoral, Atrapro Antipruritic Hydrogel, Atrapro CP, Atrapro Dermal Spray, Caphosol, Ceracade, Ceramax, Derpixa, Dexeryl, Eletone, Emulsion SB, EpiCeram, Halucort, HPRPlus, Hyclodex, Hylatopic Plus, Hypocyn Dermal Spray, Iliderm, KamDoy Rx, Kendall Amorphous Hydrogel, Keragel, Keragelt, Kivik, MediHoney, Microcyn, Neosalus, NeutraSal, Nutraseb, Penlen, Phlag, PR Cream, Presera, Promiseb, Pruclair, Prumyx, RadiaPlexRx, SalivaMax, Strata GRT, Suvicort, Synerderm, Zanabin	Removed Atopaderm, Atopiclair, Entty Spraym, HPR, Hylaguard, Neocera, Tetrix and Vexasyn as they are off the market. Updated references.	2/15/2026
Dulera	Step Therapy	Dulera® (mometasone furoate/formoterol fumarate)	Annual review. No changes.	2/15/2026
Entresto	Medical Necessity	Entresto® (valsartan-sacubitril)	Annual review with no changes.	2/15/2026
Erleada	Notification	Erleada® (apalutamide)	Annual review with no change to coverage criteria. Updated references.	2/15/2026
Hemlibra	Notification	Hemlibra® (emicizumab-kxwh)	Annual review with no changes to clinical coverage criteria. Updated reference.	2/15/2026
Levorphanol	Step Therapy	Levorphanol	Annual review. Updated references.	2/15/2026
Lytgobi	Notification	Lytgobi® (futibatinib)	Annual review. No changes to coverage criteria.	2/15/2026
Nourianz	Medical Necessity	Nourianz® (istradefylline)	Annual review. Updated references.	2/15/2026
Opfolda	Notification	Opfolda® (miglustat)	Annual review with no change to coverage criteria.	2/15/2026
Retevmo	Notification	Retevmo® (selpercatinib)	Annual review with no changes to clinical criteria. Updated background and references.	2/15/2026
Taltz	Notification	Taltz® (ixekizumab) *Taltz is excluded from coverage for the majority of our benefits	Annual review. Updated examples with no change to clinical intent.	2/15/2026
Therapeutic Duplication - Administrative override	Misc	Therapeutic Duplication	Reviewed with no changes.	2/15/2026
Upneeq	Medical Necessity	Upneeq® (oxymetazoline) 0.1% ophthalmic solution	Annual review. Updated references.	2/15/2026
Verquvo	Notification	Verquvo® (vericiguat)	Annual review with no changes.	2/15/2026
Vizimpro	Notification	Vizimpro® (dacomitinib)	Annual review. No changes to coverage criteria.	2/15/2026
Vyleesi	Medical Necessity	Vyleesi™ (bremelanotide)	Annual review. Updated references.	2/15/2026
Xdemvy	Medical Necessity	Xdemvy™ (lotilaner) ophthalmic solution 0.25%	Annual review. Updated references.	2/15/2026
Yupelri	Medical Necessity	Yupelri® (revefenacin inhalation solution)	Annual review. Updated references.	2/15/2026
Actemra, Tyenne	Notification	Actemra® (tocilizumab) and Tyenne® (tocilizumab-aazg) *This program applies to the subcutaneous formulation of tocilizumab.	Annual review. Updated not used in combination verbiage and examples with no change to clinical intent. Updated references.	3/1/2026
Addyi	Medical Necessity	Addyi™ (flibanserin)	Annual review. Updated references.	3/1/2026
Apokyn	Notification	Apokyn® (apomorphine) injection	Annual review with no changes to coverage criteria.	3/1/2026
Apokyn	Medical Necessity	Apokyn® (apomorphine) injection	Annual review with no changes to coverage criteria. Updated references.	3/1/2026
Continuous glucose monitors, sensors and transmitters (all brands)	Medical Necessity	Continuous glucose monitors, sensors and transmitters (all brands)	Added MiniMed Instinct to program.	3/1/2026
Emflaza, Jaythari, Kymbee, and Pyquvi	Notification	Emflaza® (deflazacort), Jaythari (deflazacort), and Pyquvi (deflazacort)	Added Jaythari, Kymbee, and Pyquvi to program.	3/1/2026
Emflaza, Jaythari, Kymbee, and Pyquvi	Medical Necessity	Emflaza® (deflazacort), Jaythari (deflazacort), and Pyquvi (deflazacort)	Added Jaythari, Kymbee, and Pyquvi to program.	3/1/2026
