



## Commercial Business

BULLETIN (4/1/2026)

### 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
Aimovig, Ajovy, Emgality	Notification	Aimovig® (erenumab), Ajovy® (fremanezumab), Emgality® (galcanezumab)	Updated criteria to only diagnosis for cluster headaches and updated statement for Emgality 100 mg of on concomitant use of CGRPs. Updated references.	4/1/2026
Aimovig, Ajovy, Emgality	Medical Necessity	Aimovig® (erenumab), Ajovy® (fremanezumab), Emgality® (galcanezumab)	Updated background section with pediatric information for Ajovy. Removed Nurtec and Qulipta as options for Ajovy. Added bypass for pediatric patients. Updated statement for Emgality 100 mg of on concomitant use of CGRPs. Updated references	4/1/2026
Aimovig, Ajovy, Emgality	Step Therapy	Aimovig® (erenumab), Ajovy® (fremanezumab), Emgality® (galcanezumab)	Updated background section with pediatric information for Ajovy. Removed Nurtec and Qulipta as options for Ajovy. Added bypass for pediatric patients. Updated references	4/1/2026
Aqneursa	Medical Necessity	Aqneursa™ (levacetylleucine)	Annual review without changes to coverage criteria.	4/1/2026
Aqneursa	Notification	Aqneursa™ (levacetylleucine)	Annual review without changes to coverage criteria.	4/1/2026
Attruby	Medical Necessity	Attruby™ (acoramidis)	Annual review. No changes to coverage criteria. Updated references.	4/1/2026
Attruby	Notification	Attruby™ (acoramidis)	Annual review. No changes to coverage criteria.	4/1/2026
Bimzexl	Notification	Bimzexl® (bimekizumab-bkzx)	Annual review. Updated combination examples and language with no change to clinical intent.	4/1/2026
Caplyta	Medical Necessity	Caplyta® (lumateperone)	Added lurasidone to step one options for schizophrenia. Added requirements for new indication of major depressive disorder.	4/1/2026
Chenodal	Step Therapy	Chenodal™ (chenodiol)	Archive program.	4/1/2026
Cosentyx	Notification	Cosentyx® (secukinumab) prefilled syringe or Sensoready pen	Annual review. Updated not used in combination verbiage and examples with no change to clinical intent. Updated reference.	4/1/2026
Crinone	Step Therapy	Crinone® (progesterone gel)	Annual review. Updated references.	4/1/2026
Daurismo	Notification	Daurismo™ (glasdegib)	Removed relapsed/refractory disease as a component of repeating the initial successful induction regimen per uses no longer recommended by NCCN. Updated references.	4/1/2026
Dawnzera	Medical Necessity	Dawnzera™ (donidalorsen)	New program.	4/1/2026
Dawnzera	Notification	Dawnzera™ (donidalorsen)	New program.	4/1/2026
Forzinity	Medical Necessity	Forzinity™ (elamipretide)	New program.	4/1/2026
Forzinity	Notification	Forzinity™ (elamipretide)	New program.	4/1/2026
Interstitial Lung Disease Agents - Esbriet, Jascayd and Ofev	Medical Necessity	Interstitial Lung Disease Agents - Esbriet® (pirfenidone), Jascayd™ (nerandomilast) and Ofev® (nintedanib)	Addition of Jascayd to program and addition of coverage criteria for progressive pulmonary fibrosis. Updated coverage criteria for idiopathic pulmonary fibrosis to include Jascayd. Updated Ofev coverage criteria by removing chronic fibrosing interstitial lung disease with progressive phenotype and including Ofev into the section for progressive pulmonary fibrosis. Updated references.	4/1/2026

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<b>Interstitial Lung Disease Agents - Esbriet, Jascayd and Ofev</b>	Notification	Interstitial Lung Disease Agents - Esbriet® (pirfenidone), Jascayd™ (nerandomilast) and Ofev® (nintedanib)	Addition of Jascayd to program and addition of coverage criteria for progressive pulmonary fibrosis. Updated coverage criteria for idiopathic pulmonary fibrosis to include Jascayd. Updated Ofev coverage criteria by removing chronic fibrosing interstitial lung disease with progressive phenotype and including Ofev into the section for progressive pulmonary fibrosis. Updated references.	4/1/2026
