



## Commercial Business

BULLETIN (6/1/2026)

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

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Akeega	Step Therapy	Akeega™ (niraparib and abiraterone acetate)	Annual review. Updated name of manufacturer savings program. Updated references.	6/1/2026
Bonjesta, Diclegis	Medical Necessity	Bonjesta® (doxylamine/pyridoxine extended-release), Diclegis® (doxylamine/pyridoxine delayed-release)	Annual review. Updated references.	6/1/2026
Bronchitol	Step Therapy	Bronchitol® (mannitol)	Annual review with no change to coverage criteria. Updated reference.	6/1/2026
Bronchitol	Notification	Bronchitol® (mannitol)	Annual review. No changes to coverage criteria. Updated reference.	6/1/2026
Cinryze	Medical Necessity	Cinryze® (C1 esterase inhibitor, human)	Annual review. Updated tried/failed requirements differentiated by age and added Andembry for ages 12 and above. Added exclusion disclaimer for Cinryze. Updated list of examples of prophylactic and acute HAE therapies. Updated references.	6/1/2026
Cinryze	Notification	Cinryze® (C1 esterase inhibitor, human)	Annual review. No changes to coverage criteria. Updated examples of preventive HAE agents.	6/1/2026
Cobenfy	Medical Necessity	Cobenfy™ (xanomeline and trospium chloride)	Annual review with no changes.	6/1/2026
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.	6/1/2026
Crexont, Rytary	Step Therapy	Crexont™ (carbidopa/levodopa extended-release), Rytary® (carbidopa/levodopa extended-release)	Annual review. Updated references.	6/1/2026
Ebglyss	Medical Necessity	Ebglyss® (lebrikizumab-lbkz)	Annual review with no change to clinical criteria. Updated reference.	6/1/2026
Ebglyss	Notification	Ebglyss® (lebrikizumab-lbkz)	Annual review with no change to clinical criteria. Updated reference.	6/1/2026
Elmiron	Step Therapy	Elmiron® (pentosan polysulfate sodium)	Annual review. Updated references.	6/1/2026
Filspari	Medical Necessity	Filspari™ (sparsentan)	Added budesonide as a corticosteroid example. Removed step through SGLT2 and Vanrafia. Updated references.	6/1/2026
Haegarda	Medical Necessity	Haegarda® (C1 esterase inhibitor Subcutaneous, human)	Annual review. Updated list of examples of prophylactic and acute HAE treatments. Updated references.	6/1/2026
Haegarda	Notification	Haegarda® (C1 esterase inhibitor Subcutaneous, human)	Annual review. No changes to coverage criteria. Updated examples of HAE preventive agents.	6/1/2026
Hetlioz, Hetlioz LQ	Medical Necessity	Hetlioz®, Hetlioz LQ™ (tasimelteon)	Annual review. Updated references.	6/1/2026
Hetlioz, Hetlioz LQ	Notification	Hetlioz®, Hetlioz LQ™ (tasimelteon)	Annual review. Updated references.	6/1/2026
Hympavzi	Notification	Hympavzi™ (marstacimab-hncq)	Annual review. Added “or reduction in frequency” to all indications. Updated references.	6/1/2026
Icotyde	Medical Necessity	Icotyde™ (icotrokinra)	New program.	6/1/2026
Icotyde	Notification	Icotyde™ (icotrokinra)	New program.	6/1/2026

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<b>Korlym</b>	Notification	Korlym® (mifepristone)	Annual review with no changes to coverage criteria.	6/1/2026
<b>Nuplazid</b>	Notification	Nuplazid® (pimavanserin)	Annual review with no changes.	6/1/2026
<b>Nurtec ODT, Qulipta, Ubrelvy, Zavzpret</b>	Notification	Nurtec® ODT (rimegepant), Qulipta® (atogepant), Ubrelvy®(ubrogepant), Zavzpret™ (zavegepant)	Annual review. Updated language on concomitant CGRP use.	6/1/2026
<b>Nurtec ODT, Qulipta, Ubrelvy, Zavzpret</b>	Step Therapy	Nurtec® ODT (rimegepant), Qulipta® (atogepant), Ubrelvy®(ubrogepant), Zavzpret™ (zavegepant)	Annual review. No changes.	6/1/2026
<b>Nurtec ODT, Qulipta, Ubrelvy, Zavzpret</b>	Medical Necessity	Nurtec® ODT (rimegepant), Qulipta® (atogepant), Ubrelvy®(ubrogepant), Zavzpret™ (zavegepant)	Annual review. Updated language on concomitant CGRP use.	6/1/2026
<b>Omnipod 5, Twiist</b>	Medical Necessity	Omnipod® 5, Twiist™	Annual review. Updated references.	6/1/2026
<b>Omnipod 5, Twiist</b>	Notification	Omnipod® 5, Twiist™	Annual review. Updated references.	6/1/2026
<b>OmvoH</b>	Notification	OmvoH® (mirikizumab-mrkz) This program applies to the subcutaneous formulation of OmvoH.	Updated Application to add Individual Exchange benefit plans. Updated combination examples and language with no change to clinical intent. Updated reference.	6/1/2026
<b>OmvoH</b>	Medical Necessity	OmvoH® (mirikizumab-mrkz) This program applies to the subcutaneous formulation of OmvoH.	Updated establishment of therapy on the medical benefit and combination examples and language with no change to clinical intent. Updated reference.	6/1/2026
<b>Orladeyo</b>	Notification	Orladeyo® (berotralstat)	Annual review. Updated program by notating that Orladeyo is typically excluded from coverage. Updated list of examples of prophylactic HAE treatments. Updated background and references by updating FDA labeled indication.	6/1/2026
