Review at Launch Medication List

Last Updated: October 1, 2020

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Related Commercial Policy
• Review at Launch for New to Market Medications

Related Oxford Policy
• Review at Launch for New to Market Medications

Instructions for Use

This Review at Launch (RAL) Medication List provides the listing of medications that are excluded from the medical benefit until the date the medication is reviewed by UnitedHealthcare or are reviewed against available clinical evidence.

The Review at Launch Medication List applies to: UnitedHealthcare Commercial plan members, including All Savers and affiliate plans such as UnitedHealthcare of the Mid-Atlantic, UnitedHealthcare Oxford, Neighborhood Health Partnership and UnitedHealthcare of the River Valley.

This list is supported by the applicable *Review at Launch for New to Market Medications* Medical Benefit Drug Policy.

When determining whether Review at Launch applies to the individual member, the member specific benefit plan document must be referenced. The terms of the member specific benefit plan document [e.g., Certificate of Coverage (COC), Schedule of Benefits (SOB), and/or Summary Plan Description (SPD)] may differ greatly from the standard benefit plan upon which this Medical Benefit Drug Policy is based. In the event of a conflict, the member specific benefit plan document supersedes the applicable Medical Benefit Drug Policy and List. All reviewers must first identify member eligibility, any federal or state regulatory requirements, and the member specific benefit plan coverage prior to use of this Medical Benefit Drug Policy. Other Policies and Coverage Determination Guidelines may apply. UnitedHealthcare reserves the right, in its sole discretion, to modify its Policies and Guidelines as necessary.

Benefit Considerations

This medication list applies to certain newly launched medications that are healthcare provider administered and are currently under review by the UnitedHealthcare Pharmacy and Therapeutics (P&T) Committee. The medications may be excluded from coverage while the medication is listed on this document or will be reviewed against available clinical evidence, which includes applicable Medical Benefit Drug Policies.

RAL Date	HCPCS Codes	Medication
06/19/2020	C9399, J3490	Scenesse® (afamelanotide)
06/19/2020	C9399, J3490, J3590	Uplinza™ (inebilizumab-cdon)
08/18/2020	C9399, J3490, J3590	Viltepso™ (Viltolarsen)

List History/Revision Information

Date	Summary of Changes
10/01/2020	• Removed Monoferric™ (ferric derisonmaltose), Tepezza™ (teprotumumab-trbw), and Vyepti™ (eptinezumab-jjmr); prior authorization requirements effective Oct. 1, 2020
08/18/2020	• Added Viltepso™ (Viltolarsen)
07/01/2020	• Removed Adakveo® (crizanlizumab-tmca), Avsola™ (infliximab-axxq), Givlaari® (givosiran), Reblozyl® (luspatercept-aamt), and Vyondys 53™ (golodirsen) ; prior authorization requirements effective Jul. 1, 2020
06/19/2020	• Added Scenesse® (afamelanotide) and Uplinza™ (inebilizumab-cdon)
04/01/2020	• Added Vyepti™ (eptinezumab-ijmr)
03/01/2020	• Added Avsola™ (infliximab-axxq)
02/01/2020	• Added Monoferric™ (ferric derisonmaltose) and Tepezza™ (teprotumumab-trbw)
01/22/2020	• Removed Xembify® [Immune Globulin Subcutaneous (Human) – klhw] [prior authorization requirements apply Jan. 1, 2020; refer to the Medical Benefit Drug Policy titled Immune Globulin (IVIG and SCIG) for coverage guidelines]
12/16/2019	• Added Givlaari® (givosiran) and Vyondys 53™ (golodirsen)
11/25/2019	• Added Adakveo® (crizanlizumab-tmca) and Reblozyl® (luspatercept-aamt)
10/01/2019	• Removed Evenity™ (romosozumab-aqqg), Zolgensma® (onasemnogene abeparvovec-xioi), and Cutaquig® [Immune Globulin Subcutaneous (Human) – hipp]; prior authorization requirements effective October 1, 2019
08/01/2019	• Added Xembify® [Immune Globulin Subcutaneous (Human) – klhw]
07/01/2019	• Removed Ultomiris™ (ravulizumab-cwvz); prior authorization requirements effective Jul. 1, 2019
06/10/2019	• Added Cutaquig® [Immune Globulin Subcutaneous (Human) – hipp]
05/29/2019	• Added Zolgensma® (onasemnogene abeparvovec-xioi)
04/15/2019	• Added Evenity™ (romosozumab-aqqg)
04/01/2019	• Removed Gamifant® (emapalumab-lzsg) and Revcovi™ (elapegademase-lvlr); prior authorization requirements effective Apr. 1, 2019
01/01/2019	• Added Ultomiris™ (ravulizumab-cwvz) • Removed Ilumya™ (tildrakizumab-asmn) and Onpattro™ (patisiran); prior authorization requirements effective Jan. 1, 2019
11/20/2018	• Added Gamifant® (emapalumab-lzsg) • Removed Panzyga® (immune globulin intravenous, human-ifas); prior authorization requirements for HCPCS code J1599 previously in effect
11/08/2018	• Added Panzyga® (immune globulin intravenous, human-ifas)
10/09/2018	• Added Revcovi™ (elapegademase-lvlr)
10/01/2018	• Removed Crysvita® (burosumab-twza); prior authorization requirements effective Oct. 1, 2018
08/15/2018	• Added Onpattro™ (patisiran)
06/26/2018	• Added Ilumya™ (tildrakizumab-asmn)
04/23/2018	• Added Crysvita® (burosumab-twza)
04/01/2018	• Removed Luxturna™ (voretigene neparvovec-rzyl); prior authorization requirements effective Apr. 1, 2018
01/01/2018	• New list; includes Luxturna™ (voretigene neparvovec-rzyl)