Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective April 15, 2025 (unless otherwise noted)

Note – Log-in is needed for policy update 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
Amplitude-Modulated Radiofrequency Electromagnetic Fields Therapy – (0581)	Updated	• No change in coverage.
Balloon Sinus Ostial Dilation for Chronic Sinusitis and Eustachian Tube Dilation – (0480)	Updated	Important changes in coverage criteria/policy: • Added a header for adult specific criteria of Eustachian tube balloon dilation (ETBD) for clarity. • Revised policy statement to remove criteria for prior evaluation with nasal endoscopy from adult ETBD section. • Added policy statements/criteria for pediatric ETBD.
Blepharoplasty, Reconstructive Eyelid	Updated	No changes in coverage criteria/policy, changes for clarification:

Surgery, and Brow Lift - (0045)		• Clarification regarding light reflex requirement for photographs for upper eyelid reconstructive blepharoplasty to be consistent with same criterion under upper eyelid ptosis. • Add "photographs demonstrate" to the bullet point "findings consistent with visual field loss documented on visual field testing" to be consistent with bullets listed under blepharoplasty and ptosis repair.
Bone Mineral Density Measurement – (0300)	Updated	Minor change in coverage criteria/policy: • Reworded coverage policy statement for clarity and transparency.
Breast Reconstruction Following Mastectomy or Lumpectomy - (0178)	Updated	Important changes in coverage criteria/policy: • Revised policy statement for breast reconstruction following mastectomy or lumpectomy. • Removed policy statement for intraoperative assessment of tissue perfusion. • Revised policy statement for skin and soft tissue substitutes considered medically necessary. • Revised policy statement for skin and soft tissue substitutes considered experimental, investigational, or unproven. Added Essence Acellular Dermal Matrix to list of EIU products. • Removed policy statement for the use of adipose-derived stem cells in autologous fat transplantation and xenograft cartilage grafting. • Removed policy statement for subsequent surgical implantation of a new U.S. Food and Drug Administration (FDA)-approved breast implant. • Removed policy statement for external breast prostheses and mastectomy bras.
Liver and Liver Kidney Transplantation – (0355)	Updated	Important change in coverage criteria/policy: • Added policy statement for pediatric simultaneous liver-kidney transplantation (SLKT)
Otoplasty and External Ear Reconstruction – (0335)	Updated	**Posting date 4/15/2026, Effective date 7/15/2026** Important change in coverage criteria/policy: External ear reconstruction surgery: • Add photo documentation requirements for hearing devices, in addition to eyewear. • Add 'oblique' view as an acceptable photo option.

		• Clearly link medical necessity for all devices to the correction of an active condition by including the phrase 'current hearing or visual deficit' in the policy statement. • Clearly communicate that surgery is appropriate to support use of prescription lenses only by adding the word 'prescription' to describe eyewear. • Add 'cochlear implants' to policy statement as an appropriate reason for surgery. Otoplasy: For clarification, add the following examples of indications that apply to the not medically necessary for 'any' indication policy statement: • Psychological symptom treatment with no other indication. • Appearance improvement with no other indication. • Non-prescriptive sunglasses use.
Tissue-Engineered Skin Substitutes - (0068)	Updated	Important changes in coverage criteria/policy: • Removed Acuseal Cardiovascular Patch, Alloderm, AmnioMTM Injectable, AmnioPro Flow, Apligraf, BioDfactor™, BioDRestore flowable, BioNextPatch, CellerateRX®, Conexa™, Dermagraft, dermamatrix, Integra™ Bilayer Matrix Wound Dressing, Integra Dermal Regeneration Template, Integra Matrix, Neoform™ Dermis, Neox® Wound Matrix, NeuroMatrix™, NeuroMend Collagen Nerve Wrap, Nucel Bioactive Amniotic Suspension, Preclude Dura Substitute, RX Flow, Rx Membrane, SERI Surgical, Suprathel, TenoGlide, Transcyte, Veritas Collagen Matrix, Xceed™, Xenform Soft Tissue Repair Matrix (discontinued and/or no longer available or no longer managed) • Added Galaflex Lite to existing coverage statement • Added coverage for Avance nerve graft • Added the following products to EIU policy statement: A/C wrap, AMNIOCORD, Biolab membrane wrap flow, Biolab tri-membrane wrap flow, CTM Flow, CTM Thick, Curamatrix, Dermabind sl n or dermabind sl + or dermabind sl x, Essence Acellular Dermal Matrix, GrowFX Connective Tissue Matrix, Pretect, Revive ft, Renati ac membrane, Revival ac, Tutoplast® Pericardium Allograft/Tutoplast Processed Pericardium
Allergy Testing and Non-Pharmacologic Treatment - (0070)	Updated	• No change in coverage
Cardiac Ablation of Abnormal Electrical Rhythms - (0529)	Updated	• No change in coverage.

Category III Current Procedural Terminology (CPT®) Codes - (0558)	Updated	**Posted 1/15/2026, Effective 4/15/2026** • No change in coverage.
Drug-Eluting Devices for Use Following Endoscopic Sinus Surgery - (0481)	Updated	• No change in coverage.
Glaucoma Surgical Procedures - (0035)	Updated	• No change in coverage
Surgical Treatment for Chest Wall Deformities - (0309)	Updated	• No change in coverage.
Tumor In Vitro Chemosensitivity and Chemoresistance Assays - (0203)	Updated	• No change in coverage.
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
Acupuncture - (CPG024)	Updated	• No change in coverage.
Axial/Spinal Decompression Therapy/Mechanical Traction (Provided in a Clinic Setting) - (CPG275)	Updated	• No change in coverage.
Home Traction Devices - Cervical and Lumbar - (CPG265)	Updated	• No change in coverage.
eviCore Guidelines	**New, Updated,**	**Comments**

