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, IA, IL, IN, KS, LA, MD, MI, MO, MS, NC, NE, NJ, NM, NY, OH, OK, SC, TN, TX, VA, WA, WI and WY.

Medication/Policy	Change(s)	Effective date
Administrative - Maryland Copay Adjustment	Annual review with no changes to coverage criteria.	10/1/2026
Bonsity®, Forteo®	Annual review with no change to coverage criteria. Updated references.	10/1/2026
Bylvay®	Annual review. Added requirement Bylvay® will not be used in combination with Livmarli® for Alagille syndrome or progressive familial intrahepatic cholestasis in both initial and reauthorization criteria. Updated background and references.	10/1/2026
Duopa®	Annual review with no changes to coverage criteria. Updated references.	10/1/2026
Ekterly®	Annual review with no changes to coverage criteria. Updated references.	10/1/2026
Kerendia®	Annual review with no changes to coverage criteria. Updated references.	10/1/2026
Livmarli®	Annual review. Added requirement Livmarli® will not be used in combination with Bylvay® for Alagille syndrome or progressive familial intrahepatic cholestasis in both initial and reauthorization criteria. Updated background and references.	10/1/2026
Nuedexta®	Annual review with no changes to coverage criteria. Updated formatting.	10/1/2026
Omnipod® 5, Twiist™	Clarified quantity limit exception to include all Omnipod® 5 products.	9/1/2026
Promacta®, Alvaiz®	Annual review with no changes to coverage criteria. Updated references and formatting.	10/1/2026
Sivextro®	Archive program.	10/1/2026

United Healthcare®

Medication/Policy	Change(s)	Effective date
Talzenna®	Annual review. Added recurrent unresectable to disease type criteria under breast cancer. Updated references.	10/1/2026
Truqap®	Updated coverage criteria to include prostate cancer based on new indication. Updated background and references.	10/1/2026
Tryngolza®	Added criteria for severe hypertriglyceridemia. Updated background and references.	10/1/2026
Vivjoa®	Annual review. Updated eligible patient.	10/1/2026
Voxzogo®	Added requirement Voxzogo® will not be used in combination with another C-type natriuretic peptide (CNP) analog for both initial and reauthorization. Removed requirement of no limb-lengthening surgery from initial and reauthorization criteria. Added age requirement to reauthorization criteria.	10/1/2026
Xolair®	Corrected formatting for consistency. Updated criteria for chronic urticaria required prerequisite therapy.	10/1/2026
Xolremdi®	Annual review with no changes to coverage criteria.	10/1/2026
Yuviwel®	Removed requirement of no limb-lengthening surgery from initial and reauthorization criteria. Added age requirement to reauthorization criteria.	10/1/2026

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, IN, KS, LA, MO, NE, NJ, NY, TN, and WY; 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; UnitedHealthcare of Wisconsin, Inc., and UnitedHealthcare Plan of the River Valley in Iowa. Administrative services provided by United HealthCare Services, Inc. or their affiliates.