Q4 2026 Preferred drug list updates

UnitedHealthcare Community Plan

Effective October 1, 2026, we're making the following changes to the UnitedHealthcare Community Plan preferred drug list (PDL). Our Pharmacy and Therapeutics Committee updates this PDL quarterly.

These changes apply to:

- The following states: Colorado (CO), Hawaii (HI), Indiana (IN), Maryland (MD), Michigan (MI) Nebraska (NE), New Jersey (NJ), Nevada (NV), Pennsylvania (PA), Rhode Island (RI) and Virginia (VA)
- The following programs and plans: New York Children's Health Insurance Program (NY CHIP), New York Essential Plan (NY EPP) and Pennsylvania CHIP (PA CHIP)

These changes don't apply to Arizona, Florida, Kansas, New Mexico, North Carolina, Texas or Washington.

New medications on PDL

Medication	Description	States and plans in scope
albuterol inhaler (additional generic Proair®/Proventil® NDCs)	Indicated for the treatment or prevention of bronchospasm in patients with reversible obstructive airway disease and for prevention of exercise-induced bronchospasm.	CO, HI, MD, NJ, NY CHIP, NY EP, PA CHIP, RI
cefpodoxime suspension	Indicated for the treatment of susceptible bacterial infections. **We require prior authorization for members >12 years old.**	CO, HI, MD, NJ, NY CHIP, NY EP, PA CHIP, RI
dapagliflozin/metformin tablets	Indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. **We require prior authorization.**	CO, HI, MD, NJ, NY CHIP, PA CHIP, RI
FC2 female condom	Indicated for pregnancy prevention and reduction of exposure to sexually transmitted infections.	CO, HI, IN, MD, NE, NJ, NV, NY CHIP, NY EP, PA CHIP, RI, VA

New medications on PDL (cont.)

Medication	Description	States and plans in scope
fluocinolone otic oil	Indicated for the treatment of chronic eczematous external otitis.	CO, HI, MD, NJ, NV, NY CHIP, NY EP, PA CHIP, RI, VA
fluticasone diskus	Indicated for the maintenance treatment of asthma and prevention of asthma symptoms.	CO, HI, MD, NJ, NY CHIP, NY EP, PA CHIP, RI
tofacitinib tablets	Indicated for the treatment of certain inflammatory and autoimmune conditions, including rheumatoid arthritis, psoriatic arthritis, juvenile idiopathic arthritis, ankylosing spondylitis, and ulcerative colitis. **We require prior authorization.**	CO, HI, MD, NJ, NY CHIP, PA CHIP, RI

Changes to coverage

Medication	Description	States and plans in scope
Breyna® inhaler	Indicated for the treatment of asthma and chronic obstructive pulmonary disease. **We no longer require prior authorization.**	CO, HI, MD, NJ, NY CHIP, PA CHIP, RI
budesonide/formoterol inhaler	Indicated for the treatment of asthma and chronic obstructive pulmonary disease. **We no longer require prior authorization.**	CO, HI, MD, NJ, NY CHIP, PA CHIP, RI
dapagliflozin tablets	Indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus. **We no longer require prior authorization.**	CO, HI, MD, NJ, NY CHIP, PA CHIP, RI
tadalafil 2.5 mg tablets	Indicated for the treatment of benign prostatic hyperplasia. **We require prior authorization.**	CO, HI, MD, NE, NJ, NV, NY CHIP, NY EP, PA CHIP, RI

Medications no longer on the PDL

We're removing the following medication(s) from our PDL:

Medication	Description	States and plans in scope
albuterol inhaler (authorized generic Ventolin®)	Indicated for the treatment or prevention of bronchospasm in patients with reversible obstructive airway disease and for prevention of exercise-induced bronchospasm. Alternatives include the generics for Proair® or Proventil® inhalers. **We require prior authorization.**	CO, HI, MD, NJ, NY CHIP, PA CHIP, RI
alendronate oral solution	Indicated for the treatment and prevention of osteoporosis. Alternatives include alendronate tablets. **We require prior authorization.**	CO, HI, MD, NJ, NY CHIP, NY EP, PA CHIP, RI
Anoro® Ellipta® inhaler	Indicated for the maintenance treatment of chronic obstructive pulmonary disease. Alternatives include the authorized generic of Anoro® inhaler. **We require prior authorization.**	CO, HI, MD, NJ, NY CHIP, PA CHIP, RI
apraclonidine ophthalmic solution	Indicated for the short-term treatment of elevated intraocular pressure in patients with glaucoma. Alternatives include brimonidine ophthalmic solution. **We require prior authorization.**	CO, HI, MD, NJ, NY CHIP, NY EP, PA CHIP, RI
betaxolol ophthalmic solution	Indicated for the treatment of elevated intraocular pressure in patients with ocular hypertension or open-angle glaucoma. Alternatives include timolol and carteolol ophthalmic solution. **We require prior authorization.**	CO, HI, MD, NJ, NY CHIP, NY EP, PA CHIP, RI

Medications no longer on the PDL (cont.)

