# Pharmacy clinical criteria

**Effective Feb. 15, 2026**, these are clinical criteria updates for UnitedHealthcare Community Plan of Texas CHIP, STAR, STAR Kids and STAR+PLUS plans.

| Clinical criteria guidelines | Clinical criteria updates |
|---|---|
| **Allergen Extracts** | • Odactra: added criteria<br>• Odactra: updated minimum age to 5 years (from 12 years)<br>• Palforzia: updated minimum age to 1 year (from 4 years) |
| **Calcitonin Gene-Related Peptide Receptor (CGRP) Antagonists, Prophylaxis** | • Ajovy: updated age check for patients 6 years and older with episodic migraine diagnosis |
| **Cystic Fibrosis Agents** | • Alyftrek: added criteria as approved by the Drug Utilization Review Board (DUR) |
| **Cytokine and CAM Antagonists** | • Leqselvi: added criteria as approved by the DUR Board<br>• Tremfya: added criteria to check for Crohn's disease<br>• Rinvoq: added criteria to check for giant cell arteritis |
| **Dipeptidyl Peptidase-4 (DPP-4) Inhibitors** | • New prior authorization |
| **Duchenne Muscular Dystrophy (DMD) Agents** | • Emflaza: HHSC retired the prior authorization criteria and Emflaza Prior Authorization Request (HHS Form 1347). The Duchenne Muscular Dystrophy Agents criteria guide now includes Emflaza.<br>• Duvyzat: added criteria as approved by the DUR Board<br>• Changed the criteria guide's name from "Systemic Corticosteroids" to "Duchenne Muscular Dystrophy Agents" |
| **Gaucher's Disease Agents** | • Removed the negating diagnosis for pregnancy table (no longer a part of the criteria) |
| **Glatiramer** | • Copaxone: added to the Drugs Requiring PA section |
| **Hereditary Angioedema Agents** | • Kalbitor: removed from the Drugs Requiring PA section – Healthcare professional administered only<br>• Dawnzera: added criteria as approved by the DUR Board |



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|---|---|
| **Hyperlipidemia Agents** | • Praluent: removed check for a PA form, updated question 2 to say "Deny" if the answer is "No", and removed the manual check for the diagnosis of HeFH<br>• Repatha: removed check for a PA form<br>• PCSK9 products: HHSC retired the prior authorization criteria and PCSK9 Inhibitors Prior Authorization Request (HHS Form 1355). The Hyperlipidemia Agents clinical criteria guide now includes PCSK9 products. |
| **Imcivree** | • Updated question 1 in the initial review criteria from 6 years to 2 years<br>• Updated the approval duration to 365 days for initial approval for all indications<br>• Added a check for end-stage renal disease (ESRD) to renewal criteria |
| **Immunomodulators, Topical** | • Anzupgo: added to the Opzelura Drugs Requiring PA section<br>• Opzelura: updated age check to 2 years of age and older for atopic dermatitis indication |
| **Monoclonal Antibody Agents** | • Dupixent: added criteria for to check for bullous pemphigoid<br>• Dupixent: added new indication of chronic spontaneous urticaria as approved by the DUR Board<br>• Nucala: added new indication of chronic obstructive pulmonary disease and an eosinophilic phenotype as approved by the DUR Board<br>• Airduo Digihaler: removed from the Supporting Tables section – products discontinued |
| **Opioid Policy** | • Added max days' supply check of 34 days for subsequent fills |
| **Oxybate Products** | • Lumryz: added to the Drugs Requiring PA section |
| **Phosphodiesterase-5 (PDE-5) Inhibitors** | • Opsynvi: removed from the Drugs Requiring Prior Authorization section<br>• Opsynvi: refer to the Pulmonary Hypertension Agents criteria guide |
| **Pulmonary Hypertension Agents** | • Opsynvi: added to Drugs Requiring Prior Authorization section<br>• Winrevair and Yutrepia: added to the Drugs Requiring PA section<br>• Ventavis: removed from the Drugs Requiring PA section and supporting tables – discontinued<br>• Remodulin: added to the Injectable PH Drugs Requiring PA section |
| **Topical Antifungals for Onychomycosis** | • New prior authorization |
| **Transthyretin Agents** | • Tegsedi: removed criteria – product discontinued<br>• Wainua: added criteria as approved by the DUR Board |
| **Xifaxan** | • Added levofloxacin to question 3 and Table 3 for Xifaxan 200 mg |

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