## Commercial Business

## BULLETIN (4/1/2024)

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

| | UM Type | Trade Name (Generic Name) | Summary of Changes | Implementation Date |
|---|---|---|---|---|
| **Augtyro** | Notification | Augtyro™ (repotrectinib) | New program | 4/1/2024 |
| **Bonjesta, Diclegis** | Medical Necessity | Bonjesta® (doxylamine/pyridoxine extended-release), Diclegis® (doxylamine/pyridoxine delayed-release) | Annual review with no changes. | 4/1/2024 |
| **Chenodal** | Step Therapy | Chenodal™ (chenodiol) | Annual review with no change to coverage criteria. | 4/1/2024 |
| **Cosentyx** | Notification | Cosentyx® (secukinumab) prefilled syringe or Sensoready pen | Added coverage criteria for new indication for Hidradenitis Suppurativa (HS). Updated background and reference. | 4/1/2024 |
| **Cosentyx** | Medical Necessity | Cosentyx® (secukinumab) prefilled syringe or Sensoready pen | Added coverage criteria for new indication for Hidradenitis Suppurativa (HS). Updated state mandate footnote. Updated background and reference. | 4/1/2024 |
| **Crinone** | Step Therapy | Crinone® (progesterone gel) | Annual review. No changes. | 4/1/2024 |
| **Cuvrior** | Notification | Cuvrior™ (trientine tetrahydrochloride) | Annual review with no changes to coverage criteria. | 4/1/2024 |
| **Daurismo** | Notification | Daurismo™ (glasdegib) | Annual review with no change to clinical criteria. Updated reference. | 4/1/2024 |
| **Diabetes Medications - DPP4 Inhbitors** | Step Therapy | Januvia® (sitagliptin), Janumet® (sitagliptin/metformin immediate-release), Janumet® XR (sitagliptin/metformin extended-release) | Annual review. Updated mandate language for Connecticut. Updated products typically excluded from coverage. Updated references. | 4/1/2024 |
| **Diabetes Medications – GLP-1 & Dual GIP/GLP-1 Receptor Agonists** | Step Therapy | Bydureon BCise® (exenatide extended-release), Byetta® (exenatide), Mounjaro® (tirzepatide), Ozempic® (semaglutide), Rybelsus® (semaglutide), Trulicity® (dulaglutide), Victoza® (liraglutide) | Annual review. Removed Adlyxin. Updated state mandate language. Updated references. | 4/1/2024 |
| **Doptelet** | Notification | Doptelet® (avatrombopag) | Annual review with no changes to coverage criteria. | 4/1/2024 |
| **Elmiron** | Step Therapy | Elmiron® (pentosan polysulfate sodium) | Annual review. Updated references. | 4/1/2024 |
| **Fluticasone propionate HFA - Non-Formulary** | Non-Formulary | Fluticasone propionate HFA | Added eosinophilic esophagitis to criteria | 4/1/2024 |
| **Hetlioz, Hetlioz LQ** | Medical Necessity | Hetlioz®, Hetlioz LQ™ (tasimelteon) | Annual review. Updated step therapy mandate note to include Mississippi. | 4/1/2024 |
| **Hetlioz, Hetlioz LQ** | Notification | Hetlioz®, Hetlioz LQ™ (tasimelteon) | Annual review. Updated references. | 4/1/2024 |
| **Jesduvroq** | Notification | Jesduvroq® (daprodustat) | New program | 4/1/2024 |
| **Jesduvroq** | Medical Necessity | Jesduvroq® (daprodustat) | New program | 4/1/2024 |
| **Kerendia** | Notification | Kerendia® (finerenone) | Annual review. Updated references. | 4/1/2024 |
| **Lotronex** | Notification | Lotronex® (alosetron) | Annual review. No changes. | 4/1/2024 |
| **Mavenclad** | Notification | Mavenclad® (cladribine) | Annual review with no change to clinical criteria. | 4/1/2024 |
| **Mavenclad** | Step Therapy | Mavenclad® (cladribine) | Annual review with no change to coverage criteria. Updated teriflunomide with Aubagio as an example. | 4/1/2024 |

| | UM Type | Trade Name (Generic Name) | Summary of Changes | Implementation Date |
|---|---|---|---|---|
| **Nuplazid** | Notification | Nuplazid® (pimavanserin) | Annual review. Updated references. Updated background information. | 4/1/2024 |
| **Ogsiveo** | Notification | Ogsiveo™ (nirogacestat) | New program | 4/1/2024 |
| **Omvoh** | Notification | Omvoh™ (Mirikizumab-mrkz) | New program | 4/1/2024 |
| **Omvoh** | Medical Necessity | Omvoh™ (Mirikizumab-mrkz) | New program | 4/1/2024 |
| **Orencia** | Notification | Orencia® (abatacept) | Updated Background for updated indication for PsA for patients 2 years of age and older. Updated reference. | 4/1/2024 |
| **Orencia** | Medical Necessity | Orencia® (abatacept) | Updated PsA criteria based on updated indication for patients 2 years of age or older. Updated Background, References, and state mandate footnote. | 4/1/2024 |
| **Orencia** | Step Therapy | Orencia® (abatacept) | Updated PsA criteria based on new indication for patients 2 years of age and older. Updated background and reference. | 4/1/2024 |
| **Promacta** | Notification | Promacta® (eltrombopag) | Annual review. Reformatted criteria without change to clinical intent. Updated background per label and updated reference. | 4/1/2024 |
| **Qlosi, Vuity** | Medical Necessity | Qlosi (pilocarpine)™ 0.4% ophthalmic solution, Vuity® (pilocarpine) 1.25% ophthalmic solution | Added Qlosi. Updated references. | 4/1/2024 |
| **Regranex** | Notification | Regranex® (becaplermin gel) | Annual review. No changes. | 4/1/2024 |
| **Rozlytrek** | Notification | Rozlytrek™ (entrectinib) | Annual review with update to background. No changes to clinical criteria. Updated references. | 4/1/2024 |
| **Sandostatin** | Notification | Sandostatin® (octreotide acetate) | Annual review with no changes to coverage criteria. Updated background and references. | 4/1/2024 |
