Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective April 15, 2025 (unless otherwise noted)

Note – Log-in is needed for policy Updated sections marked with an asterisk *. Use this link to log-in, Cigna for Health Care Professionals > Resources > Reimbursement and Payment Policies.

Medical Coverage Policy	New, Updated, or Retired?	Comments

Allergy Testing and Non-Pharmacologic Treatment– (0070)	Updated	Important **changes** in coverage criteria:
		• Removed the following non-implemented clinically criteria:
		  ○ LTT associated with joint replacement surgery
		  ○ LHR in vitro allergy testing
		  ○ Subcutaneous allergen immunotherapy for the treatment of hymenoptera.

Amplitude-Modulated Radiofrequency Electromagnetic Fields (AM RF-EMF) Therapy – (0581)	New	This is a NEW Coverage Policy **Posting 4/15/25, Effective 7/15/25.**

Beta-Amyloid and Phosphorylated Tau Biomarker Testing for Alzheimer's Disease - (0580)	New	This is a NEW Coverage **Policy Posting 4/15/25, Effective 7/15/25**.
Breast Cancer Reconstruction Following Mastectomy or Lumpectomy- (0178)	Updated	Important changes in coverage criteria: • Changed GalaFLEX Scaffold from EIU to medically necessary • Changed GalaFLEX 3D Scaffold (formerly known as GalaFORM 3D) from EIU to medically necessary • Changed GalaFLEX 3DR Scaffold (formerly known as GalaSHAPE 2D) from EIU to medically necessary

Inflammatory Bowel Disease - Testing for the Diagnosis and Management - (0121)	Updated	Important **changes** in coverage criteria:
		• Removed all criteria that isn't clinically managed.
		  ○ testing for serological and genetic markers
		  ○ therapeutic drug monitoring for IBD
		• Fecal calprotectin remains

Nucleic Acid Pathogen Testing - (0530)	Updated	This is an Updated policy, **Posting 4/15/25, Effective 7/15/25.** Important **changes** in coverage criteria: • Added herpes simplex (HSV) Types 1&2 and varicella zoster virus (VZV) panel as medically necessary • Increased number of respiratory pathogens that are considered medically necessary from 'up to 5' to 'up to 11' • Increased number of gastrointestinal pathogens that are considered medically necessary from 'up to 5' to 'up to 11' • Added CPT code 87625 as medically necessary for human papilloma virus (HPV) testing

		• Removed CPT 0353U from policy criteria section for chlamydia and for gonorrhea
Bone Mineral Density Measurement – (0300)	Updated	Important **changes** in coverage criteria: No change in coverage: • Revised policy statements for CPT 0691T and 0743T. • Removed policy statements for all other CPT codes.
Laboratory Testing for Transplantation Rejection - (0465)	Updated	Minor **changes** in coverage criteria: • Added examples to existing EIU statement for donor-derived cell-free DNA testing due to two new codes being released 4/1/2025. • Added statement that a lab test that combines the use of donor-derived cell-free DNA is EIU
Liver and Liver-Kidney Transplantation – (0355)	Updated	Important **changes** in coverage criteria: • Expanded coverage by REVISING criteria for: ➢ hepatocellular carcinoma (HCC), ➢ metabolic disease, ➢ perihilar or hilar cholangiocarcinoma, ➢ neuroendocrine tumors, and ➢ hepatic artery thrombosis • Expanded coverage by adding NEW criteria for: ➢ intrahepatic cholangiocarcinoma, ➢ colorectal cancer metastatic to the liver (CRLM), ➢ hepatic epithelioid hemangioendothelioma (HEHE), ➢ hepatic adenomas, ➢ cystic fibrosis, ➢ familial amyloid polyneuropathy (FAP), ➢ hepatopulmonary syndrome, ➢ portopulmonary hypertension, ➢ primary hyperoxaluria.
Scar Revision - (0328)	Updated	Important **changes** in coverage criteria:

		• Removed all criteria that isn't clinically managed:
		  ○ intralesional corticosteroid injections
		  ○ silicone gel sheeting and silicone combination kits
		  ○ excision, skin grafting, and flap surgery.
		
		Minor **edits** to coverage statements for clarity.

Transthoracic Echocardiography in Adults – (0510)	Updated	Important **changes** in coverage criteria **Posting 4/15/25, Effective 7/15/25:** • Updated the frequency policy statement.
Miscellaneous Musculoskeletal Procedures - (0515)	Updated	Minor **changes** in coverage criteria/policy: • Revised noncoverage statement for healing response technique from "experimental, investigational, or unproven" to "not medically necessary". • Removed policy statement for subacromial balloon spacer as aligned code is not implemented.
Tissue-Engineered Skin Substitutes - (0068)	Updated	Important **changes** in coverage criteria: • Added coverage for dural repair, multiple products. • Added coverage for Kerecis for diabetic foot ulcers. • Added coverage for Alloderm for use in parotidectomy to prevent Frey's syndrome. • Added coverage of Galaflex in breast reconstruction • Added coverage for Phasix mesh/Gore Bio A for paraesophageal/hiatal hernia repair in certain scenarios when a hiatal hernia would be unable to be primarily closed. • Added coverage for Actigraft for diabetic foot ulcers. • Removed Symbotex from the policy • Added not covered: Multiple new codes and products • Removed the following codes and corresponding products because they are being removed from precert and will no longer be managed: Q4107 Graftjacket, Q4110 Primatrix, Q4121 TheraSkin.
Transcatheter Ablation for the Treatment of Supraventricular	Updated	**Posting 4/15/2025; Effective 7/15/2025** Important **changes** in coverage criteria:

Tachycardia in Adults – (0529)		• Title change from "Transcatheter Ablation for the Treatment of Supraventricular Tachycardia in Adults" to "Cardiac Ablation of Abnormal Electrical Rhythms in Adults". • Expanded the scope of the coverage policy by adding a medically necessary statement for 'ventricular arrhythmias' and 'PVCs'. • Limited coverage by adding an EIU statement for thoracoscopic epicardial ablation for the treatment of atrial flutter.
Drug-Eluting Devices for Use Following Endoscopic Sinus Surgery - (0481)	Updated	• No change in coverage.
Ablative Treatments for Malignant Breast Tumors – (0540)	Updated	• No change in coverage.
Blepharoplasty, Reconstructive Eyelid Surgery, and Brow Lift - (0045)	Updated	• No change in coverage.
Orthotic Devices and Shoes - (0543)	Updated	• No change in coverage.
Category III Current Procedural Terminology (CPT®) codes – (0558)	Updated	• No change in coverage.
Compression Devices - (0354)	Updated	• No change in coverage.
Gait Analysis – (0315)	Updated	• No change in coverage.
Glaucoma Surgical Procedures - (0035)	Updated	• No change in coverage.
Intensive Behavioral Interventions – (EN0499)	Updated	• No change in coverage.

Otoplasty and External Ear Reconstruction - (0335)	Updated	• No change in coverage.
Surgical Treatment of Chest Wall Deformities - (0309)	Updated	• No change in coverage.
Wheelchairs/Power Operated Vehicles - (0030)	Updated	• No change in coverage.
Speech Therapy – (0177)	Retired	• **Retired 4/15/2025** due to lack of business need secondary to non-implementation.
Helicobacter Pylori Serology Testing – (0308)	Retired	• **Retired 4/1/2025** due to lack of business need secondary to non-implementation.
MCG Guidelines	**New, Updated, or Retired?**	• **Comments**
MCG Guidelines (Commercial)	Updated	• **Effective 3/28/2025**
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
Acupuncture - (CPG 024)	Updated	• No change in coverage.

Home Traction Devices – Cervical and Lumbar - (CPG 265)	Updated	• No change in coverage.
Axial/Spinal Decompression Therapy/Mechanical Traction (Provided in a Clinic Setting) – (CPG 275)	Updated	• No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-EviCore Gastrointestinal Endoscopic Procedure Guidelines	Updated	Posted **3/14/2025**; Effective **5/1/2025**: Capsule Endoscopy: • No clinical changes. Posted **4/1/2025**; Effective **7/1/2025**: Minor **change:** • Capsule Endoscopy: ○ Removed section for patency capsule, as this indication is not managed.
Cobranded Cigna-EviCore High-Tech Imaging Guidelines	Updated	Posted **4/1/2025;** Effective **5/15/2025** No clinical changes: • Pediatric Abdomen Imaging • Preface to the Imaging Guidelines

		Posted **4/1/2025;** Effective **7/1/2025**
		
		Important **changes** in coverage criteria:
		
		• One guideline was Updated with a clinical change which will limit coverage:
		  ○ Breast Imaging
		  ▪ For breast MRI indications, added "40**" as age at which screening can start for members with BARD1, RAD51C, RAD51D mutation(s).
		
