

# 2026 Q2 preferred drug list updates UnitedHealthcare Community Plan

**Effective April 1, 2026**, we're making the following changes to the UnitedHealthcare Community Plan preferred drug list (PDL). Our Pharmacy and Therapeutics Committee updates this PDL quarterly.

## These changes apply to:

- The following states: Arizona (AZ), Colorado (CO), Hawaii (HI), Indiana (IN), Maryland (MD), Michigan (MI), Nebraska (NE), New Jersey (NJ), New Mexico (NM), Nevada Nevada (NV), Pennsylvania (PA), Rhode Island (RI) and Virginia (VA)
- The following programs and plans: New York Children's Health Insurance Program (NY CHIP), New York Essential Plan (NY EP) and Pennsylvania CHIP (PA CHIP)

These changes don't apply to Florida, Kansas, North Carolina, Texas or Washington.

## New medications on PDL

Medication	Description	States and plans in scope
<b>Eplerenone tablets</b>	Indicated for heart failure and the treatment of hypertension.	CO, HI, IN, MD, NJ, NM, NV, NY CHIP, NY EP, PA, PA CHIP, RI, VA
<b>Lacosamide oral solution</b>	Indicated for the treatment of partial-onset seizures and primary generalized tonic-clonic seizures. <b>Preferred for members &lt; 9 years old and prior authorization required for all other members.</b>	CO, HI, IN, NE, NJ, NM, NY CHIP, NY EP, PA CHIP, RI
<b>Starjemza™ SC injection</b>	Indicated for the treatment of adult patients with plaque psoriasis, psoriatic arthritis, ulcerative colitis, or Crohn's disease. <b>We require prior authorization.</b>	CO, HI, MD, NJ, NM, NY CHIP, NY EP, PA CHIP, RI
<b>Wainua® SC injection</b>	Indicated for polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults. <b>We require prior authorization.</b>	CO, HI, MD, NE, NJ, NM, NY CHIP, NY EP, PA, PA CHIP, RI, VA

## Changes to coverage

Medication	Description	States and plans in scope
<b>Erlotinib tablets</b>	Indicated for the treatment of non-small cell lung cancer and pancreatic cancer. <b>We no longer require prior authorization.</b>	CO, HI, IN, MD, MI, NJ, NM, NY CHIP, NY EP, PA CHIP, RI, VA
<b>Gefitinib tablets</b>	Indicated for the treatment of non-small cell lung cancer. <b>We no longer require prior authorization.</b>	CO, HI, IN, MD, MI, NJ, NM, NY CHIP, NY EP, PA CHIP, RI, VA
<b>Tetrabenazine tablets</b>	Indicated for the treatment of chorea associated with Huntington's disease and used off label for tardive dyskinesia and Tourette's syndrome. <b>We no longer require prior authorization.</b>	CO, HI, MD, MI, NJ, NM, NY CHIP, NY EP, PA CHIP, RI
<b>Tranexamic acid tablets</b>	Indicated for the treatment of cyclic heavy menstrual bleeding. <b>We no longer require prior authorization.</b>	CO, HI, IN, MD, NE, NJ, NM, NV, NY CHIP, NY EP, PA, PA CHIP, RI, VA
<b>Varenicline tablets</b>	Indicated for use as an aid to smoking cessation treatment. <b>We no longer require prior authorization.</b>	CO, HI, NE, NJ, NV, NY EP, PA CHIP, RI

## Medication no longer on PDL

We're removing the following medication(s) from our PDL:

Medication	Description	States and plans in scope
<b>Elmiron® capsules</b>	Indicated for the relief of bladder pain or discomfort associated with interstitial cystitis. Alternatives include amitriptyline and hydroxyzine. <b>We require prior authorization.</b>	CO, HI, IN, MD, MI, NE, NJ, NM, NV, NY CHIP, NY EP, PA, PA CHIP, RI, VA
<b>Brand Eplclusa® tablets and pellets</b>	Indicated for the treatment of Hepatitis C. Alternative includes the authorized generic with prior authorization. <b>We require prior authorization.</b>	NY EP
<b>Brand Harvoni® tablets and pellets</b>	Indicated for the treatment of Hepatitis C. Alternative includes the authorized generic with prior authorization. <b>We require prior authorization.</b>	NY EP

## Medication no longer on PDL (cont.)

We're removing the following medication(s) from our PDL:

Medication	Description	States and plans in scope
<b>Erythromycin DR 250 mg tablets</b>	Indicated for the treatment of infections caused by susceptible strains of designated microorganisms. Alternatives include Erythromycin Base 250 mg or 500 mg. <b>We require prior authorization.</b>	CO, HI, MD, NJ, NM, NY CHIP, NY EP, PA CHIP, RI
<b>Tegsedi™ SC injection</b>	Indicated for polyneuropathy of hereditary transthyretin-mediated amyloidosis in adults. Tegsedi™ will be pulled from the market by the manufacturer. Alternative includes Wainua® with prior authorization. <b>We require prior authorization.</b>	CO, HI, IN, MD, NE, NJ, NM, NY CHIP, NY EP, PA, PA CHIP, RI, VA
<b>Vitrakvi® capsules and oral solution</b>	Indicated for the treatment of neurotrophic receptor tyrosine kinase-positive solid tumors. Alternative includes Rozlytrek® with prior authorization. <b>We require prior authorization.</b>	CO, HI, IN, MD, NJ, NM, NY CHIP, NY EP, PA CHIP, RI, VA

## Medication alternatives

We may cover medication alternatives for medications not on our PDL. If you feel a medication alternative is medically appropriate for a patient, and you'd like to prescribe it, please do one of the following:

- Contact the member's pharmacy to request the prescription
- Submit an electronic prescription using Optum Rx ePrescribe
  - For more information, visit [Electronic Prescribing \(eRx\) to Optum Home Delivery](#) resource
- Write a new prescription and give it to your patient (where state regulations permit)

If a preferred alternative medication isn't medically appropriate for a patient, please request a PDL prior authorization exception by calling Optum Rx prescriber prior authorization at **800-310-6826**. If the medication meets our medical necessity criteria, we'll continue to cover it for that patient.



### Resources

As of April 1, 2026, you can view the changes at [UHCprovider.com/plans](#) > Health Plans by State > Medicaid (Community Plan) > Pharmacy Resources and Physician Administered Drugs.