# 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 |
|---|---|---|
| **Adalimumab** | Added bypass to allow for continuation of brand Humira®. | 9/1/2026 |
| **Afinitor®, Torpenz®, Yulithira™** | Added Yulithira™ to policy. | 9/1/2026 |
| **Benlysta®** | Annual review. Updated not used in combination drugs without change in clinical intent. Updated reference. | 9/1/2026 |
| **Carbaglu®** | Annual review with no changes to coverage criteria. | 9/1/2026 |
| **Cibinqo®** | Annual review with no changes to coverage criteria. Updated references. | 9/1/2026 |
| **Duvyzat®** | Annual review with no changes to coverage criteria. | 9/1/2026 |
| **Fasenra®** | Annual review. Added Exdensur® (depemokimab) to the list of examples of anti-interleukin 5 therapies. Added coverage criteria for hypereosinophilic syndrome. Updated background and references. | 9/1/2026 |
| **Hepcludex®** | New program. | 9/1/2026 |
| **Juxtapid®** | Added age bypass based on expanded indication and age limitations for Repatha. ® Added requirements for claim history or submission of medical records to document current therapy with Juxtapid® in order to bypass step therapy criteria. Removed requirement to not be used in combination with proprotein convertase subtilisin/kexin type 9 (PCSK9) inhibitors based on updated guidelines. Updated background and references. | 9/1/2026 |
| **Leqselvi™** | Annual review with no changes to coverage criteria. Updated references. | 9/1/2026 |

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| Medication/Policy | Change(s) | Effective date |
|---|---|---|
| **Leqselvi™ - Colorado** | Annual review with no changes to coverage criteria. Updated references. | 9/1/2026 |
| **Lerochol™** | New program. | 9/1/2026 |
| **Linzess®, Symproic®** | Updated Linzess® indication to include expanded age range for functional constipation to 2 years and older as well as for irritable bowel syndrome with constipation in those 7 years and older in background section. Updated references. | 9/1/2026 |
| **Lynparza®** | Annual review. Removed ovarian cancer treatment outside maintenance per National Comprehensive Cancer Network (NCCN) guidelines. Revised coverage for homologous recombination deficiency (HRD) positive ovarian cancer to allow monotherapy maintenance (without bevacizumab) per NCCN recommendations. Updated background and references. | 9/1/2026 |
| **Nubeqa®** | Annual review. Updated examples of gonadotropin-releasing hormone (GnRH) analogs with no change to clinical intent. Updated background and references. | 9/1/2026 |
| **Relistor®** | Annual review with no changes to coverage criteria. Minor formatting changes. Updated references. | 9/1/2026 |
| **Revlimid®** | Updated criteria for B-cell lymphoma, systemic light chain amyloidosis, Kaposi sarcoma, histiocytic neoplasms, and Castleman disease based on NCCN updates. Added new coverage criteria for cutaneous lymphoma per NCCN recommendation. Updated background and references. | 9/1/2026 |
| **Skyrizi®** | Annual review. Updated background to include plaque psoriasis and psoriatic arthritis for pediatric patients 6 years of age and older. Updated combination examples and language with no change to clinical intent. Updated references. | 9/1/2026 |
| **Somavert®** | Annual review with no changes to coverage criteria. | 9/1/2026 |
| **Spravato®** | Updated references. | 9/1/2026 |
| **Tremfya®** | Corrected combination therapy language in psoriatic arthritis initial authorization section. Updated references. | 7/15/2026 |
| **Vowst™** | Updated references. | 9/1/2026 |
| **Vyvgart Hytrulo®** | Updated coverage criteria for expanded indication of generalized myasthenia gravis. Added CD19-directed cytolytic antibodies to the list of drugs not to be used in combination with Vyvgart Hytrulo®. Updated background and references. | 9/1/2026 |
| **Weight Loss** | Updated Imcivree® section to include new FDA approved indication for acquired hypothalamic obesity and updated reauthorization requirements to include measures for pediatric patients. Updated references. | 9/1/2026 |

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|---|---|---|
| **Xifaxan®** | Annual review with no changes to coverage criteria. Updated references. | 9/1/2026 |

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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