| **Sedatvie Hypnotic Agents - Belsomra, DayVigo, Quviviq, Rozerem** | Step Therapy | Belsomra® (suvorexant), DayVigo® (lemborexant), Quviviq® (daridorexant), Rozerem®* (ramelteon) | Annual review. Removed Zolpimist from step therapy program since this product is no longer on the market. | 4/1/2024 |
| **Selzentry** | Notification | Selzentry® (maraviroc) | Annual review. Revised duration of authorization. | 4/1/2024 |
| **Sohonos** | Medical Necessity | Sohonos™ (palovarotene) | New program | 4/1/2024 |
| **Statins - Lescol XL, Livalo, Zypitamag** | Step Therapy | Lescol® XL (brand and generic fluvastatin extended-release), Livalo® (brand and generic pitavastatin calcium), Zypitamag® (pitavastatin magnesium) | Annual review. Updated to include generic Livalo. Updated references. | 4/1/2024 |
| **Stromectol** | Notification | Stromectol® (ivermectin) oral dosage form | Annual review. Updated references. | 4/1/2024 |
| **Sucraid** | Notification | Sucraid (sacrosidase) oral solution | Annual review with no changes to coverage criteria. Updated reference. | 4/1/2024 |
| **Sucraid** | Medical Necessity | Sucraid (sacrosidase) oral solution | Annual review. Updated confirmation of diagnosis requirements for initial authorization. Simplified reauthorization criteria. Updated references. | 4/1/2024 |
| **Tavalisse** | Notification | Tavalisse® (fostamatinib) | Annual review with no changes to clinical coverage criteria. | 4/1/2024 |
| **Tavneos** | Notification | Tavneos® (avacopan) | Annual review with no changes. | 4/1/2024 |
| **Tavneos** | Medical Necessity | Tavneos® (avacopan) | Annual review with no changes. | 4/1/2024 |
| **Tibsovo** | Notification | Tibsovo® (ivosidenib) | Updated background and criteria to include new indication for relapsed or refractory MDS with a susceptible IDH1 mutation. Updated references. | 4/1/2024 |
| **Topical Products - New Jersey and New York** | Notification | Topical Products | Annual review. No changes. | 4/1/2024 |
| **Truqap** | Notification | Truqap™ (capivasertib) | New program | 4/1/2024 |
| **Vitrakvi** | Notification | Vitrakvi® (larotrectinib) | Annual review with no changes to clinical criteria. Updated references. | 4/1/2024 |
| **Xphozah** | Notification | Xphozah® (tenapanor) | New program | 4/1/2024 |
| **Xpovio** | Notification | Xpovio® (selinexor) | Annual review. Updated background. Updated indicated formatting for consistency. Included coverage criteria for diffuse large B-cell lymphoma according to NCCN recommendations and updated reference. | 4/1/2024 |
| **Zilbrysq** | Notification | Zilbrysq® (zilucoplan) | New program | 4/1/2024 |

|  | UM Type | Trade Name (Generic Name) | Summary of Changes | Implementation Date |
|---|---|---|---|---|
| **Zilbrysq** | Medical Necessity | Zilbrysq® (zilucoplan) | New program | 4/1/2024 |
| **Zilxi** | Notification | Zilxi® (minocycline) | Annual review. No changes. | 4/1/2024 |
| **Zoryve** | Notification | Zoryve® (roflumilast) | Added criteria for Zoryve foam for seborrheic dermatitis. Updated background and reference. | 4/1/2024 |
| **Zoryve** | Medical Necessity | Zoryve® (roflumilast) | Added criteria for Zoryve foam for seborrheic dermatitis. Updated background and reference. | 4/1/2024 |
| **Actemra** | Medical Necessity | Actemra® (tocilizumab)<br>This program applies to the subcutaneous formulation of tocilizumab. | Removed Olumiant as a preferred product for RA. Updated state mandate footnote to 30-day trial for Connecticut. | 5/1/2024 |
| **Actemra, Actemra ACTPen** | Step Therapy | Actemra® (tocilizumab), Actemra (tocilizumab) ACTPen<br>*This step criteria refers to the subcutaneous formulations of tocilizumab. | Removed Olumiant as a preferred product for RA. | 5/1/2024 |
| **Afrezza** | Medical Necessity | Afrezza® (insulin human) | Annual review. Updated references. Updated state mandate language. | 5/1/2024 |
| **Anticonvulsants** | Notification | Aptiom® (eslicarbazepine acetate), Banzel® (rufinamide), Briviact® (brivaracetam), Diacomit® (stiripentol), Epidiolex® (cannabidiol), Fintepla® (fenfluramine), Fycompa® (perampanel), Nayzilam® (midazolam), Onfi® (clobazam), Sabril® (vigabatrin), Sympazan® (clobazam), Valtoco® (diazepam), Xcopri® (cenobamate), Ztalmy® (ganaxolone) | Removed Vimpat from criteria. | 5/1/2024 |
| **Arikayce** | Medical Necessity | Arikayce® (amikacin liposome inhalation suspension) | Annual review with no change to coverage criteria. | 5/1/2024 |
| **Bosulif** | Notification | Bosulif® (bosutinib) | Annual review with no changes to coverage criteria. Updated background and references. | 5/1/2024 |
| **Brexafemme** | Medical Necessity | Brexafemme® (ibrexafungerp) | Annual review. Updated mandated states. | 5/1/2024 |
| **Buphenyl, Olpruva, Pheburane** | Notification | Buphenyl® (sodium phenylbutyrate), Olpruva™ (sodium phenylbutyrate), Pheburane® (sodium phenylbutyrate), sodium phenylbutyrate | Added Olpruva and Pheburane, including statement that Olpruva and Pheburane are typically excluded from coverage. Updated references | 5/1/2024 |
| **Cayston** | Notification | Cayston® (aztreonam for inhalation solution) | Annual review. Updated background. No changes to coverage criteria. | 5/1/2024 |
| **Cayston** | Step Therapy | Cayston® (aztreonam for inhalation solution) | Annual review with no changes to coverage criteria. Updated background and references. | 5/1/2024 |
