

**Oscar Clinical Guidelines - Pharmacy  
2026 Q2 (June) P&T Summary of Changes**

**Revisions/Off-Cycle Reviews**

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
CeQur Simplicity Insulin Delivery System (PG192, Ver. 5)	Clinical Indication	<ol style="list-style-type: none"> <li>1. Removed prescriber specialty as it is a manual, bolus-only wearable insulin patch.</li> <li>2. Removed specific suboptimal glycemic control conditions and changed to broader “The member has suboptimal glycemic control (e.g., hemoglobin A1c &gt;7.0%, hypoglycemia, hyperglycemia, glucose variability/fluctuations)”.</li> <li>3. Addressed the product line extension in which the FDA clearance extends wear time up to seven days and introduces a new 1-unit bolus dosing option.</li> <li>4. If the request is for the 2U CeQur Simplicity 2.4ml Extended Wear Patch: 1 box (containing 5 patches) per 30 days. If the request is for the 1U CeQur Simplicity 2.4ml Extended Wear Patch: 1 box (containing 4 patches) per 30 days.</li> <li>5. Added inserter kit quantity limit of 1 inserter per 365 days to align with the formulary listing.</li> </ol>	Yes	8/3/2026

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<p>Vyvgart (efgartigimod alfa-fcab) and Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) (PG191, Ver. 5)</p>	<p>Clinical Indication</p>	<p>Generalized Myasthenia Gravis (gMG)</p> <ol style="list-style-type: none"> <li>Per label expansion to treat in any serotype, removal of positive serologic test for anti-acetylcholine receptor (anti-AChR) antibodies.</li> <li>Clarified the trial and failure of 2 standard therapies for gMG is each from a different class. Added methotrexate as an additional example for non-steroidal immunosuppressive therapy. Added intravenous immunoglobulin (IVIG) as an additional option for trial and failure due to differences in treatment options based on serotype.</li> <li>Removed plan's quantity limit of 4 syringes every 28 days.</li> </ol>	<p>Yes</p>	<p>8/3/2026</p>
<p>Autoimmune Conditions Exceptions Criteria For Certain States (PG286, Ver. 8)</p>	<p>Table 1. Drugs for autoimmune conditions (non-infliximab products)</p>	<p>Effective 7/1/2026</p> <ol style="list-style-type: none"> <li>For non-radiographic axial spondyloarthritis, added that if the requested product is Cimzia, and the member is currently breastfeeding, pregnant, or planning pregnancy.</li> </ol> <p>Effective 8/3/2026</p> <ol style="list-style-type: none"> <li>Added generic adalimumab-bwwd as a targeted product for ankylosing spondylitis (AS), Crohn's disease (CD), hidradenitis supprativa (HS), plaque psoriasis (PsO), polyarticular juvenile idiopathic arthritis (pJIA),</li> </ol>	<p>Yes</p>	<p>7/1/2026 &amp; 8/3/2026</p>

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
		<p>psoriatic arthritis (PsA), rheumatoid arthritis, ulcerative colitis (UC), and uveitis.</p> <p>3. Added generic ustekinumab IV as a targeted product for CD and UC. Added ustekinumab subcutaneous (SC) as a targeted product for CD, PsO, PsA, and UC.</p>		
<p>Autoimmune Conditions Specialty Exceptions All Other States (PG287, Ver. 1)</p>	<p>Table 1. Drugs for autoimmune conditions (non-infliximab products)</p>	<p>Effective 7/1/2026</p> <p>1. For non-radiographic axial spondyloarthritis, added that if the requested product is Cimzia, and the member is currently breastfeeding, pregnant, or planning pregnancy.</p> <p>Effective 8/3/2026</p> <p>1. Added Yesintek (SC) (ustekinumab-kfce) to be co-preferred with Stelara (SC) (ustekinumab) for Crohn’s Disease, Plaque Psoriasis, and Ulcerative Colitis.</p> <p>2. Added generic adalimumab-bwwd as a targeted product for ankylosing spondylitis (AS), Crohn's disease (CD), hidradenitis supprativa (HS), plaque psoriasis (PsO), polyarticular juvenile idiopathic arthritis (pJIA), psoriatic arthritis (PsA), rheumatoid arthritis (RA), ulcerative colitis (UC), and uveitis.</p> <p>3. Added generic ustekinumab IV as a targeted product for CD and UC. Added ustekinumab subcutaneous (SC) as a targeted product for</p>	<p>Yes</p>	<p>7/1/2026 &amp; 8/3/2026</p>