<b>Orserdu</b>	Notification	Orserdu™ (elacestrant)	Annual review with no changes to coverage criteria.	6/1/2026
<b>Osphena</b>	Notification	Osphena® (ospemifene)	Annual review. Updated references.	6/1/2026
<b>Palforzia</b>	Notification	Palforzia [Peanut (Arachis hypogaea) Allergen Powder-dnfp]	Annual review. No changes.	6/1/2026
<b>Palforzia</b>	Medical Necessity	Palforzia [Peanut (Arachis hypogaea) Allergen Powder-dnfp]	Annual review. No changes.	6/1/2026
<b>Palsonify</b>	Medical Necessity	Palsonify™ (paltusotine)	New program.	6/1/2026
<b>Piqray</b>	Notification	Piqray® (alpelisib)	Annual review with no changes to coverage criteria.	6/1/2026
<b>Qelbree</b>	Medical Necessity	Qelbree® (viloxazine)	Annual review. Updated references.	6/1/2026
<b>Regranex</b>	Notification	Regranex® (becaplermin gel)	Annual review. Reference updated.	6/1/2026
<b>Repository Corticotropins - Acthar Gel, Purified Cortrophin Gel</b>	Medical Necessity	Repository Corticotropins - Acthar Gel® (repository corticotropin injection), Purified Cortrophin Gel™ (repository corticotropin injection USP)	Annual review with no changes to criteria. Updated references.	6/1/2026
<b>Repository Corticotropins - Acthar Gel, Purified Cortrophin Gel</b>	Notification	Repository Corticotropins - Acthar Gel® (repository corticotropin injection), Purified Cortrophin Gel™ (repository corticotropin injection USP)	Annual review with no changes to criteria. Updated references.	6/1/2026
<b>Repository Corticotropins - Acthar Gel, Purified Cortrophin Gel</b>	Step Therapy	Repository Corticotropins - Acthar Gel® (repository corticotropin injection), Purified Cortrophin Gel™ (repository corticotropin injection USP)	Annual review with no changes to step criteria. Updated references.	6/1/2026
<b>Reyvow</b>	Step Therapy	Reyvow® (lasmiditan)	Archive program.	6/1/2026
<b>Reyvow</b>	Medical Necessity	Reyvow® (lasmiditan)	Annual review. No changes.	6/1/2026
<b>Reyvow</b>	Notification	Reyvow® (lasmiditan)	Archive program.	6/1/2026
<b>Savaysa</b>	Step Therapy	Savaysa® (edoxaban)	Annual review with updated references.	6/1/2026
<b>Statins - Lescol XL, Livalo, Zypitamag</b>	Step Therapy	Lescol® XL (brand and generic fluvastatin extended-release), Livalo® (brand and generic pitavastatin calcium), Zypitamag® (pitavastatin magnesium)	Annual review. No changes.	6/1/2026
<b>Stromectol (ivermectin)</b>	Notification	Stromectol® (ivermectin) oral dosage form	Annual review. Updated references.	6/1/2026

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<b>Sublingual Immunotherapy (SLIT)</b>	Notification	Sublingual Immunotherapy (SLIT) – Grastek (Timothy grass pollen allergen extract), Odactra (Dermatophagoides farinae/Dermatophagoides pteronyssinus allergen extract), Oralair (Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens allergen extract), Ragwitek (Short Ragweed Pollen allergen extract)	Annual review. Updated references.	6/1/2026
<b>Sublingual Immunotherapy (SLIT)</b>	Medical Necessity	Sublingual Immunotherapy (SLIT) - Grastek (Timothy grass pollen allergen extract), Odactra (Dermatophagoides farinae/Dermatophagoides pteronyssinus allergen extract), Oralair (Sweet Vernal, Orchard, Perennial Rye, Timothy, and Kentucky Blue Grass Mixed Pollens allergen extract), Ragwitek (Short Ragweed Pollen allergen extract)	Annual review. Updated references.	6/1/2026
<b>Sutent</b>	Notification	Sutent® (sunitinib malate)	Annual review with no changes to coverage criteria. Updated references.	6/1/2026
<b>Takhzyro</b>	Medical Necessity	Takhzyro® (lanadelumab-flyo)	Annual review. Updated list of examples of prophylactic and acute HAE treatments. Updated criteria by removing requirement to document frequency of HAE attacks. Updated references.	6/1/2026
<b>Takhzyro</b>	Notification	Takhzyro® (lanadelumab-flyo)	Annual review. No changes to coverage criteria. Updated examples of preventive HAE agents. Updated reference.	6/1/2026
<b>Tarpeyo</b>	Medical Necessity	Tarpeyo® (budesonide delayed-release capsules)	Removed corticosteroid step and updated references.	6/1/2026
<b>Tazorac</b>	Medical Necessity	Tazorac® (tazarotene)	Annual review. Updated background section and references.	6/1/2026
<b>Tazverik</b>	Notification	Tazverik® (tazemetostat)	Annual review with no changes to coverage criteria.	6/1/2026
<b>Tukysa</b>	Notification	Tukysa® (tucatinib)	Annual review. Changed wording for CNS cancers.	6/1/2026
<b>Ustekinumab</b>	Medical Necessity	Ustekinumab: Imuldosa (ustekinumab-srlf), Otulfi® (ustekinumab-aaaz), Pyzchiva® (ustekinumab-ttwe), Selarsdi™ (ustekinumab-aekn), Starjemza™ (ustekinumab-hmny), Stelara® (ustekinumab), Steqeyma® (ustekinumab-stba), Ustekinumab-ttwe, Wezlana™ (ustekinumab-aaub), and Yesintek™ (ustekinumab-kfce)	Starjemza removed from drugs typically excluded from coverage. Updated combination examples and language with no change to clinical intent. Updated combination examples and language with no change to clinical intent.	6/1/2026
