

What's New Medical Pharmaceutical Policy September 2026 Updates

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

MBP 371.0 Favlyxa (fluorouracil) – New Policy

- Medical record documentation that Favlyxa is prescribed by a hematologist or oncologist **AND**
- Medical record documentation of age greater than or equal to 18 years of age **AND**
- Medical record documentation of one of the following:
 - Adenocarcinoma of the Colon and Rectum **OR**
 - Adenocarcinoma of the Breast **OR**
 - Gastric Adenocarcinoma **OR**
 - Pancreatic Adenocarcinoma

AND

- Medical record documentation of therapeutic failure, intolerance, or contraindication to generic fluorouracil 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 372.0 Avopel (etoposide) – New policy

- Medical record documentation that Avopel is prescribed by a hematologist or oncologist **AND**
- Medical record documentation of age greater than or equal to 18 years of age **AND**
- Medical record documentation of refractory testicular cancer **OR** Medical record documentation of small cell lung cancer

AND

- Medical record documentation of therapeutic failure, intolerance, or contraindication to generic etoposide 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 373.0 Loargys (pegzilarginase-nbln) – New Policy

- Prescription written by a metabolic disease specialist **AND**
- Medical record documentation of age ≥ 2 years **AND**
- Medical record documentation of a diagnosis of Arginase 1 Deficiency as evidenced by one of the following:
 - Pathogenic variants in ARG1 on molecular genetic testing; **OR**
 - Diminished erythrocyte arginase enzyme activity (i.e., $<1\%$ of normal in red blood cell extracts) **AND**
- Medical record documentation that the member is enrolled in Study IMM-PEG-005 to obtain Immedica Pharma's Nor-NOHA Blood Collection Tubes and Loargys Arginine Assay **AND**
- Medical record documentation of baseline plasma arginine levels ≥ 250 $\mu\text{mol/L}$ **AND**
- Medical record documentation that Loargys will be used in conjunction with a protein-restricted diet **AND**
- Medical record documentation of member's weight **AND**
- Medical record documentation that the dose does not exceed 0.2 mg/kg once weekly

AUTHORIZATION DURATION: Approval will be given for an initial duration of six (6) months or less if the reviewing provider feels it is medically appropriate. After the initial six (6) month approval, subsequent approvals will be for a duration of twelve (12) months or less if the reviewing provider feels it is medically appropriate, requiring:

- Medical record documentation of one of the following:
 - Plasma arginine levels between 50 $\mu\text{mol/L}$ –150 $\mu\text{mol/L}$ **OR**
 - Plasma arginine levels are outside normal range and medical record documentation that the dose will be adjusted per labeling* **AND**
- Medical record documentation of member's weight **AND**

- Medical record documentation that the dose does not exceed 0.2 mg/kg once weekly

MBP 91.0 Yervoy (Ipilimumab) – Updated Policy

1. Melanoma

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation that patient is 12 years of age or older **AND**
- Medical record documentation that Yervoy will be used as a single agent or in combination with nivolumab (Opdivo) **AND**
- Medical record documentation of unresectable or metastatic melanoma **AND**
- ~~One of the following:~~
 - ~~Medical record documentation of use in combination with nivolumab for first line therapy **OR**~~
 - ~~Medical record documentation of use as a single agent or in combination with nivolumab as second line or subsequent therapy for disease progression if not previously used **OR**~~
 - ~~Medical record documentation of use as a single agent reinduction therapy in select patients who experienced no significant systemic toxicity during prior ipilimumab therapy and who relapse after initial clinical response or progress after stable disease >3 months~~

OR

- Prescription written by a hematologist/oncologist **AND**
- Medical record documentation that patient is 18 years of age or older **AND**
- Medical record documentation of use as a single agent for adjuvant therapy:
 - For Stage IIIA with metastases > 1 mm, or Stage IIIB or Stage IIIC cutaneous melanoma with nodal metastases following a complete lymph node dissection or resection **OR**
 - Following complete lymph node dissection and/or complete resection of nodal recurrence