		Posted **4/15/2025;** Effective **5/15/2025**
		
		Important **changes** in coverage criteria:
		
		• One guideline was Updated with clinical changes which will expand coverage:
		  ○ Musculoskeletal Imaging

Cobranded Cigna-EviCore Laboratory Management Clinical Guidelines	Updated	Posted **4/1/2025**; Effective **7/1/2025**:
		
		Important **changes** in coverage criteria.
		
		• One new guideline:
		  ○ Primary Ciliary Dyskinesia Genetic Testing
		• Four guidelines were Updated with clinical changes which will expand coverage:
		  ○ Liquid Biopsy Testing
		  ○ Somatic Mutation Testing
		  ○ Mitochondrial Disorders Genetic Testing
		  ○ Polymerase Gamma (POLG) Related Disorders Genetic Testing
		• One guideline was Updated with clinical changes which may limit coverage:
		  ○ Cardiomyopathy and Arrhythmia Genetic Testing
		• One guideline was retired:
		  ○ BCR-ABL Negative Myeloproliferative Neoplasm Testing

		• The remaining guidelines had no clinically impactful changes.

Cobranded Cigna-EviCore Musculoskeletal Management Guidelines	Updated	Posted **4/1/2025**; Effective **7/1/2025**:
		
		Minor **change**:
		
		• One guideline was Updated with minor clinical changes which may impact coverage:
		  ○ CMM-318: Shoulder Arthroplasty/ Replacement/ Resurfacing/ Revision/ Arthrodesis
		• The remaining guidelines had no clinically impactful changes:
		  ○ Preface to the Comprehensive Musculoskeletal Management (CMM) Guidelines
		  ○ CMM-200: Epidural Steroid Injections
		  ○ CMM-203: Sacroiliac Joint Procedures
		  ○ CMM-208: Ablations/Denervations of Facet Joints and Peripheral Nerves
		  ○ CMM-210: Implantable Intrathecal Drug Delivery Systems
		  ○ CMM-211: Spinal Cord and Dorsal Root Ganglion Stimulation
		  ○ CMM-311: Knee Replacement/Arthroplasty
		  ○ CMM-312: Knee Surgery - Arthroscopic and Open Procedures
		  ○ CMM-313: Hip Replacement/Arthroplasty
		  ○ CMM-314: Hip Surgery-Arthroscopic and Open Procedures
		  ○ CMM-315: Shoulder Surgery-Arthroscopic and Open Procedures
		  ○ CMM-201: Facet Joint Injections/Medial Branch Blocks
		  ○ CMM-204: Prolotherapy
		  ○ CMM-207: Epidural Adhesiolysis
		  ○ CMM-209: Regional Sympathetic Blocks

Cobranded Cigna-EviCore Spine Surgery Guidelines	Updated	Posted **4/1/2025**; Effective **7/1/2025**: Important **changes** in coverage criteria.

		• Two guidelines were Updated with clinical changes which will expand coverage:
		  ○ CMM-608: Lumbar Decompression
		  ○ CMM-609: Lumbar Fusion (Arthrodesis)
		• One guideline was Updated with clinical changes which will limit coverage:
		  ○ CMM-611: Sacroiliac Joint Fusion and Stabilization
		• The remaining guidelines had no clinically impactful changes:
		  ○ CMM-606: Lumbar Microdiscectomy (Laminotomy, Laminectomy, or Hemilaminectomy)
		  ○ CMM-308: Intradiscal Procedures
		  ○ CMM 401: Discography
		  ○ CMM-600: Preface to Spine Surgery Guidelines
		  ○ CMM-601: Anterior Cervical Discectomy and Fusion
		  ○ CMM-602: Cervical Total Disc Arthroplasty
		  ○ CMM-603: Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty)
		  ○ CMM-604: Posterior Cervical Fusion
		  ○ CMM-605: Cervical Microdiscectomy
		  ○ CMM-607: Primary Vertebral Augmentation (Percutaneous Vertebroplasty/Kyphoplasty) and Sacroplasty
		  ○ CMM-610: Lumbar Total Disc Arthroplasty
		  ○ CMM-612: Grafts
		  ○ CMM-613: Thoracic Decompression/Discectomy
		  ○ CMM-614: Thoracic / Thoracolumbar Fusion (Arthrodesis)
		  ○ CMM-615: Electrical and Low Frequency Ultrasound Bone Growth Stimulation (Spine)
		  ○ CMM-616: Vertebral Body Tethering for Adolescent Idiopathic Scoliosis

Administrative Policy	**New, Updated,**	**Comments**

	or Retired?	
		• No Updates for April 2025
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Antibiotics – Linezolid (Zyvox), Sivextro - (IP0372)	Updated	**Effective: 4/1/2025** • **Linezolid – Other Uses with Supportive Evidence:** • **Tuberculosis:** This condition and criteria for approval was added to the policy under "Other Uses with Supportive Evidence."
Brands with Bioequivalent Generics – (IP0011)	Updated	**Effective 4/1/2025** • **Added** Pepcid to support medical necessity review for Employer Plans and Individual and Family Plans. • **Removed** Marinol; the criteria has been relocated to Dronabinol Products – (IP0719).
Cystic Fibrosis Transmembrane Conductance Regulator – Alyftrek - (IP0723)	New	**Effective 4/1/2025** • New Policy
Cystic Fibrosis Transmembrane Conductance Regulator – Kalydeco (IP0431)	Updated	**Effective: 4/1/2025** • The Policy title was changed to Cystic Fibrosis Transmembrane Conductance Regulator – Kalydeco. Previously, Cystic Fibrosis – Kalydeco.

		• **<u>Added "Documentation</u>**: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, and/or other information."
		
		• **Cystic Fibrosis:**
		  • **Updated** criteria **from** "Patient has at least ONE of the following mutations in the cystic fibrosis transmembrane conductance regulator gene that is considered to be a pathogenic or likely pathogenic variant:" **to** "Documentation is provided that the patient has at least ONE of the following mutations in the cystic fibrosis transmembrane conductance regulator gene that is considered to be a pathogenic or likely pathogenic variant:"
		  • **Cystic Fibrosis, Patient Homozygous for the F508del Mutation in the Cystic Fibrosis Transmembrane Conductance Regulator Gene.** "Conductance" was added to the verbiage for this condition not covered.
		  • **Cystic Fibrosis, Patient with Unknown Cystic Fibrosis Transmembrane Conductance Regulator Gene Mutation.** "Conductance" was added to the verbiage for this condition not covered.
		  • **Combination Therapy with Other Cystic Fibrosis Transmembrane Conductance Regulator Modulator(s).** This condition not covered was modified to refer to the class of cystic fibrosis transmembrane conductance regulator modulator(s). Previously individual agents were listed. A Note was added to list examples of the cystic fibrosis transmembrane conductance regulators.
		
		• **Preferred Product Table:**
		  • **Added** "Patient is ≥ 2 years of age AND the patient meets ONE of the following (a or b):"

		• **Updated from** "Failure, contraindication, or intolerance with to elexacaftor/tezacaftor /ivacaftor (Trikafta™)" **to** "Patient has tried, and according to the prescriber has experienced inadequate efficacy OR a significant intolerance with Trikafta (tablets or oral granules) [may require prior authorization]" • **Added** "Patient has at least one mutation in the cystic fibrosis transmembrane conductance regulator gene that is considered to be a pathogenic or likely pathogenic variant that is not covered by Trikafta (tablets or oral granules) [may require prior authorization]." • **Updated from** "Individual has previously been started on, or is currently receiving Kalydeco" **to** "Patient has already been started on therapy with Kalydeco." • **Removed** "Approve if the patient has at least one of the following mutations in the cystic fibrosis transmembrane regulator (CFTR) gene: 2789+5G › A, 3272-26A › G, 3849+10kbC › T, 711+3A › G, OR E831X."
Cystic Fibrosis Transmembrane Conductance Regulator – Orkambi (IP0432)	Updated	**Effective: 4/1/2025** • The Policy title was changed to Cystic Fibrosis Transmembrane Conductance Regulator – Orkambi. Previously, Cystic Fibrosis – Orkambi. • **Added "Documentation**: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, and/or other information." • **Cystic Fibrosis Homozygous for the F508del Mutation in the Cystic Fibrosis Transmembrane Conductance Regulator Gene**. "Conductance" was added to this criteria. • **Updated** criteria **from** "Patient has TWO copies of the F508del mutation in the CFTR gene" **to** "Documentation is provided that the patient has TWO copies of the F508del mutation in the cystic fibrosis transmembrane conductance regulator gene."

