"What's New" Medical Pharmaceutical Policy July 2026 Updates

The following policy updates and reviews apply to all GHP members (Commercial, Marketplace, TPA, Medicare and Medicaid):

MBP 367.0 Pemrydi RTU (pemetrexed) – New Policy

- Medical record documentation that Pemrydi RTU will be used in combination with pembrolizumab and platinum chemotherapy for initial treatment of patients with metastatic non-squamous non-small cell lung cancer (NSCLC) AND documentation of no EGFR or ALK genomic tumor aberrations **OR**
- Medical record documentation that Pemrydi RTU will be used in combination with cisplatin for the initial treatment of patients with locally advanced or metastatic, non-squamous NSCLC **OR**
- Medical record documentation that Pemrydi RTU will be used as a single agent for the maintenance treatment of patients with locally advanced or metastatic, non-squamous NSCLC whose disease has not progressed after four cycles of platinum-based first-line chemotherapy **OR**
- Medical record documentation that Pemrydi RTU will be used as a single agent for the treatment of patients with recurrent, metastatic non-squamous, non-small cell lung ancer (NSCLC) after prior chemotherapy **OR**
- Medical record documentation that Pemrydi RTU will be used in combination with cisplatin for initial treatment of malignant pleural mesothelioma whose disease is unresectable or who are otherwise not candidates for curative surgery

AND

- Medical record documentation of therapeutic failure, intolerance, or contraindication to generic pemetrexed products

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

MBP 225.0 Uplizna (inebilizumab-cdon) – Updated Policy

Immunoglobulin G4-Related Disease (IgG4-RD)

- Medical record documentation that Uplizna is prescribed by or in consultation with a rheumatologist, hepatologist, immunologist, endocrinologist, nephrologist, or other provider with experience in treating IgG4-RD **AND**
- Medical record documentation of age 18 years or older **AND**
- Medical record documentation of a confirmed diagnosis of IgG4-RD based on the American College of Rheumatology/European League Against Rheumatism (ACR/EULAR) classification criteria **AND**
- Medical record documentation of involvement of at least 1 or more organ (e.g., pancreas, kidneys, orbital structures, salivary glands, and retroperitoneum) in a manner consistent with IgG4-RD **AND**
- Medical record documentation that the patient is refractory to or has a contraindication for the use of glucocorticoids **AND**
- Medical record documentation that Uplizna will not be used in combination with a disease modifying therapy for the treatment of IgG4-RD (e.g., rituximab)

AUTHORIZATION DURATION: Initial approval will be for 12 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

QUANTITY LIMIT:
Initial 12-month Authorization: Rx count of 3
Subsequent 12 month authorizations: 30 mL per 180 days; max qty supply: 30; min day supply: 168; max day supply: 180

Generalized Myasthenia Gravis (gMG)

- Medical record documentation that Uplizna is prescribed by or in consultation with a neurologist **AND**
- Medical record documentation of age 18 years or older **AND**
- Medical record documentation of a diagnosis of generalized myasthenia gravis (gMG) that is anti-acetylcholine receptor (AChR) positive OR anti-muscle-specific tyrosine kinase (MuSK) antibody positive **AND**
- Medical record documentation of Myasthenia Gravis Foundation of America Clinical Classification (MGFA) Class II to IVa **AND**
- Medical record documentation of a baseline Myasthenia Gravis-Activities of Daily Living (MG-ADL) score greater than or equal to 6 **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to corticosteroids **AND**
- Medical record documentation of therapeutic failure on intolerance to, or contraindication to at least two (2) non-steroidal immunosuppressive therapies OR has failed at least one (1) immunosuppressive therapy and required chronic plasmapheresis or plasma exchange (PE) **AND**
- Medical record documentation of failure on, intolerance to, or contraindication to intravenous immunoglobulin (IVIG).

AUTHORIZATION DURATION: Initial approval will be for 6 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 6 months and will require:

- Medical record documentation of continued disease improvement or lack of disease progression **AND**
- Medical record documentation that the member is responding positively to therapy as evidenced by an improvement of Myasthenia Gravis-Activities of Daily Living (MG-ADL) total score from baseline.

The medication will no longer be covered if patient experiences toxicity or worsening of disease.