	or Retired?	
Cobranded Cigna-EviCore Guidelines	Updated	**Effective 3/14/2026** One guideline was updated with no clinically impactful changes: • Clinical Information to Establish Medical Necessity
Cobranded Cigna-EviCore Lab Management Guidelines	New / Updated	**Effective 4/10/2026** Seven new guidelines: • APOE Variant Analysis for Alzheimer Disease Testing • Carrier Screening Panels, Including Targeted, Pan-Ethnic, Universal, and Expanded (replaced Expanded Carrier Screening Panels guideline) • Duchenne and Becker Muscular Dystrophy Testing • Multiple Endocrine Neoplasia Type 1 Genetic Testing • Multiple Endocrine Neoplasia Type 2 Genetic Testing • Peutz-Jeghers Syndrome Genetic Testing Von Hippel-Lindau Disease Genetic Testing
Cobranded Cigna-EviCore Sleep Disordered Breathing Diagnosis and Treatment Guidelines	Updated	**Posted 1/30/2026, Effective 5/1/2026** Important changes in coverage criteria: • Numerous clinical changes will expand and limit coverage.
Cobranded Cigna-EviCore Vascular Intervention Guidelines	Updated	**Posted 12/26/2025; Effective 4/1/2026** Important **changes** in coverage criteria. Two guidelines were updated with clinical changes which will expand and limit coverage: • Cerebrovascular Intervention • Peripheral Vascular Intervention
Administrative Policy	**New, Updated, or Retired?**	**Comments**

Cigna Healthcare Medicare Advantage Coverage Policy Development and Application – (A018)	Retired	• **Effective April 1, 2026.**
Preventive Care Services – (A004)	Updated	Important changes in coverage criteria/policy: • Remove three-visit limitation language from genetic and nutritional counseling. • Remove nonspecific 'Health Promotion/Prevention of Illness or Injury Counseling' section of the policy. Associate preventive medicine counseling codes (99401-99404, 99411-99412) with more specific guideline supported section of the policy, as applicable. • Add precertification language to magnetic resonance imaging (MRI) breast screening. • Remove precertification language from CT colonography. Remove duplication of code 74263. • Add precertification language to preexposure prophylaxis (PrEP) medication code J0799 • Separate pathology and sedation codes into their own subsection within the 'Colonoscopy Screening Following Positive Results' section of the policy and associate them with designated wellness codes. • Add vaccine codes 90624, 90638, 90655, 90660, 90673 to the 'Routine Immunizations' section of the policy.
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Neurology - Aduhelm - (IP0200)	Retired	**Effective 4/15/2026**
Amyloidosis – Amvuttra (IP0478)	Updated	**Effective 4/15/2026** No criteria changes.
Barth Syndrome – Forzinity for Individual	New	**Effective 4/1/2026** New policy

and Family Plans - (IP0786)		
Brands with Bioequivalent Generics - (IP0011)	Update	**Effective 4/1/2026** **Removed for Employer Plans:** Daliresp
Cardiology – Cardamyst for Individual and Family Plans - (IP0783)	New	**Effective 4/1/2026** New policy
Chelating Agents – Iron Chelators (Oral) - (IP0271)	Updated	**Effective 4/1/2026** **Employer Plans and Individual and Family Plans Preferred Product Tables:** **Added** "[e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber," to Exjade, Ferriprox (500 mg and 1000 mg three times a day) Jadenu, Jadenu Sprinkles criteria**.** **Added** "may require prior authorization" to all products
Ciprofloxacin-fluocinolone for Individual and Family Plans - (IP0468)	Retired	**Effective 4/15/2026** **ciprofloxacin/fluocinolone otic solution and Otovel relocated to Pharmacy and Medical Prior Authorization (1407)**
Cystic Fibrosis – Bronchitol - (IP0126)	Updated	**Effective 4/1/2026** No criteria changes. **Added** a policy statement.
Cystic Fibrosis Transmembrane Conductance Regulator – Kalydeco - (IP0431)	Updated	**Effective 4/1/2026** **Updated** the documentation requirements to current standards. **Cystic Fibrosis.** The term "mutation" was replaced by "variant" for the following requirements: The patient has at least ONE of the following variants in the cystic fibrosis transmembrane conductance regulator gene that is considered pathogenic or likely pathogenic; and the patient has evidence of abnormal cystic fibrosis transmembrane conductance regulator function as demonstrated by two cystic fibrosis-causing cystic fibrosis transmembrane conductance regulator variants.

		Conditions Not Recommended for Approval **Cystic Fibrosis, Patient Homozygous for the *F508del* Variant in the Cystic Fibrosis Transmembrane Conductance Regulator Gene.** The term "mutation" was replaced by "variant" in this condition not recommended for approval. **Cystic Fibrosis, Patient with Unknown Cystic Fibrosis Transmembrane Conductance Regulator Gene Variant.** The term "mutation" was replaced by "variant" in this condition not recommended for approval.
Cystic Fibrosis Transmembrane Conductance Regulator – Symdeko - (IP0433)	Updated	**Effective 4/1/2026** **Updated** the documentation requirements to current standards. **Cystic Fibrosis.** The term "mutation" was replaced by "variant" for the following requirements: The patient has at least ONE of the following variants in the cystic fibrosis transmembrane conductance regulator gene that is considered pathogenic or likely pathogenic; the patient has TWO copies of the *F508del* variant; and the patient has evidence of abnormal cystic fibrosis transmembrane conductance regulator function as demonstrated by two cystic fibrosis-causing cystic fibrosis transmembrane conductance regulator variants. **Conditions Not Recommended for Approval** **Cystic Fibrosis, Patient with Unknown Cystic Fibrosis Transmembrane Conductance Regulator Gene Variant.** The term "mutation" was replaced by "variant" in this condition not recommended for approval.
Dermatology – Vtama Drug Quantity Management Policy – Per Days - (DQM024)	New	**Effective 4/1/2026** New policy.
Diabetes – Glucagon-Like Peptide-1 Agonists for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (IP0701)	Updated	**Effective 4/1/2026** Adlyxin was removed from the policy (obsolete). **Conditions Not Covered.** Updated the Weight Loss Treatment statement.

