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, OH, OK, SC, TN, TX, VA, WA, WI and WY.

Medication/Policy	Change(s)	Effective date
Andembry®	New program.	1/1/2026
Brinsupri™	New program.	1/1/2026
Cimzia®	Updated examples with no change to clinical intent. Updated references.	1/1/2026
Cimzia® - Colorado	Updated examples with no change to clinical intent. Updated references.	1/1/2026
Clomid®, Milophene™	Annual review. Added New York to ovulation induction operation note for 2026 implementation. Updated cut-offs for semen analysis based off of updated guidance from the World Health Organization. Updated references. Added Milophene™ to policy.	1/1/2026
Cotellic®	Updated coverage criteria for central nervous system cancers and histiocytic neoplasms based on National Comprehensive Cancer Network (NCCN) recommendations.	1/1/2026
Cystaran®	Annual review. Updated references. Added state mandate language.	1/1/2026
Emflaza®, Jaythari, Pyquvi™	Added Jaythari and Pyquvi™ to policy.	1/1/2026
Duvyzat®	Added criterion for initial authorization addressing previous treatment with gene therapy for Duchenne muscular dystrophy (DMD). Removed criterion from reauthorization addressing previous treatment with gene therapy for DMD.	1/1/2026
Ekterly®	Added criteria requiring trial, failure, or contraindication to other hereditary angioedema products based on age.	1/1/2026
Entresto®	Annual review. No changes to clinical content.	1/1/2026
Erleada®	Annual review with no change to coverage criteria. Updated references.	1/1/2026
Harliku™	New program.	1/1/2026
Hycamtin®	Annual review. Updated Merkel cell carcinoma criteria based on current NCCN recommendations. Updated background.	1/1/2026

Iclusig®	Annual review. Updated chronic myeloid leukemia criteria based on current NCCN recommendations. Updated background and references.	1/1/2026
Jakafi®	Removed reference to footnote from essential thrombocytopenia section. Updated coverage criteria for myelofibrosis, polycythemia vera, immunotherapy-related toxicities, and T-cell lymphoma based on NCCN recommendations. Updated references.	1/1/2026
Sapropterin	Added Zelvysia™ to program. Added Sephience™ to combination use criteria. Updated references.	1/1/2026
Nuvigil®, Provigil®	Archiving policy.	1/1/2026
Ojjaara	Annual review. Updated coverage criteria for higher-risk myelofibrosis per NCCN recommendations	1/1/2026
Opfolda®	Annual review with no changes to coverage criteria.	1/1/2026
Palynziq®	Added Sephience™ to combination use criteria. Revised requirement for trial of sapropterin therapy to remove specified length of trial and to exclude patients with two null mutations in trans. Updated references.	1/1/2026
Relyvrio™	Archiving policy.	1/1/2026
Rezdiffra™	Added combination use language. Added medical record submission requirement to initial authorization criteria for confirming fibrosis stage F2 or F3. Updated references.	1/1/2026
Rinvoq®	Updated criteria to reflect updated ulcerative colitis and Crohn's disease indication regarding tumor necrosis factor (TNF) blockers. Updated background and reference. Updated combination examples and language with no change to clinical intent.	1/1/2026
Sephience™	New program.	1/1/2026
Simponi®	Updated background and criteria to address new pediatric indication for ulcerative colitis. Updated reference.	1/1/2026
Sprycel®, Phyrago™	Added Phyrago™ to policy. Updated references.	1/1/2026
Step Therapy - Duobrii®	Annual review with no changes to coverage criteria.	1/1/2026
Step Therapy - Inhaled Corticosteroids (ICS)	Annual review with no changes to coverage criteria. Updated reference.	1/1/2026
Step Therapy - Inhaled Corticosteroids (ICS) - New York	New market specific policy created in alignment with state mandate.	1/1/2026

Step Therapy - Oral Nonsteroidal Anti-Inflammatory Drugs (NSAIDs) - New York	New market specific policy created in alignment with state mandate.	1/1/2026
Step Therapy - Savella® - New York	New market specific policy created in alignment with state mandate.	1/1/2026
Step Therapy - Serotonin (5-HT) Receptor Agonists	Annual review with no changes to coverage criteria. Updated references.	1/1/2026
Step Therapy - Serotonin (5-HT) Receptor Agonists - New York	New market specific policy created in alignment with state mandate.	1/1/2026
Step Therapy - Serotonin Norepinephrine Reuptake Inhibitors - New York	New market specific policy created in alignment with state mandate.	1/1/2026
Tarceva®	Archiving policy.	1/1/2026
Tegsedi™	Archiving policy.	1/1/2026
Testosterone	Added requirement male at birth to orchiectomy, panhypopituitarism and genetic disorders requirement section. Updated references.	1/1/2026
Testosterone - Illinois	Added requirement male at birth to orchiectomy, panhypopituitarism and genetic disorders requirement section. Updated references.	1/1/2026
Tobacco Cessation (Health Care Reform Zero Dollar Cost Share Review)	Chantix® brand name added to policy as it is back on market.	1/1/2026
Valchlor®	Annual review with no changes to coverage criteria. Updated reference.	1/1/2026
Veozah®	Annual review. Updated references.	1/1/2026
Votrient®	Annual review. Added additional soft tissue sarcomas to align with NCCN and reformatted soft tissue sarcoma criteria. Updated oncocytic carcinoma criteria to remove radioactive iodine criteria. Removed staging system criteria for Merkel Cell Carcinoma. Updated references.	1/1/2026
Wegovy™	Added coverage for metabolic dysfunction-associated steatohepatitis (MASH). Updated references.	1/1/2026

Wegovy™ - New Mexico, New York	Added New York to list of markets the policy applies to. Updated hemoglobin A1c cut-off in major adverse cardiovascular events section from greater than to greater than or equal to. Added coverage for MASH. Updated references.	1/1/2026
Xdemvy®	Annual review with no changes to coverage criteria. Updated references.	1/1/2026
Zoryve®	Added Zoryve® 0.05% cream to atopic dermatitis criteria. Updated background and references.	1/1/2026