Drug Coverage Policy

Effective Date....................4/15/2026
Coverage Policy Number............. 1407

Pharmacy and Medical Prior Authorization

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Coverage Policy

Policy Statement
This policy supports the following drug medical necessity review:

- **Drugs requiring Pharmacy or Medical Prior Authorization for Employer Group Plans and/or Individual and Family Plans where no other coverage policy or criteria are specified**
- **Individual and Family Plans non-formulary drug exception criteria**

I. Drugs requiring pharmacy or medical prior authorization where no other coverage policy or criteria are specified are considered medically necessary when **BOTH** of the following is met **(1 and 2):**

1. **ONE** of the following (A or B):
   A. Use is approved and listed in the FDA product information (Label) and the dosage, frequency, site of administration, and duration of therapy is not contraindicated or otherwise not recommended in the Label; OR
   B. Use is supported according to standard medical reference compendia (for example, Clinical Pharmacology, Micromedex, Wolters Kluwer Facts and Comparisons) and is not contraindicated or otherwise not recommended in the FDA product information (Label)
2. And where available, use of therapeutic alternatives unless otherwise specified or clinically inappropriate.

   Note: Prior use of all formulary or covered alternatives meets criteria, unless there are more than five alternatives available, where five will be the maximum required number of alternatives.

Approval duration is up to 12 months.

Conditions Not Covered
Any other use is considered not medically necessary. Criteria will be updated as new published data are available.

II. Individual and Family Plan non-formulary drug criteria. Non-formulary drugs are considered medically necessary when the product-specific criteria are met:

Refer to: **Drugs Requiring Medical Necessity Review for Individual and Family Plans**

This is an up-to-date list of products alphabetized by *Therapy Class* and *Brand Name*.

Conditions Not Covered
Any other exception is considered not medically necessary. Criteria will be updated as new published data are available.

Documentation: Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information.

Background

OVERVIEW
Health benefit plans vary, drugs that are not part of the covered drug list may be approved for coverage when medical necessity criteria are met through the coverage review process. Doctors and health care professionals can log in to CignaForHCP.com to learn more about which medications require prior authorization. Customers can log in to the myCigna App or myCigna.com, or check plan materials, to learn more about how medications are covered.

In general, to be eligible for coverage a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and be medically necessary. In developing medical necessity exception criteria within coverage policies

criteria incorporate information from U.S. Food and Drug Administration-approved labeling[1], the standard medical reference compendia[2-4] and peer-reviewed, evidence-based scientific literature or guidelines.

References

1. U.S. Food and Drug Administration. Drugs@FDA. U.S. Department of Health & Human Services: http://www.accessdata.fda.gov/scripts/cder/drugsatfda/.
2. Clinical Pharmacology powered by ClinicalKey. Philadelphia (PA): Elsevier. c2021- [cited 2025 March 24]. Available from: http://www.clinicalkey.com.
3. Individual Drug Name Entries. Drug Facts and Comparisons. eFacts [online] 2025. Available from Wolters Kluwer Health, Inc.
4. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/