Diabetes – Glucagon-Like Peptide-1 Agonists for Individual and Family Plans - (IP0702)	Updated	**Effective 4/1/2026** **Conditions Not Covered.** Updated the Weight Loss Treatment statement.
Dronabinol Products - (IP0719)	Updated	**Effective 4/15/2026** No criteria changes.
Drugs Requiring Medical Necessity Review for Employer Plans (1602)	Updated	**Effective 4/1/2026** **Added preferred product requirement criteria for the following products:** Fycompa oral suspension (effective 4/15/2026), Auvi-Q, epinephrine auto-injector authorized generic, EpiPen, EpiPen Jr, Symjepi, Premarin tablets (effective 4/15/2026), pyridostigmine 30 mg tablets, potassium chloride 40 mEq powder for solution, and Renthyroid **Updated preferred product step requirement for the following products:** Novolog Mix 70/30 FlexPen and vials, Soaanz, TobraDex ST, and Zylet **Removed preferred product requirement criteria for the following product:** Rayos
Drugs Requiring Medical Necessity Review for Employer Plans (1602)	Updated	**Effective 4/15/2026** **Added preferred product requirement criteria for the following products:** Javadin (effective 5/1/2026), Nuzyra (effective 5/1/2026), Subvenite oral suspension (effective 5/1/2026), insulin aspart protamine/insulin aspart Flexpen and vial, Lynkuet, Vyscoxa, tobramycin 0.3%/loteprednol etabonate 0.5% ophthalmic suspension (effective 5/1/2026), and Pokonza solution (effective 5/1/2026) **Updated preferred product requirement criteria for the following products:** Seysara (effective 5/1/2026), Veozah, and Gemtesa (effective 5/1/2026)
Epinephrine Injection (Self-Administered) (IP0385)	Retired	**Effective 4/1/2026** Auvi-Q, epinephrine auto-injector authorized generic, EpiPen, EpiPen Jr, and Symjepi relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602)]
Familial Chylomicronemia Syndrome – Tryngolza (IP0733)	Updated	**Effective 4/1/2026** **Familial Chylomicronemia Syndrome.** The requirement for a patient to be diagnosed by biallelic pathogenic variants, inconclusive genetic test results, or a clinical diagnosis was modified to state at least one of the following. The requirement for a fasting triglyceride level ≥ 880 mg/dL at baseline for a clinical diagnosis was removed, along

		with the corresponding Note. The requirement for recurrent episodes of pancreatitis was modified to state a history of acute pancreatitis. The clinical diagnosis was modified to require one of a history of acute pancreatitis not caused by alcohol or cholelithiasis or history of recurrent hospitalizations for severe abdominal pain without other explainable cause and not both. Lipidologist was added to the specialist requirement.
Graft-Versus-Host Disease – Ryoncil (IP0732)	Updated	**Effective 4/1/2026** No criteria changes.
Hematology – Enjaymo – (IP0405)	Updated	**Effective 4/15/2026** **Added** the following note to provide examples of signs and symptoms associated with cold agglutinin disease. "Note: Examples include symptomatic anemia (e.g., anemia associated with fatigue, weakness, shortness of breath, heart palpitations, lightheadedness, chest pain), acrocyanosis, Raynaud's syndrome, hemoglobinuria, disabling circulatory symptoms, or a major adverse vascular event (e.g., thrombosis)." **Added** the following note to provide examples of secondary causes of cold agglutinin syndrome. "Note: Examples of secondary causes of cold agglutinin syndrome include infection, rheumatologic diseases, and active hematologic malignancies.". **Dosing:** Updated dosing from "Weight of 39 kg to less than 75 kg" to "Patient weighs < 75 kg" ○ **Conditions Not Covered:** Removed Paroxysmal Cold Hemoglobinuria.
Hematoloty – Reblozyl (IP0115)	Updated	**Effective 4/1/2026** **Documentation Instructions.** **Updated from** "Documentation is required where noted in the criteria. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information **to** "Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, prescription receipts and/or other information. All documentation must include patient-specific identifying information" **Transfusion Dependent Beta-Thalassemia:** For Initial Therapy, the duration of approval was changed to 6 months; previously, it was 4 months. For Initial Therapy and for a Patient Currently Receiving Reblozyl, a requirement was added that the patient is not currently receiving Aqvesme (mitapivat tablets).