QUANTITY LIMIT:
Initial 12-month Authorization: Rx count of 3
Subsequent 12 month authorizations: 30 mL per 180 days; max qty supply: 30; min day supply: 168; max day supply: 180

MBP 342.0 Opdivo Qvantig (nivolumab-hyaluronidase-nvhy) – Updated Policy

1. ***Melanoma***
   - Prescription written by a hematologist/oncologist **AND**
   - Medical record documentation that patient is ≥ ~~18 years~~ 12 years of age **AND**
   - Medical record documentation of one of the following:
     - A diagnosis of unresectable or metastatic melanoma **AND**
     - Opdivo Qvantig is being used as a single agent ~~following combination treatment with intravenous nivolumab and ipilimumab~~

     OR
     - A diagnosis of completely resected (no evidence of disease) Stage IIB, Stage IIC, Stage III, or Stage IV melanoma **AND**
     - Opdivo Qvantig is being used in the adjuvant setting **AND**
     - Opdivo Qvantig is being used as a single agent

**(*Note: The FDA-approved treatment duration for use of Opdivo Qvantig in the adjuvant setting for completely resected stage IIB, stage IIC, stage III, and stage IV melanoma is for up to 1 year, see specific reauthorization criteria below.)*

2. ***Renal Cell Carcinoma***
   - Prescription written by a hematologist/oncologist **AND**
   - Medical record documentation that patient is ≥ 18 years of age **AND**
   - Medical record documentation of use as a single agent for ~~relapse or for surgically unresectable~~ advanced ~~or metastatic~~ renal cell carcinoma **AND**
   - Medical record documentation of a therapeutic failure on or intolerance to prior anti-angiogenic therapy, including, but not limited to, Sutent (sunitinib), Votrient (pazopanib), Inlyta (axitinib), Nexavar (sorafenib), Avastin (bevacizumab), Afinitor (everolimus), or Torisel (temsirolimus).

OR

   - Medical record documentation of previously untreated advanced renal cell carcinoma AND one of the following:
     - Medical record documentation that Opdivo Qvantig will be given in combination with cabozantinib (Cabometyx)

     OR

     - Medical record documentation that the patient is at intermediate to poor risk (defined as having 1 or more 6 prognostic risk factors as per the IMDC criteria*) AND Medical record documentation that Opdivo Qvantig will be given as monotherapy following combination treatment with intravenous nivolumab and ipilimumab

*IMDC Criteria risk factors include:

1. Less than one year from time of initial renal cell carcinoma diagnosis to randomization
2. Karnofsky performance status <80%
3. Hemoglobin less than the lower limit of normal
4. Corrected calcium of greater than 10 mg/dL
5. Platelet count greater than the upper limit of normal
6. Absolute neutrophil count greater than the upper limit of normal

3. ***Colorectal Cancer***
   - Prescription written by a hematologist/oncologist **AND**
   - Medical record documentation that patient is ≥ ~~18 years~~ 12 years of age **AND**
   - Medical record documentation of a diagnosis of metastatic colorectal cancer **AND**
   - Medical record documentation of microsatellite instability-high (MSI-H) or mismatch repair deficient (dMMR) disease **AND**
   - One of the following:
     - Medical record documentation of progression following treatment with a fluoropyrimidine, oxaliplatin, and irinotecan ~~**AND**~~ as a single agent **OR**
     - Medical record documentation that Opdivo Qvantig is being used ~~as a single agent or~~ as a single agent following combination treatment with intravenous nivolumab and ipilimumab (Yervoy).

4. ***Hepatocellular Carcinoma (HCC)***
   - Prescription written by a hematologist/oncologist **AND**
   - Medical record documentation of a diagnosis of unresectable or metastatic hepatocellular carcinoma **AND**
   - One of the following:
     - Medical record documentation of a therapeutic failure on or intolerance to sorafenib (Nexavar) **AND**
     - Medical record documentation that Opdivo Qvantig will be used as a single-agent following combination treatment with intravenous nivolumab and ipilimumab (Yervoy).

     OR

- Medical record documentation that Opdivo Qvantig is being used as a single-agent in the first-line setting following combination treatment with intravenous nivolumab and ipilimumab (Yervoy).