| **Cuvrior** | Notification | Cuvrior™ (trientine tetrahydrochloride) | Annual review. Added footnote indicating Cuvrior is typically excluded from coverage. Updated authorization durations to 12 months. | 5/1/2024 |
| **Cuvrior** | Medical Necessity | Cuvrior™ (trientine tetrahydrochloride) | New program. | 5/1/2024 |
| **Egrifta SV** | Notification | Egrifta SV™ (tesamorelin for injection) | Annual review with no changes to coverage criteria. | 5/1/2024 |
| **Empaveli** | Notification | Empaveli® (pegcetacoplan) | Added Fabhalta to list of examples of other complement inhibitors used for the treatment of PNH. Revised initial authorization to 12 months. Included criteria for therapeutic duplication. Updated references. | 5/1/2024 |
| **Empaveli** | Medical Necessity | Empaveli® (pegcetacoplan) | Added Fabhalta to list of examples of other complement inhibitors used for the treatment of PNH. Revised initial authorization to 12 months. Updated references. | 5/1/2024 |
| **Endari** | Medical Necessity | Endari® (L-glutamine Powder for Solution) | Annual review. No changes. | 5/1/2024 |
| **Fabhalta** | Notification | Fabhalta® (iptacopan) | New program | 5/1/2024 |
| **Fabhalta** | Medical Necessity | Fabhalta® (iptacopan) | New program | 5/1/2024 |
| **Firazyr, Sajazir** | Notification | Firazyr® (icatibant), icatibant, Sajazir™ (icatibant) | Added coverage exclusion statement for brand Firazyr and Sajazir. Revised wording of criteria without changes to clinical intent. | 5/1/2024 |

|  | UM Type | Trade Name (Generic Name) | Summary of Changes | Implementation Date |
|---|---|---|---|---|
| **Firazyr, Sajazir** | Medical Necessity | Firazyr® (icatibant), icatibant, Sajazir™ (icatibant) | Added coverage exclusion statement for brand Firazyr and Sajazir. Added Kalbitor to list of other products indicated for the acute treatment of HAE attacks. | 5/1/2024 |
| **Forteo** | Step Therapy | Forteo® (teriparatide) | Annual review with no changes to step criteria. Updated background and references. | 5/1/2024 |
| **Fosrenol** | Step Therapy | Fosrenol® (lanthanum carbonate) | Annual review. Updated references. | 5/1/2024 |
| **Fruzaqla** | Notification | Fruzaqla™ (fruquintinib) | New program | 5/1/2024 |
| **Glumetza, Fortamet** | Medical Necessity | Glumetza® (metformin extended-release modified release, brand and generic) and metformin osmotic extended-release (generic Fortamet®) | Annual review. Updated references. Updated state mandate language and requirement for C | 5/1/2024 |
| **Harvoni** | Notification | Harvoni® (ledipasvir/sofosbuvir) | Annual review. Added cirrhosis criteria for treatment of chronic hepatitis C - genotype 4, 5 or 6. | 5/1/2024 |
| **Ibrance** | Notification | Ibrance® (palbociclib) | Annual review. Specified type of unresectable WD-DDLS to be retroperitoneal per NCCN recommendation. Updated references to separate out package insert references for Ibrance capsules and tablets. | 5/1/2024 |
| **Inbrija** | Notification | Inbrija® (levodopa inhalation powder) | Revised initial authorization to 12 months. | 5/1/2024 |
| **Inbrija** | Medical Necessity | Inbrija® (levodopa inhalation powder) | Annual review. Revised initial authorization to 12 months. Updated references. | 5/1/2024 |
| **Inqovi** | Notification | Inqovi® (decitabine and cedazuridine) tablet | Annual review with no changes to coverage criteria. Updated references. | 5/1/2024 |
| **Invokana - Non-Formulary** | Non-Formulary | Invokana® (canagliflozin) | Annual review. Updated background section, references and diabetes footnote. | 5/1/2024 |
| **Iwilfin** | Notification | Iwilfin™ (eflornithine) | New program | 5/1/2024 |
| **Jaypirca** | Notification | Jaypirca® (pirtobrutinib) | Added coverage for updated labeled indication for CLL/SLL in patients who have received at least two lines of therapy, including a BTK inhibitor and a BCL-2 inhibitor. Updated references. | 5/1/2024 |
| **Jivi** | Notification | Jivi® (antihemophilic factor [recombinant], PEGylated-aucl) | Annual review with no changes to clinical coverage criteria. Updated references. | 5/1/2024 |
| **Juxtapid** | Notification | Juxtapid® (lomitapide) | Annual review. Changed initial authorization period to 12 months. | 5/1/2024 |
| **Juxtapid** | Medical Necessity | Juxtapid® (lomitapide) | Updated diagnostic criteria per European Atherosclerosis Society guidance. Changed initial authorization period to 12 months. Updated references. | 5/1/2024 |
| **Ketodan** | Step Therapy | ketoconazole foam (generic Extina®) (ketoconazole), Ketodan® (ketoconazole) foam | Annual review. Updated references. Updated to clarify the generic products and removed brand Extina due to product discontinuation. | 5/1/2024 |
| **Keveyis** | Notification | Keveyis® (dichlorphenamide) | Annual review. Updated reference. | 5/1/2024 |
| **Kevzara** | Medical Necessity | Kevzara® (sarilumab) Injection | Removed Olumiant as a preferred product for RA. Updated state mandate footnote to 30-day trial for Connecticut. | 5/1/2024 |
| **Kevzara** | Step Therapy | Kevzara® (sarilumab) Injection | Removed Olumiant as a preferred product for RA. | 5/1/2024 |
| **Kineret** | Step Therapy | Kineret® (anakinra) | Removed Olumiant as a preferred product for RA. | 5/1/2024 |
| **Kisqali** | Notification | Kisqali® (ribociclib) | Annual review. Updated background and added clinical criteria for endometrial carcinoma per NCCN. Updated reference. | 5/1/2024 |
