



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
Anzupgo®	New program.	3/1/2026
Attruby™	Annual review with no changes to coverage criteria. Updated references.	3/1/2026
Azole Antifungals	Annual review with no changes to coverage criteria. Updated references.	3/1/2026
Calcitonin Gene-Related Peptides (CGRP)	Updated background section with pediatric information for Ajovy®. Added bypass for pediatric patients. Updated statement for Emgality® 100 mg of on concomitant use of CGRPs. Updated references.	3/1/2026
Dawnzera™	New program.	3/1/2026
Emflaza®, Jaythari, Kymbee™, Pyquvi™	Added Kymbee™ to policy.	3/1/2026
Forzinity™	New program.	3/1/2026
Idiopathic Pulmonary Fibrosis	Addition of Jascayd® to program and coverage criteria for idiopathic pulmonary fibrosis. Updated references.	3/1/2026
Jesduvroq	Annual review with no changes to coverage criteria.	3/1/2026
Lotronex®	Annual review with no changes to coverage criteria. Updated references.	3/1/2026
Miplyffa®	Annual review with no changes to coverage criteria. Updated references.	3/1/2026
Orladeyo®	Updated coverage criteria based on updated FDA indication by separating tried/failed therapies based on age limitations for Haegarda®. Updated background and references.	3/1/2026
Rozlytrek®	Annual review. Expanded section on solid tumors to specify each type with their own criteria based on FDA label and National Comprehensive Cancer Network (NCCN) guidance.	3/1/2026

Medication/Policy	Change(s)	Effective date
Sirturo®	Annual review. Updated background to reflect expanded label. Updated reference.	3/1/2026
Sivextro®	Annual review with no changes to coverage criteria. Updated references.	3/1/2026
Sucraid®	Annual review with no changes to coverage criteria.	3/1/2026
Testosterone - Illinois	Simplified criteria for gender dysphoria in alignment with state mandate.	3/1/2026
Tremfya®	New program.	3/1/2026
Truqap®	Annual review with no changes to coverage criteria. Updated references.	3/1/2026
Vitrakvi®	Annual review. Expanded section on solid tumors to specify each type with their own criteria based on FDA label and NCCN guidance.	3/1/2026
Vowst™	Annual review with no changes to coverage criteria.	3/1/2026
Voxact®	New program.	3/1/2026
Vyndaqel®, Vyndamax™	Annual review with no changes to coverage criteria. Updated references.	3/1/2026
Xphozah®	Annual review. Updated serum phosphorus requirement. Updated references.	3/1/2026

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, 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.