



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
Agamree®	Annual review with no changes to coverage criteria. Updated background.	12/1/2026
Baxfendy®	New program.	12/1/2026
Besremi®	Annual review. Added coverage for essential thrombocythemia per updated FDA label and for initial treatment of chronic myeloid leukemia during pregnancy per National Comprehensive Cancer Network (NCCN) recommendation. Updated references.	12/1/2026
Belbuca®, Butrans®	Annual review with no changes to coverage criteria. Updated background and references.	12/1/2026
Caprelsa®	Annual review. Updated criteria for thyroid carcinoma per NCCN and FDA label. Updated references.	12/1/2026
Continuous Glucose System - Illinois	Removed provider education attestation and visit requirement in alignment with state mandate.	12/1/2026
Cystaran®	Annual review with no changes to coverage criteria.	12/1/2026
Egrifta™	Annual review with no changes to coverage criteria.	12/1/2026
Empaveli®	Annual review. Updated criteria for C3 glomerulopathy (C3G) or primary immune-complex membranoproliferative glomerulonephritis (IC-MPGN) to align with FDA label update. Updated references.	12/1/2026
Entyvio® Subcutaneous	Annual review with no changes to coverage criteria. Updated references.	12/1/2026
HIV Pre-Exposure and Post-Exposure Prophylaxis - Illinois	Updated applicable medications list.	12/1/2026

Medication/Policy	Change(s)	Effective date
Imbruvica®	Annual review. Updated B-cell lymphoma criteria based on NCCN recommendations, including simplifying mantle cell lymphoma criteria and removing marginal zone lymphoma subtypes. Updated background and references.	12/1/2026
Iressa®	Annual review with no changes to coverage criteria. Updated references.	12/1/2026
Step Therapy - NSAIDs	Annual review with no changes to coverage criteria. Updated background.	12/1/2026
Step Therapy - NSAIDs - New York	Annual review with no changes to coverage criteria. Updated background.	12/1/2026
Leqembi® IQLIK	Added initial authorization criteria for Leqembi IQLIK treatment initiation for Alzheimer's disease. Simplified magnetic resonance imaging monitoring criteria. Revised Leqembi IQLIK dosing regimen criteria based on 18 months of cumulative Leqembi therapy, including a pre-18-month pathway and medical-record documentation requirements for continued starting-dose therapy beyond 18 months. Updated references.	11/1/2026
Leqselvi™	Updated safety check language and references.	12/1/2026
Lipfendra®	New program.	12/1/2026
Nurtec®, Qulipta®, Ubrelvy®, Zavzpret®	Updated background. Clarified language on concomitant small molecule calcitonin gene-related peptide use.	12/1/2026
Motofen®	Annual review with no changes to coverage criteria.	12/1/2026
Mulpleta®	Annual review with no changes to coverage criteria. Updated reference.	12/1/2026
Multaq®	Annual review with no changes to coverage criteria. Updated reference.	12/1/2026
Nereus™	New program.	12/1/2026
Ohtuvayre®	Annual review with no changes to coverage criteria. Updated references.	12/1/2026
orphenadrine/aspirin/caffeine	Annual review with no changes to coverage criteria.	12/1/2026
Saphnelo®	New program.	11/1/2026
Signifor®	Annual review with no changes to coverage criteria.	12/1/2026
Sohonos®	Annual review. Added requirement for submission of medical records documenting clinical findings and genetic testing. Added requirement that Sohonos is not used in combination with Pasatru™. Updated references.	12/1/2026
Spevigo®	Annual review. Updated combination examples and language with no change to clinical intent. Updated references.	12/1/2026

Medication/Policy	Change(s)	Effective date
Step Therapy - Overactive Bladder Agents	Annual review with no changes to coverage criteria. Removed references to Enablex® and Ditropan® since products are obsolete. Updated background and references.	12/1/2026
Strensiq®	Annual review with no changes to coverage criteria.	12/1/2026
Trutakna™	New program.	12/1/2026
Turalio®	Annual review. Updated coverage criteria for histiocytic neoplasms per NCCN recommendations.	12/1/2026
Tykerb®	Annual review. Updated coverage criteria for central nervous system cancers. Removed coverage criteria for colon and rectal cancers based on NCCN recommendations.	12/1/2026
Tymlos®	Annual review. Added Bonsity® as an example of a parathyroid hormone analog. Updated references.	12/1/2026
Valchlor®	Annual review with no changes to coverage criteria. Updated references.	12/1/2026
Wakix® - Colorado	Created state specific version for Colorado without Sunosi® step.	12/1/2026
Xenazine®	Annual review with no changes to coverage criteria.	12/1/2026
Zymfentra®	Annual review with no changes to coverage criteria. Updated reference.	12/1/2026

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.