| **Kisqali Femara Co-Pack** | Notification | Kisqali® Femara® Co-Pack (ribociclib/letrozole) | Annual review. Updated background and added clinical criteria for endometrial carcinoma per NCCN. Updated reference. | 5/1/2024 |
| **Krazati** | Notification | Krazati™ (adagrasib) | Annual review. Added criteria for NCCN recommended use of Krazati in colon cancer, rectal cancer, ampullary adenocarcinoma and pancreatic adenocarcinoma. Updated background and references. | 5/1/2024 |
| **Kynmobi** | Notification | Kynmobi® (apomorphine) sublingual film | Archive program | 5/1/2024 |
| **Kynmobi** | Medical Necessity | Kynmobi® (apomorphine) sublingual film | Archive program | 5/1/2024 |

| | UM Type | Trade Name (Generic Name) | Summary of Changes | Implementation Date |
|---|---|---|---|---|
| **Lenvima** | Notification | Lenvima® (lenvatinib) | Annual review. Updated thyroid cancer criteria based on label and NCCN. Updated hepatobiliary and thymic cancer based on NCCN recommendations. Updated references. | 5/1/2024 |
| **Livtencity** | Notification | Livtencity (maribavir) | Annual review. Updated background and reference. | 5/1/2024 |
| **Lorbrena** | Notification | Lorbrena® (lorlatinib) | Annual review. Added criteria for NCCN recommended use of Lorbrena in uterine sarcoma, peripheral T-Cell lymphoma and large B-cell lymphoma. Updated background and references. | 5/1/2024 |
| **Lucemyra** | Medical Necessity | Lucemyra® (lofexidine) | Annual review. Nevada footnote added. Updated references. | 5/1/2024 |
| **Minocycline ER** | Medical Necessity | minocycline extended-release tablet (generic Solodyn™), Minolira™ (minocycline extended-release tablet ), Solodyn (minocycline extended-release tablet), Ximino® (minocycline extended-release capsule) | Annual review. No changes. | 5/1/2024 |
| **Multisource Brand/Modified Release Anticonvulsants** | Medical Necessity | Multisource Brand/Modified Release Anticonvulsants – Banzel®, Depakote®, Depakote ER®, Felbatol®, Keppra®, Keppra XR®, Lamictal, Lamictal XR, Lamictal ODT (brand and generic), Lyrica®, Motpoly XR, Mysoline®, Neurontin®, Onfi®, Sabril®, Topamax®, Trileptal®, Vimpat®, Zonegran® | Added Motpoly XR to criteria. | 5/1/2024 |
| **Mytesi** | Notification | Mytesi™ (crofelemer) | Annual review with no changes to coverage criteria. | 5/1/2024 |
| **New and Therapeutic Equivalent Medications - Excluded Drug** | Medical Necessity | New and Therapeutic Equivalent Medications - Excluded Drug | Added Imbruvica 140mg and 280mg tablet, methylphenidate extended-release tablet, Millipred, Ogsiveo, Sodium Oxybate, ursodiol 200mg and 400mg capsule, Xdemvy, zolpidem capsule<br>Revised Adhansia XR, Adzeys XR-ODT, Aptensio XR, Cotempla XR-ODT, Daytrana, Dyanavel XR, Evekeo, Focalin XR, Forteo, Pentasa, Quillichew ER, Quillivant XR, Relexxi 72mg, Relexxi/methylphenidate extended-relesae 45mg and 63mg, Ritalin LA, Sogroya, Teriparatide (from brand only to single source brand), Trilipix, Votrient<br>Removed fluoxetine 60mg tablet, Skytrofa, Sympazan<br>Update to Connecticut trial requirement from 60 days to 30 days. | 5/1/2024 |
| **New and Therapeutic Equivalent Medications - Prior Authorization** | Medical Necessity | New and Therapeutic Equivalent Medications - Prior Authorization | Added Imbruvica 140mg and 280mg tablet, methylphenidate extended-release tablet, Millipred, Ogsiveo, ursodiol 200mg and 400mg capsule, Xdemvy, zolpidem capsule<br>Revised Adhansia XR, Adzenys XR-ODT, Aptensio XR, Cotempla XR-ODT, Daytrana, Dyanavel XR, darifenacin, Evekeo (to brand only), Focalin XR, Forteo (to brand and generic), Mydayis, Pentasa, Quillichew ER, Quillivant XR, Relexxi 72mg, Relexxi/methylphenidate extended-release 45mg and 63mg, Ritalin LA, Sodium Oxybate, Sogroya, Trilipix (to brand only), Votrient<br>Removed fluoxetine 60mg tablet, Hemangeol, Skytrofa, Sohonos, Sympazan<br>Update to Connecticut trial requirement from 60 days to 30 days. | 5/1/2024 |
| **Nocdurna** | Medical Necessity | Nocdurna® (desmopressin acetate) | Annual review. Increased initial authorization to 12 months. Updated references. | 5/1/2024 |
| **Ojjaara** | Step Therapy | Ojjaara™ (momelotinib) | New program | 5/1/2024 |
| **Olumiant** | Medical Necessity | Olumiant® (baricitinib) | Updated criteria to require a failure, contraindication or intolerance to two preferred products for RA removing failure of TNF or needle-phobia. Added adalimumab preferred product footnote. | 5/1/2024 |
| **Olumiant** | Step Therapy | Olumiant® (baricitinib) | New program | 5/1/2024 |

| | UM Type | Trade Name (Generic Name) | Summary of Changes | Implementation Date |
|---|---|---|---|---|
| **Orencia** | Medical Necessity | Orencia® (abatacept)<br>*This program applies to the subcutaneous formulation of abatacept | Removed Olumiant as a preferred product for RA. | 5/1/2024 |
| **Orencia** | Step Therapy | Orencia® (abatacept)<br>*This program applies to the subcutaneous formulation of abatacept | Removed Olumiant as a preferred product for RA. | 5/1/2024 |
| **Orgovyx** | Notification | Orgovyx™ (relugolix) | Annual review with no changes to coverage criteria. Updated references. | 5/1/2024 |
| **Oriahnn, MyFembree** | Medical Necessity | Oriahnn® (elagolix and estradiol/norethindrone), MyFembree® (relugolix and estradiol hemihydrate/norethindrone) | Annual review. Updated failure language. Updated state mandate language. Updated authorization duration. Updated references. | 5/1/2024 |