<b>Komzifti</b>	Notification	Komzifti™ (ziftomenib)	New program.	4/1/2026
<b>Kygevvi</b>	Notification	Kygevvi® (doxecitine and doxribtimine)	New program.	4/1/2026
<b>Lotronex</b>	Notification	Lotronex® (alosetron)	Annual review. No changes.	4/1/2026
<b>Miplyfaa</b>	Medical Necessity	Miplyffa® (arimoclomol)	Annual review without changes to coverage criteria. Updated references.	4/1/2026
<b>Miplyfaa</b>	Notification	Miplyffa® (arimoclomol)	Annual review without changes to coverage criteria.	4/1/2026
<b>Mycapssa</b>	Medical Necessity	Mycapssa® (octreotide)	Annual review. For initial authorization, removed requirements for previous surgery, radiation, or bromocriptine, added Lanreotide Injection as an example of lanreotide, added note that injectable somatostatin analogs may be subject to additional benefit and coverage review requirements, and added prescriber requirement. For reauthorization, added example of positive clinical response. Added exclusion footnote. Updated background and references.	4/1/2026
<b>Mycapssa</b>	Notification	Mycapssa® (octreotide)	Annual review. Added Lanreotide Injection as an example of lanreotide and note that injectable somatostatin analogs may be subject to additional benefit and coverage review requirements. Added exclusion footnote.	4/1/2026
<b>Odomzo</b>	Notification	Odomzo® (sonidegib)	Annual review. No changes to coverage rationale. Updated references.	4/1/2026
<b>Ogsiveo</b>	Notification	Ogsiveo™ (nirogacestat)	Annual review with no changes to coverage criteria. Updated references.	4/1/2026
<b>Orencia</b>	Notification	Orencia® (abatacept) *This program applies to the subcutaneous formulation of abatacept	Annual review. Updated not used in combination verbiage and examples with no change to clinical intent. Updated reference.	4/1/2026
<b>Orladeyo</b>	Medical Necessity	Orladeyo® (berotralstat)	Updated coverage criteria based on updated FDA indication by separating tried/failed therapies based on age limitations for Haegarda and Andembry. Updated background and references.	4/1/2026
<b>Revuforj</b>	Notification	Revuforj® (revumenib)	Annual review. Added criteria for new indication per FDA label. Updated references.	4/1/2026
<b>Rozlytrek</b>	Notification	Rozlytrek™ (entrectinib)	Annual review. Expanded section on solid tumors to specify each type with their own criteria based on FDA label and NCCN guidance.	4/1/2026
<b>Selzentry</b>	Notification	Selzentry® (maraviroc)	Annual review with no changes to coverage criteria.	4/1/2026
<b>Sucraid</b>	Medical Necessity	Sucraid (sacrosidase) oral solution	Annual review with no changes to coverage criteria.	4/1/2026
<b>Sucraid</b>	Notification	Sucraid (sacrosidase) oral solution	Annual review with no changes to coverage criteria.	4/1/2026
<b>Tavalisse</b>	Notification	Tavalisse® (fostamatinib disodium hexahydrate)	Annual review with no changes to clinical coverage criteria.	4/1/2026
<b>Tavneos</b>	Notification	Tavneos® (avacopan)	Annual review with no changes to coverage criteria.	4/1/2026
<b>Tavneos</b>	Medical Necessity	Tavneos® (avacopan)	Annual review. Added "or in consultation with" for prescriber requirement in the initial criteria.	4/1/2026
<b>Tibsovo</b>	Notification	Tibsovo® (ivosidenib)	Annual review. Removed age cutoff ≥ 60 years of age for AML per NCCN guidelines. Updated references.	4/1/2026
<b>Truqap</b>	Notification	Truqap™ (capivasertib)	Annual review. No changes to coverage criteria. Updated references.	4/1/2026
<b>Vitrakvi</b>	Notification	Vitrakvi® (larotrectinib)	Annual review. Expanded section on solid tumors to specify each type with their own criteria based on FDA label and NCCN guidance.	4/1/2026