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
		CD, PsO, PsA, and UC.		
(Commercial) Preferred Physician-Administered Specialty Drugs (CG052, Ver. 36)	Medical Preferred Drug List	<ol style="list-style-type: none"> <li>Added Armlupeg (pegfilgrastim-unne) [Q5169], Filkri (filgrastim-laha) [NOC], Qivigy (immune globulin human-kthm) [J1577] as non-preferred.</li> <li>Added new Q or J codes for: Jobevne (bevacizumab-nwgd) [Q5160], Yesafili (afibercept-jbvf) [Q5155], Nufymco (ranibizumab-leyk) [Q5168], Exdensur (depemokimab-ulaa) [J2361].</li> </ol>	Yes	11/2/2026
Short-Acting Granulocyte Colony-Stimulating Factors - Medical Benefit Preferred Physician-Administered Drug Exceptions Criteria (CG080, Ver. 5)	Medical Preferred Drug List	<ol style="list-style-type: none"> <li>Added Filkri (filgrastim-laha) [NOC] as non-preferred.</li> </ol>	Yes	11/2/2026

### New Guidelines

Clinical Guideline	Details	Effective Date
N/A		

### Annual Reviews

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
azelaic acid 15% gel (PG059, Ver. 8)	Clinical Indication	1. Extended authorization duration from 12 months to 36 months.	Yes	8/3/2026
Filsuvez (birch triterpenes) (PG211, Ver. 3)	Clinical Indications	<ol style="list-style-type: none"> <li>Coverage for Recessive Dystrophic Epidermolysis Bullosa (RDEB) changed from unproven/not medically necessary to medically necessary.</li> <li>Asking for prescriber specialty, will not use with other drugs for EB, and prescribed at a dose and frequency within FDA approved labeling including 1 tube per target wound per day unless clinical rationale is provided for exceeding this limit.</li> <li>Diagnosis of RDEB supported by genetic testing, member is 6 months of age or older, and the target wound is of partial thickness, present for at least 21 days but less than 9 months, clean in appearance, adequate granulation tissue, excellent vascularization, and no evidence it is infected. There is documentation of the size of the target wound at baseline and receiving</li> </ol>	Yes	8/3/2026

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
		<p>standard-of-care wound preventive or treatment therapies. The member is unable to use, or has tried and failed Vyjuvek (beremagene geperpavec-svdt). Authorization of 6 months.</p> <p>4. In continued care, the member has wound healing documented by decrease in wound size, decrease in number of partial-thickness wounds, increase in granulation tissue, or partial or complete wound closure. The target wound remains open or a new wound needs treatment. Filsuvez will not be applied on target wound(s) that have completely healed, continue to receive wound care standard of care, and no evidence of unacceptable toxicity with monitoring of adverse events like skin squamous cell carcinoma. Continued care of 6 months.</p>		
	<p>Experimental or Investigational or unproven</p>	<p>1. Added Epidermolysis Bullosa (EB) simplex, Kindler syndrome, and other types of EB that are not dystrophic or junctional.</p>		

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	Not Medically Necessary	<ol style="list-style-type: none"> <li>1. Filsuvez (birch triterpenes) for dominant dystrophic epidermolysis bullosa (DDEB) is considered not medically necessary. Efficacy with Filsuvez (birch triterpenes) has not been proven to be better than placebo. In the pivotal EASE trial (NCT03068780), the primary endpoint was the proportion of patients with first complete closure of the target wound within 45 days (N=223). In the subgroup analysis, at day 45 (±7 days), complete wound closure in patients with DDEB in the placebo group (50%) was equal to the Filsuvez group (50%). In this subgroup with DDEB (n=20), Vyjuvek treatment failed to reach statistical significance [95% confidence interval (CI) for the treatment difference: -47.8, 47.8].</li> <li>2. Filsuvez (birch triterpenes) for Junctional Epidermolysis Bullosa (JEB) is considered not medically necessary. Efficacy with Filsuvez (birch triterpenes) has not been proven to be better than placebo. In the pivotal EASE trial (NCT03068780), the primary endpoint was the proportion of patients with first complete closure of the target wound within 45 days (N=223). In the subgroup analysis, at day 45 (±7 days), complete wound closure in patients with JEB was higher in the placebo group</li> </ol>		