| **Orilissa** | Medical Necessity | Orilissa® (elagolix) | Annual review. Updated failure language. Updated state mandate language. Updated authorization duration. Updated references. | 5/1/2024 |
| **Oxbryta** | Notification | Oxbryta™ (voxelotor) | Annual review. Simplified reauthorization criteria and updated authorization durations to 12 months. Updated reference. | 5/1/2024 |
| **Oxbryta** | Medical Necessity | Oxbryta™ (voxelotor) | Annual review. Updated initial authorization duration to 12 months. Updated references. | 5/1/2024 |
| **Oxervate** | Notification | Oxervate® (cenegermin-bkbj) ophthalmic solution | Annual review with no change to clinical criteria. Updated reference. | 5/1/2024 |
| **Oxervate** | Medical Necessity | Oxervate® (cenegermin-bkbj) ophthalmic solution | Annual review with no change to clinical criteria. Updated reference. | 5/1/2024 |
| **PAH Agents** | Notification | Adcirca® (tadalafil), Adempas® (riociguat), Alyq™ (tadalafil), Letairis® (ambrisentan), Liqrev® (sildenafil) oral suspension, Opsumit® (macitentan), Orenitram™ (treprostinil), Revatio® (sildenafil citrate) oral powder for suspension, Tadliq® (tadalafil) oral suspension, Tracleer® (bosentan), Tyvaso® (treprostinil), Tyvaso DPI™ (treprostinil), Uptravi® (selexipag), Ventavis® (iloprost) | Annual review. Added Liqrev oral suspension for PAH and updated exclusion footnote. Updated background and references. | 5/1/2024 |
| **PAH Agents** | Medical Necessity | Adcirca® (tadalafil), Adempas® (riociguat), Alyq™ (tadalafil), Letairis® (ambrisentan), Liqrev® (sildenafil) oral suspension, Opsumit® (macitentan), Orenitram™ (treprostinil), Revatio® (sildenafil citrate) oral powder for suspension, Tadliq® (tadalafil) oral suspension, Tracleer® (bosentan), Tyvaso® (treprostinil), Tyvaso DPI™ (treprostinil), Uptravi® (selexipag), Ventavis® (iloprost) | Annual review. Added Liqrev oral suspension for PAH and updated exclusion footnote. Updated background and references. | 5/1/2024 |
| **Praluent** | Medical Necessity | Praluent® (alirocumab) | Updated diagnostic criteria per European Atherosclerosis Society guidance. Updated references. | 5/1/2024 |
| **Praluent** | Notification | Praluent® (alirocumab) | Simplified reauthorization criteria. | 5/1/2024 |
| **Pulmozyme** | Notification | Pulmozyme® (dornase alfa) | Annual review with no changes to coverage criteria. | 5/1/2024 |
| **Ravicti** | Notification | Ravicti® (glycerol phenylbutyrate oral liquid) | Annual review with no change to clinical coverage. | 5/1/2024 |
| **Ravicti** | Medical Necessity | Ravicti® (glycerol phenylbutyrate oral liquid) | Annual review with no change to clinical coverage. | 5/1/2024 |
| **Ravicti** | Step Therapy | Ravicti® (glycerol phenylbutyrate oral liquid) | Annual review with no change to clinical coverage. Updated reference. | 5/1/2024 |
| **Recorlev** | Notification | Recorlev® (levoketoconazole) | Annual review with no changes to coverage criteria. Updated reference. | 5/1/2024 |
| **Repatha** | Notification | Repatha® (evolocumab) | Simplified reauthorization criteria. | 5/1/2024 |
| **Repatha** | Medical Necessity | Repatha® (evolocumab) | Updated diagnostic criteria per European Atherosclerosis Society guidance. Simplified reauthorization criteria. Updated references. | 5/1/2024 |
| **Rezlidhia** | Notification | Rezlidhia™ (olutasidenib) | Annual review with no change to coverage criteria. Updated reference. | 5/1/2024 |

| | UM Type | Trade Name (Generic Name) | Summary of Changes | Implementation Date |
|---|---|---|---|---|
| **Slynd** | Medical Necessity | Slynd® (drospirenone) | Annual review. Updated criteria to note a progesterone-only contraceptive due to the approval of the over-the-counter contraceptive. | 5/1/2024 |
| **Slynd** | Step Therapy | Slynd® (drospirenone) | Annual review. Updated progestin only contraceptive to e.g. due to the over the counter product. | 5/1/2024 |
| **Suboxone** | Medical Necessity | Suboxone® (Brand Only) | Removed Bunavail from program, it is off the market. Added Nevada mandate. Updated references. | 5/1/2024 |
| **Tarpeyo** | Medical Necessity | Tarpeyo® (budesonide delayed-release capsules) | Updated indication and references. | 5/1/2024 |
| **Testosterone** | Medical Necessity | Androderm®, Androgel®, Fortesta®, Jatenzo®, Natesto®, Kyzatrex™, Testim®, testosterone topical solution (generic Axiron®), testosterone transdermal gel (generic Testim), Tlando™, Vogelxo®, Xyosted® | Annual review. Updated references. | 5/1/2024 |
| **Tetrabenazine** | Notification | Tetrabenazine (Xenazine®) | Annual review. No changes to clinical coverage criteria. | 5/1/2024 |
| **Vemlidy** | Medical Necessity | Vemlidy® (tenofovir alafenamide) | Added Nevada footnote. | 5/1/2024 |
| **Verquvo** | Medical Necessity | Verquvo® (vericiguat) | Annual review. Updated references. | 5/1/2024 |
| **Viekira Pak** | Notification | Viekira Pak (ombitasvir, paritaprevir, and ritonavir tablets; dasabuvir tablets) | Annual review with no changes to coverage criteria. | 5/1/2024 |
| **Wainua** | Notification | Wainua™ (eplontersen) | New program | 5/1/2024 |
| **Wainua** | Medical Necessity | Wainua™ (eplontersen) | New program | 5/1/2024 |
| **Welireg** | Notification | Welireg™ (belzutifan) | Added criteria for advanced renal cell carcinoma. Updated background and references. | 5/1/2024 |