<b>Ustekinumab</b>	Notification	Ustekinumab: Imuldosa (ustekinumab-srlf), Otulfi® (ustekinumab-aaaz), Pyzchiva® (ustekinumab-ttwe), Selarsdi™ (ustekinumab-aekn), Starjemza™ (ustekinumab-hmny), Stelara® (ustekinumab), Steqeyma® (ustekinumab-stba), Ustekinumab-ttwe, Wezlana™ (ustekinumab-aaub), and Yesintek™ (ustekinumab-kfce)	Starjemza removed from drugs typically excluded from coverage. Updated combination examples and language with no change to clinical intent.	6/1/2026
<b>Vanrafia</b>	Medical Necessity	Vanrafia™ (atrasentan)	Added budesonide as a corticosteroid example. Updated references.	6/1/2026
<b>Vascepa</b>	Medical Necessity	Vascepa® (icosapent ethyl)	Annual review. Updated risk factors to mirror cardiovascular disease risk assessment in adults. Updated references.	6/1/2026
<b>Vascepa</b>	Notification	Vascepa® (icosapent ethyl)	Annual review. Updated risk factors to mirror cardiovascular disease risk assessment in adults. Updated references.	6/1/2026
<b>Voquezna</b>	Medical Necessity	Voquezna® (vonoprazan)	Annual review. Updated references.	6/1/2026
<b>Zelboraf</b>	Notification	Zelboraf® (vemurafenib)	Annual review with no change to coverage criteria.	6/1/2026
<b>Zokinvy</b>	Notification	Zokinvy™ (lonafarnib)	Annual review with no change to coverage criteria. Updated background and reference.	6/1/2026
<b>Zycubo</b>	Notification	Zycubo® (copper histidinate)	New program.	6/1/2026

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<b>Adbry</b>	Medical Necessity	Adbry® (tralokinumab-ldrm)	Annual review with no changes to coverage criteria. Updated combination use language with no change to clinical intent. Updated reference.	7/1/2026
<b>Adbry</b>	Notification	Adbry® (tralokinumab-ldrm)	Annual review with no changes to coverage criteria. Updated combination use language with no change to clinical intent. Updated reference.	7/1/2026
<b>Afrezza</b>	Medical Necessity	Afrezza® (insulin human)	Annual review. Updated references.	7/1/2026
<b>Aqvesme</b>	Notification	Aqvesme™ (mitapivat)	New program.	7/1/2026
<b>Aqvesme</b>	Medical Necessity	Aqvesme™ (mitapivat)	New program.	7/1/2026
<b>Austedo, Austedo XR</b>	Medical Necessity	Austedo® (deutetrabenazine), Austedo XR® (deutetrabenazine)	Annual review with no change to clinical criteria.	7/1/2026
<b>Austedo, Austedo XR</b>	Notification	Austedo® (deutetrabenazine), Austedo XR® (deutetrabenazine)	Annual review with no change to clinical criteria.	7/1/2026
<b>Beriner</b>	Medical Necessity	Beriner® (C1 esterase inhibitor [human])	Annual review. Added additional examples of acute HAE agents.	7/1/2026
<b>Bimzelx</b>	Medical Necessity	Bimzelx® (bimekizumab-bkzx)	Annual review. Updated combination examples and language with no change to clinical intent. Added Sotyktu as a step therapy agent for PsA. Added Icotyde as a step therapy agent for PsO. Updated examples with no change to clinical intent.	7/1/2026
<b>Bimzelx</b>	Step Therapy	Bimzelx® (bimekizumab-bkzx)	Annual review. Added Sotyktu as a step therapy agent for PsA. Updated references. Added Icotyde as a step therapy agent for PsO.	7/1/2026
<b>Brukinsa</b>	Step Therapy	Brukinsa® (zanubrutinib)	Added requirement to document contraindication or intolerance to preferred alternatives, or reason patient is not an appropriate candidate for the preferred alternatives.	7/1/2026
<b>Cablivi</b>	Notification	Cablivi® (caplacizumab-yhdp)	Annual review with no change to clinical criteria. Updated background and reference.	7/1/2026
<b>Calquence</b>	Notification	Calquence® (acalabrutinib)	Annual review with no change to clinical criteria.	7/1/2026
<b>Caplyta</b>	Notification	Caplyta® (lumateperone)	Updated to add MDD based on updated labeling.	7/1/2026
<b>Cardamyst</b>	Medical Necessity	Cardamyst™ (etripamil)	New program.	7/1/2026
<b>CGRP Receptor Antagonists - Aimovig, Ajovy, Emgality</b>	Medical Necessity	Aimovig® (erenumab), Ajovy® (fremanezumab), Emgality® (galcanezumab)	Updated reauthorization section to separate Ajovy out for patients over 18 and under 18 years of age. Updated CGRP language throughout.	7/1/2026
<b>CGRP Receptor Antagonists - Aimovig, Ajovy, Emgality</b>	Notification	Aimovig® (erenumab), Ajovy® (fremanezumab), Emgality® (galcanezumab)	Updated CGRP language throughout.	7/1/2026
<b>Cibinqo</b>	Notification	Cibinqo® (abrocitinib) tablets	Annual review. Updated combination use language with no change to clinical intent.	7/1/2026
<b>Compounds and Bulk Powders</b>	Notification	Compounds and Bulk Powders	Clarified that pediatric patients may be approved based on indication regardless of FDA labeled age of approval.	7/1/2026