Revision Details

Summary of Changes	Review Date	Effective Date
Added Individual and Family Plan product-specific medical necessity criteria for: Airsupra, Bijuva, Condylox, Jylamvo, Likmez, podofilox 0.5%, Pokonza, Trexall, Xatmep, Zituvio	2/13/2024	5/1/2024
Added Individual and Family Plan product-specific medical necessity criteria for: Bromfenac 0.07%, Cabtreo, and Zituvio	3/7/2024	5/1/2024
Added Individual and Family Plan product-specific medical necessity criteria for: tetracycline, gabapentin, Gralise, Blue Link glucose test strips, Indocin, indomethacin, bromfenac, BromSite, Adthyza, halobetasol, Lexette	3/21/2024	6/1/2024
Added Individual and Family Plan product-specific medical necessity criteria for: Kiprofen, Sovuna, Ermeza, levothyroxine, Thyquidity, Tirosint, Tirosint-SOL, Glucose Test Strips, Lancets, Altreno, Retin-A Micro Pump 0.06% gel, tretinoin 0.025%, 0.05% 0.1% cream, tretinoin 0.01%, 0.025%, 0.05% gel, tretinoin gel micro 0.04%, 0.08%, 0.1% pump, tretinoin gel micro 0.04%, 0.1% tube, adapalene 0.1% cream/ lotion/ solution/ swab, adapalene 0.3% gel/ gel pump, Differin 0.1% lotion, adapalene-benzoyl peroxide 0.1-2.5% gel pump, adapalene-benzoyl peroxide 0.3-2.5% gel pump, Epiduo Forte 0.3-2.5% gel pump **Removed** Individual and Family Plan product-specific medical necessity criteria for: Blue Link glucose test strips	4/25/2024	7/15/2024
Added Individual and Family Plan product-specific medical necessity criteria for: Absorica 10 mg, 20 mg, 25 mg, 30 mg, 35 mg, 40 mg capsules, Absorica LD capsules, Aplenzin tablets, Auvelity tablets, baclofen 15 mg tablets, bupropion hydrochloride 450 mg extended-release tablets, doxycycline monohydrate IR 40 mg capsules, Forfivo XL tablets, isotretinoin 25 mg, 35 mg capsules, Multaq tablets, Oracea 40 mg capsules, sitagliptin tablets **Updated** Individual and Family Plan product-specific medical necessity criteria for: Zituvio tablets	5/23/2024	8/1/2024
Added Individual and Family Plan product-specific medical necessity criteria for: Alrex, Gemtesa tablets, Ilevro, insulin glargine, insulin glargine SoloStar, insulin glargine-yfgn, insulin glargine Max SoloStar, Lantus, Lantus SoloStar, loteprednol etabonate 0.2%, mirabegron extended-release tablets, Myrbetriq granules, Myrbetriq tablets, Nevanac ophthalmic suspension 0.1%, Rezvoglar, Semglee-yfgn, Toujeo SoloStar, Toujeo Max SoloStar, Xcopri **Removed** Individual and Family Plan product-specific medical necessity criteria for: Glucose Test Strips, Lancets	6/27/2024	9/1/2024

Added Individual and Family Plan product-specific medical necessity criteria for: Libervant, Rextovy.	8/15/2024	9/15/2024
Added Individual and Family Plan product-specific medical necessity criteria for: Carac, Klisyri, imiquimod 3.75%, Zyclara 3.75%, Zyclara 2.5%, ondansetron ODT 16mg, carbinoxamine maleate 4 mg/ 5 mL suspension, Karbinal ER suspension, Innopran XL, Inderal LA, Inderal XL, Kapspargo, Katerzia, Norliqva, hydrocortisone 2% lotion, sitagliptin-metformin, Estratest FS, Furoscix, Clinpro 5000, Fraiche 5000 Previ, Fraiche 5000 Sensitive, Just Right 5000, Prevident 1.1%, Prevident Kids 5000 PPM, Prevident 5000 Booster Plus, Prevident Dry Mouth, Prevident Orthodefens, Prevident 5000 Plus, Prevident Rinse 0.2%, Prevident 5000 Sensitive, Prevident 5000 Enamel. **Updated** Individual and Family Plan product-specific medical necessity criteria for: Rextovy, loteprednol etabonate 0.2%	9/19/2024	10/15/2024
Added Individual and Family Plan product-specific medical necessity criteria for: Focinvez, Myhibbin, allopurinol 200 mg oral tablet, Posfrea IV injection	10/3/2024	11/1/2024
Added Individual and Family Plan product-specific medical necessity criteria, **EFFECTIVE on 1/1/2025** for: sulconazole nitrate 1% cream, sulconazole nitrate 1% solution, Ergomar, alogliptin tablet, Nesina, Onglyza, alogliptin and metformin tablet, alogliptin and pioglitazone tablet, Kazano, Kombiglyze XR, Oseni, sitagliptin and metformin oral tablet, Zituvimet, Zituvimet XR, Glyxambi, Qtern, Steglujan, Trijardy XR, insulin glargine, insulin glargine Solostar 100 units/ mL, insulin glargine-YFGN 100 units/ mL, insulin glargine Max Solostar U300 300 units/ mL, Lantus, Lantus SoloStar, Levemir, Rezvoglar Kwikpen, Semglee (non-YFGN), Semglee-YFGN, Toujeo Solostar, Toujeo Max SoloStar, Femring, Imvexxy, Premarin, Serevent Diskus, naproxen sodium controlled-release/ extended-release 375 mg, Creon, Pertzye, Zenpep, ArmonAir Digihaler, Flovent Diskus, Flovent HFA, fluticasone propionate HFA, fluticasone inhalation powder, Pulmicort Flexhaler, Advair Diskus, Advair HFA, AirDuo Digihaler, AirDuo Respiclick, fluticasone furoate and vilanterol inhalation powder, fluticasone propionate and salmeterol HFA oral inhalation, Symbicort, Breztri Aerosphere, Osphena	10/24/2024	12/1/2024
Added Individual and Family Plan product-specific medical necessity criteria: Fanapt, Clindesse, Glimepiride 3 mg, Xhance, fluticasone propionate/ salmeterol, Ohtuvayre, Zoryve 0.15% cream, Zoryve 0.3% cream, Zoryve foam.	11/7/2024	12/15/2024
Added Individual and Family Plan product-specific medical necessity criteria: Clenpiq, Moviprep, Plenvu, Suprep, Sutab **Updated** Individual and Family Plan product-specific medical necessity criteria: Suflave.	11/14/2024	1/1/2025
Added Individual and Family Plan product-specific medical necessity criteria: potassium chloride ER tablet, clobetasol propionate 0.05% ophthalmic suspension, Dolobid, estradiol gel 0.06%, Estratest HS.	12/19/2024	1/15/2025
Added Individual and Family Plan product-specific medical necessity criteria: Crexont, carbamazepine chewable, Neffy, Betimol, timolol hemihydrates ophthalmic, Undecatrex.	1/16/2025	2/15/2025
Added Individual and Family Plan product-specific medical necessity criteria: Twyneo, Opipza, Emrosi, insulin aspart protamine-insulin aspart (NovoLog 70/30 mix generic) **Updated** Individual and Family Plan product-specific medical necessity criteria: Differin lotion, Epiduo Forte, Ergomar	1/30/2025	3/1/2025
Added Individual and Family Plan product-specific medical necessity criteria: insulin aspart (NovoLog generic), Novolog, Eucrisa	2/20/2025	4/1/2025
Added Individual and Family Plan product-specific medical necessity criteria: Azelex cream; clonidine 0.17 mg extended-release tablet; Nexiclon XR tablet; Adlarity transdermal system; donepezil and extended release memantine capsule; Namzaric; metronidazole 125 mg oral tablet; Arakoda tablet; Coartem tablet; Krintafel tablet; Cobenfy capsule; topiramate 50 mg oral sprinkle capsule; labetalol 400 mg oral tablet; nimodipine 60 mg/ 20 mL oral	3/20/2025	5/1/2025

