Policy Number	Policy Title	Description	RevisionNotes	Date of Revision
HIM.PA.169	Berotralstat (Orladeyo)	Berotralstat (Orladeyo®) is a plasma kallikrein inhibitor.	RT4: updated to reflect pediatric extension down to 2 years of age and added new oral pellet dosage form.	2/1/2026
HIM.PA.178	Immune Globulins	The following are immune globulins requiring prior authorization: Alyglo™, Asceniv™, Bivigam®, Cutaquig®, Cuvitru™, Flebogamma® DIF, GamaSTAN®, GamaSTAN® S/D, Gammagard® liquid, Gammagard® liquid ERC, Gammagard® S/D, Gammaked™, Gammaplex®, Gamunex®-C, Hizentra®, HyQvia®, Octagam®, Panzyga®, Privigen®, Qivigy®, Xembify®, and Yimmugo®.	HCPCS code removed [J1572].	2/1/2026
CP.PHAR.468	Aducanumab-avwa (Aduhelm)	Aducanumab-avwa (Aduhelm™) is a monoclonal antibody targeting amyloid beta.	Removed HCPCS code [J0172].	2/1/2026
CP.PHAR.422	Cladribine (Mavenclad)	Cladribine (Mavenclad®) is a cytotoxic purine antimetabolite.	For brand Mavenclad requests, added redirection to generic per SDC request.	2/1/2026
CP.PHAR.526	Fibrinogen Concentrate [Human] (Fibryga, RiaSTAP), Fibrinogen, Human-chmt (Fesilty)	The following are fibrinogen (coagulation factor I) products requiring prior authorization: fibrinogen concentrate [human] (Fibryga®, RiaSTAP®) and fibrinogen, human-chmt (Fesilty™).	RT4: added newly approved Fesilty.	2/1/2026
CP.PHAR.600	Trofinetide (Daybue)	Trofinetide (Daybue™) is an insulin-like growth factor 1 (IGF-1) analog.	RT4: added new Daybue Stix formulation; revised approval durations to 12 months.	2/1/2026
CP.PHAR.620	Pirtobrutinib (Jaypirca)	Pirtobrutinib (Jaypirca®) is a noncovalent Bruton tyrosine kinase (BTK) inhibitor.	RT4: for CLL/SLL, updated FDA Approved Indication(s) section to reflect conversion from accelerated approval to full approval; for CLL/SLL, simplified prior therapy requirements to "Member has received prior treatment with a covalent BTK inhibitor" per updated prescribing information and simplified Richter's transformation requirement per NCCN compendium; for all indications, extended initial approval duration from 6 to 12 months.	2/1/2026
CP.PHAR.629	Retifanlimab-dlwr (Zynyz)	Retifanlimab-dlwr (Zynyz®) is a programmed death receptor-1 (PD-1)–blocking antibody.	RT4: updated FDA Approved Indication(s) section for MCC from accelerated approval to full approval per PI; extended Medicaid and HIM initial approval durations from 6 months to 12 months for this maintenance medication for a chronic condition; for MCC, added pathway for in-transit regional disease and primary regional disease per NCCN compendium and removed requirement of "Disease is not amenable to surgery or radiation therapy" for metastatic or recurrent locally advanced disease per PI.	2/1/2026
CP.PHAR.720	Nipocalimab-aahu (Imaavy)	Nipocalimab-aahu (Imaavy™) is a neonatal Fc receptor blocker.	HCPCS code updates: added [J9256], removed [C9305].	2/1/2026
CP.PMN.199	Esketamine (Spravato)	Esketamine (Spravato™) is a non-competitive N-methyl D-aspartate (NMDA) receptor antagonist.	HCPCS codes updates: added [J0013], removed [S0013].	2/1/2026
CP.PHAR.385	Corticosteroids for Ophthalmic Injection (Dextenza, Iluvien, Ozurdex, Retisert, Xipere, Yutiq)	The following are corticosteroids for ophthalmic injection requiring prior authorization: dexamethasone intravitreal implant (Ozurdex®), dexamethasone ophthalmic insert (Dextenza®), fluocinolone acetonide intravitreal implant (Iluvien®, Retisert®, Yutiq®), and triamcinolone acetonide suprachoroidal injection (Xipere®).	In Section V, clarified maximum dose is every 6 months.	2/1/2026
CP.PHAR.458	Inebilizumab-cdon (Uplizna)	Inebilizumab-cdon (Uplizna®) is an anti-CD19-directed cytolytic antibody.	RT4: added criteria for the newly approved indication of gMG; for NMOSD and IgG4-RD, extended initial approval durations for Medicaid and HIM from 6 to 12 months and revised all approval durations for Commercial to "6 months or to the member's renewal date, whichever is longer".	2/1/2026
CP.PHAR.495	Mitomycin Instillation Solution (Jelmyto, Zusduri)	Mitomycin (for pyelocalyceal solution [Jelmyto®] and for intravesical solution [Zusduri™]) is an alkylating drug.	HCPCS code added [J9282] and removed [J9999, C9399].	2/1/2026
CP.PHAR.609	Prademagene Zamikeracel (Zevaskyn)	Prademagene zamikeracel (Zevaskyn™) is an autologous cell sheet-based gene therapy.	Added Coding Implications section with HCPCS code [J3389].	2/1/2026