		• **Cystic Fibrosis, Heterozygous for the F508del Mutation in the Cystic Fibrosis Transmembrane Conductance Regulator Gene Mutation.** "Conductance" was added to the verbiage for this condition not covered. • **Combination Therapy with Other Cystic Fibrosis Transmembrane Conductance Regulator Modulator(s).** This condition not covered was modified to refer to the class of cystic fibrosis transmembrane conductance regulator modulator(s). Previously individual agents were listed. A Note was added to list examples of the cystic fibrosis transmembrane conductance regulators. • **Preferred Product Table:** • **Updated from** "Failure, contraindication, or intolerance with to Trikafta" **to** "Patient is ≥ 2 years AND the patient has tried, and according to the prescriber has experienced inadequate efficacy OR a significant intolerance with Trikafta (tablets or oral granules) [may require prior authorization]." • **Updated from** "Patient is < 2 years of age, approve" **to** "Patient is < 2 years of age." • **Updated from** "If the patient has been started on Orkambi, approve" **to** "Patient has already been started on therapy with Orkambi."
Cystic Fibrosis Transmembrane Conductance Regulator – Symdeko (IP0433)	Updated	**Effective: 4/1/2025** • The Policy title was changed to Cystic Fibrosis Transmembrane Conductance Regulator – Symdeko. Previously, Cystic Fibrosis – Symdeko. • **Added "Documentation**: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, and/or other information." • **Cystic Fibrosis:**

		• **Updated** criteria **from** "Patient meets ONE of the following (i or ii):" **to** "Documentation is provided that the patient meets ONE of the following (i or ii):"
		• **Cystic Fibrosis, Patient with Unknown Cystic Fibrosis Transmembrane Conductance Regulator Gene Mutation.** "Conductance" was added to the verbiage for this condition not covered.
		• **Combination Therapy with Other Cystic Fibrosis Transmembrane Conductance Regulator Modulator(s).** This condition not covered was modified to refer to the class of cystic fibrosis transmembrane conductance regulator modulator(s). Previously individual agents were listed. A Note was added to list examples of the cystic fibrosis transmembrane conductance regulators.
		• **Preferred Product Table:**
		  • **Updated from** "Failure, contraindication, or intolerance to elexacaftor/tezacaftor/ ivacaftor (Trikafta™)" **to** "Patient has tried and according to the prescriber has experienced inadequate efficacy OR a significant intolerance with Trikafta(tablets or oral granules) [may require prior authorization]."**Added** "Patient has at least one mutation in the cystic fibrosis transmembrane regulator gene that is considered to be a pathogenic or likely pathogenic variant that is not covered by Trikafta (tablets or granules) [may require prior authorization]."
		  • **Removed** "At least ONE of the following mutations in the cystic fibrosis transmembrane regulator (CFTR) gene: 711+3A › G, E831X, 2789+5G › A, 3272-26A › G, OR 3849 + 10kbC › T."
		  • **Updated from** "Currently receiving Symdeko" **to** "Patient has already been started on therapy with Symdeko."

Cystic Fibrosis Transmembrane Conductance Regulator – Trikafta - (IP0434)	Updated	**Effective: 4/1/2025** • The Policy title was changed to Cystic Fibrosis Transmembrane Conductance Regulator – Trikafta. Previously, Cystic Fibrosis – Trikafta.

		• **Added "Documentation**: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, and/or other information."
		• **Cystic Fibrosis**:
		  • **Updated** criteria **from** "Patient has at least ONE of the following mutations in the cystic fibrosis transmembrane conductance regulator gene that is considered to be a pathogenic or likely pathogenic variant:" **to** "Documentation provided that the patient has at least ONE of the following mutations in the cystic fibrosis transmembrane conductance regulator gene that is considered to be a pathogenic or likely pathogenic variant:"
		  • The criterion that the patient has at least one of the following mutations in the cystic fibrosis transmembrane conductance regulator gene that is considered pathogenic or likely pathogenic was Updated to include 94 additional gene mutations.
		  • **Cystic Fibrosis, Patient with Unknown Cystic Fibrosis Transmembrane Conductance Regulator Gene Mutation.** "Conductance" was added to the verbiage for this condition not covered.
		  • **Combination Therapy with Other Cystic Fibrosis Transmembrane Conductance Regulator Modulator(s).** This condition not covered was modified to refer to the class of cystic fibrosis transmembrane conductance regulator modulator(s). Previously individual agents were listed. A Note was added to list examples of the cystic fibrosis transmembrane conductance regulators.

Diabetes – Glucagon-Like Peptide-1 Agonists for Individual and Family Plans - (IP0702)	Updated	**Effective 4/1/2025** • **Removed** the metformin requirement from all products. • **Removed** preferred product requirements from Liraglutide, Mounjaro, Ozempic and Rybelsus.

		• **Updated** the Victoza preferred product requirement to a MSB approach.
Dronabinol Products - (IP0719)	New	**Effective: 4/1/2025** • New coverage policy
Drugs Requiring Medical Necessity Review for Employer Plans - (1602)	Updated	**Effective: 4/1/2025** • **Added "Documentation**: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information." • **Added preferred product step requirement for the following products:** • Admelog, Apidra, Fiasp, Fiasp PumpCart, insulin aspart 100 units/mL injection (authorized generic for Novolog), NovoLog, and Vtama
Gamifant - (IP0113)	Updated	**Effective: 4/15/2025** • No criteria changes.
Hemophilia – Gene Therapy – Beqvez - (IP0648)	Updated	**Effective: 3/27/2025** • **Hemophilia B:** The requirement that the patient does not have a history of Factor IX inhibitors (with documentation required) was removed from this section. The requirement that prophylactic therapy with Factor IX will not be given after Beqvez administration once adequate Factor IX levels have been achieved was removed, along with the related Note. The Note that provides examples of advanced liver impairment and/or advanced fibrosis was removed. However, the criterion that the patient does not have evidence of advanced liver impairment and/or advanced fibrosis remains.

		• **Conditions Not Recommended for Approval:** The condition of "Patient with a History of Factor IX Inhibitors" was added to this section. Previously, this was in a criterion related to the diagnosis of hemophilia B.
Hemophilia – Gene Therapy – Hemgenix - (IP0535)	Updated	**Effective: 3/27/2025** • **Hemophilia B:** The requirement that the patient does not have a history of Factor IX inhibitors (with documentation required) was removed from this section. The requirement that prophylactic therapy with Factor IX will not be given after Hemgenix administration once adequate Factor IX levels have been achieved was removed, along with the related Note. The Note that provides examples of advanced liver impairment and/or advanced fibrosis was removed. However, the criterion that the patient does not have evidence of advanced liver impairment and/or advanced fibrosis remains. • **Conditions Not Recommended for Approval:** The condition of "Patient with a History of Factor IX Inhibitors" was added to this section. Previously, this was in a criterion related to the diagnosis of hemophilia B.
Cystic Fibrosis Transmembrane Conductance Regulator – Kalydeco (IP0431)	Updated	• **Effective: 4/1/2025** • The Policy title was changed to Cystic Fibrosis Transmembrane Conductance Regulator – Kalydeco. Previously, Cystic Fibrosis – Kalydeco. • **Added "Documentation**: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, and/or other information." • **Cystic Fibrosis:** • **Updated** criteria **from** "Patient has at least ONE of the following mutations in the cystic fibrosis transmembrane conductance regulator gene that is considered to be a pathogenic or likely pathogenic variant:" **to** "Documentation is provided that the patient has at least ONE of the

		following mutations in the cystic fibrosis transmembrane conductance regulator gene that is considered to be a pathogenic or likely pathogenic variant:" • **Cystic Fibrosis, Patient Homozygous for the F508del Mutation in the Cystic Fibrosis Transmembrane Conductance Regulator Gene.** "Conductance" was added to the verbiage for this condition not covered. • **Cystic Fibrosis, Patient with Unknown Cystic Fibrosis Transmembrane Conductance Regulator Gene Mutation.** "Conductance" was added to the verbiage for this condition not covered. • **Combination Therapy with Other Cystic Fibrosis Transmembrane Conductance Regulator Modulator(s).** This condition not covered was modified to refer to the class of cystic fibrosis transmembrane conductance regulator modulator(s). Previously individual agents were listed. A Note was added to list examples of the cystic fibrosis transmembrane conductance regulators. • **Preferred Product Table:** • **Added** "Patient is ≥ 2 years of age AND the patient meets ONE of the following (a or b):" • **Updated from** "Failure, contraindication, or intolerance with to elexacaftor/tezacaftor /ivacaftor (Trikafta™)" **to** "Patient has tried, and according to the prescriber has experienced inadequate efficacy OR a significant intolerance with Trikafta (tablets or oral granules) [may require prior authorization]" • **Added** "Patient has at least one mutation in the cystic fibrosis transmembrane conductance regulator gene that is considered to be a pathogenic or likely pathogenic variant that is not covered by Trikafta (tablets or oral granules) [may require prior authorization]." • **Updated from** "Individual has previously been started on, or is currently receiving Kalydeco" **to** "Patient has already been started on therapy with Kalydeco."