solution; Aspruzyo Sprinkle; prucalopride 1 mg, 2 mg oral tablet; hydrocortisone 2.5% topical solution; Soliqua; Xultophy; metformin immediate release 750 mg; dapagliflozin-metformin extended-release tablet; Invokamet; Invokamet XR; Segluromet; Gabarone 100 mg, 400 mg tablet; bismuth subcitrate 140 mg/ metronidazole 125 mg/ tetracycline 125 mg; Omeclamox-Pak; Pylera; Talicia; Voquezna Dual Pak; Voquezna Triple Pak; zileuton extended-release tablet; Zyflo tablet; baclofen 5 mg/ 5 mL oral solution; Fenopron 300 mg; Iopidine ophthalmic solution; Vtama cream; Finacea foam; Finacea gel; Trintellix **Updated** Individual and Family Plan product-specific medical necessity criteria: Gemtesa		
Updated Individual and Family Plan product-specific medical necessity criteria: Posfrea, Focinvez, dapagliflozin metformin extended-release tablet	4/3/2025	5/15/2025
Updated Individual and Family Plan product-specific medical necessity criteria: Myrbetriq, Gemtesa **Removed** Individual and Family Plan product-specific medical necessity criteria: mirabegron, Posfrea, Focinvez	5/1/2025	6/1/2025
Added Individual and Family Plan product-specific medical necessity criteria: Angeliq, Duavee, Premphase, Prempro, Veltassa, Onapgo, Xromi, GlucaGen, GlucaGen Hypokit, Gvoke, Zegalogue, Twiist, Fulvicin P/G, griseofulvin ultramicrosize 165mg, Journavx, Tezruly, metaxolone, clobetasol propionate cream, Zunveyl, Inzirqo, meclizine, ferric citrate, Auryxia, Raldesy, Auranofin, Ridaura, Aptiom, Briviact, carbamazepine chewable, Elepsia XR, Eprontia, Fycompa, Motpoly XR, Oxtellar XR, oxcarbazepine ER, Spritam, topiramate, Trokendi XR, Zonisade, Kristalose, lactulose, halcinonide **Updated** Individual and Family Plan product-specific medical necessity criteria: Furoscix, Bijuva, Xcopri	5/22/2025	7/1/2025
Added Individual and Family Plan product-specific medical necessity criteria: clocortolone 0.1% pump, clocortolone pivalate 0.1% cream, doxepin 5% cream, doxepin 5% cream, prudoxin 5% cream, Afrezza, Climara Pro, Elestrin, Evamist, halcinonide 0.1% cream, Halog 0.1% cream, sumatriptan/ naproxen sodium tablets, Treximet, Konvomep, omeprazole/sodium bicarbonate capsules, omeprazole/sodium bicarbonate suspension, Voquezna tablets, Zegerid capsules, Zegerid packets, Vowst capsules, clemastine syrup, Thalitone, Siklos **Updated** Individual and Family Plan product-specific medical necessity criteria: Veozah, carbinoxamine maleate 4 mg/5 mL, Karbinal ER	6/26/2025	8/1/2025
Added Individual and Family Plan product-specific medical necessity criteria: azelaic acid 15% gel, Combogesic, Arbli, Edarbi, Ryclora, carbinoxamine maleate 6 mg tablets, RyVent, Lamictal XR starter, sitagliptin and metformin hydrochloride extended-release tablets (authorized generic for Zituvimet XR), Glumetza (metformin extended-release tablets), Metformin ER osmotic tablets (Fortamet). Metformin ER tablets (Glumetza), metformin immediate release 625 mg tablets, Symbravo, Zelsuvmi, ibuprofen 800mg and famotidine 26.6mg tablet, naproxen and esomeprazole magnesium 375 mg/20 mg or 500 mg/20 mg delayed-release tablet, Vimovo, rabeprazole sodium delayed-release capsules (authorized generic of Aciphex Sprinkle), Yosprala, Hemiclor, and Renthyroid **Updated Individual and Family Plan product-specific medical necessity criteria:** Alkindi Sprinkle, alogliptin tablet (Nesina authorized generic), Nesina, alogliptin and metformin tablets (Kazano authorized	7/17/2025	9/1/2025

