Q4 2025 preferred drug list updates

UnitedHealthcare Community Plan

Effective Oct. 1, 2025, 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 (NV), Pennsylvania (PA), Rhode Island (RI), Virginia (VA) and Washington (WA)
- The following programs and plans: New York Children's Health Insurance Program (NY CHIP), New York Essential Plan (NY EP), Pennsylvania CHIP (PA CHIP) and Texas (Medicaid)

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

New medications on PDL

Medication	Description	States and plans in scope
Desvenlafaxine ER tablets	Indicated for the treatment of major depressive disorder.	CO, HI, NE, NJ, NM, NV, NY CHIP, NY EP, PA CHIP, RI
Escitalopram oral solution	Indicated for the treatment of major depressive disorder and generalized anxiety disorder.	CO, HI, NJ, NE, NM, NV, NY CHIP, NY EP, PA CHIP, RI
Fluoxetine tablets	Indicated for the treatment of major depressive disorder, obsessive compulsive disorder, bulimia nervosa and panic disorder.	CO, HI, NJ, NE, NM, NV, NY CHIP, NY EP, PA CHIP, RI
Paroxetine ER tablets	Indicated for the treatment of major depressive disorder, panic disorder, social anxiety disorder and premenstrual dysphoric disorder.	CO, HI, NJ, NE, NM, NV, NY CHIP, NY EP, PA CHIP, RI
Venlafaxine ER tablets	Indicated for the treatment of major depressive disorder, generalized anxiety disorder, social anxiety disorder and panic disorder.	CO, HI, NJ, NE, NM, NV, NY CHIP, NY EP, PA CHIP, RI
Vilazodone tablets	Indicated for the treatment of major depressive disorder.	CO, HI, NJ, NE, NM, NV, NY CHIP, NY EP, PA CHIP, RI

New medications on PDL (cont.)

Medication	Description	States and plans in scope
FreeStyle Libre® 3	Continuous glucose monitoring (CGM) system for use in managing diabetes. **We require prior authorization.**	CO, HI, MD, MI, NE, NJ, NY CHIP, NY EP, NM, NV, PA CHIP, RI, VA, WA
FreeStyle Libre® 2 Plus and 3 Plus	CGM system for use in managing diabetes. **We require prior authorization.**	CO, HI, MD, MI, NE, NJ, NY CHIP, NY EP, NM, NV, PA CHIP, RI, VA, WA
Memantine ER capsules	Indicated for the treatment of moderate to severe dementia of the Alzheimer's disease type.	CO, HI, MD, NJ, NM, NV, NY CHIP, NY EP, PA CHIP, RI
Ramelteon tablets	Indicated for the treatment of insomnia characterized by difficulty with sleep onset.	CO, HI, NJ, NM, NV, NY CHIP, NY EP, PA CHIP, RI
Sodium polystyrene sulfonate powder	Indicated as a potassium binder for the treatment of hyperkalemia.	CO, HI, MD, NJ, NE, NM, NV, NY CHIP, NY EP, PA, PA CHIP, RI
Tobramycin nebulizer 300 mg/ 5 mL	Indicated for the management of cystic fibrosis in adults and pediatric patients 6 years and older with Pseudomonas aeruginosa. **We require prior authorization.**	CO, HI, IN, MD, NJ, NM, NV, NY CHIP, NY EP, PA CHIP, RI

Changes to coverage

Medication	Description	States and plans in scope
Abiraterone 250 mg tablets	Indicated for the treatment of patients with metastatic castration-resistant prostate cancer who have received prior chemotherapy. **We'll no longer require prior authorization.**	CO, HI, IN, MD, NJ, NM, NV, NY CHIP, NY EP, PA CHIP, RI
Imatinib tablets	Indicated for the treatment of several types of cancer and blood conditions, including multiple leukemia conditions. **We'll no longer require prior authorization.**	CO, HI, IN, MD, NJ, NM, NV, NY CHIP, NY EP, PA CHIP, RI, VA

Changes to coverage (cont.)

Medication	Description	States and plans in scope
Temozolomide capsules	Indicated for the treatment of glioblastoma multiforme (GBM) and refractory anaplastic astrocytoma patients who have experienced disease progression. **We'll no longer require prior authorization.**	CO, HI, IN, MD, NJ, NM, NV, NY CHIP, NY EP, PA CHIP, RI
Armodafinil tablets	Indicated to improve wakefulness in patients with excessive sleepiness associated with obstructive sleep apnea, narcolepsy or shift work disorder. **We'll no longer require a diagnosis check.**	CO, HI, NJ, NM, NV, NY CHIP, NY EP, PA CHIP, RI
Modafinil tablets	Indicated to improve wakefulness in patients with excessive sleepiness associated with obstructive sleep apnea, narcolepsy or shift work disorder. **We'll no longer require a diagnosis check.**	CO, HI, NJ, NM, NV, NY CHIP, NY EP, PA CHIP, RI
Asmanex® HFA	Indicated for maintenance treatment of asthma as prophylactic therapy. **We'll no longer require prior authorization.**	CO, HI, MD, NJ, NM, NV, NY CHIP, PA CHIP, RI
Asmanex® Twisthaler®	Indicated for maintenance treatment of asthma as prophylactic therapy. **We'll no longer require prior authorization.**	CO, HI, MD, NJ, NM, NV, NY CHIP, PA CHIP, RI
Febuxostat tablets	Indicated for the chronic management of hyperuricemia in patients with gout. **We'll no longer require step therapy.**	CO, HI, IN, MD, NJ, NM, NV, NY CHIP, NY EP, PA CHIP, RI