| **Xalkori** | Notification | Xalkori® (crizotinib) | Annual review. Updated background and coverage criteria for cutaneous melanoma per NCCN. Updated references. | 5/1/2024 |
| **Xalkori - Non-Formulary** | Non-Formulary | Xalkori® (crizotinib) | Annual review. Updated background and coverage criteria for cutaneous melanoma per NCCN. Updated references. | 5/1/2024 |
| **Xospata** | Notification | Xospata®(gilteritinib) | Annual review. Updated treatment criteria for AML to include additional NCCN recommendations. | 5/1/2024 |
| **Yonsa** | Notification | Yonsa® (abiraterone acetate) | Annual review. Updated background. | 5/1/2024 |
| **Yonsa** | Step Therapy | Yonsa® (abiraterone acetate) | Annual review. No changes to step therapy criteria. Updated reference. | 5/1/2024 |
| **Zepatier** | Notification | Zepatier® (elbasvir/grazoprevir) | Annual review. Updated polymorphism criteria for treatment of chronic hepatitis C genotype 1a infection in treatment-naïve, PegIFN/RBV-experienced patients with baseline NS5A polymorphisms to include "one or more". Added treatment - naïve requirement in criteria for Chronic Hepatitis C - Genotype 4 -Treatment-naïve patients. | 5/1/2024 |
| **Zepatier** | Medical Necessity | Zepatier® (elbasvir/grazoprevir) | Annual review. Updated polymorphism criteria for treatment of chronic hepatitis C genotype 1a infection in treatment-naïve, PegIFN/RBV-experienced, or PegIFN/RBV/protease inhibitor-experienced patients with baseline NS5A polymorphisms to include "one or more". | 5/1/2024 |
| **Zykadia** | Notification | Zykadia® (ceritinib) | Annual review. Updated background and coverage criteria for inoperable inflammatory myofibroblastic tumor and anaplastic large cell lymphoma per NCCN. Updated reference. | 5/1/2024 |
| **Zykadia - Non-Formulary** | Non-Formulary | Zykadia® (ceritinib) | Annual review. Updated background and coverage criteria for inoperable inflammatory myofibroblastic tumor and anaplastic large cell lymphoma per NCCN. Updated reference. | 5/1/2024 |

| | UM Type | Trade Name (Generic Name) | Summary of Changes | Implementation Date |
|---|---|---|---|---|
| **Adbry** | Notification | Adbry™ (tralokinumab-ldrm) | Annual review. Removed age requirement from criteria. Updated background and reference. | 6/1/2024 |
| **Adbry** | Medical Necessity | Adbry™ (tralokinumab-ldrm) | Annual review. Clarified topical steroid potency in atopic dermatitis with no change to clinical intent or coverage criteria. Updated background and reference. | 6/1/2024 |
| **Afstyla** | Notification | Afstyla® (antihemophilic factor [recombinant], single chain) | Annual review with no changes to coverage criteria. Updated reference. | 6/1/2024 |
| **Afstyla** | Medical Necessity | Afstyla® (antihemophilic factor [recombinant], single chain) | Annual review with no changes to coverage criteria. | 6/1/2024 |
| **Aimovig, Ajovy, Emgality** | Notification | Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab) | Annual review. Increased the initial authorization to 12 months. Updated references. | 6/1/2024 |
| **Aimovig, Ajovy, Emgality** | Medical Necessity | Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab) | Annual review. Updated initial authorization to 12 months. Added episodic to cluster headaches in section header. Updated mandate language. Updated references. | 6/1/2024 |
| **Aimovig, Ajovy, Emgality** | Step Therapy | Aimovig (erenumab), Ajovy (fremanezumab), Emgality (galcanezumab) | Annual review. Updated state mandate language. Updated references. | 6/1/2024 |
| **Akeega** | Step Therapy | Akeega™ (niraparib and abiraterone acetate) | New program. | 6/1/2024 |
| **Benefit Determination – Mifeprex 200 mg and mifepristone (generic Mifeprex) 200 mg** | Misc | Mifeprex 200 mg and mifepristone (generic Mifeprex) 200 mg | Annual review. No updates. | 6/1/2024 |
| **Benznidazole** | Notification | Benznidazole | Annual review. No changes. | 6/1/2024 |
| **Bronchitol** | Notification | Bronchitol® (mannitol) | Annual review. No change to coverage criteria. Updated reference. | 6/1/2024 |
| **Bronchitol** | Step Therapy | Bronchitol® (mannitol) | Annual review with no change to coverage criteria. Updated reference. | 6/1/2024 |
| **Caplyta** | Notification | Caplyta® (lumateperone) | Annual review. Updated reference. | 6/1/2024 |
| **Cibinqo** | Notification | Cibinqo™ (abrocitinib) tablets | Annual review. Removed age requirement from criteria. Updated reference. | 6/1/2024 |
| **Cibinqo** | Medical Necessity | Cibinqo™ (abrocitinib) tablets | Annual review. Clarified topical steroid potency in atopic dermatitis with no change to clinical intent or coverage criteria. Updated state mandate footnote and reference. | 6/1/2024 |
| **Cinryze** | Notification | Cinryze® (C1 esterase inhibitor, human) | Annual review. No changes to coverage criteria. | 6/1/2024 |
| **Cinryze** | Medical Necessity | Cinryze® (C1 esterase inhibitor, human) | Annual review with update to diagnostic criteria for HAE with normal C1 inhibitor levels. Simplified reauthorization criteria. Updated reference. | 6/1/2024 |
| **Compounds and Bulk Powders** | Notification | Compounds and Bulk Powders | Annual review. No changes. | 6/1/2024 |