		Myelodysplastic Syndrome: For initial therapy, the requirement was removed that the patient has ring sideroblast positivity or the patient has a serum erythropoietin level ≤ 500 mU/mL. The requirement was removed that the patient currently requires blood transfusions, defined as at least two red blood cell units over the previous 8 weeks. The requirement that the pretreatment hemoglobin level is < 10.0 g/dL was changed to according to the prescriber, the patient has symptomatic anemia. Updated authorization duration for continuing therapy with Rebozyl from 6 months to 1 year. **Myelodysplastic/Myeloproliferative Neoplasm:** The requirements were removed that the patient has ring sideroblast positivity and thrombocytosis defined as a platelet count ≥ 450 x 10^9/L. Also, the following requirements were removed: patient does not have a confirmed mutation with deletion 5q[del(5q)]; patient currently requires blood transfusions transfusions, defined as at least two red blood cell units over the previous 8 weeks; and Reblozyl will not be used in combination with an erythropoiesis stimulating agent. The requirement that the pretreatment hemoglobin level is < 10.0 g/dL was changed to according to the prescriber, the patient has anemia. **Myelofibrosis:** This was added as a new condition of approval. Dosing for this indication was also added.
Hematology – Ryplazim - (IP0382)	Updated	**Effective 4/15/2026** **Patient is Currently Receiving Ryplazim:** Added criteria to include ONE of the following: clinical response to Ryplazim, as determined by the prescriber, and a note with examples of clinical response; OR a trough plasminogen activity level ≥ 10% (absolute change in plasminogen activity) above the baseline trough level (prior to initiating Ryplazim). Added prescribed by or in consultation with a hematologist.
Hematology – Rytelo (IP0692)	Updated	**Effective 4/1/2026** **Myelodysplastic Syndrome:** For initial, therapy the following requirements were removed: patient has transfusion-dependent anemia, defined as requiring transfusion of ≥ 4 red blood cell units over an 8-week period, and according to the prescriber, patient has not responded, lost response to, or is ineligible for erythropoiesis-stimulating agents along with the note of examples of erythropoiesis-stimulating agents. The following requirements were added: Patient does not have a confirmed mutation with deletion 5q [del(5q)], and according to the prescriber, the patient has symptomatic anemia **[documentation required]**. **Preferred Product Table.** **Removed** "Patient has tried lenalidomide" for Employer Plans and Individual and Family Plans

Hemophilia – Gene Therapy – Beqvez (IP0648)	Retired	**Effective 4/15/2026**
Hemophilia – Gene Therapy – Hemgenix (IP0535)	Updated	**Effective 4/15/2026** No criteria changes. ○
HIV Products (P0050)	Updated	**Effective 4/1/2026** **Removed** abacavir, abacavir-lamivudine, efavirenz, fosamprenavir calcium, lamivudine, maraviroc, nevirapine, tenofovir disoproxil fumarate from the policy.
Homozygous Familial Hypercholesterolemia – Evkeeza (IP0128)	Updated	**Effective 4/15/2026** No criteria changes.
Hyaluronic Acid Derivatives (Intraarticular) (IP0322)	Updated	**Effective 4/1/2026** **Osteoarthritis of the Knee: Patient has Already Received One or More Courses of Therapy With a Hyaluronic Acid Derivative (Intraarticular) in the Same Knee: Added** "Preferred product criteria are met for the product(s) as listed in the below table(s)."
Hydroxyprogesterone Caproate (IP0370)	Retired	**Effective 4/15/2026** •
Hypoactive Sexual Desire Disorder – Addyi (IP0116)	Updated	**Effective 4/1/2026** For both initial and continuation criteria, the criterion related to premenopausal women was removed. Added a criterion that the patient is < 65 years of age. Removed the condition not recommended for approval related to postmenopausal women.
Hypoactive Sexual Desire Disorder – Vyleesi (IP0117)	Updated	**Effective 4/1/2026** No criteria changes.
Immune Globulin (5026)	Updated	**Effective 4/1/2026** **Added** Yimmugo® to the policy along with preferred product criteria for Employer Plans and Individual and Family Plans. **Coding Information**

		Removed HCPCS E0779 & E0781 **Added** HCPCS J1553 with an effective date of 4/1/2026. · Removed the effective date of 1/1/2025 from HCPCS J1552.
Inflammatory Conditions – Cibinqo Prior Authorization Policy - (IP0677)	Updated	**Effective 4/1/2026** No criteria changes.
Inflammatory Conditions – Cosentyx Subcutaneous Drug Quantity Management Policy – Per Days - (DQM002)	Updated	**Effective 4/1/2026** **Cosentyx 150mg/ml – 2 pack (300mg dose) prefilled syringe or SensoReady pen:** This product and criteria were clarified and 150mg/ml products broken into individual lines in the Drug Quantity Limits table for the prefilled syringe 2-pack and Sensoready pen 2-pack that it is two 150 mg/mL prefilled syringes/SensoReady pens per carton to equal a 300mg dose. **Cosentyx 300 mg UnoReady pens and Cosentyx 150 mg prefilled syringes or SensoReady pens:** Criteria were updated to approve an additional quantity for a patient with hidradenitis suppurativa who has tried a dose of 300 mg once every 4 weeks and, according to the prescriber, requires a dose of 300 mg once every 2 weeks. Previously, criteria approved an additional quantity if a patient with hidradenitis suppurativa required a dose of 300 mg once every 2 weeks.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy: Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists - (PSM013)	Updated	**Effective 4/15/2026** **Appendix A.** **Non-Adalimumab Preferred Products:** For psoriatic arthritis, psoriasis, Crohn's disease, and ulcerative colitis, Imuldosa subcutaneous (NDCs starting with 69448) was added as a Preferred Ustekinumab SC product. **Amjevita (NDCs starting with 55513):** Added to the policy as a Non-Preferred Step 3 product with the same exception criteria as the other Non-Preferred Step 3 adalimumab products.
Oxandrolone (IP0496)	Retired	**Effective 4/15/2026**
Inflammatory Conditions – Adalimumab Products	Updated	**Effective 4/15/2026** **Appendix A.** **Non-Adalimumab Preferred Products:**

Preferred Specialty Management Policy for Individual and Family Plans - (PSM014)		For psoriatic arthritis, psoriasis, Crohn's disease, and ulcerative colitis, Imuldosa subcutaneous (NDCs starting with 69448) was added as a Preferred Ustekinumab SC product. • **Amjevita (NDCs starting with 55513):** Added to the policy as a Non-Preferred Step 3 product with the same exception criteria as the other Non-Preferred Step 3 adalimumab products
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Legacy Drug List Plans - (PSM003)	Updated	**Effective 4/15/2026** **Appendix A.** **Non-Adalimumab Preferred Products:** For psoriatic arthritis, psoriasis, Crohn's disease, and ulcerative colitis, Imuldosa subcutaneous (NDCs starting with 69448) was added as a Preferred Ustekinumab SC product. • **Amjevita (NDCs starting with 55513):** Added to the policy as a Non-Preferred Step 3 product with the same exception criteria as the other Non-Preferred Step 3 adalimumab products
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists Plans - (PSM009)	Updated	**Effective 4/15/2026** **For Psoriatic Arthritis:** Imuldosa subcutaneous (NDCs starting with 69448) was added as a Preferred ustekinumab subcutaneous product.
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Legacy	Updated	**Effective 4/15/2026** • **For Psoriatic Arthritis:** Imuldosa subcutaneous (NDCs starting with 69448) was added as a Preferred ustekinumab subcutaneous product.