MBP 280.0 Lunsumio and Lunsumio Velo (mosunetuzumab-axgb) – Updated Policy

- Medical record documentation that Lunsumio or Lunsumio Velo is written by a hematologist or oncologist **AND**
- Medical record documentation of age greater than or equal to 18 years of age **AND**
- Medical record documentation of a diagnosis with relapsed or refractory follicular lymphoma **AND**
- Medical record documentation of prior treatment with two or more lines of therapy

AUTHORIZATION DURATION: Approval of Lunsumio or Lunsumio Velo will be given for an initial authorization of 6 months or less if the reviewing provider feels it is medically appropriate. One subsequent approval will be given for 12 months or less if the reviewing provider feels it is medically appropriate, not to exceed the limitations outlined below.

MBP 239.0 Rybrevant (amivantamab-vmjw) and Rybrevant Faspro (amivantamab-hyaluronidase-lpuj) – Updated Policy

- Medical record documentation that Rybrevant or Rybrevant Faspro is prescribed by a hematologist or oncologist **AND**
 - Medical record documentation of age greater than or equal to 18 years **AND**
 - Medical record documentation of a diagnosis of with locally advanced or metastatic non-small cell lung cancer (NSCLC) **AND**
 - One of the following:
 - Medical record documentation of epidermal growth factor receptor (EGFR) exon 20 insertion mutations as determined by an FDA approved test* **AND** one of the following:
 - Medical record documentation of disease progression on or following prior treatment with a platinum-based chemotherapy **AND** that Rybrevant or Rybrevant Faspro will be used as a single agent **OR**
 - Medical record documentation that Rybrevant or Rybrevant Faspro is being used as first line treatment **AND** that Rybrevant or Rybrevant Faspro will be used in combination with carboplatin and pemetrexed
- OR**
- Medical record documentation of epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations as determined by an FDA-approved test **AND** one of the following:
 - Medical record documentation that Rybrevant or Rybrevant Faspro is being used as first-line treatment **AND** Rybrevant or Rybrevant Faspro will be used in combination with Lazcluze (Lazertinib) **OR**

- Medical record documentation of disease progression on or following treatment with an epidermal growth factor receptor (EGFR) tyrosine kinase inhibitor AND Rybrevant **or Rybrevant Faspro** will be used in combination with carboplatin and pemetrexed

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.

The following policies were reviewed with no changes:

- MBP 58.0 Prialt
- MBP 64.0 Arranon
- MBP 65.0 Torisel
- MBP 78.0 Istodax
- MBP 97.0 Kyprolis
- MBP 138.0 Onivyde
- MBP 149.0 Ameluz
- MBP 289.0 Elfabrio
- MBP 291.0 Lamzede
- MBP 338.0 Bizengri
- MBP 346.0 Emrelis

The following policies were retired:

- MBP 2.0 Synagis
- MBP 189.0 Lumoxiti
- MBP 308.0 Roctavian

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

MBP 369.0 iDose TR (travoprost intracameral implant) – New Policy

- Prescription written by or in consultation with an ophthalmologist **AND**
- Medical Record documentation of a diagnosis of open-angle glaucoma (OAG) or ocular hypertension (OHT) **AND**
- Medical record documentation that patient has not received a previous administration of iDose TR to the requested eye within the past 12 months **AND**
- Medical record documentation of a baseline, pre-implantation, central corneal endothelial cell density prior to the initial administration of iDose TR* **AND**
- Medical record documentation of intolerance to, contraindication to, or therapeutic failure on three topical ophthalmic prostaglandin analogs (drops), one of which must be travoprost **AND**
- Medical record documentation of intolerance to, contraindication to, or use of Durysta

*Note: Specular microscopy is performed to evaluate the corneal endothelium and establish baseline, pre-implantation, corneal endothelial cell density