generic), alogliptin and pioglitazone tablets (Oseni authorized generic), Kazano, Oseni, Glyxambi, Qtern, Trijardy XR, Dolobid, Myrbetriq Granules, Auryxia, ferric citrate tablets (Auryxia authorized generic), ArmonAir Digihaler, Flovent Diskus, Flovent HFA, fluticasone propionate HFA (authorized generic of Flovent HFA), fluticasone inhalation powder (authorized generic of Flovent Diskus), Pulmicort Flexhaler, Airsupra, Advair HFA, AirDuo Digihaler, AirDuo RespiClick, fluticasone propionate/ salmeterol inhalation powder (AirDuo Respiclick authorized generic), fluticasone furoate and vilanterol inhalation powder, fluticasone propionate/salmeterol HFA oral inhalation, Breztri Aerosphere, and Inzirqo **Removed Individual and Family Plan product-specific medical necessity criteria:** Onapgo		
Added Individual and Family Plan product-specific medical necessity criteria for the following products: Dapsone gel 7.5% (brand), Atralin, Differin cream, Differin gel pump, Retin-A Cream (0.025%, 0.05%, and 0.1%), Retin-A Gel (0.025% and 0.01%), Retin-A Micro Gel (0.04% and 0.1%), Retin-A Micro Gel Pump (0.04%, 0.08%, and 0.1%), bisoprolol fumarate 2.5 mg tablets, Bucapsol capsules, Khindivi, Admelog, Admelog SoloStar, Apidra, Apidra SoloStar, Fiasp, Fiasp PumpCart, Lyumjev, Lyumjev KwikPen, Lyumjev Tempo Pen, Merilog, Merilog SoloStar, budesonide extended release 9mg tablets, budesonide rectal foam, Uceris rectal foam, Uceris tablets, Crinone 4% Gel, Crinone 8% Gel, Noritate, and Zilxi **Updated Individual and Family Plan product-specific medical necessity criteria for the following products:** Glyxambi, Qtern, Steglujan, Trijardy XR, insulin aspart (authorized generic for NovoLog), NovoLog, Ermeza, levothyroxine capsules (Tirosint generic), Thyquidity, Tirosint, Tirosint-SOL, Zoryve 0.3% cream, and Zoryve 0.3% foam	8/21/2025	10/1/2025
Added Individual and Family Plan product-specific medical necessity criteria for the following products: valsartan oral solution (previously Prexxartan), Fanapt titration pack, topiramate oral solution (authorized generic for Eprontia), Denavir, penciclovir 1% cream, Xerese, Lopressor oral solution, Micort HC 2.5 % rectal cream, dicyclomine 40 mg tablets, baclofen 10 mg/5 mL oral solution, ibuprofen 300 mg tablets, and Tri-Vitamin Drops with Fluoride **Updated Individual and Family Plan product-specific medical necessity criteria for the following product:** topiramate 50 mg oral sprinkle capsule	10/2/2025	11/1/2025
Added Individual and Family Plan product-specific medical necessity criteria for the following products: Seysara, Cleocin Vaginal Ovules, Nuvessa, Xaciato, Conjupri, levamlodipine tablets, Novolin 70/30 FlexPen and vials, Novolin N FlexPen and vials, Novolin R FlexPen and vials, Novolog Mix 70/30 FlexPen and vials, Estring, Gloperba, Fosrenol oral powder, Fosrenol chewable tablets, lanthanum carbonate chewable tablets, Renvela oral powder, sevelamer carbonate powder for oral suspension, sevelamer hydrochloride tablet (authorized generic for Renagel), Velphoro, Spiriva HandiHaler, tiotropium bromide inhalation powder (generic for Spiriva HandiHaler), Spiriva Respimat, Yupelri, Edluar, Silenor, zolpidem 7.5 mg capsules (brand), Belsomra, Dayvigo, Quviviq, and sertraline 150 mg and 200 mg capsules. **Updated Individual and Family Plan product-specific medical necessity criteria for the following products:** insulin aspart protamine/insulin aspart, Flexpen and vials (authorized generic of Novolog Mix 70/30), Femring, Imvexxy, Premarin Vaginal Cream, and Osphena.	10/23/2025	12/1/2025
Added Individual and Family Plan product-specific medical necessity criteria for the following products: doxepin 3 mg and 6 mg tablets (Silenor authorized generic) and zolpidem 1.75 mg and 3.5 mg sublingual tablet (generic for Intermezzo)	10/30/2025	12/1/2025
Added Individual and Family Plan product-specific medical necessity criteria for the following products: Tolak, butalbital 50	11/13/2025	12/15/2025