Prescription Drug Lists Plans - (PSM016)		
Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy for Individual and Family Plan Prescription Drug Lists - (PSM011)	Updated	**Effective 4/15/2026** **For Crohn's Disease and Ulcerative Colitis:** Imuldosa intravenous (NDCs starting with 69448) was added as a Preferred ustekinumab intravenous product.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists - (PSM006)	Updated	**Effective 4/15/2026** **For Psoriatic Arthritis:** Imuldosa subcutaneous (NDCs starting with 69448) was added as a Preferred ustekinumab subcutaneous product.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Individual and Family Plans - (PSM010)	Updated	**Effective 4/15/2026** ○ **For Psoriatic Arthritis:** Imuldosa subcutaneous (NDCs starting with 69448) was added as a Preferred ustekinumab subcutaneous product.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Legacy	Updated	**Effective 4/15/2026** **For Psoriatic Arthritis:** Imuldosa subcutaneous (NDCs starting with 69448) was added as a Preferred ustekinumab subcutaneous product.

Prescription Drug Lists - (PSM018)		
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists - (PSM001)	Updated	**Effective 4/15/2026** For **Psoriatic Arthritis, Plaque Psoriasis, Crohn's Disease,** and **Ulcerative Colitis,** Imuldosa subcutaneous (SC) (NDCs starting with 69448) was added as a Preferred ustekinumab SC product. The criteria for the following Non-Preferred Products were updated to include Imuldosa SC as a Preferred product: Cimzia, Simponi SC, Bimzelx, Cosentyx SC, Siliq, Ilumya, Entyvio SC, Orencia SC, Rinvoq, Rinvoq LQ, and Xeljanz/XR.
Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)	Updated	**Effective 4/15/2026** For **Psoriatic Arthritis, Plaque Psoriasis, Crohn's Disease,** and **Ulcerative Colitis,** Imuldosa subcutaneous (SC) (NDCs starting with 69448) was added as a Preferred ustekinumab SC product. The criteria for the following Non-Preferred Products were updated to include Imuldosa SC as a Preferred product: Cimzia, Simponi SC, Bimzelx, Siliq, Ilumya, Entyvio SC, Omvoh SC, Orencia SC, Rinvoq, Rinvoq LQ, Xeljanz/XR, Taltz and Velsipity.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Legacy Prescription Drug Lists - (PSM017)	Updated	**Effective 4/15/2026** • For **Psoriatic Arthritis, Plaque Psoriasis, Crohn's Disease,** and **Ulcerative Colitis,** Imuldosa subcutaneous (SC) (NDCs starting with 69448) was added as a Preferred ustekinumab SC product. The criteria for the following Non-Preferred Products were updated to include Imuldosa SC as a Preferred product: Cimzia, Simponi SC, Bimzelx, Cosentyx SC, Siliq, Ilumya, Entyvio SC, Orencia SC, Rinvoq, Rinvoq LQ, and Xeljanz/XR.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Standard/Performance, Value/Advantage, and	Updated	**Effective 4/15/2026** **Imuldosa SC (NDCs starting with 69448):** Moved from a Step 3 Non-Preferred Product to a Step 1 Preferred Ustekinumab Product.

Total Savings Prescription Drug Lists - (PSM021)		
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Legacy Prescription Drug List Plans - (PSM022)	Updated	**Effective 4/15/2026** **Imuldosa SC (NDCs starting with 69448):** Moved from a Step 3 Non-Preferred Product to a Step 1 Preferred Ustekinumab Product.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Individual and Family Plans - (PSM023)	Updated	**Effective 4/15/2026** **Imuldosa SC (NDCs starting with 69448):** Moved from a Step 3 Non-Preferred Product to a Step 1 Preferred Ustekinumab Product.
Inflammatory Conditions – Ustekinumab Intravenous Products Preferred Specialty Management Policy - (PSM024)	Updated	**Effective 4/15/2026** **Imuldosa intravenous (NDCs starting with 69448):** Moved from a Non-Preferred Product to a Preferred Ustekinumab Product. **Ustekinumab-ttwe intravenous** was removed from the policy. •
Iron Replacement – Ferumoxytol (IP0750)	Updated	**Effective 4/1/2026** The name of the policy was changed to as listed from Iron Replacement – Feraheme. Throughout the policy, reference to "Feraheme" was changed to "ferumoxytol".
Iron Replacement – Injectafer (IP0748)	Updated	**Effective 4/1/2026** • No criteria changes.

