

26Q2 HIM Criteria Summary Table Live

Policy Number	Policy Title	RevisionNotes
CP.PHAR.599	Marnetegrane autotemcel (Kresladi)	RT4: Drug is now FDA approved – criteria updated per FDA labeling: removed minimum age requirement, removed option for those with an HLA-matched sibling donor, and updated dose requirement; references reviewed and updated. Added ICHRA line of business and PDAC language.
CP.PHAR.599_PEPP	Marnetegrane autotemcel (Kresladi)_PEPP	FDA approved drug, finalized into "CP.PHAR.599 Marnetegrane autotemcel (Kresladi) 03.31.26"
CP.PHAR.736	Relacorilant (Lifyorli)	Drug is now FDA approved (adopted from CP.PHAR.736_PEPP) – criteria added for new indication of ovarian cancer.
CP.PHAR.746	Navepegritide (Yuviwel)	RT1: Drug is now FDA approved – criteria updated per prescribing information to include weight-based dosing and quantity limits; added to continued therapy requirement that Yuviwel is not prescribed concurrently with Voxzogo and any human growth hormone products; added ICHRA line of business; references reviewed and updated.
CP.PHAR.777_PEPP	Adrabetadex (VTS-270)_PEPP	Policy created pre-emptively
CP.PHAR.778_PEPP	Garetosmab (REGN2477)_PEPP	Policy created pre-emptively
CP.PHAR.779_PEPP	Imlifidase (IdeS)_PEPP	Policy created pre-emptively
CP.PHAR.780_PEPP	Isaralgagene Civaparovec (ST-920)_PEPP	Policy created pre-emptively
CP.PMN.308	Difamilast (Adquey)	Policy created.
HIM.PA.180	Insulin Icodec-abae (Awiqli)	Policy created.
HIM.PA.SP60	Biologic and Non-biologic DMARDs	2Q 2026 annual review: RT4: added newly approved autoinjector formulation for Pyzchiva; RT4: added newly approved single-dose vial for SC injection for Selarsdi; RT4: applied Idacio’s pediatric age extensions for HS and UV; no other significant changes; references reviewed and updated. RT4: for Sotyktu, added newly approved PsA indication; added Sotyktu to Appendix C for contraindications/boxed warnings section; RT4: for Cosentyx, added newly approved HS pediatric extension for ages ≥ 12 years. Added Otezla XR to description section and list of agents in “medically necessary when the following criteria are met” statement.

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