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 Adalimumab-bwwd (unbranded Hadlima™) to policy.	4/1/2026
Arikayce®	Annual review with no change to coverage criteria. Updated references.	4/1/2026
Bosulif®	Annual review. Updated references.	4/1/2026
Brexafemme®	Annual review. Removed the 7-day trial requirement of fluconazole for treatment of vulvovaginal candidiasis based on Centers for Disease Control and Prevention (CDC) guidelines. Updated references.	4/1/2026
Brukinsa®	Added coverage for progressive follicular lymphoma and primary central nervous system lymphoma. Updated background and references.	4/1/2026
Buphenyl®, Olpruva®, Pheburane®	Annual review with no changes to coverage criteria. Updated references.	4/1/2026
Crenessity®	Annual review with no changes to coverage criteria.	4/1/2026
Cuvrior®	Annual review with no changes to coverage criteria.	4/1/2026
Enbumyst™, Furoscix®, Lasix® ONYU	Added Enbumyst™ and Lasix® ONYU to criteria.	4/1/2026
Firazyr®, Sajazir™	Updated examples of acute treatments for hereditary angioedema attacks. No changes to coverage criteria. Updated references	4/1/2026
Ibrance®	Annual review. Updated coverage criteria to include new section for uterine neoplasms. Updated references.	4/1/2026
State Mandate Zero Dollar Cost Share Hormone Therapy - Illinois	Updated House Bill 4664 to state mandates. Updated language for accepted diagnoses to align with mandates.	4/1/2026

United Healthcare®

Medication/Policy	Change(s)	Effective date
Non-Formulary Gender Affirming Treatment	Vaniqa® removed from policy due to market removal.	4/1/2026
Interstitial Lung Disease Agents	Addition of Jascayd® to program and addition of coverage criteria for progressive pulmonary fibrosis. Updated coverage criteria for idiopathic pulmonary fibrosis to include Jascayd®. Updated Ofev® coverage criteria by removing chronic fibrosing interstitial lung disease with progressive phenotype and including Ofev® into the section for progressive pulmonary fibrosis. Updated references.	4/1/2026
Juxtapid®	Annual review with no changes to coverage criteria. Updated references.	4/1/2026
Lenvima®	Updated criteria based on current National Comprehensive Cancer Network (NCCN) recommendations. Updated references.	4/1/2026
Lorbrena®	Annual review. Added criteria for pediatric diffuse high-grade glioma. Updated background and references.	4/1/2026
Orilissa®	Annual review. Updated references.	4/1/2026
Oxervate®	Annual review with no changes to coverage criteria.	4/1/2026
Pulmozyme®	Annual review. Updated references.	4/1/2026
Redemplo®	New program.	4/1/2026
Rhapsido®	New program.	4/1/2026
Taltz®	Annual review. Updated examples with no change to clinical intent. Updated references.	4/1/2026
Tarpeyo®	Annual review. Updated references.	4/1/2026
Tryngolza®	Annual review. Simplified generic confirmation criteria. Added combination use criteria. Updated references.	4/1/2026
Tryvio™	Annual review. Updated background.	4/1/2026
Ustekinumab	Corrected non-formulary footnote to reflect products in scope with no changes to coverage criteria. Updated references.	4/1/2026
Velsipity®	Annual review. Updated examples with no change to clinical intent. Updated references.	4/1/2026
Wainua®	Annual review with no changes to coverage criteria.	4/1/2026
Wayrilz™	New program.	4/1/2026
Wegovy®	Removed body mass index requirement in cardiovascular risk reduction reauthorization criteria. Updated to include tablets and differentiate approved indications by formulation. Updated footnote to clarify weight loss indication as benefit exclusion.	4/1/2026

Medication/Policy	Change(s)	Effective date
Wegovy® - New Mexico, New York	Removed body mass index requirement in cardiovascular risk reduction reauthorization criteria. Updated to include tablets and differentiate approved indications by formulation.	4/1/2026
Xospata®	Annual review. Updated background.	4/1/2026
Zepbound®	Updated footnote to clarify weight loss indication as benefit exclusion.	4/1/2026
Zykadia®	Annual review. Updated background and coverage criteria for uterine neoplasms per NCCN. Updated references.	4/1/2026