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
Abirtega™, Zytiga®	Annual review with no changes to coverage criteria. Updated references.	11/1/2026
Cabometyx®	Annual review. Updated criteria for thyroid cancer, soft tissue sarcoma, and neuroendocrine tumor to align with National Comprehensive Cancer Network (NCCN).	11/1/2026
Central Nervous System Stimulants	Annual review with no changes to coverage criteria. Updated background and references.	11/1/2026
Corlanor®	Annual review. Updated reauthorization formatting and references.	11/1/2026
Doptelet®	Updated immune thrombocytopenia criteria verbiage.	11/1/2026
Emsam®	Annual review with no changes to coverage criteria.	11/1/2026
Emsam® - Colorado, Texas	Annual review with no changes to coverage criteria.	11/1/2026
Ibrance®	Updated coverage criteria for breast cancer and well-differentiated/dedifferentiated liposarcoma (WD-DDLS). Updated background and references.	11/1/2026
Idhifa®	Annual review. Added section for myelodysplastic syndromes based on NCCN recommendations.	11/1/2026
Inlyta®	Annual review. Added new criteria for endometrial carcinoma based on NCCN recommendations. Updated criteria for thyroid cancer. Updated criteria for renal cell carcinoma and renamed to kidney cancer per NCCN recommendations/verbiage.	11/1/2026
Interferon	Annual review with no changes to coverage criteria. Updated background and references.	11/1/2026
Iqirvo®	Annual review with no changes to coverage criteria.	11/1/2026

United Healthcare®

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Jakafi®, Jakafi XR™	Update authorization durations from 6 to 12 months.	11/1/2026
Lokelma®, Veltassa®	Annual review with no changes to coverage criteria. Updated references.	11/1/2026
Medical Foods, Nutritional Supplements, Enteral Nutrition	Annual review with no changes to coverage criteria. Updated references.	11/1/2026
Nexavar®	Annual review. Updated criteria for hepatocellular carcinoma, thyroid cancer, ovarian/fallopian tube peritoneal cancer, salivary gland tumor, and gastrointestinal stromal tumors. Updated background and references.	11/1/2026
State Mandate Non-Formulary Substance Use Disorder	Archived program.	11/1/2026
Step Therapy - Leukotriene Modifiers	Annual review with no changes to coverage criteria. Updated background.	11/1/2026
Sunosi®	Annual review with no changes to coverage criteria. Updated references.	11/1/2026
Tobramycin Inhalation	Annual review. Updated coverage criteria for noncystic fibrosis bronchiectasis. Updated references.	11/1/2026
Topical Retinoids	Annual review. Added Trilitas™ to policy and removed obsolete Avita®.	11/1/2026
Vafseo®	Annual review with no changes to coverage criteria. Updated references.	11/1/2026
Wakix®	Annual review with no changes to coverage criteria. Updated references.	11/1/2026
Xifaxan®	Updated initial authorization criteria to include submission of medical records for hepatic encephalopathy and irritable bowel syndrome with diarrhea (IBS-D) indications.	11/1/2026
Yonsa®	Annual review with no changes to coverage criteria. Updated references.	11/1/2026
Zilbrysq®	Added CD19-directed cytolytic drugs and immune globulins to the list of products not to be used in combination with. Added Rystiggo® to the list of neonatal Fc receptor (FcRn) blocker examples. Updated reference.	11/1/2026
Zoryve®	Updated background to reflect new age for plaque psoriasis of 2 years of age and older. Updated references.	11/1/2026