<b>Dasatinib - Dasatinib (generic), Phyrago, and Sprycel</b>	Notification	Dasatinib - Dasatinib (generic), Phyrago™, and Sprycel®	Renamed the program. Added Phyrago to the program. Updated criteria changing Sprycel to dasatinib. Noted Sprycel and Phyrago are excluded from coverage for the majority of our benefits with generic dasatinib covered, adding a footnote. Updated references.	7/1/2026
<b>Diabetes Medications – GLP-1 &amp; Dual GIP/GLP-1 Receptor Agonists</b>	Notification	Mounjaro® (tirzepatide), Ozempic® (semaglutide), Rybelsus® (semaglutide), Trulicity® (dulaglutide), Victoza® (liraglutide)	Annual review. Removed Byetta and Bydureon BCise. Updated background section and references.	7/1/2026
<b>Dupixent</b>	Medical Necessity	Dupixent® (dupilumab)	Added criteria for the new indication for allergic fungal rhinosinusitis. Updated background and reference.	7/1/2026
<b>Dupixent</b>	Notification	Dupixent® (dupilumab)	Added criteria for the new indication for allergic fungal rhinosinusitis. Updated background and reference.	7/1/2026
<b>Evrysdi</b>	Medical Necessity	Evrysdi® (risdiplam)	Annual review. Added Itvisma as an example of gene therapy. Updated references.	7/1/2026
<b>Evrysdi</b>	Notification	Evrysdi® (risdiplam)	Annual review. Added Itvisma as an example of gene therapy. Updated reference.	7/1/2026
<b>Filsuvez</b>	Medical Necessity	Filsuvez® (birch triterpenes) topical gel	Annual review with no changes to criteria.	7/1/2026
<b>Filsuvez</b>	Notification	Filsuvez® (birch triterpenes) topical gel	Annual review with no changes to criteria.	7/1/2026

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<b>Fluticasone propionate HFA Non-Formulary</b>	Non-Formulary	Fluticasone propionate HFA	Annual review. Added medical record requirement.	7/1/2026
<b>Glumetza, Metformin XR</b>	Medical Necessity	Glumetza® (metformin extended-release modified release, brand and generic) and metformin osmotic extended-release (generic Fortamet®)	Annual review. Updated references.	7/1/2026
<b>Gomekli</b>	Notification	Gomekli™ (mirdametinib)	Annual review with no change to clinical criteria.	7/1/2026
<b>Hernexeos</b>	Notification	Hernexeos© (zongertinib)	Removed requirement patient has received prior systemic therapy. Updated background and references.	7/1/2026
<b>Human Growth Hormone</b>	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®)	Added SGA, NS, and ISS as covered indications for Sogroya. Within congenital GHD, pediatric GHD, adolescent GHD, and SGA sections, added requirements for documentation that all other etiologies for growth failure have been ruled out. Updated background and references.	7/1/2026
<b>Human Growth Hormone</b>	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®)	Added SGA, NS, and ISS as covered indications for Sogroya. Removed Ngenla, Skytrofa, and Sogroya from congenital GHD section. Within congenital GHD, pediatric GHD, adolescent GHD, and SGA sections, added requirements that all other etiologies for growth failure have been ruled out. Updated background and references.	7/1/2026
<b>Ilumya</b>	Medical Necessity	Ilumya® (tildrakizumab-asmn)	Annual review. Updated combination examples and language with no change to clinical intent. Updated references. Added Icotyde as a step therapy agent for PsO. Updated examples with no change to clinical intent.	7/1/2026
<b>Ilumya</b>	Step Therapy	Ilumya® (tildrakizumab-asmn)	Annual review. Updated references. Added Icotyde as a step therapy agent for PsO.	7/1/2026
<b>Ingrezza</b>	Medical Necessity	Ingrezza® (valbenazine)	Annual review with no change to clinical criteria.	7/1/2026
<b>Ingrezza</b>	Notification	Ingrezza® (valbenazine)	Annual review. No changes to clinical coverage criteria.	7/1/2026
<b>Inrebic</b>	Step Therapy	Inrebic® (fedratinib)	Annual review. Added additional diagnosis of ‘myeloid/lymphoid neoplasms with eosinophilia and JAK2 rearrangement in chronic phase or blast phase’ into coverage criteria. Updated background.	7/1/2026
<b>Kygevvi</b>	Medical Necessity	Kygevvi® (doxecitine and doxribtimine)	New program.	7/1/2026
<b>Lonsurf</b>	Notification	Lonsurf® (trifluridine/tipiracil)	Annual review. Updated criteria for colorectal cancer by removing specific criteria related to RAS mutation. Added new coverage criteria for appendiceal neoplasms and cancers.	7/1/2026
<b>Mavenclad</b>	Notification	Mavenclad® (cladribine)	Annual review with no change to clinical criteria.	7/1/2026
<b>Mavenclad</b>	Step Therapy	Mavenclad® (cladribine)	Annual review with no changes.	7/1/2026
<b>Northera</b>	Medical Necessity	Northera® (droxidopa)	Annual review. No changes.	7/1/2026
<b>Olumiant</b>	Medical Necessity	Olumiant® (baricitinib)	Annual review. Updated combination examples and language with no change to clinical intent.	7/1/2026
<b>Olumiant</b>	Step Therapy	Olumiant® (baricitinib)	Annual review with no change to clinical coverage criteria. Updated references.	7/1/2026