AUTHORIZATION DURATION: Initial approval will be for a period of 6 months to allow for one-time administration. Subsequent approvals will be for a period of 6 months to allow for one-time administration. All subsequent requests will require:

- Medical record documentation of improvement from baseline in the signs and symptoms of the treated indication sustained for a duration of 12 months or more **AND**
- Medical record documentation that symptoms have returned to such a degree that repeat implantation is required **AND**
- Medical record documentation that the patient has not received a previous administration of iDose TR to the requested eye within the past 12 months **AND**
- Medical record documentation a pre-implantation, central corneal endothelial cell density prior to the readministration of iDose TR

QUANTITY LIMIT: One implant per eye per 12 months

The following policies were reviewed with no changes:

- MBP 150.0 Sustol
- MBP 202.0 Evenity

The following policies that apply to Commercial, Marketplace, TPA, and Medicaid GHP members were reviewed with no changes:

- MBP 235.0 Abecma
- MBP 256.0 Carvykti

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

MBP 300.0 Medical Benefit Drug Optimization Program – Updated Policy (effective 1/1/27)

II. Purpose/Objective:

To provide a policy of coverage regarding certain complex, rare disease, and specialty drugs, which are required to be obtained from and billed by a Specialty Pharmacy and are not eligible for direct reimbursement to a provider or facility.

This policy applies to these medications:

- | | |
|---|---|
| 1. AbobotulinumtoxinA (Dysport) | 35. Elranatamab (Elrexio) |
| 2. Ado-Trastuzumab Emtansine (Kadcyla) | 36. Enfortumab Vedotin (Padcev) |
| 3. Alemtuzumab (Lemtrada) | 37. Epcoritamab (Epkinly) |
| 4. Amivantamab (Rybrevant) | 38. Eribulin (Halaven) |
| 5. Amivantamab and Hyaluronidase (Rybrevant Faspro) | 39. Etoposide (Avopef) |
| 6. Aripiprazole (Abilify Maintena, Abilify Asimtufii) | 40. Fam-Trastuzumab Deruxtecan (Enhertu) |
| 7. Aripiprazole lauroxil (Aristada Initio, Aristada) | 41. Ferric Carboxymaltose (Injectafer) |
| 8. Arsenic Trioxide (Trisenox) | 42. Ferric Derisomaltose (Monoferic) |
| 9. Asparaginase (Erwinia [Recombinant]) (Rylaze) | 43. Fluphenazine deconate |
| 10. Atezolizumab (Tecentriq) | 44. Fluorouracil (Favlyxa) |
| 11. Atezolizumab and Hyaluronidase-tqjs (Tecentriq Hybreza) | 45. Fosdenopterin (Nulibry) |
| 12. Avelumab (Bavencio) | 46. Gemtuzumab Ozogamicin (Mylotarg) |
| 13. Belantamab Mafodotin (Blenrep) | 47. Guselkumab (Tremfya) |
| 14. Belatacept (Nulojix) | 48. Haloperidol deconate |
| 15. Belinostat (Beleodaq) | 49. Imetelstat (Rytelo) |
| 16. Blinatumomab (Blinicyto) | 50. IncobotulinumtoxinA (Xeomin) |
| 17. Brentuximab Vedotin (Adcetris) | 51. Inotuzumab Ozogamicin (Besponsa) |
| 18. Bortezomib | 52. Ipilimumab (Yervoy) |
| 19. Cabazitaxel (Jevtana) | 53. Irinotecan liposomal (Onivyde) |
| 20. Capsaicin (Qutenza) | 54. Isatuximab (Sarclisa) |
| 21. Carboplatin (Kyxata) | 55. Lanreotide (Somatuline Depot) |
| 22. Carfilzomib (Kyprolis) | 56. Lecanemab (Leqembi) |
| 23. Cemiplimab (Libtayo) | 57. Levoleucovorin (Khapzory) |
| 24. Collagenase (Xiaflex) | 58. Loncastuximab Tesirine (Zynlonta) |
| 25. Cosibelimab (Unloxcyt) | 59. Lurbinectedin (Zepzelca) |
| 26. Datopotamab Deruxtecan (Datroway) | 60. Luspatercept (Reblozyl) |
| 27. Daunorubicin and Cytarabine (Liposomal) (Vyxeos) | 61. Margetuximab (Margenza) |
| 28. Daratumumab (Darzalex) | 62. Melphalan (Ivra) |
| 29. Daratumumab and Hyaluronidase (Darzalex Faspro) | 63. Mirikizumab (Omvo) |
| 30. DaxibotulinumtoxinA (Daxxify) | 64. Mirvetuximab Soravtansine (Elahere) |
| 31. Donanemab (Kisunla) | 65. Mogamulizumab (Poteligeo) |
| 32. Dostarlimab (Jemperli) | 66. Mosunetuzumab (Lunsumio) |
| 33. Durvalumab (Imfinzi) | 67. Mosunetuzumab (Lunsumio Velo) |
| 34. Elotuzumab (Empliciti) | 68. Naxitamab (Danyelza) |
| | 69. Necitumumab (Portrazza) |
| | 70. Nedosiran (Rivfloza) |
| | 71. Nivolumab (Opdivo) |
| | 72. Nivolumab and hyaluronidase-nvhy (Opdivo Qvantig) |
| | 73. Obinutuzumab (Gazyva) |
| | 74. Octreotide (Sandostatin LAR) |