The following policies were reviewed with no changes:

- MBP 36.0 Abraxane
- MBP 53.0 Eraxis
- MBP 82.0 Jevtana
- MBP 177.0 Prevymis IV
- MBP 180.0 Kanuma
- MBP 216.0 Trodelvy
- MBP 219.0 Fetroja
- MBP 311.0 Xacduro
- MBP 312.0 Veopoz
- MBP 313. Rezzayo
- MBP 314.0 Loqtorzi
- MBP 334.0 Vyloy

The following policies were retired:

- MBP 142.0 Portrazza

The following policy updates and reviews apply to Commercial, Marketplace, TPA, and Medicare GHP members only:

MBP 360.0 Exdensur (depemokimab-ulaa) – New Policy

- Prescription written by an allergist, immunologist or pulmonologist **AND**
- Medical record documentation of patient age greater than or equal to 12 years **AND**
- Medical record documentation of a diagnosis of severe eosinophilic asthma **AND**
- Medical record documentation that Exdensur (depemokimab) is being used as add-on maintenance treatment **AND**
- Medical record documentation of a blood eosinophil count of either ≥ 300 cells/mcL (0.30 K/µl) during the 12-month period before screening and/or ≥ 150 cells/mcL (0.15 K/µl) within 3 months of the start of therapy **AND**
- Medical record documentation of:
    - Intolerance to or not well controlled or very poorly controlled symptoms* despite at least a 3-month trial of: high-dose inhaled corticosteroids and/or oral systemic corticosteroids plus a long-acting beta agonist **OR**
    - Two or more exacerbations in the previous 12 months requiring additional medical treatment (oral corticosteroids, emergency department or urgent care visits, or hospitalization) despite current therapy with high-dose inhaled corticosteroids plus a long-acting beta agonist **AND**
- Insured individuals must be adherent with current therapeutic regimen and must demonstrate appropriate inhaler technique **AND**
- Medical record documentation that the medication will not be used in combination with another biologic medication indicated for asthma treatment (e.g., Fasenra (benralizumab), Cinqair (reslizumab), Dupixent (dupilumab), Xolair (omalizumab), Tezspire (Tezepelumab), Nucala (Mepolizumab)

AUTHORIZATION DURATION: Initial approval will be for 12 months or less if the reviewing provider feels it is medically appropriate. Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate and will require medical record documentation of

continued disease improvement or lack of disease progression. The medication will no longer be covered if patient experiences toxicity or worsening of disease.

QUANTITY LIMITS: 1 mL (100 mg) every 6 months

MBP 361.0 Ryzneuta (efbemalenograstim alfa-vuxw) – New Policy

1. Primary Prophylaxis - the prevention of febrile neutropenia (FN) when the risk of FN due to the myelosuppressive chemotherapy regimen is 20% or greater. Those regimens include but are not limited to:

- TC (paclitaxel/cisplatin, or cyclophosphamide/docetaxel or docetaxel/cisplatin or paclitaxel/carboplatin)
- MVAC (methotrexate, vinblastine, doxorubicin, cisplatin)
- AC (doxorubicin, cyclophosphamide, docetaxel)
- AT (doxorubicin, paclitaxel)
- TIC (paclitaxel, ifosfamide, mesna, cisplatin)
- VAPEC-B (vincristine, doxorubicin, prednisolone, etoposide, cyclophosphamide, bleomycin)
- DHAP (dexamethasone, cisplatin, cytarabine)

NOTE: *Regimens not specified in this document must be listed on a nationally recognized guideline stating risk of FN of greater than 20%.*

AND

- For requests for Neulasta/Neulasta Onpro, medical record documentation of a therapeutic failure on, intolerance to, or contraindication to Ziextenzo, Udenyca, Nyvepria, Fylnetra, Stimufend, **AND** Fulphila.

OR

For the prevention of FN when the risk of developing FN is less than 20%, but any other risk factor listed below is present:

- Age 65 years or greater
- Poor performance status
- Previous history of FN
- Extensive prior radiation or chemotherapy treatment
- Poor nutritional status
- Recent surgery or Open wounds or active infection
- Advanced cancer
- Persistent neutropenia
- Bone marrow involvement by tumor
- Liver dysfunction (bilirubin >2.0)
- Renal dysfunction (CrCl <50)

AND

- For requests for Neulasta/Neulasta Onpro, medical record documentation of a therapeutic failure on, intolerance to, or contraindication to Ziextenzo, Udenyca, Nyvepria, Fylnetra, Stimufend, **AND** Fulphila.

