Pharmacy drug list

Updates and clinical criteria for UnitedHealthcare Community Plan of Texas CHIP, STAR, STAR Kids and STAR+PLUS plans. Effective Oct. 1, 2024.

<table>
<tr><th>Medications</th><th>Clinical criteria guidelines</th><th>Clinical criteria updates</th></tr>
<tr><td>Buprenorphine/naloxone
2 mg/0.5 mg SL film
4 mg/1 mg SL film
8 mg/2 mg SL film
2 mg/0.5 mg SL
8 mg/2 mg SL</td><td rowspan="4">Buprenorphine Agents</td><td rowspan="4">Updated approval duration to 180 days</td></tr>
<tr><td>Buprenorphine
2 mg tablet SL
8 mg tablet SL</td></tr>
<tr><td>Suboxone®
12 mg/3 mg film
2 mg/0.5 mg film
4 mg/1 mg film
8 mg/2 mg film</td></tr>
<tr><td>Zubsolv®
0.7 mg/0.18 mg tablet SL
1.4 mg/0.36 mg tablet SL
11.4 mg/2.9 mg tablet SL
2.9 mg/0.71 mg tablet SL
5.7 mg/1.4 mg tablet SL
8.6 mg/2.1 mg tablet SL</td></tr>
<tr><td>Litufloᵀᴹ (ritlecitinib)
50 mg capsule</td><td>Cytokine and CAM Antagonists</td><td>Updated with new prior authorization requirement</td></tr>
</table>

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Medications	Clinical criteria guidelines	Clinical criteria updates
Humira® (adalimumab) 10 mg/0.1 mL syringe 20 mg/0.2 mL syringe 40 mg/0.4 mL syringe Pen 80 mg/0.8 mL PEDI CROHN 80 mg/0.8 Pen PEDIUC 80 mg PEDI CROHN 80-40 mg Pen 40 mg/0.4 mL PEN CRHN-UC-HS 80 mg PEN PS-UV-AHS 80-40 mg 40 mg/0.8 mL syringe Pen 40 mg/0.8 mL PEN CROHN-UC-HS 40 mg PEN PS-UV-ADOL HS 40 mg	**Cytokine and CAM Antagonists**	Corrected Humira criteria logic for Crohn's disease pathway to check for history of conventional therapy
Adalimumab-adaz 40 mg pen/syringe **Adalimumab-adbm** 40 mg pen/syringe CRHN 40 mg PEN PSORIA-UV 40 mg **Adalimumab-fkjp** 20 mg syringe 40 mg pen/syringe **Adalimumab-ryvk** AI 40 mg **Amjevita™ (adalimumab-atto)** 10 mg/0.2 mL syringe 20 mg/0.4 mL syringe 40 mg/0.8 mL autoinjector 40 mg/0.8 mL syringe	**Cytokine and CAM Antagonists**	Added adalimumab biosimilar drugs requiring prior authorization

Medications	Clinical criteria guidelines	Clinical criteria updates
Cyltezo® (adalimumab-adbm) 10 mg/0.2 mL syringe 20 mg/0.4 mL syringe 40 mg/0.4 mL syringe 40 mg/0.8 mL syringe Pen 40 mg/0.4 mL Pen 40 mg/0.8 mL pen crh-uc-hs 40 mg pen crh-uc-hs 40 mg pen psoria-uv 40 mg pen psoria-uv 40 mg	**Cytokine and CAM Antagonists**	Added adalimumab biosimilar drugs requiring prior authorization
Hadlima (adalimumab-bwwd) 40 mg/0.4 mL syringe Pushtouch 40 mg/0.4 mL 40 mg/0.8 mL syringe PushTouch autoinjector 40 mg/0.8 mL		
Hulio® (adalimumab-fkjp) 20 mg/0.4 mL syringe 40 mg/0.8 mL 40 mg/0.8 mL syringe Pen 40 mg/0.8 mL		
Hyrimoz® (adalimumab-adaz) 10 mg/0.1 mL syringe 20 mg/0.2 mL syringe 40 mg/0.4 mL syringe PEDI CROHN 80 mg PEDI CROHN 80-40 mg Pen 40 mg/0.4 mL Pen 80 mg/0.8 mL PEN CROHN-UC 80 mg PEN PSORIA 80-40 mg		
Simlandi® (adalimumab-ryvk) AI 40 mg/0.4 mL		
Cosentyx® (secukinumab) 300 mg dose, 2 pens/2 syringes 150 mg/mL pen inject/syringe 75 mg/0.5 mL syringe 150 mg/mL pen inject/syringe		Added indication for hidradenitis suppurativa