<b>Voyxact</b>	Medical Necessity	Voyxact® (sibeprenlimab-szsl)	New program.	4/1/2026

Guideline/Policy Name	UM Type	Trade Name (Generic Name)	Summary of Changes	Implementation Date
<b>Vyndaqel, Vyndamax</b>	Medical Necessity	Vyndaqel® (tafamidis meglumine) and Vyndamax™ (tafamidis)	Annual review. No changes to coverage criteria.	4/1/2026
<b>Vyndaqel, Vyndamax</b>	Notification	Vyndaqel® (tafamidis meglumine) and Vyndamax™ (tafamidis)	Annual review. No changes to coverage criteria.	4/1/2026
<b>Xphozah</b>	Medical Necessity	Xphozah® (tenapanor)	Annual review. Updated serum phosphorus requirement. Updated references.	4/1/2026
<b>Xphozah</b>	Notification	Xphozah® (tenapanor)	Annual review with no changes to criteria. Updated reference.	4/1/2026
<b>Xpovio</b>	Notification	Xpovio® (selinexor)	Annual review. Updated references.	4/1/2026
<b>Zilbrysq</b>	Notification	Zilbrysq® (zilucoplan)	Annual review. Modified concomitant use statement and added Imaavy to the list of examples of FcRn blockers. Updated reference.	4/1/2026
<b>Non-Solid Oral and Suppository Dosage Forms</b>	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), Subvenite® (lamotrigine), Sympazan® (clobazam)®, Syndros® (dronabinol), Tezruly™ (terazosin), Tiglutik® (riluzole), Tirosint®-Sol (levothyroxine), Valsartan oral solution, Vyscoxa™ (celecoxib), Xatmep® (methotrexate), Xelstry™ (dextroamphetamine), Xromi® (hydroxyurea), Zegerid® for suspension (omeprazole and sodium bicarbonate), Zonisade® (zonisamide)	Subvenite and Vyscoxa added to criteria.	5/1/2026
<b>Addyi</b>	Medical Necessity	Addyi™ (flibanserin)	Updated based on new FDA approval for women ages 65 and less.	5/1/2026
<b>Akeega</b>	Notification	Akeega® (niraparib and abiraterone acetate)	Added criteria for metastatic castration-sensitive prostate cancer (mCSPC). Updated background and references.	5/1/2026
<b>Alvaiz, eltrombopag, Promacta</b>	Notification	Alvaiz® (eltrombopag), eltrombopag, and Promacta® (eltrombopag)	Updated background and clinical coverage criteria adding eltrombopag (generic Promacta).	5/1/2026
<b>Alyftrek</b>	Medical Necessity	Alyftrek™ (vanzacaftor/tezacaftor/deutivacaftor)	Annual review. No changes to coverage criteria. Updated references.	5/1/2026
<b>Alyftrek</b>	Notification	Alyftrek™ (vanzacaftor/tezacaftor/deutivacaftor)	Annual review. No changes to coverage criteria. Updated reference.	5/1/2026
<b>Anzupgo</b>	Medical Necessity	Anzupgo® (delgocitinib)	New program.	5/1/2026
<b>Anzupgo</b>	Notification	Anzupgo® (delgocitinib)	New program.	5/1/2026
<b>Arikayce</b>	Medical Necessity	Arikayce® (amikacin liposome inhalation suspension)	Annual review with no change to coverage criteria. Updated references.	5/1/2026
<b>Bosulif</b>	Notification	Bosulif® (bosutinib)	Annual review with no changes to coverage criteria. Updated references.	5/1/2026
<b>Bosulif</b>	Step Therapy	Bosulif® (bosutinib)	Annual review with no change to step criteria. Updated background and references.	5/1/2026
<b>Brexafemme</b>	Medical Necessity	Brexafemme® (ibrexafungerp)	Annual review. Removed the 7-day trial requirement of fluconazole for treatment of vulvovaginal candidiasis based on CDC guidelines. Updated references.	5/1/2026

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<b>Brukinsa</b>	Notification	Brukinsa® (zanubrutinib)	Annual review. Added coverage for progressive FL and primary CNS lymphoma. Updated background and references.	5/1/2026
<b>Brukinsa</b>	Step Therapy	Brukinsa® (zanubrutinib)	Annual review with no changes to step criteria. Updated name of patient support program. Updated background and references.	5/1/2026