Ryzneuta may also be considered medically necessary for any of the following:

2. Secondary Prophylaxis – prevention of FN when a previous cycle of chemotherapy resulted in a neutropenic complication and for which primary prophylaxis was not received, and a dose reduction will compromise disease-free or overall survival or treatment outcome.

AND

- For requests for Neulasta/Neulasta Onpro, medical record documentation of a therapeutic failure on, intolerance to, or contraindication to Ziextenzo, Udenyca, Nyvepria, Fylnetra, Stimufend, **AND** Fulphila.

AUTHORIZATION: When approved, the duration of the authorization will be for 6 months.

MBP 195.0 Spravato (esketamine) – Updated Policy

For Treatment Resistant Depression

- Medical record documentation of age ≥ 18 **AND**
- Medical record documentation of diagnosis of major depression disorder (MDD), consistent with the FDA approved indication **AND**
- Medical record documentation of Spravato being used for treatment-resistant depression as defined by failure of at least two antidepressants from two different classes at an optimized dose for at least 6 weeks **AND**
- ~~Medical record documentation that Spravato will be used as monotherapy OR in combination with a newly initiated antidepressant **AND**~~
- Medical record documentation of the patient's baseline depression status using an appropriate rating scale (e.g. PHQ-9, Clinically Useful Depression Outcome Scale, Quick Inventory of Depressive Symptomatology-Self Report 16 Item, MADRS, HAM-D) **AND**
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to at least one augmentation therapy (e.g., lithium, antipsychotic, stimulant) in combination with an antidepressant at an optimized dose for at least 6 weeks ~~olanzapine/fluoxetine capsules~~ **AND**
- Medical record documentation that all potential drug interactions and other applicable safety concerns have been ~~addressed~~ assessed by the prescriber and addressed with the member when appropriate (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling of the beneficiary about the risks associated with the use of both medications when they interact, and education on potential adverse effects including the risk for abuse, misuse, and addiction).

For acute suicidal ideation and behavior

- Medical record documentation of age ≥ 18 years **AND**
- Medical record documentation that Spravato will be used in combination with an oral antidepressant **AND**
- Medical record documentation of diagnosis of major depression disorder (MDD) **AND**
- Medical record documentation of a recent hospital admission (within 4 weeks) due to depressive symptoms with acute suicidal ideation and behavior **AND**
- Medical record documentation that Spravato was started inpatient **AND**
- Medical record documentation that Spravato will not exceed the FDA-approved duration of 4 weeks **AND**
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature **AND**
- Medical record documentation that all potential drug interactions and other applicable safety concerns have been ~~addressed~~ assessed by the prescriber and addressed with the member when appropriate (such as discontinuation of the interacting drug, dose reduction of the interacting drug, or counseling of the beneficiary about the risks associated with the use of both medications when they interact, and education on potential adverse effects including the risk for abuse, misuse, and addiction).

Authorization Duration for treatment resistant depression:
Initial approval will be for 1 month or less if the reviewing provider feels it is medically appropriate. For continued coverage, the following criteria is required.

- Medical record documentation of clinical improvement in depression symptoms as measured by an appropriate rating scale (compared to previous measurement) **AND**
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

Subsequent approvals will be for an additional 12 months or less if the reviewing provider feels it is medically appropriate. For continued coverage, the following criteria is required.

- Medical record documentation of clinical improvement or lack of progression in depression symptoms as measured by an appropriate rating scale (compared to previous measurement) **AND**
- Medical record documentation of a prescribed dose and administration that is consistent with FDA-approved package labeling, nationally recognized compendia, or peer-reviewed medical literature

Quantity Limits for treatment resistant depression:
For the initial 1 month authorization: ~~23~~ 24 devices per 28 days
For subsequent authorizations:

- 56 mg dose pack: 8 devices per 28 days
- 84 mg dose pack: 12 devices per 28 days

Authorization Duration for depressive episodes with acute suicidal ideation: Approval will be for one (1) 4 week approval for the FDA approved maximum of 24 devices. Requests for authorizations exceeding these limits will require the following medical record documentation of peer-reviewed literature citing well-designed clinical trials to indicate that the member's healthcare outcome will be improvement by dosing beyond the FDA-approved treatment duration.

