



## 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 |
|--|--|----------------|
| 2026 IFP Administrative State Mandate Guideline  | Added Indiana step therapy for metastatic cancer mandate.  | 7/1/2026       |
| 2026 IFP Preventive Medications Zero Dollar Cost Share Review Administrative Guideline | Removed coverage criteria for aspirin.   | 8/1/2026       |
| Actimmune®   | Annual review with no changes to coverage criteria. Updated reference.   | 8/1/2026       |
| Alecensa®  | Annual review with no changes to coverage criteria. Updated references.  | 8/1/2026       |
| Cometriq®  | Annual review with no changes to coverage criteria. Updated references.  | 8/1/2026       |
| Ctexli®  | Annual review. Removed term cholestanol storage disease without change to clinical intent. Updated references.   | 8/1/2026       |
| Dupixent®  | Updated background and reference to reflect expanded age range for chronic spontaneous urticaria indication. Updated initial authorization combination therapy requirement for asthma for consistency with reauthorization criteria. | 8/1/2026       |
| Filspari®  | Added focal segmental glomerulosclerosis diagnosis. Updated references.  | 8/1/2026       |
| Follicle-Stimulating Hormone (FSH)   | Updated term "controlled ovarian stimulation" to "ovarian stimulation." Updated background and references.   | 8/1/2026       |

| Medication/Policy  | Change(s)  | Effective date |
|--|--|----------------|
| <b>Gilotrif®</b>   | Updated coverage criteria for non-small cell lung cancer and non-nasopharyngeal head and neck cancer to align with National Comprehensive Cancer Network (NCCN). Updated references. | 8/1/2026       |
| <b>Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists</b> | Added Ozempic® tablets to policy.  | 8/1/2026       |
| <b>Gonadotropin-Releasing Hormone (GnRH) Antagonists</b> | Annual review with no changes to coverage criteria. Updated term "controlled ovarian stimulation" to "ovarian stimulation." Updated background and references.                       | 8/1/2026       |
| <b>Growth Hormone</b>                                    | Removed dosing requirements. Added growth hormone deficiency in transition phase adolescent patients as covered indication for Skytrofa® and Sogroya®. Updated references.           | 8/1/2026       |
| <b>Human Chorionic Gonadotropin (HCG)</b>                | Annual review with no changes to coverage criteria. Updated term "controlled ovarian hyperstimulation" to "ovarian stimulation." Updated background and references.                  | 8/1/2026       |
| <b>Iron Chelators</b>                                    | Annual review with no changes to coverage criteria.  | 8/1/2026       |
| <b>Jakafi®, Jakafi XR™</b>                               | Added Jakafi XR™ to policy.  | 8/1/2026       |
| <b>Kisqali®</b>  | Annual review with no changes to coverage criteria. Updated references.  | 8/1/2026       |
| <b>Kisqali® Femara® Co-Pack</b>                          | Annual review with no changes to coverage criteria. Updated references.  | 8/1/2026       |
| <b>Menopur®</b>  | Annual review with no changes to coverage criteria. Updated term "controlled ovarian stimulation" to "ovarian stimulation." Updated background and references.                       | 8/1/2026       |
| <b>Nemludio®</b>   | Annual review with no changes to coverage criteria. Updated references.  | 8/1/2026       |
| <b>Ocaliva®</b>  | Archive program.   | 8/1/2026       |
| <b>OFS - Cetrotide®</b>                                  | Annual review with no changes to coverage criteria. Updated term "controlled ovarian stimulation" to "ovarian stimulation." Updated background and references.                       | 8/1/2026       |
| <b>OFS - Gonadotropins</b>                               | Annual review with no changes to coverage criteria. Updated term "controlled ovarian stimulation" to "ovarian stimulation." Updated background and references.                       | 8/1/2026       |
| <b>Orkambi®</b>  | Annual review with no changes to coverage criteria. Updated references.  | 8/1/2026       |
| <b>Pulmonary Arterial Hypertension (PAH)</b>             | Annual review with no changes to coverage criteria. Updated background and references.   | 8/1/2026       |

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|---|---|----------------|
| <b>Palyzqiq®</b>                            | Annual review. Updated background with expanded indication in pediatric patients 12 years of age and older. Added examples of branded and branded generics of sapropterin to combination use criterion. Updated language in sapropterin step bypass due to biallelic PAH pathogenic variants with no residual enzyme activity with no change in clinical intent. Updated references.  | 8/1/2026       |
| <b>Samsca®</b>                              | Added criterion requiring either serum sodium < 125 mEq/L or less marked hyponatremia that is symptomatic.  | 8/1/2026       |
| <b>Stivarga®</b>                            | Annual review. Added coverage for appendiceal neoplasms. Updated coverage for colorectal cancer, soft tissue sarcoma, and gastrointestinal stromal tumors per NCCN. Updated background and references.  | 8/1/2026       |
| <b>Sucraid®</b>                             | Within initial authorization section, removed lactase activity from small bowel endoscopic biopsy requirement, updated prescriber requirement, and added requirements involving evaluation and management of competing etiologies of gastrointestinal symptoms, nutrition consultation, and baseline symptom severity documentation. Within reauthorization section, added specific measures for positive clinical response requirement, updated dietary modification criterion and removed specialty prescriber requirement. Updated references. | 8/1/2026       |
| <b>Syprine®</b>                             | Annual review with no changes to coverage criteria.   | 8/1/2026       |
| <b>Tagrisso®</b>                            | Annual review. Updated background and criteria for non-small cell lung cancer per NCCN.   | 8/1/2026       |
| <b>Ustekinumab</b>                          | Updated background for Crohn's disease treatment. Updated examples for plaque psoriasis with no change to clinical intent. Updated reference.   | 8/1/2026       |
| <b>Vijoice®</b>                             | Annual review with no changes to coverage criteria. Updated references.   | 8/1/2026       |
| <b>Winrevair™</b>                           | Annual review with no changes to coverage criteria. Updated background and reference.   | 8/1/2026       |
| <b>Xermelo®</b>                             | Annual review with no changes to coverage criteria.   | 8/1/2026       |
| <b>Xtandi®</b>                              | Annual review with no changes to coverage criteria. Updated references.   | 8/1/2026       |
| <b>Xyrem®, Xywav®, Lumryz™</b>              | Added requirement to not have duplicate therapy with another oxybate product.   | 8/1/2026       |
| <b>Xyrem®, Xywav®, Lumryz™ - Colorado</b>   | Added requirement to not have duplicate therapy with another oxybate product.   | 8/1/2026       |
| <b>Xyrem®, Xywav®, Lumryz™ - New Mexico</b> | Added requirement to not have duplicate therapy with another oxybate product.   | 8/1/2026       |

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|---|--|----------------|
| <b>Zepbound®</b>                        | Updated reauthorization criteria to not require Apnea-Hypopnea Index (AHI), Respiratory Disturbance Index (RDI), or Respiratory Event Index (REI) reduction for patients on positive airway pressure (PAP) therapy. Updated prescriber requirement to include pulmonologist, otolaryngologist, and physicians experienced in the evaluation and management of obstructive sleep apnea. | 8/1/2026       |
| <b>Zepbound® - New Mexico, New York</b> | Updated reauthorization criteria to not require AHI/RDI/REI reduction for patients on PAP therapy. Updated prescriber requirement to include pulmonologist, otolaryngologist, and physicians experienced in the evaluation and management of obstructive sleep apnea.  | 8/1/2026       |
| <b>Zeposia®</b>                         | Converted policy from non-formulary to prior authorization. Removed step therapy requirement for multiple sclerosis.   | 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.