<b>Ophthalmic Agents - Qlosi, Vizz, Vuity, Yuvezzi</b>	Medical Necessity	Qlosi (pilocarpine)™ 0.4% ophthalmic solution, Vizz™ (aceclidine) 1.44% ophthalmic solution, Vuity® (pilocarpine) 1.25% ophthalmic solution, Yuvezzi™ (carbachol/brimonidine) 2.75%/0.1% ophthalmic solution	Added Yuvezzi. Updated references.	7/1/2026

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Orencia	Step Therapy	Orencia® (abatacept)	Annual review with no changes to coverage criteria. Added Sotyktu as a step therapy agent for PsA. Updated background and references.	7/1/2026
Orencia	Medical Necessity	Orencia® (abatacept)	Annual review. Updated combination examples and language with no change to clinical intent. Added Sotyktu as a step therapy agent for PsA. Updated references.	7/1/2026
Prudoxin, Zonalon	Medical Necessity	Prudoxin® (doxepin), Zonalon® (doxepin)	Annual review with updated references.	7/1/2026
Prudoxin, Zonalon	Notification	Prudoxin® (doxepin), Zonalon® (doxepin)	Annual review. No changes.	7/1/2026
Radicava ORS	Medical Necessity	Radicava ORS® (edaravone)	Annual review, updated references.	7/1/2026
Romvimza	Notification	Romvimza™ (vimseltinib)	Annual review with no change to clinical criteria.	7/1/2026
Rubraca	Step Therapy	Rubraca® (rucaparib)	Annual review with no changes to criteria. Updated references.	7/1/2026
Ruconest	Medical Necessity	Ruconest® (C1 esterase inhibitor [recombinant])	Annual review. No changes to coverage criteria. Added examples of HAE acute agents.	7/1/2026
Sandostatin	Notification	Sandostatin® (octreotide acetate)	Annual review. Added separate criteria sections for FDA-labeled indications, diarrhea associated with metastatic carcinoid tumors and VIP-secreting tumors. Simplified criteria for neuroendocrine/adrenal tumors, thymoma/thymic carcinoma, and malignant bowel obstruction. Removed non-FDA labeled indication, bleeding esophageal varices. Updated Background and References.	7/1/2026
Siliq	Medical Necessity	Siliq (brodalumab)	Annual review. Updated combination examples and language with no change to clinical intent. Updated references. Added Icotyde as a step therapy agent for PsO. Updated examples with no change to clinical intent.	7/1/2026
Siliq	Step Therapy	Siliq (brodalumab)	Annual review. Updated references. Added Icotyde as a step therapy agent for PsO.	7/1/2026
Sotyktu	Medical Necessity	Sotyktu™ (deucravacitinib)	Added criteria for active psoriatic arthritis. Updated references.	7/1/2026
Sotyktu	Notification	Sotyktu™ (deucravacitinib)	Added criteria for active psoriatic arthritis. Updated combination examples and language with no change to clinical intent. Updated reference.	7/1/2026
Spravato	Medical Necessity	Spravato® (esketamine)	Annual review, updated references.	7/1/2026
Spravato	Notification	Spravato® (esketamine)	Annual review. Updated references.	7/1/2026
Suboxone	Medical Necessity	Suboxone® (Brand Only)	Annual review. Updated references.	7/1/2026
Taltz	Medical Necessity	Taltz (ixekizumab)	Annual review. Updated combination examples and language with no change to clinical intent. Added Sotyktu as a step therapy agent for PsA. Updated references. Added Icotyde as a step therapy agent for PsO. Updated examples with no change to clinical intent.	7/1/2026
Taltz	Step Therapy	Taltz (ixekizumab)	Annual review. Added Sotyktu as a step therapy agent for PsA. Updated references. Added Icotyde as a step therapy agent for PsO.	7/1/2026
Talzenna	Step Therapy	Talzenna® (talazoparib)	Annual review with no change to coverage criteria. Updated references.	7/1/2026
Velsipity	Step Therapy	Velsipity™ (etrasimod)	Annual review with no changes. Updated references.	7/1/2026
Velsipity	Medical Necessity	Velsipity™ (etrasimod)	Annual review. Updated drug examples and combination language with no change to clinical intent. Updated reference.	7/1/2026
Velsipity	Notification	Velsipity™ (etrasimod)	Annual review. Updated combination examples and language with no change to clinical intent. Updated reference.	7/1/2026
Venclexta	Notification	Venclexta® (venetoclax)	Annual review. Updated criteria for Acute Lymphoblastic Leukemia (ALL), Acute Myeloid Leukemia (AML), Mantle Cell Lymphoma, Multiple Myeloma, and Myelodysplastic Syndromes based on NCCN recommendations. Updated references.	7/1/2026
Viberzi	Medical Necessity	Viberzi® (eluxadolone)	Annual review. Updated references.	7/1/2026

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
<b>Weight Loss/Appetite Suppression</b>	Notification	Weight Loss/Appetite Suppression – 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), Vykat XR™ (diazoxide choline), Wegovy® (semaglutide) injection, Wegovy® (semaglutide) tablet and Zepbound™ (tirzepatide)	Clarified there is no BMI requirement for MASH indication.	7/1/2026