Iron Replacement – Monoferric (IP0749)	Updated	**Effective 4/1/2026** No criteria changes.
LymePak (IP0352)	Retired	**Effective 4/15/2026** Product voluntarily withdrawn by the manufacturer in 2023.
Methotrexate Injection Step Therapy Standard / Performance Drug List Plans (ST0001)	Updated	**Effective 4/15/2026** No criteria changes.
Muscular Dystrophy – Amondys 45 (IP0137)	Updated	**Effective 4/15/2026** ○ No criteria changes.
Muscular Dystrophy – Exondys (IP0135)	Updated	**Effective 4/15/2026** No criteria changes.
Migraine – Nurtec ODT (IP0147)	Updated	**Effective 4/15/2026** **Preventive Treatment of Episodic Migraine.** Existing requirements were reformatted into separate sets of requirements for Initial Therapy and Continuation of Therapy.
Migraine – Qulipta (IP0377)	Updated	**Effective 4/15/2026** **Migraine Headache Prevention.** Existing requirements were reformatted into separate sets of requirements for Initial Therapy and Continuation of Therapy.
Migraine – Ubrelvy (IP0148)	Updated	**Effective 4/15/2026** No criteria changes.
Multiple Sclerosis (Oral - Other)– Teriflunomide for Employer Plans: Standard/ Performance, Value/Advantage, Legacy, Total Savings	Updated	**Effective 4/1/2026** **Updated** the preferred product requirement. In the Appendix, it was noted that Mavenclad is available as a generic. Also, Tysabri and Tyruko are now cited in the Appendix as follows: Natalizumab Intravenous Products (Tysabri, biosimilar).

Prescription Drug Lists - (IP0252)		
Multiple Sclerosis (Oral – Other) - Teriflunomide for Individual and Family Plans - (IP0560)	Updated	**Effective 4/1/2026** **Updated** the preferred product requirement. In the Appendix, it was noted that Mavenclad is available as a generic. Also, Tysabri and Tyruko are now cited in the Appendix as follows: Natalizumab Intravenous Products (Tysabri, biosimilar).
Muscular Dystrophy – Agamree - (IP0624)	Updated	**Effective 4/1/2026** **Added** a policy statement. **Updated** the Conditions Not Covered statement.
Muscular Dystrophy – Deflazacort - (IP0131)	Updated	**Effective 4/1/2026** Jaythari oral suspension was added to the policy. No criteria changes. Emflaza oral suspension preferred product requirements updated with the addition of Jaythari oral suspension as a preferred product alternative option.
Multiple Sclerosis (Oral – Other) – Cladribine (IP0261)	Update	**Effective 4/15/2026** **Updated** the policy statement. ○ **Added** preferred product requirements, requiring a step through the generic, for Mavenclad on Employer Plans.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy for Legacy Prescription Drug List Plans - (PSM004)	Update	**Effective 4/15/2026** **Ulcerative Colitis:** Imuldosa subcutaneous (NDCs starting with 69448) was added to the policy as a Preferred ustekinumab subcutaneous product.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred	Update	**Effective 4/15/2026** **Ulcerative Colitis:** Imuldosa subcutaneous (NDCs starting with 69448) was added to the policy as a Preferred ustekinumab subcutaneous product.

Specialty Management Policy for Individual and Family Plans - (PSM008)		
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy: Standard/Performance, Value/Advantage, Total Savings Prescription Drug List Plans - (PSM015)	Update	**Effective 4/15/2026** • **Ulcerative Colitis:** Imuldosa subcutaneous (NDCs starting with 69448) was added to the policy as a Preferred ustekinumab subcutaneous product.
Nephrology – Jesduvroq (IP0604)	Update	**Effective 4/15/2026** • **Updated** policy template
Neurology – Oxybate Products (IP0103)	Update	**Effective 4/1/2026** Update to clarify step therapy requirements for Xyrem, allowing stepping through sodium oxybate products more broadly rather than limiting to a specific generic or manufacturer. • Removed the Amneal product from the preferred product criteria box table in acknowledgement of its authorized generic status transitioning to a true generic.
Neurology - Tonmya (IP0795)	New	**Effective 4/15/2026** • New policy.
Oncology (Injectable – CAR-T) – Abecma (IP0168)	Updated	**Effective 4/15/2026** No criteria changes.

Oncology (Injectable – CAR-T) – Carvykti (IP0414)	Updated	**Effective 4/15/2026** ○ No criteria changes.
Oncology (Injectable – CAR-T) – Kymriah (IP0197)	Updated	**Effective 4/15/2026** ○ No criteria changes.
Oncology (Injectable – CAR-T) – Yescarta (IP0198)	Updated	**Effective 4/15/2026** No criteria changes.
Oncology Medications - (1403)	Updated	**Effective 4/1/2026** **Beizray.** **Added** criteria for Beizray **Keytruda IV.** **Updated from** "Patient has been started on Keytruda; Patient meets **ALL** of the following: Patient has recurrent, unresectable, oligometastatic, or metastatic disease; The medication is used in combination with cisplatin and gemcitabine; According to the prescriber, the patient has inadequate efficacy, contraindication, or significant intolerance to **Loqtorzi (toripalimab intravenous infusion)** [may require prior authorization]; Patient meets **ALL** of the following: Patient has recurrent, unresectable, oligometastatic, or metastatic disease; Tumor is tumor mutational burden-high (TMB-H) [≥ 10 mutations/megabase]; Medication is used for subsequent therapy; Patient meets **ALL** of the following: Patient has recurrent or metastatic disease; AND Tumor is programmed death-ligand 1 positive (combined positive score [CPS] ≥ 1)" to "According to the prescriber, the patient has tried, and has had inadequate efficacy or significant intolerance or patient has a contraindication to Loqtorzi;; OR Patient has been started on Keytruda IV or Keytruda Qlex; OR Patient has a diagnosis of head and neck squamous cell carcinoma other than nasopharyngeal carcinoma" **Keytruda Qlex.** **Added** criteria for Keytruda Qlex **Revlimid.** **Added** documentation requirements. **Zykadia.** **Removed** criteria for Zykadia for Individual and Family Plans