| **Dry Eye Disease - Cequa, Miebo, Restasis MultiDose, Tyrvaya, Vevye, Xiidra** | Medical Necessity | Cequa™ (cyclosporine 0.09% ophthalmic solution), Miebo™ (perfluorohexyloctane), Restasis® MultiDose™ (cyclosporine 0.05% ophthalmic emulsion), Tyrvaya™ (varenicline nasal spray), Vevye™ (cyclosporine 0.1%) | Updated the initial authorization to 12 months. Updated references. | 6/1/2024 |
| **Dry Eye Disease - Cequa, Miebo, Restasis, Restasis MultiDose, Tyrvaya, Vevye, Xiidra** | Notification | Cequa™ (cyclosporine 0.09% ophthalmic solution), Miebo™ (perfluorohexyloctane), Restasis® (cyclosporine 0.05% ophthalmic emulsion), Restasis MultiDose™ (cyclosporine 0.05% ophthalmic emulsion), Tyrvaya™ (varenicline nasal spray), Vevye™ (cyclosporine 0.1%), Xiidra® (lifitegrast 5% ophthalmic solution) | Updated initial authorization to 12 months. Updated references. | 6/1/2024 |
| **Dupixent** | Medical Necessity | Dupixent®(dupilumab) | Clarified topical steroid potency in atopic dermatitis with no change to clinical intent or coverage criteria. Removed weight requirement from Eosinophilic Esophagitis criteria. Updated state mandate footnote, background and reference. | 6/1/2024 |
| **Dupixent** | Notification | Dupixent®(dupilumab) | Removed weight requirement from Eosinophilic Esophagitis criteria. Updated background and reference. | 6/1/2024 |
| **Esbriet, Ofev** | Notification | Esbriet® (pirfenidone) and Ofev® (nintedanib) | Annual review. No change in coverage criteria. Updated references. | 6/1/2024 |
| **Esbriet, Ofev** | Medical Necessity | Esbriet® (pirfenidone) and Ofev® (nintedanib) | Annual review. No change in coverage criteria. Updated references. | 6/1/2024 |

| | UM Type | Trade Name (Generic Name) | Summary of Changes | Implementation Date |
|---|---|---|---|---|
| **Esperoct** | Notification | Esperoct®[antihemophilic factor (recombinant), glycopegylated-exei] | Annual review with no changes to coverage criteria. | 6/1/2024 |
| **Esperoct** | Medical Necessity | Esperoct®[antihemophilic factor (recombinant), glycopegylated-exei] | Annual review with no changes to clinical criteria. | 6/1/2024 |
| **Esperoct** | Step Therapy | Esperoct®[antihemophilic factor (recombinant), glycopegylated-exei] | Annual review with no changes to clinical criteria. | 6/1/2024 |
| **Furoscix** | Notification | Furoscix® (furosemide injection) | Annual review. Updated background to include limitations of use. Updated reference. | 6/1/2024 |
| **Furoscix** | Medical Necessity | Furoscix® (furosemide injection) | Annual review. Updated background to include limitations of use. Updated reference. | 6/1/2024 |
| **Glaucoma Agents - Travatan Z, Vyzulta, Zioptan** | Step Therapy | Travatan Z® (travoprost), Vyzulta® (latanoprostene), Zioptan® (tafluprost) | Annual review. Travatan Z added to the step therapy. | 6/1/2024 |
| **Haegarda** | Notification | Haegarda® (C1 esterase inhibitor Subcutaneous, human) | Annual review. No changes to coverage criteria. | 6/1/2024 |
| **Haegarda** | Medical Necessity | Haegarda® (C1 esterase inhibitor Subcutaneous, human) | Annual review with update to diagnostic criteria for HAE with normal C1 inhibitor levels. Updated language for reauthorization criteria. | 6/1/2024 |
| **Impavido** | Notification | Impavido (miltefosine) | Annual review. Updated references. | 6/1/2024 |
| **Insulin Delivery Devices** | Step Therapy | Insulin Delivery Devices | New program. | 6/1/2024 |
| **Javygtor, Kuvan** | Notification | Javygtor™ (sapropterin dihydrochloride), Kuvan® (sapropterin dihydrochloride) | Annual review. Updated authorization approval duration to 12 months. Updated reference. | 6/1/2024 |
| **Korlym** | Notification | Korlym® (mifepristone) | Annual review. Updated approval duration of coverage criteria to 12 months. Updated reauthorization criteria. | 6/1/2024 |
| **Lyrica CR** | Step Therapy | Lyrica® CR tablets (pregabalin ER) | Annual review. Updated references. | 6/1/2024 |
| **Ninlaro** | Notification | Ninlaro® (ixazomib) | Annual review. Updated background and coverage criteria per NCCN guidelines. Updated references. | 6/1/2024 |
| **Opioid-containing cough medicines** | Medical Necessity | Opioid-containing cough medicines (including but not limited to: Tussicaps®, Tuxarin ERTM, codeine/phenylephrine/promethazine, codeine/promethazine, hydrocodone/homatropine, hydrocodone bitartrate/guaifenesin, hydrocodone polistirex/chlorpheniramine polistirex, hydrocodone bitartrate/chlorpheniramine) | Removed Tuzistra XR as it is no longer on the market. Updated references. | 6/1/2024 |
| **Orladeyo** | Notification | Orladeyo® (berotralstat) | Annual review with no changes to clinical criteria. | 6/1/2024 |
| **Orladeyo** | Medical Necessity | Orladeyo® (berotralstat) | Annual review with update to diagnostic criteria for HAE with normal C1 inhibitor levels. | 6/1/2024 |
| **Orserdu** | Notification | Orserdu™ (elacestrant) | Annual review. Added premenopausal women treated with ovarian ablation/suppression to coverage criteria per NCCN. Updated background and references. | 6/1/2024 |
| **Osphena** | Notification | Osphena® (ospemifene) | Annual review. Updated references. | 6/1/2024 |
| **Palforzia** | Notification | Palforzia [Peanut (Arachis hypogaea) Allergen Powder-dnfp] | Annual review. Updated references. | 6/1/2024 |
| **Palforzia** | Medical Necessity | Palforzia [Peanut (Arachis hypogaea) Allergen Powder-dnfp] | Annual review. Updated references. | 6/1/2024 |