<b>Xolair</b>	Medical Necessity	Xolair® (omalizumab)	Annual review. Updated criteria regarding concomitant use for each indication. Added Exdensus to the list of IL-5 inhibitor examples.	7/1/2026
<b>Xolair</b>	Notification	Xolair® (omalizumab)	Annual review. Updated criteria regarding concomitant use for each indication. Added Exdensus to the list of IL-5 inhibitor examples.	7/1/2026
<b>Yuviwel</b>	Medical Necessity	Yuviwel® (navepegritide)	New program	7/1/2026
<b>Yuviwel</b>	Notification	Yuviwel® (navepegritide)	New program	7/1/2026
<b>Zeposia</b>	Medical Necessity	Zeposia® (ozanimod)	Annual review. Updated combination examples and language with no change to clinical intent. Updated reference.	7/1/2026
<b>Zeposia</b>	Step Therapy	Zeposia® (ozanimod)	Annual review with no changes. Updated references.	7/1/2026
<b>Zycubo</b>	Medical Necessity	Zycubo® (copper histidinate)	New program.	7/1/2026
<b>Afinitor</b>	Notification	Afinitor® (everolimus)	Annual review. Updated coverage criteria for thymomas and thymic cancers based on NCCN recommendations.	8/1/2026
<b>Alyftrek</b>	Medical Necessity	Alyftrek™ (vanzacافتor/tezacافتor/deutivacافتor)	Updated list of eligible CFTR mutations. Updated background and references.	8/1/2026
<b>Alyftrek</b>	Notification	Alyftrek™ (vanzacافتor/tezacافتor/deutivacافتor)	Updated list of eligible CFTR mutations. Updated background and reference.	8/1/2026
<b>Ampyra</b>	Notification	Ampyra® (dalfampridine)	Annual review. Updated to criteria language with no change to clinical intent. Updated reference.	8/1/2026
<b>Antidepressants - Auvelity, Exxua, Trintellix, Fetzima</b>	Step Therapy	Auvelity® (dextromethorphan/bupropion), Exxua™ (gepirone), Trintellix (vortioxetine) and Fetzima® (levomilnacipran)	Added Exxua to program. Updated references.	8/1/2026
<b>Arcalyst</b>	Notification	Arcalyst® (rilonacept)	Annual review with no change to coverage criteria. Updated reference.	8/1/2026
<b>Mifeprex - Benefit Determination</b>	Regulatory	Benefit Determination – Mifeprex 200 mg and mifepristone (generic Mifeprex) 200 mg	Annual review. No updates.	8/1/2026
<b>Camzyos</b>	Medical Necessity	Camzyos® (mavacamten)	Clarified LVOT criteria prior to starting therapy without changing clinical criteria.	8/1/2026
<b>Cholbam</b>	Notification	Cholbam™ (cholic acid)	Annual review with no change to coverage criteria. Updated reference.	8/1/2026
<b>Copiktra</b>	Notification	Copiktra® (duvelisib)	Annual review with no change to clinical criteria. Updated background and references.	8/1/2026
<b>Cosentyx</b>	Medical Necessity	Cosentyx® (secukinumab) prefilled syringe or Sensoready pen	Update to background and reference only.	8/1/2026
<b>Cosentyx</b>	Notification	Cosentyx® (secukinumab) prefilled syringe or Sensoready pen	Update to background and reference only.	8/1/2026
<b>Daraprim</b>	Medical Necessity	Daraprim® (pyrimethamine)	Annual review without change to coverage criteria. Updated references.	8/1/2026
<b>Daybue</b>	Medical Necessity	Daybue™ (trofinetide)	Annual review. No changes to clinical criteria.	8/1/2026
<b>Daybue</b>	Notification	Daybue™ (trofinetide)	Annual review. No changes to coverage criteria.	8/1/2026
<b>Dojolvi</b>	Medical Necessity	Dojolvi® (triheptanoin)	Annual review with no change to clinical criteria.	8/1/2026
<b>Dojolvi</b>	Notification	Dojolvi® (triheptanoin)	Annual review with no change to clinical coverage criteria.	8/1/2026
<b>Entyvio</b>	Notification	Entyvio® (vedolizumab) *This program applies to the subcutaneous formulation of vedolizumab	Annual review. Updated combination examples and language with no change to clinical intent. Updated reference.	8/1/2026
<b>Eohilia</b>	Medical Necessity	Eohilia™ (budesonide oral suspension)	Annual review. Updated to trial and failure language. Updated references.	8/1/2026

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
<b>Fabhalta</b>	Medical Necessity	Fabhalta® (iptacopan)	Annual review with no changes to clinical coverage criteria. Added budesonide to the list of examples of glucocorticoids. Updated references.	8/1/2026
<b>Fabhalta</b>	Notification	Fabhalta® (iptacopan)	Annual review. No changes to coverage criteria.	8/1/2026
<b>Fentanyl - Actiq, Fentora, and fentanyl citrate</b>	Step Therapy	Actiq® (fentanyl transmucosal lozenge), Fentora® (fentanyl buccal tablet), and fentanyl citrate	Archive program. Transmucosal fentanyl products are all off the market.	8/1/2026
<b>Fotivda</b>	Notification	Fotivda® (tivozanib)	Annual review with no change to clinical criteria. Updated reference.	8/1/2026
<b>Joenja</b>	Medical Necessity	Joenja® (leniolisib)	Annual review with no changes to coverage criteria. Updated references.	8/1/2026
<b>Joenja</b>	Notification	Joenja® (leniolisib)	Annual review with no changes to coverage criteria. Updated reference.	8/1/2026
<b>Lifyorli</b>	Notification	Lifyorli™ (relacorilant)	New program.	8/1/2026
<b>Lucemyra</b>	Medical Necessity	Lucemyra® (lofexidine)	Archive program.	8/1/2026