Quantity Limits for depressive episodes with acute suicidal ideation:
~~56 mg dose pack: 16 devices per 28 days~~
~~84 mg dose pack:~~ 24 devices per 28 days

MBP Eylea (aflibercept), Eylea HD (aflibercept) and Pavblu (aflibercept-ayyh) & Part B Step Therapy Drugs List & Criteria – Updated Policy

Eylea HD
OR

- Medical record documentation of a diagnosis of macular edema following retinal vein occlusion **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to an adequate trial of intravitreal bevacizumab (Avastin) given at every four (4) week dosing intervals **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to one (1) additional intravitreal VEGF inhibitor (e.g. a preferred aflibercept product or a preferred ranibizumab product) **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Vabysmo*

*Prior authorization required

MBP 60.0 Cerezyme (imiglucerase) & Part B Step Therapy Drugs List & Criteria – Updated Policy

- Documentation of a diagnosis of Type 1 or Type 3 Gaucher disease along with at least one of the following conditions:
  - anemia OR
  - thrombocytopenia OR
  - bone disease OR
  - hepatomegaly or splenomegaly **AND**
- Cerezyme® is recommended by a metabolic specialist with experience in treating Gaucher disease **AND**
- **For Type 1 Gaucher disease only:** Medical record documentation of therapeutic failure on, intolerance to, or contraindication to Vpriv in patients 4 years of age and older

MBP 218.0 Vyepti (eptinezumab-jjmr) – Updated Policy

- Prescription written by or in consultation with a neurologist or headache specialist **AND**
- Medical record documentation of the patient age greater than or equal to 18 years **AND**
- Medical record documentation of a diagnosis of migraine with or without aura, based on the ICHD-III diagnostic criteria **AND**
- Medical record documentation of the number of baseline migraine or headache days per month **AND**
- Medical record documentation of the patient experiencing 4 or more migraines per month **AND**
- Medical record documentation of therapeutic failure on, intolerance to, or contraindication to two of the following: Aimovig, Emgality, Nurtec ODT, Qulipta **AND**
- If the request is for Vyepti 300 mg every 3 months, medical record documentation of therapeutic failure on Vyepti 100 mg every 3 months **AND**
- ~~If the request is for use in combination with Botox, all of the following must be met:~~
  - ~~Medical record documentation of therapeutic failure on a minimum 3 month trial of at least one calcitonin gene-related peptide (CGRP) receptor antagonist without the concomitant use of Botox **AND**~~
  - ~~Medical record documentation of therapeutic failure on a minimum 6 month trial of Botox without the concomitant use of calcitonin gene-related peptide (CGRP) receptor antagonist **AND**~~
- Medical record documentation that Vyepti will not be used concomitantly with another calcitonin gene-related peptide (CGRP) receptor antagonist indicated for the preventive treatment of migraine (e.g. Aimovig, Ajovy, Emgality, Nurtec ODT, Qulipta)

AUTHORIZATION DURATION: Initial approval will be for six (6) months and subsequent approvals will be for twelve (12) months.

Reauthorization Criteria:

- Medical record documentation of continued or sustained reduction in migraine or headache frequency **AND**
- If the request is for Vyepti 300 mg every 3 months, medical record documentation of therapeutic failure on Vyepti 100 mg every 3 months **AND**
- ~~If the request is for use in combination with Botox, all of the following must be met:~~
  - ~~Medical record documentation of therapeutic failure on a minimum 3 month trial of at least one calcitonin gene-related peptide (CGRP) receptor antagonist without the concomitant use of Botox **AND**~~
  - ~~Medical record documentation of therapeutic failure on a minimum 6 month trial of Botox without the concomitant use of calcitonin gene-related peptide (CGRP) receptor antagonist **AND**~~
- Medical record documentation that Vyepti will not be used concomitantly with another calcitonin gene-related peptide (CGRP) receptor antagonist indicated for the preventive treatment of migraine (e.g. Aimovig, Ajovy, Emgality, Nurtec ODT, Qulipta)

The following policies were reviewed with no changes:

- MBP 22.0 Xolair
- MBP 40.0 Orencia IV
- MBP 145.0 Cinqair
- MBP 240.0 Fensolvi
- MBP 265.0 Igalmi

The following policy updates and reviews apply to Commercial, Marketplace, TPA, and Medicaid GHP members only:

MBP 224.0 Tecartus (brexucabtagene autoleucel) – Updated Policy
AUTHORIZATION DURATION: One-time six (6) month authorization for one administration of Tecartus

The following policies were reviewed with no changes:

- MBP 335.0 Aucatzyl