mg/acetaminophen 325 mg/caffeine 40 mg per 15 mL oral solution, Norgesic (effective 1/1/2026), Norgesic Forte (effective 1/1/2026), orphenadrine/aspirin/caffeine 25-385-30 mg tablets (generic for Norgesic) (effective 1/1/2026), orphenadrine/aspirin/caffeine 50-770-60 mg tablet (generic for Norgesic Forte) (effective 1/1/2026), Orphengesic Forte (effective 1/1/2026), Blujepa, Dificid, fidaxomicin tablets (generic for Dificid), fosfomycin granules for solution, Orlynvah, econazole nitrate foam, eslicarbazepine acetate tablets (generic for Aptiom), perampanel tablets (generic for Fycompa tablets), Kloxxado, Zurnai, Zimhi, Motegrity, Analpram-HC lotion, Brynovin, Kirsty, Kirsty Pen, Brekiya, Trudhesa, Amrix, chlorzoxazone 250 mg, 375 mg, and 750 mg tablet, Lorzone, methocarbamol 1000 mg tablet, baclofen oral suspension, concentrated formulation 25 mg/5mL (Fleqsuvy generic), Fleqsuvy, Lyvispah, Ozobax, Ozobax DS, and Pruradik. **Updated Individual and Family Plan product-specific medical necessity criteria for the following products:** Carac, Klisyri, Aplenzin, Opvee, prucalopride tablets (generic for Motegrity), and baclofen 5 mg/5 mL oral solution (Ozobax generic)		
Added Individual and Family Plan product-specific medical necessity criteria for the following products: Firvanq, vancomycin 25 mg/mL oral solution, Ertaczo, amcinonide 0.1% cream and lotion, Apexicon E 0.05% cream, diflorasone 0.05% cream and ointment, Phospholine Iodide, and Crotan. **Updated Individual and Family Plan product-specific medical necessity criteria for the following products:** clocortolone pivalate 0.1% cream, halcinonide 0.1% cream, Creon, Pertzye, and Zenpep (effective until 12/31/2025).	11/20/2025	1/1/2026
Updated "**<u>Documentation:</u>** Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information." **to** "**<u>Documentation:</u>** Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information." **Added Individual and Family Plan product-specific medical necessity criteria for the following products:** hydrocortisone 2.5% rectal cream, conjugated estrogens tablets, Tonmya, Zanaflex capsules, Lynkuet, Vyscoxa, Exxua, fluticasone furoate inhalation powder (authorized generic of Arnuity Ellipta), Zoryve 0.05% Cream, opium tincture 10 mg/mL (effective 3/1/2026), Jublia (effective 3/1/2026), Rexulti (effective 3/1/2026), Bevespi Aerosphere (effective 3/1/2026), Duaklir Pressair (effective 3/1/2026), Stiolto Respimat (effective 3/1/2026), umeclidinium and vilanterol inhalation powder (effective 3/1/2026), azelastine and fluticasone propionate nasal spray (generic for Dymista) (effective 3/1/2026), Dymista (effective 3/1/2026), Ryaltris (effective 3/1/2026), Omnaris (effective 3/1/2026), Qnasl (effective 3/1/2026), Qnasl Children's (effective 3/1/2026), paroxetine mesylate 7.5 mg capsules (effective 3/1/2026), Premarin tablets (effective 3/1/2026), Ulesfia (effective 3/1/2026), tizanidine capsules (effective 3/1/2026), tavaborole 5% topical solution (effective 3/1/2026), miconazole-zinc oxide-petrolatum ointment (effective 3/1/2026), and Vusion (effective 3/1/2026) **Updated Individual and Family Plan product-specific medical necessity criteria for the following products:** gabapentin extended-release tablets, Gralise, Pokonza, halobetasol propionate topical foam 0.05%, Lexette, adapalene/benzoyl peroxide 0.3-2.5% gel pump (effective 3/1/2026), Epiduo Forte (effective 3/1/2026), Blujepa (effective 3/1/2026), oxcarbazepine extended-release tablets (effective 3/1/2026), Oxtellar XR (effective 3/1/2026), Furoscix (effective 3/1/2026), Xhance (effective 3/1/2026), Veozah (effective 3/1/2026),	1/15/2026	2/15/2026