<b>Lynavoy</b>	Notification	Lynavoy (linerixibat)	New program	8/1/2026
<b>Lynavoy</b>	Medical Necessity	Lynavoy (linerixibat)	New program	8/1/2026
<b>Lyrica CR</b>	Step Therapy	Lyrica® CR tablets (pregabalin ER)	Archive program.	8/1/2026
<b>Mekinist</b>	Notification	Mekinist® (trametinib)	Annual review with no changes to clinical criteria. Updated background.	8/1/2026
<b>Methyldopa</b>	Medical Necessity	Methyldopa	Annual review with no changes.	8/1/2026
<b>Methyldopa</b>	Step Therapy	Methyldopa	Annual review with no changes.	8/1/2026
<b>Multiple Sclerosis</b>	Notification	Multiple Sclerosis - Aubagio® (teriflunomide), Avonex® (interferon β-1a), Bafiertam™ (monomethyl fumarate), Betaseron® (interferon β-1b), Copaxone® (glatiramer acetate), dimethyl fumarate, Extavia® (interferon β-1b), fingolimod, Gilenya® (fingolimod), Glatopa™ (glatiramer acetate), glatiramer acetate, Kesimpta (ofatumumab), Mayzent (siponimod)®, Plegridy™ (peginterferon β-1a), Ponvory™ (Ponesimod), Rebif® (interferon β-1a), Tascenso ODT™ (fingolimod), Tecfidera™ (dimethyl fumarate), teriflunomide, Vumerity™ (diroximel fumarate)	Removed Extavia.	8/1/2026
<b>Myalept</b>	Notification	Myalept® (metreleptin)	Annual review with no changes to coverage criteria. Updated background.	8/1/2026
<b>Myalept</b>	Medical Necessity	Myalept® (metreleptin)	Annual review with no changes to coverage criteria. Updated background and references.	8/1/2026
<b>Myqorzo</b>	Medical Necessity	Myqorzo™ (aficamten)	Clarified LVOT criteria prior to starting therapy without changing clinical criteria.	8/1/2026

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
<b>Non-Solid Oral and Suppository Dosage Forms</b>	Medical Necessity	Alkindi® Sprinkle (hydrocortisone), Arbli™ (losartan), Aspruzyo Sprinkle™ (ranolazine), Atmeksi® (methocarbamol), Atorvaliq® (atorvastatin), Brynovin™ (sitagliptin), Carospir® (spironolactone), chlorpromazine oral solution, Desmoda™ (desmopressin), Epaned® (enalapril), Eprontia® (topiramate), Ermeza™ (levothyroxine), Ezallor Sprinkle™ (rosuvastatin), Fleqsuvy® (baclofen), Flolipid (simvastatin), Imkeldi (imatinib), Indocin® (indomethacin) suspension, Indocin® (indomethacin) suppository, Inzirqo™ (hydrochlorothiazide), Javadin™ (clonidine), Jylamvo® (methotrexate), Katerzia® (amlodipine), Khindivi™ (hydrocortisone), Lopressor® (metoprolol) oral solution, Meloxicam (meloxicam) suspension, Naprosyn® (naproxen) suspension, Nexium® for suspension (esomeprazole), Norliqva® (amlodipine), Ontralfy™ (tizanidine), Ozobax® DS (baclofen), Pradaxa® (dabigatran) oral pellets, Prevacid® SoluTab™ (lansoprazole), Prograf® Granules (tacrolimus), Qbrelis® (lisinopril), Raldesy™ (trazodone), Renvela® (sevelamer carbonate) powder for suspension, Sdamlo™ (amlodipine), Sotylize® (sotalol), Subvenite® (lamotrigine), Sympazan® (clobazam), Syndros® (dronabinol), Tezruly™ (terazosin), Tiglutik® (riluzole), Tirosint®-Sol (levothyroxine), Valsartan oral solution, Vyscoxa™ (celecoxib), Xatmep® (methotrexate), Xelstrym™ (dextroamphetamine), Xromi® (hydroxyurea), Zegerid® for suspension (omeprazole and sodium bicarbonate), Zonisade® (zonisamide)	Atmeksi, Desmoda, Javadin, Ontralfy and Sdamlo added to criteria. Criteria for Katerzia updated to include step through Norliqva.	8/1/2026
<b>Phexxi/Phexx</b>	Medical Necessity	Phexxi®/Phexx® (lactic acid, citric acid, and potassium bitartrate) vaginal gel	Annual review. Added the product Phexx to the criteria	8/1/2026
<b>Pomalyst</b>	Notification	Pomalyst® (pomalidomide)	Annual review. Updated coverage criteria for Kaposi Sarcoma and systemic light chain amyloidosis based on NCCN recommendations.	8/1/2026
<b>Praluent</b>	Step Therapy	Praluent® (alirocumab)	Annual review. Updated background and references. Clarified “hyperlipidemia” criteria title to include heterozygous familial hypercholesterolemia and ASCVD.	8/1/2026
<b>Praluent</b>	Notification	Praluent® (alirocumab)	Annual review. Updated background to align with the new label. Clarified “hyperlipidemia” criteria title to include heterozygous familial hypercholesterolemia and ASCVD. Added criteria that Praluent is not to be used in combination with Leqvio in HoFH.	8/1/2026
<b>Proton Pump Inhibitors</b>	Step Therapy	Nexium® for suspension (esomeprazole), Prevacid® SoluTab™ (lansoprazole), Zegerid® for suspension (omeprazole and sodium bicarbonate)	Annual review. References updated.	8/1/2026
<b>Pyrukynd</b>	Notification	Pyrukynd® (mitapivat)	Annual review. No changes to coverage criteria.	8/1/2026
<b>Pyrukynd (2277)</b>	Medical Necessity	Pyrukynd® (mitapivat)	Annual review. No changes to coverage criteria.	8/1/2026
<b>Qfitlia</b>	Notification	Qfitlia® (fitusiran)	Annual review with no changes to clinical criteria. Updated reference.	8/1/2026
