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
Afinitor®, Torpenz®	Annual review. Updated coverage criteria for thymomas and thymic cancers based on National Comprehensive Cancer Network® (NCCN®) recommendations.	7/1/2026
Ampyra®	Annual review. Updated criteria language with no change to clinical intent. Updated reference.	7/1/2026
Camzyos®	Clarified left ventricular outflow tract criteria prior to starting therapy without changing clinical intent.	7/1/2026
Cholbam®	Annual review with no changes to coverage criteria. Updated reference.	7/1/2026
Cough and Cold	Annual review with no changes to coverage criteria. Updated references.	7/1/2026
Daraprim®	Annual review with no changes to coverage criteria. Updated references.	7/1/2026
Daybue®	Annual review with no changes to coverage criteria. Updated references.	7/1/2026
Dojolvi®	Annual review with no changes to coverage criteria.	7/1/2026
Eohilia™	Annual review with no changes to coverage criteria. Updated background and references.	7/1/2026
Fabhalta®	Annual review with no changes to clinical coverage criteria. Added budesonide to the list of examples of glucocorticoids for IgA nephropathy. Updated references.	7/1/2026
Gilotrif®	Annual review with no changes to coverage criteria.	7/1/2026
Step Therapy - Glaucoma Agents	Annual review with no changes to coverage criteria. Updated background and references.	7/1/2026

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Medication/Policy	Change(s)	Effective date
Joenja®	Annual review with no changes to coverage criteria. Updated references.	7/1/2026
Kygevvi®	New program.	7/1/2026
Lynavoy	New program.	7/1/2026
Mekinist®	Annual review with no changes to coverage criteria. Updated background.	7/1/2026
Myalept®	Annual review with no changes to coverage criteria. Updated background and references.	7/1/2026
Nurtec®, Qulipta®, Ubrelvy®, Zavzpret®	Removed step through Aimovig® for Qulipta.	7/1/2026
Pomalyst®	Updated coverage criteria for Kaposi Sarcoma and systemic light chain amyloidosis based on NCCN recommendations.	7/1/2026
Pyrukynd®	Annual review with no changes to coverage criteria. Updated reference.	7/1/2026
Rivfloza®	Annual review with no changes to coverage criteria.	7/1/2026
Rozyltrek®	Clarified acceptable diagnoses in non-small cell lung cancer section with no change to clinical intent.	7/1/2026
Samsca®	Annual review with no changes to coverage criteria.	7/1/2026
Sensipar®	Annual review. Moved prescriber requirement to end of criteria with no change to clinical intent. Updated references.	7/1/2026
Skyclarys®	Annual review with no changes to coverage criteria.	7/1/2026
Step Therapy - Antiparkinson Agents	Annual review with no changes to coverage criteria. Updated background.	7/1/2026
Step Therapy - Sedative Hypnotic Agents	Annual review with no changes to coverage criteria. Updated background and references.	7/1/2026
Tafinlar®	Annual review with no changes to coverage criteria.	7/1/2026
Thalomid®	Annual review. Updated criteria for Castleman Disease to align with NCCN.	7/1/2026
Verzenio®	Annual review. Added new coverage criteria for soft tissue sarcoma and updated coverage criteria for breast cancer based on NCCN recommendations.	7/1/2026
Vitrakvi®	Clarified acceptable diagnoses in non-small cell lung cancer section with no change to clinical intent.	7/1/2026
Voydeya™	Annual review with no changes to coverage criteria.	7/1/2026
Wegovy® - New Mexico, New York	Updated to include HD injection and differentiate approved indications by formulation. Updated background and references.	7/1/2026
Weight Loss	Added Foundayo™ to policy. Extended Saxenda® reauthorization criteria from 6 to 12 months for class alignment.	7/1/2026

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Medication/Policy	Change(s)	Effective date
Zycubo®	New program.	7/1/2026
Zydelig®	Annual review with no changes to coverage criteria.	7/1/2026

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.

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