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Medications	Clinical criteria guidelines	Clinical criteria updates
Enbrel® (etanercept) 25 mg kit 25 mg/0.5 mL syringe/vial 50 mg/mL syringe/SureClick® syringe/mini cartridge	**Cytokine and CAM Antagonists**	Updated age to 2 years and older for plaque psoriasis
Orencia® (abatacept) 125 mg/mL syringe/ClickJect 50 mg/0.4 mL syringe 87.5 mg/0.7 mL syringe		Updated age to 2 years and older for psoriatic arthritis
Entyvio® SC (vedolizumab) 108 mg/0.68 mL pen		Updated with new prior authorization requirement
Otezla® (apremilast) 30 mg tablet 28-day starter pack		Updated age for plaque psoriasis to 6 years and older
Diclofenac sodium topical gel 1% gel	**Diclofenac 3% Gel, Diclofenac 1.5% and 2% Topical Solution**	• Updated with new prior authorization requirement • Removed check for ingenol mebutate gel from question 4 in the diclofenac 3% criteria logic and diagram
Apomorphine 30 mg/3 mL cartridge	**Dopamine Agonists (Apokyn and Kynmobi)**	• Added apomorphine to drugs requiring prior authorization • Removed Apokyn and Kynmobi from drugs requiring prior authorization. Apokyn is no longer on formulary and Kynmobi has been discontinued.
Actiq® (fentanyl citrate) OTFC 200 mcg OTFC 400 mcg OTFC 600 mcg OTFC 800 mcg OTFC 1,200 mcg OTFC 1,600 mcg 12 mcg/hr patch 25 mcg/hr patch 37.5 mcg/hr patch 50 mcg/hr patch 62.5 mcg/hr patch 75 mcg/hr patch 87.5 mcg/hr patch 100 mcg/hr patch	**Fentanyl Agents**	Updated with new prior authorization requirements

Medications	Clinical criteria guidelines	Clinical criteria updates
Fentora® (fentanyl) 100 mcg buccal tablet 200 mcg buccal tablet 400 mcg buccal tablet 600 mcg buccal tablet 800 mcg buccal tablet	**Fentanyl Agents**	Updated with new prior authorization requirements
Fentanyl citrate 100 mcg buccal tablet 200 mcg buccal tablet 400 mcg buccal tablet 600 mcg buccal tablet 800 mcg buccal tablet		
Amitiza® (lubiprostone) 8 mcg capsule 24 mcg capsule	GI Motility Agents	• Added check for duplicate therapy for Amitza, Linzess, Lotronex, Motegrity, Relistor and Trulance • Updated Trulance criteria logic question No. 3: If no, go to No. 4
Lubiprostone 8 mcg capsule 24 mcg capsule		
Ibsbrela® (tenapanor) 50 mg tablet		
Linzess® (linaclotide) 72 mcg capsule 145 mcg capsule 290 mcg capsule		
Alosetron 0.5 mg tablet 1 mg tablet		
Lotronex® (alosetron) 0.5 mg tablet 1 mg tablet		
Motegrity® (prucalopride) 1 mg tablet 2 mg tablet		

Medications	Clinical criteria guidelines	Clinical criteria updates
Movantik® (naloxegol) 12.5 mg tablet 25 mg tablet **Symprioc® (naldemedine)** 0.2 mg tablet **Relistor (methylnaltrexone bromide)** 8 mg/0.4 mL syringe 12 mg/0.6 mL syringe 150 mg tablet **Trulance® (plecanatide)** 3 mg tablet **Viberzi® (eluxadoline)** 75 mg tablet 100 mg tablet	**GI Motility Agents**	• Added check for duplicate therapy for Amitza, Linzess, Lotronex, Motegrity, Relistor and Trulance • Updated Trulance criteria logic question No. 3: If no, go to No. 4
Acthar® Gel 40 units/0.5 mL SelfJect™ **HP Acthar® Gel** 80 units/mL vial	**HP Acthar**	Added Acthar 40 units/0.5 mL SelfJect
Imiquimod 5% cream packet 3.75% cream (pump) **Zyclara® (imiquimod)** 3.75% cream	**Imiquimod**	Added ICD-10 codes for genital/perianal warts for imiquimod 3.75%
Lyrica (pregabalin) 100 mg capsule 150 mg capsule 200 mg capsule 20 mg/mL oral solution 225 mg capsule 25 mg capsule 300 mg capsule 50 mg capsule 75 mg capsule	**Lyrica**	Removed age check for Lyrica IR
Fasenra™ (benralizumab) 30 mg/mL pen 10 mg/0.5 mL syringe	**Monoclonal Antibody Agents**	• Added to drugs requiring prior authorization and duplicate monoclonal antibody therapy tables • Added indication for eosinophilic asthma and updated age to greater than or equal to 6 years

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Medications	Clinical criteria guidelines	Clinical criteria updates
Opsynvi™ (macitentan/tadalafil) 10 mg/20 mg tablet 10 mg/40 mg tablet	**Pulmonary Hypertension Agents**	Updated with new prior authorization requirements
Winrevair™ (sotatercept-csrk) 45 mg 1-vial kit 45 mg 2-vial kit 60 mg 1-vial kit 60 mg 2-vial kit		
Ingrezza™ (valbenazine) 40 mg sprinkle cap 60 mg sprinkle cap 80 mg sprinkle capsule	**Vesicular Monoamine Transporter 2 Inhibitors**	Added to drug table

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