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		<p>(26.7%) vs. Filsuvez (18.6%). In this subgroup with JEB (n=26), Vyjuvek treatment failed to reach statistical significance (95% CI for the treatment difference: -40.4, 23.5).</p> <p>3. In the open label extension (OLE) trial, 78% (n=160) had RDEB, 8.8% (n=18) had DDEB, 12.2% (n=25) had JEB, and 1.0% (n=2) had EBS in the total population (N=205). However, the OLE data did not provide subgroup analysis by epidermolysis bullosa type.</p>		
<p>Dupixent (dupilumab) (PG026, Ver. 16)</p>	<p>Medical Necessity Criteria for Initial Clinical Review</p>	<p>Allergic fungal rhinosinusitis:</p> <ol style="list-style-type: none"> <li>1. Added new expanded indication “allergic fungal rhinosinusitis” to be prescribed by allergist/immunologist or otolaryngologist.</li> <li>2. Added indication requiring: age 6 years or older, weighing more than 15 kg, diagnosis based on CT scan, IgE serology or skin test, nasal polyposis confirmed by endoscopy, endoscopic nasal polyp score (NPS), eosinophilic mucin, and Lund Mackay score of <math>\geq 9</math> for unilateral polyps, and <math>\geq 12</math> for bilateral polyps; prior history of sino-nasal surgery, and positive fungal stain of sinus contents removed at time of surgery.</li> </ol> <p>Asthma:</p>	<p>Yes</p>	<p>11/2/2026</p>

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		<ol style="list-style-type: none"> <li>1. Updated trial and failure to allow for either two or more exacerbations resulting in oral/systemic corticosteroid treatment OR one or more exacerbations requiring hospitalization or intensive care unit admissions.</li> <li>2. Addition of long-acting muscarinic antagonist (LAMA) as a prior therapy for asthma that had been tried and failed or has been used at baseline.</li> </ol> <p>Bullous Pemphigoid:</p> <ol style="list-style-type: none"> <li>1. Specified it is moderate-to-severe bullous pemphigoid.</li> <li>2. Diagnosis has been confirmed by either direct immunofluorescence (DIF) study or immune serological test(s).</li> <li>3. Has characteristic clinical features of bullous pemphigoid.</li> </ol> <p>Chronic rhinosinusitis with nasal polyposis:</p> <ol style="list-style-type: none"> <li>1. Reduced trial and failure duration of intranasal steroids from 2 months to 4 weeks consistent with pivotal trial.</li> <li>2. Expanded diagnostics to include Meltzer Clinical Score of 2 or higher in both nostrils or a total endoscopic nasal polyp score (NPS) of</li> </ol>		

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		<p>at least 5 with a minimum score of 2 for each nostril.</p> <ol style="list-style-type: none"> <li>3. Expanded obstruction to include nasal blockage, congestion, or obstruction.</li> <li>4. Added symptoms to include facial pain or pressure.</li> </ol> <p>Chronic Spontaneous Urticaria (CSU):</p> <ol style="list-style-type: none"> <li>1. Lowered age to 2 years of age or older per label expansion.</li> </ol> <p>Immune checkpoint inhibitor-related toxicities:</p> <ol style="list-style-type: none"> <li>1. Updated diagnosis/grade of severity consistent with NCCN guidelines.</li> </ol> <p>Prurigo Nodularis:</p> <ol style="list-style-type: none"> <li>1. For trial and failure of one alternative added options to include topical calcineurin inhibitor, phototherapy (e.g., UVB, PUVA), or pharmacologic treatment with methotrexate or cyclosporine to the already existing option topical corticosteroid.</li> </ol>		
	<p>Medical Necessity Criteria for</p>	<p>Allergic fungal rhinosinusitis:</p> <ol style="list-style-type: none"> <li>1. Requirement that they are 6 years and older, weighing 15kg or more, and have support for improvement based on documentation of</li> </ol>		

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	Subsequent Clinical Review	<p>one of the following: improvement in symptoms, lower Lund-Mackay score, minimal or no eosinophilic mucin, reduction in nasal congestion or blockage, reduction in nasal polyps or formation of new polyps, reduction in sinus opacification, and reduced need for rescue treatment.</p> <p>Bullous Pemphigoid:</p> <ol style="list-style-type: none"> <li>1. Defined positive response as low disease activity or reduction in pruritus intensity and improvement in extent and severity of lesions.</li> </ol> <p>COPD:</p> <ol style="list-style-type: none"> <li>1. Addition of disease stability as support for positive clinical response.</li> </ol>		
	Experimental or Investigational or Unproven / Not	<ol style="list-style-type: none"> <li>1. Clarification around grade 2 pruritus for immune checkpoint inhibitor-related toxicities given changes in NCCN guidelines allowing for management in those with grade 2 pruritus who have failed gabapentinoids for at least 1 month or have a confirmed diagnosis of bullous pemphigoid.</li> <li>2. Added allergic fungal rhinosinusitis in members under 6 years of age.</li> </ol>		