		• **Removed** "Approve if the patient has at least one of the following mutations in the cystic fibrosis transmembrane regulator (CFTR) gene: 2789+5G › A, 3272-26A › G, 3849+10kbC › T, 711+3A › G, OR E831X."

Cystic Fibrosis Transmembrane Conductance Regulator – Orkambi (IP0432)	Updated	**Effective: 4/1/2025**
		
		• The Policy title was changed to Cystic Fibrosis Transmembrane Conductance Regulator – Orkambi. Previously, Cystic Fibrosis – Orkambi.
		• **Added "Documentation**: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, and/or other information."
		  • **Cystic Fibrosis Homozygous for the F508del Mutation in the Cystic Fibrosis Transmembrane Conductance Regulator Gene**. "Conductance" was added to this criteria.
		  • **Updated** criteria **from** "Patient has TWO copies of the F508del mutation in the CFTR gene" **to** "Documentation is provided that the patient has TWO copies of the F508del mutation in the cystic fibrosis transmembrane conductance regulator gene."
		  • **Cystic Fibrosis, Heterozygous for the F508del Mutation in the Cystic Fibrosis Transmembrane Conductance Regulator Gene Mutation.** "Conductance" was added to the verbiage for this condition not covered.
		  • **Combination Therapy with Other Cystic Fibrosis Transmembrane Conductance Regulator Modulator(s).** This condition not covered was modified to refer to the class of cystic fibrosis transmembrane conductance regulator modulator(s). Previously individual agents were listed. A Note was added to list examples of the cystic fibrosis transmembrane conductance regulators.
		• **Preferred Product Table:**
		  • **Updated from** "Failure, contraindication, or intolerance with to Trikafta" **to** "Patient is ≥ 2 years AND the patient has tried, and

		according to the prescriber has experienced inadequate efficacy OR a significant intolerance with Trikafta (tablets or oral granules) [may require prior authorization].” • **Updated from** “Patient is < 2 years of age, approve” **to** “Patient is < 2 years of age.” • **Updated from** “If the patient has been started on Orkambi, approve” **to** “Patient has already been started on therapy with Orkambi.”
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Legacy Drug List Plans - (PSM003)	Updated	**Effective 4/1/2025** • **Omvoh subcutaneous:** This drug was added as a Preferred Non-Adalimumab Product for Crohn’s disease and Ulcerative Colitis
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy: Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists - (PSM013)	Updated	**Effective 4/1/2025** • **Omvoh subcutaneous:** This drug was added as a Preferred Non-Adalimumab Product for Crohn’s disease and Ulcerative Colitis
Inflammatory Conditions – Omvoh Intravenous Prior Authorization Policy - (IP0662)	Updated	**Effective 4/1/2025** • **Removed:** Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists, and Legacy Prescription Drug List Plans (PSM019) from the “Note” directing to additional preferred product criteria

		requirements and exceptions. Omvoh intravenous moved to a preferred product for these prescription drug lists.
Inflammatory Conditions – Omvoh Subcutaneous Prior Authorization Policy - (IP0663)	Updated	**Effective 4/1/2025** • **Removed:** Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists (PSM001), and Legacy Prescription Drug List Plans (PSM017) from the "Note" directing to additional preferred product criteria requirements and exceptions. Omvoh subcutaneous moved to a preferred product for these prescription drug lists.
Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy for Individual and Family Plan Prescription Drug Lists - (PSM011)	Updated	**Effective 4/1/2025** • **Updated Policy Title: Removed** Employer Plans: Standard/Performance, Value/Advantage, Total Savings from the previous title. Omvoh intravenous is moving to a preferred product for Employer Plans. This policy will now only apply for Individual and Family Plans.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists - (PSM001)	Updated	**Effective 4/1/2025** • **Omvoh Subcutaneous:** For **Crohn's Disease** and **Ulcerative Colitis**, Omvoh subcutaneous was moved from Step 2a to Preferred (Step 1). • **Cimzia:** For **Crohn's Disease**, Omvoh subcutaneous was added as a Preferred Product. • **Simponi Subcutaneous:** For **Ulcerative Colitis**, Omvoh subcutaneous was added as a Preferred Product. • **Rinvoq:** For **Crohn's Disease** and **Ulcerative Colitis**, Omvoh subcutaneous was added as a Preferred Product. • **Xeljanz/Xeljanz XR:** For **Ulcerative Colitis**, Omvoh subcutaneous was added as a Preferred Product.

Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Legacy Prescription Drug Lists - (PSM017)	Updated	**Effective 4/1/2025** • **Omvoh Subcutaneous:** For **Crohn's Disease** and **Ulcerative Colitis**, Omvoh subcutaneous was moved from Step 2a to Preferred (Step 1). • **Cimzia:** For **Crohn's Disease**, Omvoh subcutaneous was added as a Preferred Product. • **Simponi Subcutaneous:** For **Ulcerative Colitis**, Omvoh subcutaneous was added as a Preferred Product. • **Rinvoq:** For **Crohn's Disease** and **Ulcerative Colitis**, Omvoh subcutaneous was added as a Preferred Product. • **Xeljanz/Xeljanz XR:** For **Ulcerative Colitis**, Omvoh subcutaneous was added as a Preferred Product.
Inflammatory Conditions – Ustekinumab Intravenous Prior Authorization Policy – (IP0686)	Updated	**Effective 4/15/2025** • Policy name was Updated to more generally list Ustekinumab Intravenous Products; previously policy was specific to Stelara Intravenous. • Otulfi, Pyzchiva, ustekinumab-ttwe, Selarsdi, Steqeyma, and Yesintek intravenous were added to the policy; the same criteria apply for all ustekinumab intravenous products. • **Updated HCPCS Coding** • **Added HCPCS**: J3358, Q9997, Q9998, Q9999
Inflammatory Conditions – Ustekinumab Subcutaneous Prior Authorization Policy - (IP0687)	Updated	**Effective 4/15/2025** • Policy name was Updated to more generally list Ustekinumab Subcutaneous Products; previously policy was specific to Stelara Subcutaneous. Wording for a patient currently receiving Stelara subcutaneous was changed to currently receiving ustekinumab subcutaneous. Wording for a patient who had previously received induction with Stelara intravenous was changed to more generally refer to ustekinumab intravenous.

		• Otulfi, Pyzchiva, ustekinumab-ttwe, Selarsdi, Steqeyma, and Yesintek subcutaneous were added to the policy; the same criteria apply for all ustekinumab subcutaneous products. • **Added HCPCS Coding Table:** • **Added HCPCS**: C9399, J3357, J3490, J3590, Q9996, Q9998, Q9999
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists - (PSM021)	New	**Effective 4/15/2025** • New policy
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Legacy Drug List Plans - (PSM022)	New	**Effective 4/15/2025** • New Policy
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred	New	**Effective 4/15/2025** • New Policy

Specialty Management Policy for Individual and Family Plans - (PSM023)		
Inflammatory Conditions – Ustekinumab Intravenous Products Preferred Specialty Management Policy - (PSM024)	New	**Effective 4/15/2025** • New Policy
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists - (PSM001)	Updated	**Effective 4/15/2025** • **For Psoriatic Arthritis, Plaque Psoriasis, Crohn's Disease, and Ulcerative Colitis**, Selsardi subcutaneous, ustekinumab-ttwe subcutaneous, and Yesintek subcutaneous were added as Preferred ustekinumab subcutaneous products. The criteria for the following Non-Preferred Products were Updated to include these Preferred ustekinumab products: Ilumya, Siliq, Entyvio subcutaneous, Rinvoq LQ, Rinvoq, Xeljanz, Bimzelx, Cimzia, Simponi subcutaneous, Cosentyx subcutaneous, and Orencia subcutaneous. Throughout the policy, a note was added indicating that a trial of multiple ustekinumab products counts as one product and examples of ustekinumab products were added including Stelara, Wezlana, Otufli, Pyzchiva, ustekinumab-ttwe, Selarsdi, Steqeyma, and Yesintek. For Crohn's Disease and Ulcerative Colitis, the note that refers to a previous trial of Stelara intravenous was changed to more generally refer to an intravenous ustekinumab product.
Inflammatory Conditions Preferred Specialty Management	Updated	**Effective 4/15/2025**