CP.PHAR.634	Epcoritamab-bysp (Epkinly)	Epcoritamab-bysp (Epkinly™) is a bispecific CD20-directed CD3 T-cell engager.	RT4: updated with newly approved indication of combination with lenalidomide and rituximab for relapsed or refractory FL and updated accelerated approved to traditional approval for FL indications; expanded monotherapy option for B-cell lymphoma subtypes per NCCN; summarized NCCN and FDA-approved uses for improved clarity; extended initial approval duration for Medicaid/HIM from 6 months to 12 months.	2/1/2026
CP.PHAR.733	Telisotuzumab Vedotin-tllv (Emrelis)	Telisotuzumab vedotin-tllv (Emrelis™) is a c-Met-directed antibody and microtubule inhibitor conjugate.	HCPCS code updates: added [J9326], removed [C9306, J9999].	2/1/2026
CP.PHAR.743	Linvoseltamab-gcpt (Lynozyfic)	Linvoseltamab-gcpt (Lynozyfic™) a bispecific B-cell maturation antigen (BCMA)-directed CD3 T-cell engager.	HCPCS code added [C9307].	2/1/2026
CP.PHAR.82	Collagenase Clostridium Histolyticum (Xiaflex)	Collagenase clostridium histolyticum (Xiaflex®) is a combination of bacterial collagenases.	Added clarification for New York Essential Plans and New York Medicaid (including CHIP), use of Xiaflex for the treatment of Peyronie's Disease is a benefit exclusion and will NOT be authorized per state regulations.	2/1/2026
CP.PMN.156	Perampanel (Fycompa)	Perampanel (Fycompa®) is a non-competitive α-amino-3-hydroxy-5-methyl-4-isoxazolepropionic acid (AMPA) glutamate receptor antagonist.	Clarified required use of generic perampanel tablets for brand tablet and oral solutions requests.	2/1/2026
CP.PMN.91	Cariprazine (Vraylar)	Cariprazine (Vraylar®) is an atypical antipsychotic.	RT4: updated criteria with pediatric extension to include age 10 years and older for bipolar disorder and age 13 years and older for schizophrenia (both previously approved only in adults) per PI; added new 0.5 mg and 0.75 mg capsule strengths per PI.	2/1/2026
CP.PHAR.05	Hyaluronate Derivatives	The following are hyaluronate derivatives requiring prior authorization: sodium hyaluronate (Euflexxa®, Gelsyn-3™, GenVisc®850, Hyalgan®, Supartz FX™, Synojoynt™, Triluron™, TriVisc™, VISCO-3™), hyaluronic acid (Durolane®), cross-linked hyaluronate (Gel-One®), hyaluronan (Hymovis®, Orthovisc®, Monovisc®), and hylan polymers A and B (Synvisc®, Synvisc One®). *For Health Insurance Marketplace (HIM), coverage of hyaluronate derivatives is excluded for the pharmacy benefit and should not be approved using these criteria; these criteria may be used for medical benefit review.	HCPCS code description revised [J7322].	2/1/2026

CP.PHAR.136	Elagolix (Orilissa), Elagolix/Estradiol/Norethinedrone (Oriahnn)	Elagolix (Orilissa®) is a gonadotropin-releasing hormone (GnRH) receptor antagonist. Elagolix/estradiol/norethinedrone; elagolix (Oriahnn®) is a combination of a GnRH receptor antagonist with an estrogen and progestin. _____ *For Health Insurance Marketplace (HIM), if request is through pharmacy benefit, Oriahnn is non-formulary and should not be approved using these criteria; refer to the formulary exception policy, HIM.PA.103.	Repeated total duration of therapy by dosage language from approval duration in continued therapy criteria for endometriosis pain per request from UM team and canned text team.	2/1/2026
CP.PHAR.556	Elivaldogene Autotemcel (Skysona)	Elivaldogene autotemcel (Skysona®) is a genetically modified autologous CD34+ cell enriched population that contains hematopoietic stem cells transduced ex vivo with a lentiviral vector encoding ABCD1 complementary deoxyribonucleic acid (cDNA) for human adrenoleukodystrophy protein.	HCPCS code update: added [J3387], removed [J3590, C9399].	2/1/2026
CP.PHAR.558	Mitapivat (Pyrukynd, Aqvesme)	Mitapivat (Pyrukynd®, Aqvesme™) is a pyruvate kinase (PK) activator.	RT4: added Aqvesme for treatment of anemia in adults with thalassemia to policy.	2/1/2026
CP.PHAR.759	Nerandomilast (Jascayd)	Nerandomilast (Jascayd®) is a phosphodiesterase 4 (PDE4) inhibitor.	RT4: added newly FDA approved indication for PPF.	2/1/2026
CP.PHAR.93	Bevacizumab (Alymsys, Avastin, Avzivi, Jobevne, Mvasi, Vegzelma, Zirabev)	Bevacizumab (Avastin®) and its biosimilars [bevacizumab-maly (Alymsys®), bevacizumab-tnjn (Avzivi®), bevacizumab-nwgd (Jobevne™), bevacizumab-awwb (Mvasi®), bevacizumab-adcd (Vegzelma™), bevacizumab-bvzr (Zirabev™)] are vascular endothelial growth factor-specific angiogenesis inhibitors.	HCPCS code added [Q5160].	2/1/2026
CP.PMN.170	Eluxadoline (Viberzi)	Eluxadoline (Viberzi®) is a mu-opioid receptor agonist.	Corrected numbering of criteria.	2/1/2026