

Preferred Drug List update

2025 — 4th quarter

The UnitedHealthcare Community Plan Preferred Drug List (PDL) is a list of prescription drugs covered by your health plan. It has recently been updated. To see which drugs are covered, find your PDL under the Pharmacies and Prescriptions section on myuhc.com. You can call the number on the back of your member ID card if you need help.

If you take one of the drugs below, ask your doctor if another drug will work for you. Your doctor may need to write a prescription for the new drug. If needed, your doctor can ask UnitedHealthcare Community Plan for a prior authorization. If the prior authorization is approved, we will continue to cover this drug.

Changes on October 1, 2025

Drugs added to the Preferred Drug List

Drug/Product Name	Comments
Desvenlafaxine ER Tablets	Indicated for the treatment of major depressive disorder.
Escitalopram Solution	Indicated for the treatment of major depressive disorder and generalized anxiety disorder.
Fluoxetine Tablets	Indicated for the treatment of major depressive disorder, obsessive compulsive disorder, bulimia nervosa, and panic disorder.
Paroxetine ER Tablets	Indicated for the treatment of major depressive disorder, panic disorder, social anxiety disorder, and premenstrual dysphoric disorder.
Venlafaxine ER Tablets	Indicated for the treatment of major depressive disorder, generalized anxiety disorder, social anxiety disorder, and panic disorder.
Vilazodone Tablets	Indicated for the treatment of major depressive disorder.

Drugs Added to the Preferred Drug List Continued

Drug/Product Name	Comments
Freestyle® Libre 3	Indicated for the monitoring of blood glucose control. Prior authorization is required
Freestyle® Libre 2 and 3 Plus	Indicated for the monitoring of blood glucose control. Prior authorization is required
Ramelteon Tablets	Indicated for the treatment of insomnia characterized by difficulty with sleep onset.
Sodium Polystyrene Sulfonate Powder	Indicated as a potassium binder for the treatment of hyperkalemia.
Tobramycin Neb 300/5mL	Indicated for the management of cystic fibrosis in adults and pediatric patients 6 years of age and older with <i>Pseudomonas aeruginosa</i> . Prior authorization is required

Changes to coverage within the Preferred Drug List

Drug/Product Name	Comments
Abiraterone 250mg Tablets	Indicated for the treatment of patients with metastatic castration-resistant prostate cancer who have received prior chemotherapy. Prior authorization is no longer required.
Imatinib Tablets	Indicated for the treatment of several types of cancer and blood conditions including multiple leukemia conditions. Prior authorization is no longer required.

Changes to coverage within the Preferred Drug List Continued

Drug/Product Name	Comments
Temozolomide Capsules	Indicated for the treatment of glioblastoma multiforme (GBM) and refractory anaplastic astrocytoma patients who have experienced disease progression. Prior authorization is no longer required.
Armodafinil Tablets	Indicated to improve wakefulness in patients with excessive sleepiness associated with obstructive sleep apnea, narcolepsy, or shift work disorder. A diagnosis check is no longer required.
Modafinil Tablets	Indicated to improve wakefulness in patients with excessive sleepiness associated with obstructive sleep apnea, narcolepsy, or shift work disorder. A diagnosis check is no longer required.
Asmanex® HFA	Indicated for maintenance treatment of asthma as prophylactic therapy. Prior authorization is no longer required.
Asmanex® Twisthaler®	Indicated for maintenance treatment of asthma as prophylactic therapy. Prior authorization is no longer required.
Febuxostat Tablets	Indicated for the chronic management of hyperuricemia in patients with gout. Step therapy is no longer required.
Hydrocortisone Ampule (generic Solu-Cortef)	Indicated for treatment in several conditions including allergic states, dermatologic diseases, endocrine disorders, gastrointestinal diseases, hematologic disorders, neoplastic diseases, ophthalmic diseases, renal diseases, respiratory diseases, and rheumatic disorders. Added to the pharmacy benefit as preferred.

Changes to coverage within the Preferred Drug List Continued

Drug/Product Name	Comments
Impavido® Capsules	Indicated for the treatment of visceral leishmaniasis, cutaneous leishmaniasis, and mucosal leishmaniasis. Prior authorization is no longer required.
Prasugrel Tablets	Indicated for the reduction of thrombotic cardiovascular events (including stent thrombosis) in patients with acute coronary syndrome. Prior authorization is no longer required.

Drugs removed from the Preferred Drug List

Drug/Product Name	Comments
Clemastine Syrup	Indicated for the relief of symptoms associated with allergic rhinitis such as sneezing, runny nose, and itching. Alternatives include Clemastine Tablets and Diphenhydramine Liquid Prior authorization is required.
Diphenhydramine Elixir	Indicated for allergic conjunctivitis, active and prophylactic treatment of motion sickness, and parkinsonism. Alternatives include Diphenhydramine 12.5mg/5ml liquid or Diphenhydramine Capsules Prior authorization is required.
Donepezil 23mg Tablets	Indicated for the treatment of dementia of the Alzheimer's type. Alternatives include Donepezil 5mg and 10mg Tablets. Prior authorization is required.

Drugs removed from the Preferred Drug List

Drug/Product Name	Comments
Erzofri® Injection	Indicated for treatment of schizophrenia and schizoaffective disorder. Alternatives include Invega Sustenna (PA Required) and Invega Trinza (PA Required) Prior authorization is required.
Naproxen EC Tablets	Indicated for the relief of the signs and symptoms of rheumatoid arthritis, osteoarthritis, ankylosing spondylitis, polyarticular juvenile idiopathic arthritis. Alternatives include Naproxen Tablets or other preferred NSAIDs Prior authorization is required.
One Touch Meters® and Test Strips	Indicated for the monitoring of blood glucose control. Alternatives include Accu-Chek Aviva, Accu-Chek Guide, Contour Next, Contour Plus Glucose Meters and Test Strips Removed from the PDL on September 1, 2025. Prior authorization is required.
Tobramycin Neb 300/4mL	Indicated for the management of cystic fibrosis in adults and pediatric patients 6 years of age and older with Pseudomonas aeruginosa. Alternatives include Tobramycin Neb 300/5mL (PA Required) Prior authorization is required.



Contact us

We're here to help make these changes as easy as possible. If you have any questions or need help, please call Member Services toll-free at **1-800-414-9025**. Thank you.

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