UnitedHealthcare Pharmacy
Clinical Pharmacy Programs

Program Number	2025 P 1502-1
Program	Prior Authorization/Notification
Medication	Inluriyo (imlunestrant)
P&T Approval Date	11/2025
Effective Date	2/1/2026

1. Background:

Inluriyo is an estrogen receptor antagonist indicated for the treatment of adults with ER-positive, HER2-negative, ESR1-mutated advanced or metastatic breast cancer with disease progression following at least one line of endocrine therapy.

2. Coverage Criteria[a]:

A. Patients less than 19 years of age

1. **Inluriyo** will be approved based on the following criterion:

   a. Patient is less than 19 years of age

   Authorization will be issued for 12 months.

B. Breast Cancer

1. Initial Authorization

a. **Inluriyo** will be approved based on **all** of the following criteria:

(1) Diagnosis of breast cancer

-AND-

(2) Breast cancer is **all** of the following:

(a) Estrogen receptor-positive (ER+)
(b) Human epidermal growth factor receptor 2-negative (HER2-)
(c) Estrogen receptor 1 (ESR1)-mutated

-AND-

(3) Disease is advanced or metastatic

-AND-

(4) Disease progression has occurred following at least one line of endocrine therapy

Authorization will be issued for 12 months.

2. Reauthorization

a. **Inluriyo** will be approved based on the following criterion:

(1) Patient does not show evidence of progressive disease while on Inluriyo therapy

Authorization will be issued for 12 months.

C. NCCN Recommended Regimens

The drug has been recognized for treatment of the cancer indication by The National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium with a Category of Evidence and Consensus of 1, 2A, or 2B

Authorization will be issued for 12 months.

[a] State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

3. Additional Clinical Rules:

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

4. References:

1. Inluriyo [package insert]. Indianapolis, IN: Lilly, LLC. September 2025.

Program	Prior Authorization/Notification - Inluriyo™ (imlunestrant)
Change Control	
11/2025	New program.