Policy for Employer Plans: Legacy Prescription Drug Lists - (PSM017)		• **For Psoriatic Arthritis, Plaque Psoriasis, Crohn's Disease, and Ulcerative Colitis**, Selsardi subcutaneous, ustekinumab-ttwe subcutaneous, and Yesintek subcutaneous were added as Preferred ustekinumab subcutaneous products. The criteria for the following Non-Preferred Products were Updated to include these Preferred ustekinumab products: Ilumya, Siliq, Entyvio subcutaneous, Rinvoq LQ, Rinvoq, Xeljanz, Bimzelx, Cimzia, Simponi subcutaneous, Cosentyx subcutaneous, and Orencia subcutaneous. Throughout the policy, a note was added indicating that a trial of multiple ustekinumab products counts as one product and examples of ustekinumab products were added including Stelara, Wezlana, Otufli, Pyzchiva, ustekinumab-ttwe, Selarsdi, Steqeyma, and Yesintek. For Crohn's Disease and Ulcerative Colitis, the note that refers to a previous trial of Stelara intravenous was changed to more generally refer to an intravenous ustekinumab product.
Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)	Updated	**Effective 4/15/2025** • **For Psoriatic Arthritis, Plaque Psoriasis, Crohn's Disease**, and Ulcerative Colitis, Selsardi subcutaneous, ustekinumab-ttwe subcutaneous, and Yesintek subcutaneous were added as Preferred ustekinumab subcutaneous products. The criteria for the following Non-Preferred Products were Updated to include these Preferred ustekinumab products: Ilumya, Siliq, Entyvio subcutaneous, Rinvoq LQ, Rinvoq, Xeljanz, Bimzelx, Cimzia, Simponi subcutaneous, Omvoh, Velsipity, Taltz, and Orencia subcutaneous. Throughout the policy, a note was added indicating that a trial of multiple ustekinumab products counts as one product and examples of ustekinumab products were added including Stelara, Wezlana, Otufli, Pyzchiva, ustekinumab-ttwe, Selarsdi, Steqeyma, and Yesintek. For Crohn's Disease and Ulcerative Colitis, the note that refers to a previous trial of Stelara intravenous was changed to more generally refer to an intravenous ustekinumab product.

Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy for Legacy Prescription Drug List Plans - (PSM004)	Updated	**Effective 4/15/2025** • **Ulcerative Colitis:** Selarsdi, ustekinumab-ttwe, and Yesintek subcutaneous were added to the policy as Preferred ustekinumab SC products. The Note was Updated to include examples of ustekinumab products.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy for Individual and Family Plans - (PSM008)	Updated	**Effective 4/15/2025** • **Ulcerative Colitis:** Selarsdi, ustekinumab-ttwe, and Yesintek subcutaneous were added to the policy as Preferred ustekinumab SC products. The Note was Updated to include examples of ustekinumab products.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy: Standard/Performance, Value/Advantage, Total Savings Prescription Drug List Plans -(PSM015)	Updated	**Effective 4/15/2025** • **Ulcerative Colitis:** Selarsdi, ustekinumab-ttwe, and Yesintek subcutaneous were added to the policy as Preferred ustekinumab SC products. The Note was Updated to include examples of ustekinumab products.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Legacy Drug List Plans - (PSM003)	Updated	**Effective 4/15/2025** • **Updated** Appendix to add Selarsdi, ustekinumab-ttwe, and Yesintek subcutaneous as Preferred Non-Adalimumab Products for psoriatic arthritis, psoriasis, Crohn's disease, and ulcerative colitis

Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)	Updated	**Effective 4/15/2025** • **For Psoriatic Arthritis, Plaque Psoriasis, Crohn's Disease**, and Ulcerative Colitis, Selsardi subcutaneous, ustekinumab-ttwe subcutaneous, and Yesintek subcutaneous were added as Preferred ustekinumab subcutaneous products. The criteria for the following Non-Preferred Products were Updated to include these Preferred ustekinumab products: Ilumya, Siliq, Entyvio subcutaneous, Rinvoq LQ, Rinvoq, Xeljanz, Bimzelx, Cimzia, Simponi subcutaneous, Omvoh, Velsipity, Taltz, and Orencia subcutaneous. Throughout the policy, a note was added indicating that a trial of multiple ustekinumab products counts as one product and examples of ustekinumab products were added including Stelara, Wezlana, Otufli, Pyzchiva, ustekinumab-ttwe, Selarsdi, Steqeyma, and Yesintek. For Crohn's Disease and Ulcerative Colitis, the note that refers to a previous trial of Stelara intravenous was changed to more generally refer to an intravenous ustekinumab product.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy: Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists - (PSM013)	Updated	**Effective 4/15/2025** • **Updated** Appendix to add Selarsdi, ustekinumab-ttwe, and Yesintek subcutaneous as Preferred Non-Adalimumab Products for psoriatic arthritis, psoriasis, Crohn's disease, and ulcerative colitis
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for	Updated	**Effective 4/15/2025**

Individual and Family Plans - (PSM014)		• **Updated** Appendix to add Selarsdi, ustekinumab-ttwe, and Yesintek subcutaneous as Preferred Non-Adalimumab Products for psoriatic arthritis, psoriasis, Crohn's disease, and ulcerative colitis
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists - (PSM006)	Updated	**Effective 4/15/2025** • **For Psoriatic Arthritis:** Selsardi subcutaneous, ustekinumab-ttwe subcutaneous, and Yesintek subcutaneous were added as Preferred ustekinumab subcutaneous products. A note was added indicating that a trial of multiple ustekinumab products counts as one product and examples of ustekinumab products were added including Stelara, Wezlana, Otufli, Pyzchiva, ustekinumab-ttwe, Selarsdi, Steqeyma, and Yesintek.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Individual and Family Plans - (PSM010)	Updated	**Effective 4/15/2025** • **For Psoriatic Arthritis:** Selsardi subcutaneous, ustekinumab-ttwe subcutaneous, and Yesintek subcutaneous were added as Preferred ustekinumab subcutaneous products. A note was added indicating that a trial of multiple ustekinumab products counts as one product and examples of ustekinumab products were added including Stelara, Wezlana, Otufli, Pyzchiva, ustekinumab-ttwe, Selarsdi, Steqeyma, and Yesintek.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Legacy Prescription Drug Lists (PSM018)	Updated	**Effective 4/15/2025** • **For Psoriatic Arthritis:** Selsardi subcutaneous, ustekinumab-ttwe subcutaneous, and Yesintek subcutaneous were added as Preferred ustekinumab subcutaneous products. A note was added indicating that a trial of multiple ustekinumab products counts as one product and examples

		of ustekinumab products were added including Stelara, Wezlana, Otufli, Pyzchiva, ustekinumab-ttwe, Selarsdi, Steqeyma, and Yesintek.
Inflammatory Conditions – Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists Plans - (PSM009)	Updated	**Effective 4/15/2025** • **For Psoriatic Arthritis:** Selsardi subcutaneous, ustekinumab-ttwe subcutaneous, and Yesintek subcutaneous were added as Preferred ustekinumab subcutaneous products. A note was added indicating that a trial of multiple ustekinumab products counts as one product and examples of ustekinumab products were added including Stelara, Wezlana, Otufli, Pyzchiva, ustekinumab-ttwe, Selarsdi, Steqeyma, and Yesintek.
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Legacy Prescription Drug Lists Plans (PSM016)	Updated	**Effective 4/15/2025** • **For Psoriatic Arthritis:** Selsardi subcutaneous, ustekinumab-ttwe subcutaneous, and Yesintek subcutaneous were added as Preferred ustekinumab subcutaneous products. A note was added indicating that a trial of multiple ustekinumab products counts as one product and examples of ustekinumab products were added including Stelara, Wezlana, Otufli, Pyzchiva, ustekinumab-ttwe, Selarsdi, Steqeyma, and Yesintek.
Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy for Individual and Family Plan	Updated	**Effective 4/15/2025** • **For Crohn's Disease and Ulcerative Colitis:** Selsardi intravenous, ustekinumab-ttwe intravenous, and Yesintek intravenous were added as Preferred ustekinumab intravenous products. A note was added indicating that a trial of multiple ustekinumab products counts as one product and examples of ustekinumab products were added including Stelara, Wezlana, Otufli, Pyzchiva, ustekinumab-ttwe, Selarsdi, Steqeyma, and Yesintek. The

Prescription Drug Lists - (PSM011)		note that refers to a previous trial of Stelara subcutaneous was changed to more generally refer to an ustekinumab subcutaneous product.