<b>Buphenyl, Olpruva, Pheburane, Sodium phenylbutyrate</b>	Notification	Buphenyl® (sodium phenylbutyrate), Olpruva® (sodium phenylbutyrate), Pheburane® (sodium phenylbutyrate), sodium phenylbutyrate	Annual review. No changes to clinical coverage criteria.	5/1/2026
<b>Camzyos</b>	Medical Necessity	Camzyos® (mavacamten)	Updated criteria for a left ventricular ejection fraction and LVOT to clarify these measurements are prior to Camzyos therapy without change to clinical intent. Added not used in combination criteria.	5/1/2026
<b>Camzyos</b>	Notification	Camzyos® (mavacamten)	Added not used in combination criteria.	5/1/2026
<b>Cayston</b>	Notification	Cayston® (aztreonam for inhalation solution)	Annual review. No changes to coverage criteria.	5/1/2026
<b>Cayston</b>	Step Therapy	Cayston® (aztreonam for inhalation solution)	Annual review. No changes to coverage criteria. Updated reference.	5/1/2026
<b>Crenessity</b>	Medical Necessity	Crenessity™(crinecerfont) oral capsule and oral suspension	Annual review with no changes.	5/1/2026
<b>Crenessity</b>	Notification	Crenessity™(crinecerfont) oral capsule and oral suspension	Annual review with no changes.	5/1/2026
<b>Cuvrior</b>	Notification	Cuvrior™ (trientine tetrahydrochloride)	Annual review with no changes to coverage criteria. Updated references.	5/1/2026
<b>dichlorphenamide, Keveyis, Ormalvi</b>	Notification	dichlorphenamide, Keveyis® (dichlorphenamide), Ormalvi™ (dichlorphenamide)	Annual review. Updated references.	5/1/2026
<b>Enbumyst, Furoscix, Lasix ONYU</b>	Medical Necessity	Enbumyst™ (bumetanide nasal spray), Furoscix® (furosemide injection), Lasix® ONYU (furosemide injection)	Added Enbumyst and Lasix ONYU to criteria. Updated Furoscix to note typically excluded.	5/1/2026
<b>Endari</b>	Medical Necessity	Endari® (L-glutamine Powder for Solution)	Annual review. Updated references.	5/1/2026
<b>Ensacove</b>	Notification	Ensacove (ensartinib)	Annual review with no change to coverage criteria. Updated references.	5/1/2026
<b>Firazyr, icatibant, Sajazir</b>	Medical Necessity	Firazyr® (icatibant), icatibant, Sajazir™ (icatibant)	Annual review. Updated examples of acute treatments for HAE attacks. No changes to coverage criteria. Updated references.	5/1/2026
<b>Firazyr, icatibant, Sajazir</b>	Notification	Firazyr® (icatibant), icatibant, Sajazir™ (icatibant)	Annual review. Updated examples of acute treatments for HAE attacks. No changes to coverage criteria. Updated references.	5/1/2026
<b>Fruzaqla</b>	Step Therapy	Fruzaqla™ (fruquintinib)	Annual review. Added criteria for appendiceal neoplasms and cancers. Updated background and references.	5/1/2026
<b>Fruzaqla</b>	Notification	Fruzaqla™ (fruquintinib)	Annual review. Added criteria for appendiceal neoplasms and cancers. Updated background and references.	5/1/2026
<b>Harliku</b>	Medical Necessity	Harliku™ (nitisinone)	Archive program	5/1/2026
<b>Harliku</b>	Notification	Harliku™ (nitisinone)	Archive program	5/1/2026
<b>Hyrnuo</b>	Notification	Hyrnuo® (sevabertinib)	New program.	5/1/2026
<b>Ibrance</b>	Notification	Ibrance® (palbociclib)	Annual review. Updated coverage criteria to include new section for uterine neoplasms. Updated references.	5/1/2026
<b>Inbrija</b>	Medical Necessity	Inbrija® (levodopa inhalation powder)	Annual review with no change in clinical criteria. Updated references.	5/1/2026
<b>Inbrija</b>	Notification	Inbrija® (levodopa inhalation powder)	Annual review. Updated reference.	5/1/2026
<b>Inqovi</b>	Notification	Inqovi® (decitabine and cedazuridine) tablet	Annual review with no changes to coverage criteria. Updated references.	5/1/2026
<b>Invokana Non-Formulary</b>	Non-Formulary	Invokana® (canagliflozin)	Annual review. Updated background section and references.	5/1/2026