- | | |
|---|---|
| 75. Olanzapine (Zyprexa Relprevv) | 94. Romiplostim (Nplate) |
| 76. OnabotulinumtoxinA (Botox) | 95. Siltuximab (Sylvant) |
| 77. Paliperidone (Invega Sustenna, Invega Hafyera, Invega Trinza) | 96. Sipuleucel T (Provenge) |
| 78. Panitumumab (Vectibix) | 97. Spesolimab (Spevigo) |
| 79. Pasireotide (Signifor LAR) | 98. Sutimlimab (Enjaymo) |
| 80. Pegloticase (Krystexxa) | 99. Tafasitamab (Monjuvi) |
| 81. Pegzilarginase (Loargys) | 100. Tagraxofusp (Elzonris) |
| 82. Pembrolizumab (Keytruda) | 101. Tarlatamab (Imdelltra) |
| 83. Pembrolizumab and Berahyaluronidase alfa-pmph (Keytruda Qlex) | 102. Tebentafusp (Kimmtrak) |
| 84. Pemetrexed (Pemrydi RTU) | 103. Temsirolimus (Torisel) |
| 85. Polatuzumab Vedotin (Polivy) | 104. Telisotuzumab Vedotin (Emrelis) |
| 86. Ramucirumab (Cyramza) | 105. Teplizumab (Tzield) |
| 87. Relatlimab and nivolumab (Opdualag) | 106. Thiotepa (Tepadina, Tepylute) |
| 88. Retifanlimab (Zynyz) | 107. Tislelizumab (Tevimbra) |
| 89. RimabotulinumtoxinB (Myobloc) | 108. Tisotumab Vedotin (Tivdak) |
| 90. Risperidone (Perseris, Risperdal Consta, Rykindo, Uzedly) | 109. Tividenofusp Alfa (Avlayah) |
| 91. Rituximab (Rituxan) | 110. Toripalimab (Loqtorzi) |
| 92. Rituximab and Hyaluronidase (Rituxan Hycela) | 111. Trabectedin (Yondelis) |
| 93. Romidepsin (Istodax) | 112. Trastuzumab (Herceptin) |
| | 113. Tremelimumab (Imjudo) |
| | 114. Ustekinumab & Ustekinumab biosimilars |
| | 115. Zolbetuximab (Vyloy) |

MBP 181.0 Site of Care – Updated Policy (effective 1/1/27)

II. Purpose/Objective:

To provide a policy of coverage regarding the use of hospital-based outpatient facilities as a site of care for drugs that require administration via intravenous or subcutaneous infusion or injection. This policy applies to these medications:

- | | |
|---|---|
| 1. Abatacept (Orencia IV) | 24. Efgartigimod Alfa (Vyvgart & Vyvgart Hytrulo) |
| 2. ADAMTS13 [Recombinant] (Adzynma) | 25. Elapegademase-lvlr (Revcovi) |
| 3. Agalsidase Beta (Fabrazyme) | 26. Elosulfase alfa (Vimizim) |
| 4. Alglucosidase Alfa (Lumizyme) | 27. Emapalumab (Gamifant) |
| 5. Alpha1-Proteinase Inhibitor [Human] products | 28. Eplontersen (Wainua PFS) |
| 6. Anifrolumab-fnia (Saphnelo) | 29. Eptinezumab (Vyepti) |
| 7. Avalglucosidase alfa-ngpt (Nexviazyme) | 30. Eteplirsan (Exondys 51) |
| 8. Axatilimab (Niktimvo) | 31. Evinacumab (Evkeeza) |
| 9. Belimumab (Benlysta IV) | 32. Galsulfase (Naglazyme) |
| 10. Benralizumab (Fasenra) | 33. Givosiran (Givlaari) |
| 11. Beremagene Geperpavec (Vyjuvek) | 34. Golodirsan (Vyondys 53) |
| 12. Burosumab (Crysvita) | 35. Golimumab (Simponi Aria) |
| 13. C1 esterase Inhibitor [Human] (Cinryze) | 36. Idursulfase (Elaprase) |
| 14. Canakinumab (Ilaris) | 37. Immune Globulin (IVIG) |
| 15. Casimersen (Amondys 45) | 38. Imiglucerase (Cerezyme) |
| 16. Certolizumab (Cimzia) | 39. Inclisiran (Leqvio) |
| 17. Cipaglucosidase alfa (Pombiliti) | 40. Inebilizumab (Uplizna) |
| 18. Crizanlizumab (Adakveo) | 41. Infliximab & infliximab biosimilar products |
| 19. Crovalimab (PiaSky) | 42. Laronidase (Aldurazyme) |
| 20. Denosumab (Prolia, Xgeva) | 43. Lumasiran (Oxlumo) |
| 21. Depemokimab (Exdensur) | 44. Mepolizumab (Nucala) |
| 22. Eculizumab & eculizumab biosimilars | 45. Natalizumab & natalizumab biosimilars |
| 23. Edaravone (Radicava) | 46. Nipocalimab (Imaavy) |

- | | |
|--|---|
| 47. Ocrelizumab (Ocrevus & Ocrevus Zunovo) | 61. Taliglucerase alfa (Elelyso) |
| 48. Olipudase alfa-rpcp (Xenpozyme) | 62. Teprotumumab (Tepezza) |
| 49. Omalizumab (Xolair) | 63. Testosterone udecanoate (Aveed) |
| 50. Pegunigalsidase Alfa (Elfabrio) | 64. Tezepelumab (Tezspire) |
| 51. Plasminogen (Ryplazim) | 65. Tildrakizumab (Ilumya) |
| 52. Pozelimab (Veopoz) | 66. Tocilizumab IV & tocilizumab IV biosimilars |
| 53. Patisiran (Onpattro) | 67. Ublituximab-xiiy (Briumvi) |
| 54. Ravulizumab (Ultomiris) | 68. Vedolizumab (Entyvio) |
| 55. Reslizumab (Cinqair) | 69. Velaglucerase alfa (Vpriv) |
| 56. Romosozumab (Evenity) | 70. Velmanase alfa (Lamzedo) |
| 57. Rozanolixizumab (Rystiggo) | 71. Vestronidase alfa-vjbk (Mepsevii) |
| 58. Sebelipase alfa (Kanuma) | 72. Viltolarsen (Viltepso) |
| 59. Secukinumab (Cosentyx IV) | 73. Vutrisiran (Amvuttra) |
| 60. Sutimlimab (Enjaymo) | |