Envarsus XR Non-Formulary	Notification/Non-Formulary	Envarsus XR™ (tacrolimus extended-release tablets)	Annual review with no changes to coverage criteria.	3/1/2026
Eucrisa	Step Therapy	Eucrisa® (crisaborole)	Annual review with no change to coverage criteria.	3/1/2026

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Gonal-f	Step Therapy	Gonal-f® (follitropin alfa)	No changes to coverage criteria. Updated background and references.	3/1/2026
Hepatitis C Direct Acting Antivirals	Step Therapy	Hepatitis C Direct Acting Antivirals - Epclusa® (sofosbuvir/velpatasvir), Harvoni® (ledipasvir/sofosbuvir), Mavyret® (glecaprevir/pibrentasvir), Sovaldi® (sofosbuvir)	Removed Zepatier because product has been withdrawn from the market. Updated background and references.	3/1/2026
HIV Medications with Pre-exposure Prophylaxis Use Zero Dollar Cost Share - Regulatory	Notification / Regulatory	HIV Medications with Pre-exposure Prophylaxis (PrEP) Use Zero Dollar Cost Share Descovy 200/25 mg, generic tenofovir fumarate 300 mg, brand Truvada 200/300 mg, and brand Viread 300 mg	Annual review. No changes.	3/1/2026
Itovebi	Notification	Itovebi™ (inavolisib)	Annual review. No changes to clinical coverage criteria. Updated references.	3/1/2026
Lidocaine Patch, ZTLido	Notification	Lidocaine Patch (Lidoderm®), ZTLido™	Annual review. Updated references.	3/1/2026
Litfulo	Notification	Litfulo™ (ritlecitinib)	Annual review. Updated combination examples and language with no change to clinical intent.	3/1/2026
Litfulo	Medical Necessity	Litfulo™ (ritlecitinib)	Annual review. Updated combination examples and language with no change to clinical intent.	3/1/2026
Livdelzi	Notification	Livdelzi® (seladelpar)	Annual review without changes to coverage criteria. Updated reference.	3/1/2026
Livdelzi	Medical Necessity	Livdelzi® (seladelpar)	Annual review without changes to coverage criteria. Updated reference.	3/1/2026
Livdelzi	Step Therapy	Livdelzi® (seladelpar)	Annual review without changes to coverage criteria. Updated reference.	3/1/2026
Lynkuet, Veozah	Medical Necessity	Lynkuet® (elinzanetant), Veozah™ (fezolinetant)	Annual review. Added Lynkuet and updated references.	3/1/2026
Mektovi	Notification	Mektovi® (binimetinib)	Annual review with no changes to coverage criteria. Updated background and references.	3/1/2026
Nucala	Medical Necessity	Nucala® (mepolizumab) * This program applies to the prefilled autoinjector and prefilled syringe formulations.	Updated criteria for COPD by removing criteria requiring symptoms of a chronic productive cough and updating post-bronchodilator FEV1 % predicted from 'greater than or equal to 30% and less than or equal to 70%' to 'greater than or equal to 20% and less than or equal to 80%'. Updated references.	3/1/2026
Ocaliva	Medical Necessity	Ocaliva® (obeticholic acid)	Annual review with no changes to coverage criteria. Updated background and references to reflect withdrawal of drug from market.	3/1/2026
Ocaliva	Step Therapy	Ocaliva® (obeticholic acid)	Annual review with no changes to coverage criteria. Updated background and references to reflect withdrawal of drug from market.	3/1/2026
Onureg	Notification	Onureg® (azacitidine)	Annual review. Added new coverage criteria for acute lymphoblastic leukemia based on NCCN guidance.	3/1/2026
Opzelura	Notification	Opzelura® (ruxolitinib)	Annual review. Updated combination examples and language with no change to clinical intent. Updated background to reflect new age recommendation for AD. Updated reference.	3/1/2026
Opzelura	Medical Necessity	Opzelura® (ruxolitinib)	Annual review. Updated combination examples and language with no change to clinical intent. Updated background to reflect new age recommendation for AD. Updated reference.	3/1/2026