<b>Iwilfin</b>	Notification	Iwilfin™ (eflornithine)	Annual review. No changes to coverage criteria. Updated reference.	5/1/2026
<b>Jaypirca</b>	Notification	Jaypirca® (pirtobrutinib)	Annual review. Revised coverage for updated labeled indication for CLL/SLL to include patients earlier in their treatment course. Updated background and references.	5/1/2026
<b>Juxtapid</b>	Medical Necessity	Juxtapid® (lomitapide)	Annual review. Updated references.	5/1/2026

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Juxtapid	Notification	Juxtapid® (lomitapide)	Annual review with no changes to coverage criteria. Updated reference.	5/1/2026
Lenvima	Notification	Lenvima® (lenvatinib)	Annual review. Updated criteria based on current NCCN recommendations. Updated references.	5/1/2026
Livtency	Notification	Livtency (maribavir)	Annual review. Updated background and reference.	5/1/2026
Lorbrena	Notification	Lorbrena® (lorlatinib)	Annual review. Added criteria for pediatric diffuse high-grade glioma. Updated background and references.	5/1/2026
Myqorzo	Medical Necessity	Myqorzo™ (aficamten)	New program.	5/1/2026
Myqorzo	Notification	Myqorzo™ (aficamten)	New program.	5/1/2026
Mytesi	Notification	Mytesi™ (crofelemer)	Annual review with no changes.	5/1/2026
Nitisinone Products - Harliku tablets, nitisinone (generic Orfadin) capsules, Nityr tablets, Orfadin capsules and oral suspension	Notification	Nitisinone Products: Harliku™ (nitisinone) tablets, nitisinone (generic Orfadin) capsules, Nityr® (nitisinone) tablets, Orfadin® (nitisinone) capsules and oral suspension	New program.	5/1/2026
Nitisinone Products - Harliku tablets, nitisinone (generic Orfadin) capsules, Nityr tablets, Orfadin capsules and oral suspension	Medical Necessity	Nitisinone Products: Harliku™ (nitisinone) tablets, nitisinone (generic Orfadin) capsules, Nityr® (nitisinone) tablets, Orfadin® (nitisinone) capsules and oral suspension	New program.	5/1/2026
Nityr	Notification	Nityr® (nitisinone)	Archive program	5/1/2026
Nocdurna	Medical Necessity	Nocdurna® (desmopressin acetate)	Archive program	5/1/2026
Orfadin	Notification	Orfadin® (nitisinone)	Archive program	5/1/2026
Orgovyx	Notification	Orgovyx™ (relugolix)	Annual review with no changes to coverage criteria. Updated references.	5/1/2026
Oriahnn, MyFembree	Medical Necessity	Oriahnn® (elagolix and estradiol/norethindrone), MyFembree® (relugolix and estradiol hemihydrate/norethindrone)	Annual review. Updated references.	5/1/2026
Orilissa	Medical Necessity	Orilissa® (elagolix)	Annual review. Updated references.	5/1/2026
Oxervate	Medical Necessity	Oxervate® (cenegermin-bkbj) ophthalmic solution	Annual review with no change to clinical criteria.	5/1/2026
Oxervate	Notification	Oxervate® (cenegermin-bkbj) ophthalmic solution	Annual review with no change to clinical criteria.	5/1/2026
PAH Agents	Medical Necessity	Adcirca® (tadalafil), Adempas® (riociguat), Alyq™ (tadalafil), Letairis® (ambrisentan), Liqrev® (sildenafil) oral suspension, Opsumit® (macitentan), Opsyvni® (macitentan/tadalafil), Orenitram™ (treprostinil), Revatio® (sildenafil citrate) oral powder for suspension, Tadliq® (tadalafil) oral suspension, Tracleer® (bosentan), Tyvaso® (treprostinil), Tyvaso DPI™ (treprostinil), Upravi® (selexipag), Ventavis® (iloprost), Yutrepia™ (treprostinil)	Added Yutrepia to coverage criteria as a new product. Added Yutrepia to the list of products that are typically excluded from coverage. Updated background and references.	5/1/2026