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	Medically Necessary	<ol style="list-style-type: none"> <li>3. Added chronic rhinosinusitis with nasal polyps in members under 12 years of age.</li> <li>4. Removed chronic idiopathic urticaria as it is an older term and already addressed with chronic spontaneous urticaria.</li> </ol>		
Imcivree (PG088, Ver. 8)	Clinical Indication	<ol style="list-style-type: none"> <li>1. For all indications added that there is there is documentation of the member's baseline weight and body mass index (BMI) (in the past 60 days) prior to treatment with Imcivree (setmelanotide) and Imcivree (setmelanotide) is being prescribed at a dose and frequency that is within FDA approved labeling.</li> <li>2. For new indication Acquired Hypothalamic Obesity (HO) added additional option for neurologist for prescriber specialty, age, diagnosis of acquired hypothalamic obesity supported by being a hypothalamic lesion, tumor, damage, or injury, experiencing weight gain that began within the first 12 months after the onset of hypothalamic damage, age and body mass index (BMI), no evidence of weight loss &gt;2% in last 3 months, and no evidence of bariatric surgery. Authorization of 12 months.</li> <li>3. For Pro-opiomelanocortin (POMC), Proprotein Convertase Subtilisin/Kexin Type 1 (PCSK1), or</li> </ol>	Yes	11/2/2026

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		<p>Leptin Receptor (LEPR) Deficiency extended authorization duration from 4 months to 12 months due to clinical data at 1 year.</p> <p>4. For reauthorization for all indications asking The member is tolerating dosing beyond the recommended initial starting dose and at a tolerated maintenance dose that does not exceed 3 mg (0.3 mL). For HO, asking for loss of at least 5% of baseline body weight or 5% of baseline BMI for members aged less than (&lt;) 18 years. Authorization duration of 12 months.</p>		
	Experimental or Investigational or unproven	<p>1. Added Imcivree should not be used in combination with other weight loss agents (e.g., Saxenda, Wegovy, Zepbound, etc.) without other comorbidities.</p>		
Orladeyo (PG090, Ver. 8)	Clinical Indication	<p>1. Decreased age from 12 years of age to 2 years of age per label update. Included dosing for those under 12 years and over 12 years of age.</p>	Yes	8/3/2026
Benlysta (belimumab) (PG014, Ver. 9)	Clinical Indication	<p>1. For Active Systemic Lupus Erythematosus (SLE), added other indicators to support diagnosis such as clarifying antinuclear antibody [ANA] by IFA [Indirect Immunofluorescence Assay] 1:80 or higher</p>	Yes	8/3/2026

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		<p>and low complement proteins. Added cyclosporine and cyclophosphamide as examples for standard therapy.</p> <p>2. For Active Lupus Nephritis, added diagnosis confirmation by kidney biopsy as an option per 2024 ACR Guideline for the Screening, Treatment, and Management of Lupus Nephritis. Added other indicators to support diagnosis such as clarifying antinuclear antibody [ANA] by IFA [Indirect Immunofluorescence Assay] 1:80 or higher and low complement proteins. Added hydroxychloroquine and cyclophosphamide as another example of a standard therapy regimen per 2024 ACR Guideline for Lupus Nephritis.</p>		
	Experimental / Investigational or unproven	<p>1. Added idiopathic inflammatory myopathy.</p>		
Prescription Drugs for Serious Mental Illnesses-REG (PG171, Ver. 4)	Coverage Criteria	<p>1. Added clarification that the member's plan is issued for Texas.</p> <p>2. Removed the word "adequately" for trial and failure of one preferred alternative and noted unless all alternatives "are not appropriate".</p>	Yes	8/3/2026