Vtama (effective 3/1/2026), ArmonAir DigiHaler (effective 3/1/2026), Flovent Diskus (effective 3/1/2026), Flovent HFA (effective 3/1/2026), fluticasone inhalation powder (effective 3/1/2026), fluticasone propionate HFA (effective 3/1/2026), Pulmicort Flexhaler (effective 3/1/2026), Eucrisa (effective 3/1/2026), and Zoryve 0.15% cream (effective 3/1/2026)		
Added Individual and Family Plan product-specific medical necessity criteria for the following products: Javadin, desloratadine 0.5 mg/mL oral solution, carbidopa and levodopa extended-release capsules (authorized generic to Rytary), Subvenite oral suspension, Lasix Onyu, Inveltys, Lotemax SM, Lotemax (gel, ointment, and suspension), loteprednol etabonate 0.5% ophthalmic gel (authorized generic of Lotemax 0.5% ophthalmic gel), loteprednol etabonate 0.5% ophthalmic suspension (authorized generic of Lotemax 0.5% ophthalmic suspension)	1/29/2026	3/15/2026
Added Individual and Family Plan product-specific medical necessity criteria for the following products: Cleocin Pediatric, cefixime 400mg tablets, perampanel oral suspension, prednisone delayed-release tablets, ranitidine tablets, ciprofloxacin/hydrocortisone 0.2%/1% otic suspension, besifloxacin 0.6% ophthalmic suspension, potassium chloride 40 mEq powder for solution, Ecoza foam, Exelderm cream and solution, luliconazole 1% cream, Luzu, Naftin 1% gel, Oxistat cream and lotion, Xolegel, topiramate extended-release capsules, Soaanz, Zylet, ciprofloxacin and fluocinolone otic solution, Otovel, Hemangeol, Auvi-Q, epinephrine auto-injector authorized generic, EpiPen, EpiPen Jr., Symjepi, dihydroergotamine 4 mg/mL nasal spray, Migranal, pyridostigmine 30 mg tablet, Besivance, TobraDex, TobraDex ST, and Cipro HC Otic Suspension **Updated Individual and Family Plan product-specific medical necessity criteria for the following products:** econazole nitrate topical foam, sulconazole nitrate 1% cream and solution, Aptiom, eslicarbazepine tablets, Fycompa oral suspension and tablets, perampanel tablets, Trulance, and umeclidinium/vilanterol inhalation powder (generic of Anoro Ellipta)	2/19/2026	4/15/2026
Added Individual and Family Plan product-specific medical necessity criteria for the following product: Nuzyra (effective 5/1/2026)	2/26/2026	4/15/2026
Removed Individual and Family Plan product-specific medical necessity criteria: Tonmya	3/9/2026	4/15/2026

The policy effective date is in force until updated or retired.

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