PAH Agents	Notification	Adcirca® (tadalafil), Adempas® (riociguat), Alyq™ (tadalafil), Letairis® (ambrisentan), Liqrev® (sildenafil) oral suspension, Opsumit® (macitentan), Opsyvni® (macitentan/tadalafil), Orenitram™ (treprostinil), Revatio® (sildenafil citrate) oral powder for suspension, Tadliq® (tadalafil) oral suspension, Tracleer® (bosentan), Tyvaso® (treprostinil), Tyvaso DPI™ (treprostinil), Upravi® (selexipag), Ventavis® (iloprost), Yutrepia™ (treprostinil)	Added Yutrepia to coverage criteria as a new product. Added Yutrepia to the list of products that are typically excluded from coverage. Updated background and references.	5/1/2026

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<b>Plans with Weight Loss/Appetite Suppression Medication Coverage</b>	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, Imcivree® (setmelanotide), phendimetrazine, orlistat (Xenical®), Qsymia® (phentermine and topiramate extended-release), Saxenda® (liraglutide), Vykot XR™ (diazoxide choline), Wegovy® (semaglutide) injection, Wegovy® (semaglutide) tablet and Zepbound™ (tirzepatide)	Updated to add Wegovy tablet and differentiate by indication.	5/1/2026
<b>Praluent</b>	Medical Necessity	Praluent® (alirocumab)	Removed ezetimibe trial requirement for primary hyperlipidemia and ASCVD. Updated background and references.	5/1/2026
<b>Pulmozyme</b>	Notification	Pulmozyme® (dornase alfa)	Annual review with no changes to coverage criteria. Updated references.	5/1/2026
<b>Ravicti</b>	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
<b>Ravicti</b>	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
<b>Recorlev</b>	Notification	Recorlev® (levoketoconazole)	Annual review with no changes.	5/1/2026
<b>Redemplo</b>	Medical Necessity	Redemplo® (plozasiran)	New program.	5/1/2026
<b>Redemplo</b>	Notification	Redemplo® (plozasiran)	New program.	5/1/2026
<b>Rezlidhia</b>	Notification	Rezlidhia™ (olutasidenib)	Annual review. Added criteria for lower-intensity treatment induction in patients to treat AML with a susceptible IDH1 mutation who are not a candidate for intensive induction therapy or declines per NCCN. Updated background and references.	5/1/2026
<b>Rhapsido</b>	Medical Necessity	Rhapsido® (remibrutinib)	New program.	5/1/2026
<b>Rhapsido</b>	Notification	Rhapsido® (remibrutinib)	New program.	5/1/2026
<b>Rubraca</b>	Notification	Rubraca® (rucaparib)	Updated background based on updated FDA label. Updated references.	5/1/2026
<b>Tarpeyo</b>	Medical Necessity	Tarpeyo® (budesonide delayed-release capsules)	Annual review. Updated references.	5/1/2026
<b>Tetrabenazine</b>	Notification	Tetrabenazine (Xenazine®)	Annual review. Updated placement of footnote for exclusion statement for Xenazine brand tablets without change to intent. Updated references.	5/1/2026
<b>Tocilizumab - Actemra, Avtozma, Tyenne</b>	Medical Necessity	Tocilizumab: Actemra® (tocilizumab), Avtozma® (tocilizumab-anoh), and Tyenne® (tocilizumab-aazg)	Renamed program to Tocilizumab. Added Avtozma (tocilizumab-anoh) to the program. Updated Actemra and Tyenne to Tocilizumab throughout the program. Updated combination examples and language with no change to clinical intent. Updated background and reference.	5/1/2026
<b>Tocilizumab - Actemra, Avtozma, Tyenne</b>	Notification	Tocilizumab: Actemra® (tocilizumab), Avtozma® (tocilizumab-anoh), and Tyenne® (tocilizumab-aazg)	Renamed program to Tocilizumab. Added Avtozma (tocilizumab-anoh) to the program. Updated Actemra and Tyenne to Tocilizumab throughout the program. Updated background and reference.	5/1/2026
<b>Tocilizumab - Actermra, Actemra ACTPen, Avtozma, Tyenne</b>	Step Therapy	Tocilizumab: Actemra® (tocilizumab), Actemra (tocilizumab) ACTPen, Avtozma® (tocilizumab-anoh), and Tyenne® (tocilizumab-aazg)	Renamed program to Tocilizumab. Added Avtozma (tocilizumab-anoh) to the program. Updated Actemra and Tyenne to Tocilizumab throughout the program. Updated background and reference.	5/1/2026