We're removing the following medication(s) from our PDL:

Medication	Description	States and plans in scope
clemastine tablets	Indicated for the treatment of allergic rhinitis and other allergic conditions, including urticaria and pruritus. Alternatives include diphenhydramine capsules. **We require prior authorization.**	CO, HI, IN, MD, NE, NJ, NV, NY CHIP, NY EP, PA CHIP, RI, VA
diltiazem ER (12HR) capsules	Indicated for the treatment of hypertension and chronic stable angina. Alternatives include diltiazem 24HR capsules and tablets. **We require prior authorization.**	CO, HI, MD, NJ, NY CHIP, NY EP, PA CHIP, RI
Enbrel® SureClick/ Mini/ Prefilled Syringe/ Vial	Indicated for the treatment of certain inflammatory and autoimmune conditions, including rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, plaque psoriasis, and juvenile idiopathic arthritis. Alternatives include preferred adalimumab biosimilar products. These alternatives require prior authorization. **We require prior authorization.**	CO, HI, MD, NJ, NY CHIP, PA CHIP, RI
Epogen® injection	Indicated for the treatment of anemia associated with chronic kidney disease, chemotherapy, and certain other conditions. The alternative Retacrit® injection requires prior authorization. **We require prior authorization.**	CO, HI, MD, NJ, NY CHIP, NY EP, PA CHIP, RI
Incruse® Ellipta inhaler	Indicated for the maintenance treatment of chronic obstructive pulmonary disease. Alternatives include the authorized generic of Incruse® inhaler. **We require prior authorization.**	CO, HI, MD, NJ, NY CHIP, PA CHIP, RI

Medications no longer on the PDL (cont.)

We're removing the following medication(s) from our PDL:

Medication	Description	States and plans in scope
metronidazole 0.75% lotion	Indicated for the treatment of the inflammatory lesions of rosacea. Alternatives include metronidazole gel and cream. **We require prior authorization.**	CO, HI, IN, MD, NJ, NV, NY CHIP, NY EP, PA CHIP, RI
Mounjaro® injection	Indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes. The alternative Ozempic® injection requires prior authorization. **We require prior authorization.**	RI
Nocdurna® sublingual tablets	Indicated for the treatment of nocturia due to nocturnal polyuria. Alternatives include desmopressin tablets. **We require prior authorization.**	CO, HI, IN, MD, NE, NJ, NV, NY CHIP, NY EP, PA, PA CHIP, RI, VA
Phospholine® ophthalmic solution	Indicated for the treatment of glaucoma by reducing intraocular pressure. Alternatives include brimonidine ophthalmic solution. **We require prior authorization.**	CO, HI, IN, MD, MI, NE, NJ, NV, NY CHIP, NY EP, PA CHIP, RI, VA
Procrit® injection	Indicated for the treatment of anemia associated with chronic kidney disease, chemotherapy, and certain other conditions. The alternative Retacrit® injection requires prior authorization. **We require prior authorization.**	CO, HI, MD, NJ, NY CHIP, NY EP, PA CHIP, RI
quinidine tablets	Indicated for the treatment of certain life-threatening ventricular arrhythmias. Alternatives include disopyramide capsules. **We require prior authorization.**	CO, HI, IN, MD, MI, NE, NJ, NV, NY CHIP, NY EP, PA CHIP, RI, VA

Medications no longer on the PDL (cont.)

We're removing the following medication(s) from our PDL:

Medication	Description	States and plans in scope
Segluromet® tablets	Indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes. Alternatives include dapagliflozin and metformin separately. **We require prior authorization.**	CO, HI, MD, NJ, NY CHIP, PA CHIP, RI
Sirturo® tablets	Indicated for the treatment of pulmonary multidrug-resistant tuberculosis. Alternatives include disopyramide capsules and pyrazinamide tablets. **We require prior authorization.**	CO, HI, IN, MD, NE, NJ, NV, NY CHIP, NY EP, PA CHIP, RI, VA
Steglatro® tablets	Indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes. Alternatives include dapagliflozin tablets. **We require prior authorization.**	CO, HI, MD, NJ, NY CHIP, PA CHIP, RI

Medication alternatives

We may cover medication alternatives for medications not on our PDL. If you feel a medication alternative is medically appropriate for a patient, and you'd like to prescribe it, please do one of the following:

- Contact the member's pharmacy to request the prescription
- Submit an electronic prescription using Optum Rx ePrescribe
  - For more information, visit **Electronic Prescribing (eRx) to Optum Home Delivery** at optum.com
- Write a new prescription and give it to your patient (where state regulations permit)

If a preferred alternative medication isn't medically appropriate for a patient, please request a PDL prior authorization exception by calling Optum Rx prescriber prior authorization at **800-310-6826**. If the medication meets our medical necessity criteria, we'll continue to cover it for that patient.

Resources

As of October 1, 2026, you can view the changes at **UHCprovider.com/plans** > Health Plans by State > Medicaid (Community Plan) > Pharmacy Resources and Physician Administered Drugs.

Questions? We're here to help.

For chat options and contact information, visit **UHCprovider.com/contactus**.

United Healthcare® Community Plan

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