Neurology – Leqembi - (IP0547)	Updated	**Effective: 4/1/2025**
		• **Policy Title**:
		  • **Updated from** "Neurology – Leqembi (lecanemab-irmb)" **to** "Neurology – Leqembi."
		• **Coverage Policy**
		  • **Updated from** "The use of lecanemab-irmb (Leqembi) intravenous infusion is considered to be experimental, investigational, or unproven due to insufficient data establishing safety, efficacy, and improved health outcomes for any condition" **to** "Lecanemab-irmb intravenous infusion (Leqembi) is considered to be experimental, investigational, or unproven for Alzheimer's Disease due to insufficient data establishing safety, efficacy, and improved health outcomes for any condition, regardless of U.S. Food and Drug Administration (FDA) approval status. Criteria will be Updated as new published data are available."

Oncology (Injectable – CAR-T) – Aucatzyl - (IP0734)	NEW	**Effective: 4/15/2025** • New policy
Oncology Medications - (CP1403)	Updated	**Effective: 4/15/2025** • **Abraxane intravenous infusion** . • **Added** "**All Other Conditions.** Approve Abraxane intravenous infusion if the patient meets the Oncology Medications criteria above the table" • **Akeega.** • **Added** "**All Other Conditions**. Approve Akeega if the patient meets the Oncology Medications criteria above the table" • **Alunbrig.**

		• **Added** "**All Other Conditions**. Approve Alunbrig if the patient meets the Oncology Medications criteria above the table"
		• **Anktiva.**
		  • **Added** "**All Other Conditions**. Approve Anktiva if the patient meets the Oncology Medications criteria above the table"
		• **Augtyro.**
		  • **Added** "**All Other Conditions**. Approve Augtyro if the patient meets the Oncology Medications criteria above the table"
		• **Besremi.**
		  • **Removed,** for polycythemia vera, Pegasys as an alternative option
		  • **Added** "Documentation provided that the patient has:" to polycythemia vera criteria
		  • **Added** "**All Other Conditions**. Approve Besremi if the patient meets the Oncology Medications criteria above the table"
		• **Bosulif.**
		  • **Added** "**All Other Conditions**. Approve Bosulif if the patient meets the Oncology Medications criteria above the table"
		• **Braftovi.**
		  • **Added** "**All Other Conditions**. Approve Braftovi if the patient meets the Oncology Medications criteria above the table"
		• **Fruzaqla**
		  • **Added** "**All Other Conditions**. Approve Fruzaqla if the patient meets the Oncology Medications criteria above the table"
		• **Fusilev.**
		  • **Removed** criteria for Fusilev.
		• **Herceptin.**
		  • **Removed** "Currently receiving Herceptin"
		• **Herceptin Hylecta.**
		  • **Updated from** "Trial of AND cannot continue to use the alternative(s) due to a formulation difference in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction to ONE of the following:Kanjinti (trastuzumab-

		anns) [may require prior authorization], Ogivri (trastuzumab-dkst) [may require prior authorization], Trazimera (trastuzumab-qyyp) [may require prior authorization]" **to** "Trial of, contraindication, or intolerance to ONE of the following: Kanjinti (trastuzumab-anns) [may require prior authorization], Ogivri (trastuzumab-dkst) [may require prior authorization], Trazimera (trastuzumab-qyyp) [may require prior authorization]" • **Updated from** "Unable to obtain or maintain intravenoud access" **to** "Patient is unable to obtain or maintain intravenous access" • **Herzuma.** • **Removed** "Currently receiving Herzuma" • **Ibrance.** • **Added** "For premenopausal patients using in combination with fulvestrant as subsequent therapy (not initial therapy), approve if the patient has tried Verzenio" • **Added** "**All Other Conditions**. Approve Ibrance if the patient meets the Oncology Medications criteria above the table" • **Iclusig.** • **Added** "**All Other Conditions**. Approve Iclusig if the patient meets the Oncology Medications criteria above the table" • **Jemperli.** • **Added,** for Mismatch Repair Deficient (dMMR) or Microsatellite Instability-High (MSI-H) Solid Tumors – Monotherapy, "Note: Examples of solid tumors include ampullary adenocarcinoma, biliary tract cancer, breast cancer, esophageal and esophagogastric junction cancer, gastric cancer, hepatocellular cancer, and ovarian cancer." • **Added** "All Other Conditions (e.g., rectal cancer). Approve Jemperli if the patient meets the Oncology Medications criteria above the table" • **Keytruda.** • **Added** "**All Other Conditions**. Approve Keytruda if the patient meets the Oncology Medications criteria above the table" • **Khapzory.**

		• **Krazati.**
		  • **Added** "**All Other Conditions**. Approve Krazati if the patient meets the Oncology Medications criteria above the table"
		• **Lanreotide acetate (by Cipla).**
		  • **Removed** criteria for lanreotide acetate (by Cipla)
		• **Lupron Depot 7.5 mg, 22.5 mg, 30 mg, 45 mg.**
		  • **All Other Conditions**. Approve Lupron Depot 7.5 mg, 22.5 mg, 30 mg, 45 mg if the patient meets the Oncology Medications criteria above the table
		• **Mektovi.**
		  • **Added** "**All Other Conditions**. Approve Mektovi if the patient meets the Oncology Medications criteria above the table"
		• **Nilandron.**
		  • **Removed** "trial of, contraindication, or intolerance to ONE of the following: Bicalutamide, Flutamide"
		• **Orgovyx.**
		  • **Added** to criteria "For Prostate Cancer"
		• **Onivyde.**
		  • **Added** "**All Other Conditions**. Approve Onivyde if the patient meets the Oncology Medications criteria above the table"
		• **Ontruzant.**
		  • **Removed** "Currently receiving Ontruzant"
		• **Opdivo.**
		  • **Added** "**All Other Conditions**. Approve Opdivo if the patient meets the Oncology Medications criteria above the table"
		• **Orgovyx.**
		  • **Added** "**All Other Conditions**. Approve Orgovyx if the patient meets the Oncology Medications criteria above the table"
		• **Paclitaxel albumin-bound intravenous infusion.**
		  • **Added** "**All Other Conditions**. Approve paclitaxel albumin-bound intravenous infusion if the patient meets the Oncology Medications criteria above the table"

		• **Provenge.**
		  • **Added "<u>All Other Conditions.</u>** <u>Approve</u> Provenge <u>if the patient meets the Oncology Medications criteria above the table"</u>
		• **Scemblix.**
		  • For the exception to the requirement of a trial of Sprycel, the requirement that the patient has tried at least "two" other tyrosine kinase inhibitors for CML was changed to at least "one" other tyrosine kinase inhibitor for CML.
		  • **Added "All Other Conditions**. Approve Scemblix if the patient meets the Oncology Medications criteria above the table"
		• **Talzenna.**
		  • **Updated from** "For <u>*BRCA*-mutated Prostate Cancer</u>, ONE of the following: Documented trial of, contraindication, intolerance to Lynparza (olaparib) [may require prior authorization], Currently receiving Talzenna" **to** "For BRCA-mutated prostate cancer, documented trial of, contraindication, intolerance to Lynparza (Olaparib) [may require prior authorization], Patient has a homologous recombination repair (HHR) mutation OTHER THAN a BRCA-mutation (i.e., patient does not have a BRCA mutation), Currently receiving Talzenna"
		  • **Added "All Other Conditions**. Approve Talzenna if the patient meets the Oncology Medications criteria above the table"
		• **Tasigna.**
		  • **Added "All Other Conditions**. Approve Tasigna if the patient meets the Oncology Medications criteria above the table"
		• **Tecentriq.**
		  • **Added "All Other Conditions**. Approve Tecentriq if the patient meets the Oncology Medications criteria above the table"
		• **Vectibix**
		  • **Added "All Other Conditions**. Approve Vectibix if the patient meets the Oncology Medications criteria above the table"
		• **Yonsa**