Oral chemotherapeutic agents	Notification	Oral chemotherapeutic agents	Annual review. Updated background and NCCN Categories of Evidence and Consensus sections based on current NCCN language with no change to coverage criteria. Updated references.	3/1/2026
Palsonify	Notification	Palsonify™ (paltusotine)	New program.	3/1/2026
Ravicti	Step Therapy	Ravicti® (glycerol phenylbutyrate oral liquid)	Archive program.	3/1/2026
Rukobia	Notification	Rukobia (fostemsavir)	Annual review with no changes to coverage criteria.	3/1/2026
Scemblix	Notification	Scemblix® (asciminib)	Annual review. Added new coverage criteria for ALL per NCCN. Updated background and references.	3/1/2026

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Tezspire	Notification	Tezspire™ (tezepelumab-ekko) *This program applies to the prefilled pen for self-administration.	Added criteria for new indication of chronic rhinosinusitis with nasal polyps. Updated background and references.	3/1/2026
Tezspire	Medical Necessity	Tezspire™ (tezepelumab-ekko) *This program applies to the prefilled pen for self-administration.	Added criteria for new indication of chronic rhinosinusitis with nasal polyps. Updated background and references.	3/1/2026
Tonmya	Medical Necessity	Tonmya™ (cyclobenzaprine sublingual tablet)	New program.	3/1/2026
Voranigo	Notification	Voranigo® (vorasidenib)	Annual review. Separated criteria for astrocytoma and oligodendroglioma into two sections. Added WHO grade requirements for both astrocytoma and oligodendroglioma. Added 1p19q codeletion as requirement for oligodendroglioma. Updated background and reference. codeletion as requirement for oligodendroglioma. Updated background and reference.	3/1/2026
Voxzogo	Notification	Voxzogo™ (vosoritide)	Annual review with no changes to coverage criteria. Updated references.	3/1/2026
Voxzogo	Medical Necessity	Voxzogo™ (vosoritide)	Annual review with no changes to coverage criteria. Updated references.	3/1/2026
Xeljanz, Xeljanz XR, Xeljanz Oral Solution	Notification	Xeljanz®/Xeljanz® XR/Xeljanz® Oral Solution (tofacitinib)	Updated PsA criteria to include Xeljanz Oral Solution for new indication for 2 years of age and older. Updated background and reference.	3/1/2026
Xeljanz, Xeljanz XR, Xeljanz Oral Solution	Medical Necessity	Xeljanz®/Xeljanz® XR/Xeljanz® Oral Solution (tofacitinib)	Updated PsA criteria to include Xeljanz Oral Solution for new indication for 2 years of age and older. Updated background and reference.	3/1/2026
Yorvipath	Notification	Yorvipath® (palopegteriparatide)	Annual review with no changes.	3/1/2026
Yorvipath	Medical Necessity	Yorvipath® (palopegteriparatide)	Annual review with no changes.	3/1/2026
Zepbound - Obstructive Sleep Apnea Only	Notification	Zepbound® (tirzepatide) – Obstructive Sleep Apnea Only	Removed requirement for symptoms of OSA. Removed requirement to not have significant craniofacial abnormalities. Added description of mixed and central apneas.	3/1/2026
Zeposia	Notification	Zeposia® (ozanimod)	Annual review. Updated combination examples and language with no change to clinical intent.	3/1/2026
Zurzuvae	Notification	Zurzuvae® (zuranolone)	Annual review without changes to clinical criteria.	3/1/2026
Ravicti	Notification	Ravicti® (glycerol phenylbutyrate oral liquid), glycerol phenylbutyrate oral liquid	Updated program to note that brand Ravicti is typically excluded from coverage.	5/1/2026
Ravicti	Medical Necessity	Ravicti® (glycerol phenylbutyrate oral liquid), glycerol phenylbutyrate oral liquid	Updated program to note that brand Ravicti is typically excluded from coverage.	5/1/2026