Changes to coverage (cont.)

Medication	Description	States and plans in scope
Hydrocortisone ampule (generic Solu-Cortef®)	Indicated for treatment of several conditions, including allergic states, dermatologic diseases, endocrine disorders, gastrointestinal diseases, hematologic disorders, neoplastic diseases, ophthalmic diseases, renal diseases, respiratory diseases and rheumatic disorders. **Added to the pharmacy benefit as preferred.**	CO, HI, IN, MD, NJ, NE, NM, NV, NY CHIP, NY EP, PA, PA CHIP, RI
Impavido® capsules	Indicated for the treatment of visceral leishmaniasis, cutaneous leishmaniasis and mucosal leishmaniasis. **We'll no longer require prior authorization.**	CO, HI, IN, MD, NJ, NE, NM, NV, NY CHIP, NY EP, PA CHIP, RI, VA
Prasugrel tablets	Indicated for the reduction of thrombotic cardiovascular events, including stent thrombosis, in patients with acute coronary syndrome. **We'll no longer require prior authorization.**	CO, HI, MD, NJ, NM, NV, NY CHIP, 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
Clemastine syrup	Indicated for the relief of symptoms associated with allergic rhinitis such as sneezing, rhinorrhea, pruritus and lacrimation. Alternatives include clemastine tablets and diphenhydramine liquid. **We require prior authorization.**	CO, HI, IN, MD, MI, NJ, NE, NM, NV, NY CHIP, NY EP, PA, PA CHIP, RI

Medication no longer on PDL (cont.)

Medication	Description	States and plans in scope
Diphenhydramine elixir	Indicated for allergic conjunctivitis, active and prophylactic treatment of motion sickness, and parkinsonism. Alternatives include diphenhydramine 12.5 mg/5 ml liquid or diphenhydramine capsules. **We require prior authorization.**	CO, HI, MD, MI, NJ, NE, NM, NV, NY CHIP, NY EP, PA, PA CHIP, RI
Donepezil 23 mg tablets	Indicated for the treatment of dementia of the Alzheimer's disease type. Alternatives include donepezil 5 mg and 10 mg tablets. **We require prior authorization.**	CO, HI, MD, NJ, NM, NV, NY CHIP, NY EP, PA CHIP, RI
Erzofri® injection	Indicated for treatment of schizophrenia and schizoaffective disorder. Alternatives include Invega Sustenna® and Invega Trinza® (both require prior authorization). **We require prior authorization.**	CO, NJ, NE, NV, NY CHIP, NY EP, PA CHIP, RI
Naproxen EC tablets	Indicated for the relief of the signs and symptoms of rheumatoid arthritis, osteoarthritis, ankylosing spondylitis and polyarticular juvenile idiopathic arthritis. Alternatives include naproxen tablets or other preferred NSAIDs. **We require prior authorization.**	CO, HI, IN, MD, NJ, NM, NV, NY CHIP, NY EP, PA CHIP, RI
OneTouch® Meters and Test Strips	Indicated for the monitoring of blood glucose control. Alternatives include Accu-Chek® Aviva, Accu-Chek® Guide Me®, Contour® Next, Contour Plus Glucose Meters and Test Strips. **Removed from the PDL on Sept. 1, 2025. We require prior authorization.**	AZ, CO, HI, MD, MI, NE, NJ, NM, NV, NY CHIP, PA CHIP, RI, TX, VA, WA

Medication no longer on PDL (cont.)

Medication	Description	States and plans in scope
Tobramycin nebulizer 300 mg/ 4 mL	Indicated for the management of cystic fibrosis in adults and pediatric patients 6 years and older with Pseudomonas aeruginosa. Alternatives include tobramycin nebulizer 300 mg/5 mL (prior authorization required). **We require prior authorization.**	CO, HI, IN, MD, NJ, NM, NV, NY CHIP, NY EP, PA CHIP, RI

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** at optum.com
- 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 Oct. 1, 2025, you can view the changes at **UHCprovider.com/plans** > Health Plans by State > Community plan (Medicaid) > Pharmacy Resources and Physician Administered Drugs.

United Healthcare® Community Plan