Clinical Guideline	Section	Revision	Substantive Change?	Effective Date
Medical Necessity Prior Authorization Criteria for Formulary Products (PG076, Ver. 8)	Clinical Indication	<ol style="list-style-type: none"> <li>1. Renamed title of policy as Medical Necessity Prior Authorization Criteria to add “for formulary products” at the end.</li> <li>2. Added “when applicable” for trial and failure of all appropriate formulary alternatives.</li> </ol>	Yes	8/3/2026
iDose TR (travoprost intracameral implant) (CG115, Ver. 5)	Clinical Indications	<ol style="list-style-type: none"> <li>1. Label expanded to allow re-administration of iDose TR more than once in patients who maintain a healthy cornea based on long-term corneal safety profile, with no clinically significant corneal endothelial cell loss observed through three years across. Additionally, results demonstrated a second administration of iDose TR and removal of the original iDose TR implant was safe and well-tolerated, with the second iDose TR demonstrating a favorable safety profile over a 12-month evaluation period.</li> <li>2. As such, criteria updated to allow for readministration after 1 year of last iDose TR administration if corneal endothelial cell density parameters are healthy.</li> <li>3. Added that member’s central corneal endothelial cell density is at or above the manufacturer’s labeled minimum</li> </ol>	Yes	8/3/2026

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		documented by specular microscopy prior to each administration.		
Infertility Injectable Agents (PG119, Ver. 5)	Clinical Indication	<ol style="list-style-type: none"> <li>1. Updated summary to align with contemporary American Society for Reproductive Medicine (ASRM) definitions and to include individuals who require medical intervention to achieve pregnancy (including same-sex couples and single individuals pursuing parenthood) to align with current reproductive medicine practice and reduce the potential for unintended population exclusions.</li> <li>2. Unable to use preferred oral therapies: added hypogonadotropic hypogonadism and hypothalamic amenorrhea as examples for risk factors for a poor response, added advanced reproductive age, diminished ovarian reserve,, urgent fertility preservation before gonadotoxic therapy as examples for rationale provided as to why it is not clinically appropriate, and changed age to 40 years of age to align with ASRM as 40 years or older require more immediate evaluation and treatment.</li> </ol>	Yes	8/3/2026

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		3. Added “when applicable” for evaluation of partner as it is not applicable for same-sex couples or single individuals.		
Beyfortus (nirsevimab-alip) and Enflonsia (clesrovimab-cfor) (PG180, Ver. 4)	Clinical Indication	1. Beyfortus (nirsevimab-alip) or Enflonsia (clesrovimab-cfor) in infants aged <8 months added criteria addressing maternal RSV. Per the CDC’s ACIP 2025 either maternal RSV vaccination (Pfizer’s Abrysvo) or infant immunization with a long-acting RSV monoclonal antibody (nirsevimab or clesrovimab) is recommended. Most infants will not need both maternal vaccination and infant RSV antibodies. Exceptions to this added if maternal RSV vaccine was not received during pregnancy, maternal RSV vaccination status unknown, infant was born less than 14 days after maternal vaccination, or infant was born 14 or more days after maternal vaccination and there are risk factors.	Yes	11/2/2026
Palforzia [Peanut (Arachis hypogaea) Allergen	Clinical Indication	1. Policy will sunset as the manufacturer Stallergenes Greer will discontinue the commercialization of Palforzia® [Peanut (Arachis hypogaea) Allergen Powder-dnfp] as of July 31, 2026. The PALFORZIA Pathway™ Patient Hub and Walgreens Specialty	Yes	1/4/2027

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Powder-dnfp] (PG245, Ver. 2)		Pharmacies will accept the last New Patient Starts on January 30, 2026. After this date, no Initial Dose Escalation Cards will be dispensed.		
Restasis (cyclosporine ophthalmic emulsion 0.05%) (PG025, Ver. 9)	Clinical Indication	<ol style="list-style-type: none"> <li>Added that Restasis (cyclosporine ophthalmic emulsion 0.05%) is being prescribed at a dose and frequency within FDA approved labeling and within the plan's existing quantity limit.</li> <li>Removed "clinical chart documentation" standalone criteria as it is duplicative and already in the relevant criteria.</li> </ol>	Yes	11/2/2026
Niktimvo (axatilimab) (PG252, Ver. 3)	Clinical Indication	<ol style="list-style-type: none"> <li>Per NCCN 2.2026 Hematopoietic Cell Transplantation added additional trial and failure alternatives to existing list including alemtuzumab, etanercept, and rituximab.</li> </ol>	Yes	8/3/2026
Sublingual Allergy Immunotherapy (SLIT) (PG093, Ver. 7)	Clinical Indication	<ol style="list-style-type: none"> <li>Added that the member has access to epinephrine (via auto-injector or nasal spray).</li> <li>Changed contraindications to start with "no evidence of".</li> <li>Added sublingual allergy immunotherapy is being prescribed at a dose and frequency that is within FDA approved labeling OR is supported by compendia for reauthorization.</li> </ol>	Yes	8/3/2026