| **Piqray** | Notification | Piqray® (alpelisib) | Updated criteria reflecting new indication for use is adults removing criteria for postmenopausal, premenopausal with ovarian ablation/suppression and male. Updated background and references. | 6/1/2024 |
| **Prudoxin, Zonalon** | Notification | Prudoxin® (doxepin), Zonalon® (doxepin) | Annual review. No changes. | 6/1/2024 |
| **Prudoxin, Zonalon** | Medical Necessity | Prudoxin® (doxepin), Zonalon® (doxepin) | Review with no changes. | 6/1/2024 |

| | UM Type | Trade Name (Generic Name) | Summary of Changes | Implementation Date |
|---|---|---|---|---|
| **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. | 6/1/2024 |
| **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 change to coverage criteria. Updated references. | 6/1/2024 |
| **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 criteria. Updated references. | 6/1/2024 |
| **Reyvow** | Notification | Reyvow® (lasmiditan) | Annual review. No changes. | 6/1/2024 |
| **Reyvow** | Medical Necessity | Reyvow® (lasmiditan) | Annual review. No changes. | 6/1/2024 |
| **Reyvow** | Step Therapy | Reyvow® (lasmiditan) | Annual review. No changes. | 6/1/2024 |
| **Sublingual Immunotherapy (SLIT)** | 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. | 6/1/2024 |
| **Sublingual Immunotherapy (SLIT)** | 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. | 6/1/2024 |
| **Sunlenca** | Notification | Sunlenca® (lenacapavir) | Annual review with no changes to clinical criteria. Updated reference. | 6/1/2024 |
| **Supply Limits - Greater than 34 day supply for opioids at retail** | Misc | Supply Limits - Greater than 34 day supply for opioids at retail - Includes all salt forms, single and combination ingredient products short-acting and long-acting opioid formulations, and all brand and generic formulations | Annual review. No changes. | 6/1/2024 |
| **Sutent** | Notification | Sutent® (sunitinib malate) | Annual review. Updated GIST, neuroendocrine/adrenal tumors, and thyroid carcinoma per NCCN recommendations. | 6/1/2024 |
| **Takhzyro** | Notification | Takhzyro® (lanadelumab-flyo) | Annual review. No changes to coverage criteria. | 6/1/2024 |
| **Takhzyro** | Medical Necessity | Takhzyro® (lanadelumab-flyo) | Annual review. Update to diagnostic criteria for HAE with normal C1 inhibitor levels. Updated and simplified reauthorization criteria. | 6/1/2024 |
| **Tasmar** | Medical Necessity | Tasmar® (tolcapone) | Annual review. No changes. | 6/1/2024 |
| **Tazorac** | Medical Necessity | Tazorac® (tazarotene) | Annual review. Updated initial authorization to 12 months. | 6/1/2024 |
| **Tazverik** | Notification | Tazverik® (tazemetostat) | Annual review. Added NCCN recommendations to background section. Added criteria to relapsed/refractory follicular lymphoma based on NCCN recommendations. Updated references. | 6/1/2024 |

| | UM Type | Trade Name (Generic Name) | Summary of Changes | Implementation Date |
|---|---|---|---|---|
| **Test Strips - Non-Formulary** | Medical Necessity | Abbott Diabetic Meters (e.g. FreeStyle Freedom Lite, FreeStyle InsuLinx, FreeStyle Lite, FreeStyle Neo, Precision Xtra,) Abbott Test Strips (e.g. FreeStyle Insulinx, FreeStyle Lite, FreeStyle, FreeStyle Precision Neo, Precision Xtra), Ascensia Diabetic Meters, excluding Contour Next Meters (e.g. Contour, Contour Next Link), Ascensia Test Strips, excluding Contour Next Test Strips (e.g. Contour), Roche Diabetic Meters, excluding Accu-Chek Guide and Accu-Chek Guide Me (e.g. Accu-Chek Aviva Plus), Roche Test Strips, excluding Accu-Chek Guide (e.g. Accu-Chek Aviva Plus, Accu-Chek Compact, Accu-Chek Smartview) | Annual review. Updated references. | 6/1/2024 |
| **Tukysa** | Notification | Tukysa® (tucatinib) | Annual review. No changes to clinical criteria. | 6/1/2024 |
| **Vascepa** | Notification | Vascepa® (icosapent ethyl) | Annual review. No changes. | 6/1/2024 |
| **Vascepa** | Medical Necessity | Vascepa® (icosapent ethyl) | Annual review. No changes. | 6/1/2024 |
| **Viberzi** | Medical Necessity | Viberzi® (eluxadoline) | Annual review. Increased initial authorization to 12 months. | 6/1/2024 |
| **Voquezna** | Medical Necessity | Voquezna® (vonoprazan) | New program. | 6/1/2024 |
| **Wakix** | Notification | Wakix® (pitolisant) | Annual review. No changes. | 6/1/2024 |
| **Xphozah** | Medical Necessity | Xphozah® (tenapanor) | New program. | 6/1/2024 |
| **Xtandi** | Notification | Xtandi® (enzalutamide) | Annual review. Updated background and criteria with expanded indication in non-metastatic castration-sensitive setting. Updated references. | 6/1/2024 |
| **Zelboraf** | Notification | Zelboraf® (vemurafenib) | Annual review. Updated nomenclature under Thyroid carcinoma from Hurthle cell to oncocytic with no change to clinical intent. Updated reference. | 6/1/2024 |
| **Zokinvy** | Notification | Zokinvy™ (lonafarnib) | Annual review with no change to coverage criteria. | 6/1/2024 |
| **Rivfloza** | Notification | Rivfloza™ (nedosiran)<br>*This program applies to the prefilled syringe formulation | New program. | 7/1/2024 |
| **Rivfloza** | Medical Necessity | Rivfloza™ (nedosiran)<br>*This program applies to the prefilled syringe formulation | New program. | 7/1/2024 |
| **Rivfloza** | Step Therapy | Rivfloza™ (nedosiran)<br>*This program applies to the prefilled syringe formulation | New program. | 7/1/2024 |
| **Rhofade** | Medical Necessity | Rhofade® (oxymetazoline) | New program. | 9/1/2024 |