		Effective 4/15/2026 **Gleostine.** **Added** criteria for Gleostine for Employer Plans
Ophthalmology – Dry Eye Disease Cyclosporine Ophthalmic Products (IP0026)	Updated	**Effective 4/1/2026** **Removed** Cequa (cyclosporine 0.09% ophthalmic solution) from the policy. **Updated** the Individual and Family Plans Vevye preferred product requirements.
Ophthalmology – Dry Eye Disease – Miebo For Individual and Family Plans (IP0583)	Retired	**Effective 4/1/2026**
Ophthalmology – Dry Eye Disease – Tryptyr (IP0760)	Retired	**Effective 4/1/2026**
Ophthalmology – Dry Eye Disease – Tyrvaya for Individual and Family Plans (IP0395)	Retired	**Effective 4/1/2026**
Ophthalmology – Dry Eye Disease – Xiidra for Individual and Family Plans (IP0644)	Retired	**Effective 4/1/2026**
Ophthalmology – iDose TR - (IP0619)	Updated	**Effective 4/1/2026** **Policy Statement:** Approval duration was changed from 1 month (30 days) to 3 months (90 days). **Ocular Hypertension.** The statement "Approve for a one-time use in each treated eye (i.e., one implant per treated eye; a total of two implants per patient)" was changed to "Approve one implant per affected eye(s)". The requirement that patient is not receiving retreatment of eyes previously treated with iDose TR was removed. **Open-Angle Glaucoma.** The statement "Approve for a one-time use in each treated eye (i.e., one implant per treated eye; a total of two implants per patient)" was changed to

		"Approve one implant per affected eye(s)". The requirement that patient is not receiving retreatment of eyes previously treated with iDose TR was removed. **Conditions Not Recommended for Approval.** The condition "Retreatment of previously treated eye(s)" was revised to "Retreatment of previously treated eye(s) within the past 1 year".
Ophthalmology – Gene Therapy – Luxturna (IP0160)	Updated	**Effective 3/26/2026** **Policy Statement:** Approval duration was changed from 1 month (30 days) to 3 months (90 days) to allow adequate time for prescribers and patients to schedule implant procedure. **Biallelic Human Retinal Pigment Epithelial 65 kDa Protein (*RPE65*) Variant-Associated Retinal Dystrophy:** "Variant" is used in place of "mutation". For the requirement that patient has a genetically confirmed diagnosis, the word "variant" replaced the word "mutation". Added a requirement that if all of the other requirements are met, one dose of Luxturna per eye will be approved. Added a Note that the doses for the first and second eye are separated by at least 6 days.
Ophthalmology – Xipere (IP0371)	Updated	**Effective 4/15/2026** ○ No criteria changes.
Ophthalmology – Verkazia (IP0439)	Updated	**Effective 4/15/2026** **Vernal Keratoconjectivitis.** **Added** "Note: If the patient has tried an over-the-counter product in one of the categories above, this would count toward a trial. ○ **Removed** preferred product criteria
Papillomatosis-Papzimeos - (IP0765)	Update	**Effective 4/1/2026** **Policy Title:** **Removed** "Gene Therapy" from the policy title. • No criteria changes.
Parkinson's Disease – Carbidopa (IP0523)	Updated	**Effective 4/15/2026** • No criteria changes

Parkinson's Disease – Carbidopa-Levodopa (Oral) Step Therapy Policy for Employer Plans (ST006)	New	**Effective 4/15/2026** • New policy.
Pharmacy and Medical Prior Authorization (1407)	Update	**Effective 4/15/2026** **Added Individual and Family Plan product-specific medical necessity criteria for the following products:** Cleocin Pediatric, cefixime 400mg tablets, Nuzyra (effective 5/1/2026) perampanel oral suspension, prednisone delayed-release tablets, ranitidine tablets, ciprofloxacin/hydrocortisone 0.2%/1% otic suspension, besifloxacin 0.6% ophthalmic suspension, potassium chloride 40 mEq powder for solution, Ecoza foam, Exelderm cream and solution, luliconazole 1% cream, Luzu, Naftin 1% gel, Oxistat cream and lotion, Xolegel, topiramate extended-release capsules, Soaanz, Zylet, ciprofloxacin and fluocinolone otic solution, Otovel, Hemangeol, Auvi-Q, epinephrine auto-injector authorized generic, EpiPen, EpiPen Jr., Symjepi, dihydroergotamine 4 mg/mL nasal spray, Migranal, pyridostigmine 30 mg tablet, Besivance, TobraDex, TobraDex ST, and Cipro HC Otic Suspension **Updated Individual and Family Plan product-specific medical necessity criteria for the following products:** econazole nitrate topical foam, sulconazole nitrate 1% cream and solution, Aptiom, eslicarbazepine tablets, Fycompa oral suspension and tablets, perampanel tablets, Trulance, and umeclidinium/vilanterol inhalation powder (generic of Anoro Ellipta) **Removed Individual and Family Plan product-specific medical necessity criteria:** Tonmya
Psychiatry – Novel Psychotropics Drug Quantity Management Policy – Per Days (DQM022)	New	**Effective 4/1/2026** New policy
Pulmonary - Antifibrotics Jascayd for Individual and Family Plans - (IP0772)	Update	**Effective 4/1/2026** The policy name was changed to Pulmonary – Antifibrotics – Jascayd. Previously, it was Idiopathic Pulmonary Fibrosis and Related Lung Disease – Jascayd PA policy.