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Lanthanum Carbonate Chewable tablet (Fosrenol) (PG177, Ver. 4)	Clinical Indication	<ol style="list-style-type: none"> <li>1. Added if the request is for brand Fosrenol, the member is unable to use, or has tried and failed generic lanthanum carbonate.</li> <li>2. For continued care clarified that positive response is seen within the last 3 months.</li> <li>3. In continued care clarified reduction in serum phosphate level reduced to target range (3.5-5.5 mg/dL for adults).</li> </ol>	Yes	11/2/2026
Velphoro (sucroferric oxyhydroxide) (PG179, Ver. 4)	Clinical Indication	<ol style="list-style-type: none"> <li>1. Clarified for pediatric hyperphosphatemia it is based on the reporting laboratory.</li> <li>2. Added "when appropriate" after dietary restrictions and optimized dialysis regimen.</li> <li>3. Updated trial and failure from two to one alternative drug based on treatment population. One of the alternatives: calcium acetate (PhosLo) is not first line. Additionally, Per IRO feedback KDIGO states routine use of calcium-based phosphate binders (such as calcium acetate) should be restricted across all adult CKD G3a-G5D populations. Use may accelerate progressive cardiovascular calcification and expand the individual's risk of cardiovascular mortality (Kim &amp; Hwang, 2021). The other alternative lanthanum may also not be appropriate in certain scenarios (e.g., metal risks or GI anatomy limitations).</li> </ol>	Yes	8/3/2026

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<p>Sirturo (bedaquiline) (PG242, Ver. 3)</p>	<p>Clinical Indication</p>	<ol style="list-style-type: none"> <li>1. Expanded prescriber specialty to include an expert in the treatment of tuberculosis (TB) (e.g., state or county public health department, specialists affiliated with TB Centers of Excellence as designated by the CDC).</li> <li>2. Added to allow use in 14 years of age or older with rifampin-resistant, fluoroquinolone-resistant TB using the bedaquiline, pretomanid, and linezolid (BPaL) regimen or 14 years of age or older with rifampin-resistant, fluoroquinolone-susceptible TB using the bedaquiline, pretomanid, linezolid, and moxifloxacin (BPaLM) regimen per CDC 2025 and IDSA 2025.</li> <li>3. For extensively drug resistant (XDR) pulmonary TB clarified that it is with linezolid or a second-line injectable agent (e.g., amikacin, capreomycin, and kanamycin).</li> <li>4. Revised documentation showing resistance to at least rifampin (removed isoniazid) and listed accepted laboratory confirmed drug-resistant TB by either culture based testing or rapid molecular testing (latter was added).</li> </ol>	<p>Yes</p>	<p>11/2/2026</p>

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		<p>5. Added that Sirturo (bedaquiline) is being prescribed at a dose and frequency that is within FDA approved labeling OR is supported by compendia or evidence-based published dosing guidelines for the requested indication.</p>		
Oscar Clinical Guidelines	Clinical Indication	<p>List of policies to be sunset.</p> <ol style="list-style-type: none"> <li>1. fesoterodine (Toviaz) (PG102, Ver. 6)</li> <li>2. Exemestane Oral tablet (PG084, Ver. 8)</li> <li>3. Memantine (Namenda) (PG213, Ver. 2)</li> <li>4. Lurasidone (Latuda) (PG057, Ver. 8)</li> <li>5. Budesonide 3mg Delayed-Release Capsule (Entocort EC) (PG082, Ver. 7)</li> <li>6. Lacosamide (Vimpat) (PG056, Ver. 7)</li> <li>7. lamotrigine ER (PG055, Ver. 7)</li> <li>8. Lamotrigine Orally Disintegrating Tablet (PG083, Ver. 7)</li> </ol>	Yes	8/3/2026
Oscar Clinical Guidelines	Clinical Indication	<p>List of criteria that have completed the annual review process. No clinical changes.</p> <ol style="list-style-type: none"> <li>1. Rivastigmine (Exelon) (PG212, Ver. 3)</li> <li>2. Non-Formulary Mental Health Products Criteria (PG265, Ver. 2)</li> <li>3. Verkazia (cyclosporine ophthalmic emulsion) 0.1% (PG236, Ver. 3)</li> <li>4. Varubi (rolapitant) (PG178, Ver. 4)</li> </ol>	No	11/2/2026