UnitedHealthcare

Notice of changes to prior authorization requirements and coverage criteria — Individual Exchange plans

The following updates apply to Individual Exchange plans, also referred to as UnitedHealthcare Individual & Family ACA Marketplace plans, in the following states (unless otherwise noted): AL, AZ, CO, FL, GA, IL, KS, LA, MD, MI, MO, MS, NC, NJ, NM, OH, OK, SC, TN, TX, VA, WA and WI.

Medication/Policy	Change(s)	Effective date
Anticonvulsant	Added Vigpoder® to policy	4/1/2024
Arikayce®	Annual review with no change to coverage criteria.	4/1/2024
Bosulif®	Annual review with no changes to coverage criteria. Updated background and references.	4/1/2024
Brexafemme®	Annual review. No updates.	4/1/2024
Buphenyl®, Olpruva™, Pheburane®	Added Olpruva™ Updated references.	4/1/2024
CNS Stimulant	Annual review. Updated references.	4/1/2024
Egrifta™	Annual review with no changes to coverage criteria.	4/1/2024
Empaveli®	Added Fabhalta® to list of examples of other complement inhibitors used for the treatment of PNH. Revised initial authorization to 12 months. Updated references.	4/1/2024
Fabhalta®	New program.	4/1/2024
Firazyr®, Sajazir™	Added Kalbitor® to list of other products indicated for the acute treatment of HAE attacks.	4/1/2024
Ibrance®	Annual review. Specified type of unresectable WD-DDLS to be retroperitoneal per NCCN recommendation. Updated references to separate out package insert references for Ibrance® capsules and tablets.	4/1/2024
Interferon	Removed Peg-Intron®	4/1/2024
Juxtapid®	Updated diagnostic criteria per European Atherosclerosis Society guidance. Updated references.	4/1/2024
Kisqali Femaro Co-Pak®	Annual review. Updated background and added clinical criteria for endometrial carcinoma per NCCN. Updated references.	4/1/2024
Lenvima®	Annual review. Updated thyroid cancer criteria based on label and NCCN. Updated hepatobiliary and thymic cancer based on NCCN recommendations. Updated references.	4/1/2024
Lidocaine Patch	Added Lidocan™, Lidocan™ II, and Lidocan™ III.	4/1/2024
Lorbrena®	Annual review. Updated NSCLC section to include Xalkori® per NCCN recommendations. Added criteria for NCCN recommended use of Lorbrena® in uterine sarcoma, peripheral T-Cell lymphoma and large B-cell lymphoma. Updated background and references.	4/1/2024
Lorbrena® (CO only)	Archiving policy - will move into core Lorbrena® policy.	4/1/2024

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Mytesi®	Annual review with no changes to coverage criteria.	4/1/2024
Nocdurna®	Annual review. Increased initial authorization to 12 months. Updated references.	4/1/2024
Orilissa®	Annual review. Updated failure language. Updated authorization duration. Updated references.	4/1/2024
PAH	Annual review. Added Liqrev® oral suspension for PAH and added a step through generic Revatio® suspension for Tadliq® and Liqrev®. Separated Revatio® suspension section to not have step therapy apply. Updated footnote. Updated background and references.	4/1/2024
Praluent®	Updated diagnostic criteria per European Atherosclerosis Society guidance. Updated references.	4/1/2024
Pulmozyme®	Annual review with no changes to coverage criteria.	4/1/2024
Repatha®	Updated diagnostic criteria per European Atherosclerosis Society guidance. Simplified reauthorization criteria. Updated references.	4/1/2024
STI Zero Dollar Cost Share (New Mexico only)	Updated authorization verbiage to include separate authorization durations for acute and long-term treatment.	4/1/2024
Tarpeyo®	Updated indication and removed example for disease progression. Updated references.	4/1/2024
Tegsedi®	Policy reviewed and approved for application to UnitedHealthcare Value & Balance Exchange for 4/2024 implementation.	4/1/2024
Testosterone	Annual review. Updated references.	4/1/2024
Testosterone (Illinois only)	Annual review. Updated references.	4/1/2024
Wainua™	New program.	4/1/2024
Xospata®	Annual review. Updated treatment criteria for AML to include additional NCCN recommendations.	4/1/2024
Zoryve®	Added criteria for Zoryve® foam for seborrheic dermatitis. Updated background and reference.	4/1/2024
Zykadia®	Annual review. Updated background and coverage criteria for inoperable inflammatory myofibroblastic tumor and anaplastic large cell lymphoma per NCCN. Updated reference.	4/1/2024

UnitedHealthcare Individual & Family plans medical plan coverage offered by: UnitedHealthcare of Arizona, Inc.; Rocky Mountain Health Maintenance Organization Incorporated in CO; UnitedHealthcare of Florida, Inc.; UnitedHealthcare of Georgia, Inc; UnitedHealthcare of Illinois, Inc.; UnitedHealthcare Insurance Company in AL, KS, LA, MO, NJ, and TN; Optimum Choice, Inc. in MD and VA; UnitedHealthcare Community Plan, Inc. in MI; UnitedHealthcare of Mississippi, Inc.; UnitedHealthcare of New Mexico, Inc.; UnitedHealthcare of North Carolina, Inc.; UnitedHealthcare of Ohio, Inc.; UnitedHealthcare of Oklahoma, Inc.; UnitedHealthcare of South Carolina, Inc.; UnitedHealthcare of Texas, Inc.; UnitedHealthcare of Oregon, Inc. in WA; and UnitedHealthcare of Wisconsin, Inc. Administrative services provided by United HealthCare Services, Inc. or its affiliates.
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