<b>Trikafta</b>	Medical Necessity	Trikafta® (elexacaftor/tezacaftor/ivacaftor)	Annual review. No changes to coverage criteria. Updated reference.	5/1/2026
<b>Trikafta</b>	Notification	Trikafta® (elexacaftor/tezacaftor/ivacaftor)	Annual review. No changes to coverage criteria.	5/1/2026
<b>Tryngolza</b>	Medical Necessity	Tryngolza® (olezarsen)	Annual review. Simplified genetic confirmation criteria. Added combination use criteria. Updated references.	5/1/2026
<b>Tryngolza</b>	Notification	Tryngolza® (olezarsen)	Annual review. Added combination use criteria. Updated reference.	5/1/2026

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<b>Tryvio</b>	Medical Necessity	Tryvio™ (aprocintentan)	Annual review. Updated background section.	5/1/2026
<b>Wainua</b>	Medical Necessity	Wainua™ (eplontersen)	Annual review. No changes to coverage criteria.	5/1/2026
<b>Wainua</b>	Notification	Wainua™ (eplontersen)	Annual review. No changes to coverage criteria.	5/1/2026
<b>Wayrilz</b>	Medical Necessity	Wayrilz™ (rilzabrutinib)	New program.	5/1/2026
<b>Wayrilz</b>	Notification	Wayrilz™ (rilzabrutinib)	New program.	5/1/2026
<b>Wayrilz</b>	Step Therapy	Wayrilz™ (rilzabrutinib)	New program.	5/1/2026
<b>Wegovy injection, Wegovy tablets - Cardiovascular Risk Reduction and MASH Only - Non-formulary</b>	Prior Authorization / Non-Formulary	Wegovy® (semaglutide) injection, Wegovy® (semaglutide) tablets - Cardiovascular Risk Reduction and MASH Only	Removed BMI requirement in CVD reauthorization criteria. Updated to include tablets and differentiate approved indications by formulation.	5/1/2026
<b>Xalkori</b>	Notification	Xalkori® (crizotinib)	Annual review. Updated background and coverage criteria for uterine neoplasms per NCCN. Updated reference.	5/1/2026
<b>Xalkori Non-Formulary</b>	Non-Formulary	Xalkori® (crizotinib)	Annual review. Updated background and coverage criteria for uterine neoplasms per NCCN. Updated reference.	5/1/2026
<b>Xospata</b>	Notification	Xospata®(gilteritinib)	Annual review. No changes to coverage criteria.	5/1/2026
<b>Zykadia</b>	Notification	Zykadia® (ceritinib)	Annual review. Updated background and coverage criteria for uterine neoplasms per NCCN. Updated reference.	5/1/2026
<b>Zykadia Non-Formulary</b>	Non-Formulary	Zykadia® (ceritinib)	Annual review. Updated background and coverage criteria for uterine neoplasms per NCCN. Updated reference.	5/1/2026
<b>Akeega</b>	Step Therapy	Akeega™ (niraparib and abiraterone acetate)	Annual review. Updated name of manufacturer savings program. Updated references.	6/1/2026
<b>Bonjesta, Diclegis</b>	Medical Necessity	Bonjesta® (doxylamine/pyridoxine extended-release), Diclegis® (doxylamine/pyridoxine delayed-release)	Annual review. Updated references.	6/1/2026
<b>Bronchitol</b>	Step Therapy	Bronchitol® (mannitol)	Annual review with no change to coverage criteria. Updated reference.	6/1/2026
<b>Bronchitol</b>	Notification	Bronchitol® (mannitol)	Annual review. No changes to coverage criteria. Updated reference.	6/1/2026
<b>Cinryze</b>	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
<b>Cinryze</b>	Notification	Cinryze® (C1 esterase inhibitor, human)	Annual review. No changes to coverage criteria. Updated examples of preventive HAE agents.	6/1/2026
<b>Cobenfy</b>	Medical Necessity	Cobenfy™ (xanomeline and trospium chloride)	Annual review with no changes.	6/1/2026
<b>Contraceptive Medications</b>	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
<b>Crexont, Rytary</b>	Step Therapy	Crexont™ (carbidopa/levodopa extended-release), Rytary® (carbidopa/levodopa extended-release)	Annual review. Updated references.	6/1/2026
<b>Ebglyss</b>	Medical Necessity	Ebglyss® (lebrikizumab-lbkz)	Annual review with no change to clinical criteria. Updated reference.	6/1/2026