		• **Added** "**All Other Conditions**. Approve Yonsa if the patient meets the Oncology Medications criteria above the table"
Ophthalmology – Dry Eye Disesase – Eysuvis for IFP - (IP0720)	New	**Effective: 4/1/2025** • New coverage policy.
Ophthalmology – Dry Eye Disease – Lacrisert for IFP - (IP0721)	New	**Effective: 4/1/2025** • New coverage policy.
Opioid Therapy – Individual and Family Plans - (IP0562)	Updated	**Effective: 4/1/2025** • **Preferred Product Table:** • **Added** preferred product criteria for Tramadol 75mg tablet.
Parkinson's Disease – Vyalev - (IP0717)	New	**Effective 4/15/2025** • New coverage policy.
Pharmacy and Medical Prior Authorization - (1407)	Updated	**Effective: 4/1/2025** • **Added** Individual and Family Plan product-specific medical necessity criteria: insulin aspart (NovoLog generic), Novolog, Eucrisa
Psychiatry – Spravato - (IP0220)	Updated	**Effective: 4/1/2025** • **Added "Documentation:** Documentation is required for use of Spravato as noted in the criteria. Documentation may include, but is not limited to chart notes, laboratory tests, claims records, and/or other information" • **Major Depressive Disorder with Acute Suicidal Ideation or Behavior.** • **Updated from "**Patient has major depressive disorder that is considered to be severe, according to the Prescriber" **to** "Documentation is provided that

		the Patient has major depressive disorder that is considered to be severe, according to the Prescriber" • **Treatment-Resistant Depression.** • **Removed** criterion requiring "Patient is concomitantly receiving at least one oral antidepressant" due to the new indication for use as monotherapy in adults with treatment-resistant depression. • **Updated from** "Patient has demonstrated nonresponse (≤ 25% improvement in depression symptoms or scores) to at least two different antidepressants, each from a different pharmacologic • class" **to** "Documentation is provided that the Patient has demonstrated nonresponse (≤ 25% improvement in depression symptoms or scores) to at least two different antidepressants, each from a different pharmacologic class" • **Updated from** "Each antidepressant was used at therapeutic dosages for at least 6 weeks in the current episode of depression, according to the prescriber" **to** "Documentation is provided that each antidepressant was used at therapeutic dosages for at least 6 weeks in the current episode of depression, according to the prescriber"
Sickle Cell Disease – Adakveo - (IP0120)	Updated	**Effective: 4/15/2025** • No criteria changes.
Sickle Cell Disease – L-glutamine for Individual and Family Plans (IP0475)	Updated	**Effective: 4/15/2025** • No criteria changes.
Somatostatin Analogs – Lanreotide Products - (IP0323)	Updated	**Effective: 4/15/2025** • **Lanreotide subcutaneous injection.** • **Added "J1932"** to lanreotide subcutaneous injection product label

		• **Updated from** "Patient has tried Somatuline Depot" **to** "Patient has tried Somatuline Depot or lanreotide acetate (Cipla USA Inc. packager, J1930]"
Somatostatin Analogs – Octreotide Long-Acting Products - (IP0489)	Updated	**Effective 4/1/2025** • **Removed** Individual and Family Plans preferred product requirements.
Topical Retinoids – Aklief - (IP0180)	Updated	**Effective: 4/1/2025** • **Employer Plans, Individual and Family Plans Preferred Product Table.** • **Updated from** "Patient has tried a topical adapalene product, a topical tazarotene product, AND a topical tretinoin product" **to** "Patient has tried, and according to the prescriber, experienced inadequate efficacy, or significant intolerance with ALL the following (A, B, and C): A. A topical adapalene product; AND Note: Examples of topical adapalene products include Differin and adapalene. B. A topical tazarotene product; AND Note: Example of topical tazarotene products include Tazorac, tazarotene, Arazlo, Fabior. C. A topical tretinoin product. Note: Examples of topical tretinoin products include Retin-A, Retin-A Micro, tretinoin, Altreno, Atralin, Avita."
Weight Loss – Appretite Suppressants and Orlistat - (IP0420)	Updated	**Effective: 4/15/2025** • The policy title was changed to: Weight Loss – Appetite Suppressants and Orlistat (previously Weight Loss – Other Appetite Suppressants and Orlistat). • Phentermine hydrochloride and Contrave

		• **Weight Loss.** Initial Therapy. The criterion requiring that the patient has engaged in a trial of behavioral modification and dietary restriction for at least 3 months was modified to remove that the patient has failed to achieve the desired weight loss after this intervention. The criterion requiring that the patient currently has a body mass index (BMI) ≥ 30 kg/m^2 or ≥ 27 kg/m^2 for those with comorbidities besides obesity was modified as follows: this criterion was changed to "at baseline, the patient had a BMI ≥ 30 kg/m^2" OR that "at baseline, the patient had a BMI ≥ 27 kg/m^2 AND at baseline, the patient had, or currently has, at least ONE of the following weight-related comorbidities: hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, cardiovascular disease, knee osteoarthritis, asthma, chronic obstructive pulmonary disease, metabolic-dysfunction associated steatotic liver disease/non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery disease"; previously for a patient with BMI ≥ 27 kg/m^2 examples of comorbidities were hypertension, diabetes mellitus, impaired glucose tolerance, dyslipidemia, and sleep apnea, and coronary heart disease and these items were listed in a Note; a Note was added to clarify that baseline refers to baseline prior to the requested medication for weight loss. The criterion that the patient is currently engaged in behavioral modification and on a reduced calorie diet was modified to state that "the medication will be used concomitantly with behavioral modification and a reduced-calorie diet." Patient is Continuing Therapy. The criterion requiring that the patient currently has a body mass index (BMI) ≥ 30 kg/m^2 or ≥ 27 kg/m^2 for those with comorbidities besides obesity was modified as follows: this criterion was changed to "at baseline, the patient had a BMI ≥ 30 kg/m^2" OR that "at baseline, the patient had a BMI ≥ 27 kg/m^2 AND at baseline, the patient had, or currently has, at least ONE of the following weight-related comorbidities: hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, cardiovascular disease, knee osteoarthritis, asthma, chronic obstructive pulmonary disease, metabolic-dysfunction associated steatotic liver disease/non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery disease"; previously for a patient with BMI ≥ 27 kg/m^2

		examples of comorbidities were hypertension, diabetes mellitus, impaired glucose tolerance, dyslipidemia, and sleep apnea, and coronary heart disease and these items were listed in a Note; a Note was added to clarify that baseline refers to baseline prior to the requested medication for weight loss. The criterion that the patient is currently engaged in behavioral modification and on a reduced calorie diet was modified to state that "the medication will be used concomitantly with behavioral modification and a reduced-calorie diet." A Note was added to the criterion requiring that the patient has lost ≥ 5% of baseline body weight that baseline refers to baseline prior to requested medication for weight loss. • **Qsymia** • **Weight Loss, Adult.** Initial Therapy. The criterion requiring that the patient has engaged in a trial of behavioral modification and dietary restriction for at least 3 months was modified to remove that the patient has failed to achieve the desired weight loss after this intervention. The criterion requiring that the patient currently has a body mass index (BMI) ≥ 30 kg/m^2 or ≥ 27 kg/m^2 for those with comorbidities besides obesity was modified as follows: this criterion was changed to "at baseline, the patient had a BMI ≥ 30 kg/m^2" OR that "at baseline, the patient had a BMI ≥ 27 kg/m^2 AND at baseline, the patient had, or currently has, at least ONE of the following weight-related comorbidities: hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, cardiovascular disease, knee osteoarthritis, asthma, chronic obstructive pulmonary disease, metabolic-dysfunction associated steatotic liver disease/non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery disease"; previously for a patient with BMI ≥ 27 kg/m^2 examples of comorbidities were hypertension, diabetes mellitus, impaired glucose tolerance, dyslipidemia, and sleep apnea, and coronary heart disease and these items were listed in a Note; a Note was added to clarify that baseline refers to baseline prior to Qsymia. The criterion that the patient is currently engaged in behavioral modification and on a reduced calorie diet

		was modified to state that "the medication will be used concomitantly with behavioral modification and a reduced-calorie diet." Patient is Continuing Therapy. The criterion requiring that the patient currently has a body mass index (BMI) ≥ 30 kg/m^2 or ≥ 27 kg/m^2 for those with comorbidities besides obesity was modified as follows: this criterion was changed to "at baseline, the patient had a BMI ≥ 30 kg/m^2" OR that "at baseline, the patient had a BMI ≥ 27 kg/m^2 AND at baseline, the patient had, or currently has, at least ONE of the following weight-related comorbidities: hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, cardiovascular disease, knee osteoarthritis, asthma, chronic obstructive pulmonary disease, metabolic-dysfunction associated steatotic liver disease/non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery disease"; previously for a patient with BMI ≥ 27 kg/m^2 examples of comorbidities were hypertension, diabetes mellitus, impaired glucose tolerance, dyslipidemia, and sleep apnea, and coronary heart disease and these items were listed in a Note; a Note was added to clarify that baseline refers to baseline prior to Qsymia. The criterion that the patient is currently engaged in behavioral modification and on a reduced calorie diet was modified to state that "the medication will be used concomitantly with behavioral modification and a reduced-calorie diet." A Note was added to the criterion requiring that the patient has lost ≥ 5% of baseline body weight that baseline refers to baseline prior to Qsymia. • **Weight Loss, Pediatric.** Initial Therapy. The criterion requiring that the patient has engaged in a trial of behavioral modification and dietary restriction for at least 3 months was modified to remove that the patient has failed to limit weight gain or to modify comorbidities after this intervention. The criterion requiring that the patient currently has a body mass index (BMI) of ≥ 95th percentile for age and sex was modified to state that "at baseline", the patient had a BMI ≥ 95th percentile for age and sex and a Note was added to clarify that baseline refers to baseline prior to Qsymia. The criterion that

