UnitedHealthcare®

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, IL, KS, LA, MD, MI, MO, MS, NC, NJ, NM, OH, OK, SC, TN, TX, VA, WA and WI.

Medication/Policy	Change(s)	Effective date
Corlanor®	Annual review. No changes.	11/1/2024
Egaten®	Annual review. Updated reference.	11/1/2024
Growth Hormone	Combined Ngenla™, and Sogroya® into the Skytrofa® pediatric GHD sections. Combined Sogroya® with somatotropin in the adult GHD sections as the criteria is the same.	11/1/2024
Idhifa®	Annual review. Updated AML criteria based on NCCN recommendations.	11/1/2024
Inlyta®	Annual review. Updated criteria for renal cell carcinoma per NCCN guidelines. Updated references.	11/1/2024
Iquirvo®	New program.	11/1/2024
Livmarli™	Updated background with expanded PFIC indication in patients 12 months to 4 years of age. Updated examples of conventional treatment within initial authorization criteria for both PFIC and ALGS. Updated references.	11/1/2024
Lumryz™, Xywav™, Xyrem®	Updated initial authorizations to 12 months. Updated references.	11/1/2024
Medical Foods, Nutritional Supplements, Enteral Nutrition	Annual review. No updates.	11/1/2024
Motofen®	Annual review. Updated reference.	11/1/2024
Natpara®	Annual review. Updated initial authorization criteria and initial authorization duration to 12 months. Updated references.	11/1/2024
Nexavar®	Annual review with no changes. Updated background and references.	11/1/2024
Nubeqa®	Annual review with no changes. Updated references.	11/1/2024
Nuvigil®, Provigil®	Annual review. Updated references.	11/1/2024
OFS Gonadotropins	Annual review with no changes to coverage criteria. Removed reference to footnote that was not included in the policy.	11/1/2024
Ohtuvayre™	New program.	11/1/2024
Sensipar®	Annual review with no changes to coverage criteria.	11/1/2024

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Step Therapy Antigout Agents	Annual review, no changes to clinical criteria.	11/1/2024
Step Therapy Atypical Antipsychotics	Annual review, removed reference to Latuda® in the background section.	11/1/2024
Step Therapy Oral NSAID Combinations	Annual review. Updated reference.	11/1/2024
Sunosi™	Updated initial authorization to 12 months.	11/1/2024
Therapeutic Duplication	New program.	11/1/2024
Tobramycin	Annual review. Added SML and updated references.	11/1/2024
Vafseo®	New program.	11/1/2024
Vyndaqel®, Vyndamax™	Annual review. Renamed and added examples of RNA-targeted therapies for ATTR amyloidosis. Updated and added references.	11/1/2024
Wakix®	Annual review, updated references.	11/1/2024
Xenazine®	Annual review, no changes to clinical criteria.	11/1/2024