<b>Ebglyss</b>	Notification	Ebglyss® (lebrikizumab-lbkz)	Annual review with no change to clinical criteria. Updated reference.	6/1/2026
<b>Elmiron</b>	Step Therapy	Elmiron® (pentosan polysulfate sodium)	Annual review. Updated references.	6/1/2026
<b>Filspari</b>	Medical Necessity	Filspari™ (sparsentan)	Added budesonide as a corticosteroid example. Removed step through SGLT2 and Vanrafia. Updated references.	6/1/2026
<b>Haegarda</b>	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

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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
Korlym	Notification	Korlym® (mifepristone)	Annual review with no changes to coverage criteria.	6/1/2026
Nuplazid	Notification	Nuplazid® (pimavanserin)	Annual review with no changes.	6/1/2026
Nurtec ODT, Qulipta, Ubrelvy, Zavzpret	Notification	Nurtec® ODT (rimegepant), Qulipta® (atogepant), Ubrelvy®(ubrogepant), Zavzpret™ (zavegepant)	Annual review. Updated language on concomitant CGRP use.	6/1/2026
Nurtec ODT, Qulipta, Ubrelvy, Zavzpret	Step Therapy	Nurtec® ODT (rimegepant), Qulipta® (atogepant), Ubrelvy®(ubrogepant), Zavzpret™ (zavegepant)	Annual review. No changes.	6/1/2026
Nurtec ODT, Qulipta, Ubrelvy, Zavzpret	Medical Necessity	Nurtec® ODT (rimegepant), Qulipta® (atogepant), Ubrelvy®(ubrogepant), Zavzpret™ (zavegepant)	Annual review. Updated language on concomitant CGRP use.	6/1/2026
Omnipod 5, Twiist	Medical Necessity	Omnipod® 5, Twiist™	Annual review. Updated references.	6/1/2026
Omnipod 5, Twiist	Notification	Omnipod® 5, Twiist™	Annual review. Updated references.	6/1/2026
OmvoH	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
OmvoH	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
Orladeyo	Notification	Orladeyo® (bertralstat)	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
Orserdu	Notification	Orserdu™ (elacestrant)	Annual review with no changes to coverage criteria.	6/1/2026
Osphena	Notification	Osphena® (ospemifene)	Annual review. Updated references.	6/1/2026
Palforzia	Notification	Palforzia [Peanut (Arachis hypogaea) Allergen Powder-dnfp]	Annual review. No changes.	6/1/2026
Palforzia	Medical Necessity	Palforzia [Peanut (Arachis hypogaea) Allergen Powder-dnfp]	Annual review. No changes.	6/1/2026
Palsonify	Medical Necessity	Palsonify™ (paltusotine)	New program.	6/1/2026
Piqray	Notification	Piqray® (alpelisib)	Annual review with no changes to coverage criteria.	6/1/2026
Qelbree	Medical Necessity	Qelbree® (viloxazine)	Annual review. Updated references.	6/1/2026
Regranex	Notification	Regranex® (becaplermin gel)	Annual review. Reference updated.	6/1/2026
Repository Corticotropins - Acthar Gel, Purified Cortrophin Gel	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
Repository Corticotropins - Acthar Gel, Purified Cortrophin Gel	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
Repository Corticotropins - Acthar Gel, Purified Cortrophin Gel	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
Reyvow	Step Therapy	Reyvow® (lasmiditan)	Archive program.	6/1/2026
Reyvow	Medical Necessity	Reyvow® (lasmiditan)	Annual review. No changes.	6/1/2026
Reyvow	Notification	Reyvow® (lasmiditan)	Archive program.	6/1/2026

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<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
<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

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<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
<b>Tocilizumab - Actemra, Avtozma, Tyenne</b>	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
<b>Tocilizumab - Actemra, Avtozma, Tyenne</b>	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
<b>Tocilizumab - Actemra, Actemra ACTPen, Avtozma, Tyenne</b>	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