		the patient is currently engaged in behavioral modification and on a reduced calorie diet was modified to state that "the medication will be used concomitantly with behavioral modification and a reduced-calorie diet." Patient is Continuing Therapy. The criterion requiring that the patient currently has a body mass index (BMI) of ≥ 95th percentile for age and sex was modified to state that "at baseline", the patient had a BMI ≥ 95th percentile for age and sex and a Note was added to clarify that baseline refers to baseline prior to Qsymia. The criterion that the patient is currently engaged in behavioral modification and on a reduced calorie diet was modified to state that "the medication will be used concomitantly with behavioral modification and a reduced-calorie diet." The requirement that the patient had a reduction in BMI of ≥ 5% from baseline (prior to the initiation of Qsymia) was modified to remove "prior to initiation of Qsymia" and a Note was added that baseline refers to baseline prior to Qsymia. • Orlistat 102 mg (Xenical, authorized generic) • **Weight Loss, Adult.** Initial Therapy. The criterion requiring that the patient has engaged in a trial of behavioral modification and dietary restriction for at least 3 months was modified to remove that the patient has failed to achieve the desired weight loss after this intervention. The criterion requiring that the patient currently has a body mass index (BMI) ≥ 30 kg/m^2 or ≥ 27 kg/m^2 for those with comorbidities besides obesity was modified as follows: this criterion was changed to "at baseline, the patient had a BMI ≥ 30 kg/m^2" OR that "at baseline, the patient had a BMI ≥ 27 kg/m^2 AND at baseline, the patient had, or currently has, at least ONE of the following weight-related comorbidities: hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, cardiovascular disease, knee osteoarthritis, asthma, chronic obstructive pulmonary disease, metabolic-dysfunction associated steatotic liver disease/non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery disease"; previously for a patient with BMI ≥ 27 kg/m^2 examples of comorbidities were hypertension, diabetes mellitus,

		dyslipidemia, and sleep apnea, and coronary heart disease and these items were listed in a Note; a Note was added to clarify that baseline refers to baseline prior to orlistat 120 mg (Xenical, authorized generic). The criterion for a patient with an initial BMI ≥ 30 kg/m^2, or a BMI ≥ 27 kg/m^2 for those with comorbidities besides obesity if maintaining weight loss after using allow calorie diet was removed from the policy. The criterion that the patient is currently engaged in behavioral modification and on a reduced calorie diet was modified to state that "the medication will be used concomitantly with behavioral modification and a reduced-calorie diet." Patient is Continuing Therapy. The criterion requiring that the patient currently has a body mass index (BMI) ≥ 30 kg/m^2 or ≥ 27 kg/m^2 for those with comorbidities besides obesity was modified as follows: this criterion was changed to "at baseline, the patient had a BMI ≥ 30 kg/m^2" OR that "at baseline, the patient had a BMI ≥ 27 kg/m^2 AND at baseline, the patient had, or currently has, at least ONE of the following weight-related comorbidities: hypertension, type 2 diabetes, dyslipidemia, obstructive sleep apnea, cardiovascular disease, knee osteoarthritis, asthma, chronic obstructive pulmonary disease, metabolic-dysfunction associated steatotic liver disease/non-alcoholic fatty liver disease, polycystic ovarian syndrome, or coronary artery disease"; previously for a patient with BMI ≥ 27 kg/m^2 examples of comorbidities were hypertension, diabetes mellitus, impaired glucose tolerance, dyslipidemia, and sleep apnea, and coronary heart disease and these items were listed in a Note; a Note was added to clarify that baseline refers to baseline prior to orlistat 120 mg (Xenical, authorized generic). The criterion that the patient is currently engaged in behavioral modification and on a reduced calorie diet was modified to state that "the medication will be used concomitantly with behavioral modification and a reduced-calorie diet." A Note was added to the criterion requiring that the patient has lost ≥ 5% of baseline body weight to clarify that baseline refers to baseline prior to orlistat 120 mg (Xenical, authorized generic).

		• **<u>Weight Loss, Pediatric.</u>** <u>Initial Therapy</u>. The criterion requiring that the patient has engaged in a trial of behavioral modification and dietary restriction for at least 3 months was modified to remove that the patient has failed to limit weight gain or to modify comorbidities after this intervention. The criterion requiring that the patient currently has a body mass index (BMI) of ≥ 95th percentile for age and sex was modified to state that "at baseline", the patient had a BMI ≥ 95th percentile for age and sex and a Note was added to clarify that baseline refers to baseline prior a Note was added to clarify that baseline refers to baseline prior to orlistat 120 mg (Xenical, authorized generic). The criterion that the patient is currently engaged in behavioral modification and on a reduced calorie diet was modified to state that "the medication will be used concomitantly with behavioral modification and a reduced-calorie diet." <u>Patient is Continuing Therapy</u>. The criterion requiring that the patient currently has a body mass index (BMI) of ≥ 95th percentile for age and sex was modified to state that "at baseline", the patient had a BMI ≥ 95th percentile for age and sex and a Note was added to clarify that baseline refers to baseline prior a Note was added to clarify that baseline refers to baseline prior to orlistat 120 mg (Xenical, authorized generic). The criterion that the patient is currently engaged in behavioral modification and on a reduced calorie diet was modified to state that "the medication will be used concomitantly with behavioral modification and a reduced-calorie diet." The requirement that the patient had a reduction in BMI of ≥ 5% from baseline (prior to the initiation of Qsymia) was modified to remove "prior to initiation of Qsymia" and a Note was added to the criterion requiring that the patient has lost ≥ 5% of baseline body weight to clarify that baseline refers to baseline prior to orlistat 120 mg (Xenical, authorized generic).
Dermatology – Filsuvez - (IP0635)	Updated	**Effective: 4/15/2025** • No change in coverage

Dichlorphenamide - (IP0204)	Updated	• No change in coverage
Growth Disorders – Increlex - (IP0310)	Updated	• No change in coverage
Human Immunodeficiency Virus – Apretude - (IP0435)	Updated	**Effective: 4/15/2025** • No change in coverage • Updated CPT Coding: • Updated description of J0739
Hypoactive Sexual Desire Disorder – Addyi - (IP0116)	Updated	**Effective: 4/15/2025**
Hypoactive Sexual Desire Disorder – Vyleesi - (IP0117)	Updated	**Effective: 4/15/2025**
Muscular Dystrophy – Deflazacort - (IP0131)	Updated	**Effective: 4/15/2025** • No change in coverage
Muscular Dystrophy – Agamree - (IP0624)	Updated	**Effective: 4/15/2025**
Muscular Dystrophy – Vyondys 53 - (IP0136)	Updated	**Effective: 4/1/2025**
Nafarelin Acetate - (IP0415)	Updated	• No criteria change
Nephrology – Tarpeyo - (IP0413)	Updated	**Effective: 4/15/2025** • No change in coverage
Ophthalmology – Gene Therapy – Luxturna – (IP0162)	Updated	**Effective: 3/20/2025** • No criteria change.

Scenesse - (IP0159)	Updated	• No criteria change.
Tasimelteon - (IP0428)	Updated	**Effective: 4/15/2025** • No change in coverage
Drug and Biologic Medical Necessity (Injectables) – medical benefit - (2027)	Retired	**Effective: 4/15/2025**
Drug and Biologic Medical Necessity (Non-Injectables) – medical benefits - (2028)	Retired	**Effective: 4/15/2025**
Famotidine – (IP0010)	Retired	**Effective 4/1/2025**
Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy: Legacy Prescription Drug Lists - (PSM019)	Retired	**Effective 4/1/2025**
Insulins (Rapid-Acting) – (IP0065)	Retired	**Effective: 4/1/2025**
Tapinarof – (IP0497)	Retired	**Effective: 4/15/2025**
CareAllies Medical Necessity Guideline	**New, Updated, or Retired?**	**Comments**
		• All above Updates apply

Precertification Policy*	**New, Updated, or Retired?**	**Comments**
Precertification Policies	Updated	
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
DRG Readmission - (R35)	Updated	• Advance Notification: **Effective 07/01/2025**
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		• No Updates for April 2025
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**
Code Editing Policy and Guidelines	Updated	• On May 10, 2025, ClaimsXten will be updated to Second Quarter Knowledge Base content and NCCI Version 31.1 for all medical and behavioral claims we process.