<b>Rivfloza</b>	Medical Necessity	Rivfloza™ (nedosiran)	Annual review. No changes to coverage criteria.	8/1/2026
<b>Rivfloza</b>	Notification	Rivfloza™ (nedosiran)	Annual review. No changes to coverage criteria.	8/1/2026
<b>Rozlytrek</b>	Notification	Rozlytrek™ (entrectinib)	Removed “metastatic” from non-small cell lung cancer for the diagnostic criterion.	8/1/2026

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
Skyclarys	Medical Necessity	Skyclarys® (omaveloxolone)	Annual review with no changes to coverage criteria.	8/1/2026
Skyclarys	Notification	Skyclarys® (omaveloxolone)	Annual review with no changes to coverage criteria.	8/1/2026
Spevigo	Notification	Spevigo® (spesolimab-sbzo) injection *This program applies to the subcutaneous formulations of Spevigo	Annual review with no changes to clinical criteria. Updated Application to add Individual Exchange benefit plans. Updated reference.	8/1/2026
Takinlar	Notification	Tafinlar® (dabrafenib)	Annual review with no changes to coverage criteria.	8/1/2026
Thalomid	Notification	Thalomid® (thalidomide)	Annual review. Updated criteria for Castleman Disease to align with NCCN.	8/1/2026
Travatan Z, Zioptan	Step Therapy	Travatan Z® (travoprost), Zioptan® (tafluprost)	Review. Removed Vyzulta.	8/1/2026
Trikafta	Medical Necessity	Trikafta® (elexacaftor/tezacaftor/ivacaftor)	Updated background and reference without changing coverage criteria.	8/1/2026
Trikafta	Notification	Trikafta® (elexacaftor/tezacaftor/ivacaftor)	Updated background and references without changing coverage criteria.	8/1/2026
Vemlidy	Medical Necessity	Vemlidy® (tenofovir alafenamide)	Annual review with no changes to coverage criteria.	8/1/2026
Verkazia	Medical Necessity	Verkazia® (cyclosporine 0.1% ophthalmic emulsion)	Annual review. Updated references.	8/1/2026
Verquvo	Medical Necessity	Verquvo® (vericiguat)	Added Inpefa to SGLT2 options.	8/1/2026
Verzenio	Notification	Verzenio® (abemaciclib)	Annual review. Added new coverage criteria for soft tissue sarcoma and updated coverage criteria for breast cancer based on NCCN recommendations.	8/1/2026
Vitrakvi	Notification	Vitrakvi® (larotrectinib)	Removed “metastatic” from non-small cell lung cancer for the diagnostic criterion.	8/1/2026
Voydeya	Medical Necessity	Voydeya™ (danicopan)	Annual review. No changes to coverage criteria.	8/1/2026
Voydeya	Notification	Voydeya™ (danicopan)	Annual review. No changes to coverage criteria.	8/1/2026
Voyxact	Medical Necessity	Voyxact® (sibeprenlimab-szsl)	Removed SGLT2 Step. Updated language in the steroid trial.	8/1/2026
Vtama	Medical Necessity	Vtama® (tapinarof)	Annual review. Updated combination examples and language with no change to clinical intent.	8/1/2026
Vtama	Notification	Vtama® (tapinarof)	Annual review with no change to clinical criteria.	8/1/2026
Vumerity	Medical Necessity	Vumerity® (diroximel fumarate)	Annual review with no change to clinical criteria.	8/1/2026
Vumerity	Step Therapy	Vumerity® (diroximel fumarate)	Annual review. No changes to coverage criteria. Updated references.	8/1/2026
Zydelig	Notification	Zydelig® (idelalisib)	Annual review with no changes to clinical criteria.	8/1/2026
Imcivree	Medical Necessity	Imcivree® (setmelanotide)	New program. Imcivree moved out of program number 1114 to separate criteria.	9/1/2026
Plans with Weight Loss/Appetite Suppression Medication Coverage	Notification	Includes both brand and generic versions and all formulations of the listed products unless otherwise noted: Weight Loss/Appetite Suppression – phentermine (all brand products including Adipex-P® and Lomaira™), benzphetamine, Contrave® (naltrexone HCl and bupropion HCl, diethylpropion, Foundayo™ (orforglipron), phendimetrazine, orlistat (Xenical®), Qsymia® (phentermine and topiramate extended-release), Saxenda® (liraglutide), Wegovy® (semaglutide) injection, Wegovy® (semaglutide) tablet, Wegovy HD (semaglutide) and Zepbound™ (tirzepatide)	Added Foundayo and Wegovy HD to criteria. Moved Imcivree and Vykate XR to separate criteria.	9/1/2026
Tocilizumab - Actemra, Avtozma, Tyenne	Medical Necessity	Tocilizumab: Actemra® (tocilizumab), Avtozma® (tocilizumab-anoh), and Tyenne® (tocilizumab-aazg)	Tyenne noted as typically excluded from coverage starting 9/1/2026.	9/1/2026
Tocilizumab - Actemra, Avtozma, Tyenne	Notification	Tocilizumab: Actemra® (tocilizumab), Avtozma® (tocilizumab-anoh), and Tyenne® (tocilizumab-aazg)	Tyenne noted as typically excluded from coverage starting 9/1/2026.	9/1/2026
Tocilizumab - Actemra, Actemra ACTPen, Avtozma, Tyenne	Step Therapy	Tocilizumab: Actemra® (tocilizumab), Actemra (tocilizumab) ACTPen, Avtozma® (tocilizumab-anoh), and Tyenne® (tocilizumab-aazg)	Tyenne noted as typically excluded from coverage starting 9/1/2026.	9/1/2026
Vykate XR	Medical Necessity	Vykate XR™ (diazoxide choline)	New program. Vykate XR moved out of program number 1114 to separate criteria.	9/1/2026