		Progressive Pulmonary Fibrosis. This condition of approval was added to the policy. A Note of examples of conditions was provided and includes hypersensitivity pneumonitis; idiopathic non-specific interstitial pneumonitis; unclassifiable idiopathic interstitial pneumonia; autoimmune interstitial lung disease (e.g., rheumatoid arthritis interstitial lung disease); exposure-related interstitial lung disease; and mixed connective tissue disease interstitial lung disease. This condition for approval includes both Initial therapy and patients currently receiving Jascayd. A Note was added to clarify that patients initiating therapy with Jascayd could be on concomitant Ofev (nerandomilast tablets). The requirements for initial therapy are as follows: patient is ≥ 18 years of age; forced vital capacity is ≥ 40% of the predicted value; according to the prescriber, patient has fibrosing lung disease impacting more than 10% of lung volume on high-resolution computed tomography; according to the prescriber, patient has clinical signs of progression; and the medication was prescribed by or in consultation with a pulmonologist. A Note of examples of clinical signs of progression was included and lists a forced vital capacity decline ≥ 10% of the predicted value or forced vital capacity ≥5% to <10% with worsening symptoms and/or worsening imaging. The requirements for patients currently receiving Jascayd are as follows: patient is ≥ 18 years of age; patient has experienced a beneficial response to therapy over the last year while receiving Jascayd; and the medication is prescribed by or in consultation with a pulmonologist. A Note of examples of a beneficial response to therapy includes a reduction in the anticipated decline in forced vital capacity, six-minute walk distance, and/or in the number or severity of interstitial lung disease-related exacerbations.
Pulmonary - Antifibrotics - Jascayd (IP0772)	Update	**Effective 4/15/2026** **Updated** the policy title from "Pulmonary - Antifibrotics Jascayd for Individual and Family Plans" to "Pulmonary - Antifibrotics Jascayd" **Added** Employer Plans preferred product requirements requiring a step through either pirfenidone or Ofev for a diagnosis of Idiopathic Pulmonary Fibrosis and a step through Ofev for a diagnosis of Progressive Pulmonary Fibrosis. **Clarified** the Individual and Family Plans preferred product requirements only apply to a diagnosis of Idiopathic Pulmonary Fibrosis.
Pulmonary – Roflumilast (IP0609)	Update	**Effective 4/1/2026** **Policy Title:** **Updated from** "Pulmonary – Roflumilast for Individual and Family Plans" **to** "Pulmonary – Roflumilast." **Chronic Obstructive Pulmonary Disease (COPD)** **Moved** criteria for if brand Daliresp is requested to the preferred product requirement criteria table.

		Preferred Product Table: **Employer Plans** **Added** preferred product step requirement for Employer Plans **Individual and Family Plans:** **Updated from** "Trial of roflumilast tablets (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction" **to** "Patient has tried the bioequivalent generic product. roflumilast tablets (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which would result, per the prescriber in a significant allergy or serious adverse reaction." **Appendix** was updated to reflect the availability of authorized generics to Arnuity Ellipta, Flovent Diskus, Flovent HFA, Breo Ellipta, and Anoro Ellipta.
Pyridostigmine (IP0544)	Retired	**Effective 4/1/2026** Pyridostigmine 30 mg tablets relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602)]
Quantity Limitations (1201)	Update	**Effective 4/1/2026** **Removed** Vtama and relocated to a new policy, *Dermatology – Vtama Drug Quantity Management Policy – Per Days (DQM024).*
Sickle Cell Disease – Adakveo (IP0120)	Update	**Effective 4/15/2026** • No criteria changes.
Somatostatin Analogs – Lanreotide Products (IP0323)	Updated	**Effective 4/1/2026** **Preferred Product Table.** • **Updated from** "Patient meets **BOTH** of the following:Patient has tried Somatuline Depot or lanreotide acetate (Cipla USA Inc. packager, J1930 or NDC 69097-**0906**-67); AND Patient cannot continue to use the Preferred medication due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] which, according to the prescriber, would result in a significant allergy or serious adverse reaction" **to** "Patient meets ONE of the following: For Acromegaly, patient has tried one of octreotide ER injectable suspension (Sandostatin

		LAR Depot, generics), Somatuline Depot or lanreotide acetate (generic) Note: If requesting a Cipla lanreotide product, the preferred product is J1930, NDC 69097-0906-67; For Neuroendocrine Tumor(s) [NETs] of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas (including glucagonomas, gastrinomas, vasoactive intestinal peptides-secreting tumors [VIPomas], insulinomas), the following has been met: Patient has tried one of octreotide ER injectable suspension (Sandostatin LAR Depot, generics), Somatuline Depot or lanreotide acetate (generic) Note: If requesting a Cipla lanreotide product, the preferred product is J1930, NDC 69097-0906-67; For Pheochromoctoma/paraganglioma, patient has tried one of octreotide ER injectable suspension (Sandostatin LAR Depot, generics), Somatuline Depot or lanreotide acetate (generic). Note: If requesting a Cipla lanreotide product, the preferred product is J1930, NDC 69097-0906-67; For Carcinoid syndrome; small bowel bleeds/angiodysplasia related bleeding, the following has been met: Patient has tried one Somatuline Depot or lanreotide acetate (generic); Note: If requesting a Cipla lanreotide product, the preferred product is J1930, NDC 69097-0906-67"
Somatostatin Analogs – Mycapssa (IP0491)	Updated	**Effective 4/1/2026** **Preferred Product Table.** **Employer Plans** **Updated from** "Patient has tried Somatuline® Depot (lanreotide) injection [may require prior authorization]." **to** "Patient has tried ONE of octreotide ER injectable suspension (Sandostatin LAR Depot, generic), Somatuline Depot or lanreotide subcutaneous injection [may require prior authorization]. Note: If requesting a Cipla lanreotide product, the preferred product is J1930, NDC 69097-0906-67" **Individual and Family Plans.** **Updated from** "Patient has tried octreotide acetate ER (Sandostatin LAR Depot, generic) or lanreotide (Somatuline® Depot, generic) injection. [may require prior authorization]" **to** "Patient has tried ONE of octreotide ER injectable suspension (Sandostatin LAR Depot, generic), Somatuline Depot or lanreotide subcutaneous injection [may require prior authorization]. Note: If requesting a Cipla lanreotide product, the preferred product is J1930, NDC 69097-0906-67"
Somatostatin Analogs – Octreotide Long-Acting Products (IP0489)	Updated	**Effective 4/1/2026** **Preferred Product Table.**

		Updated from "ONE of the following: Acromegaly: The patient has tried Somatuline Depot.Patient with neuroendocrine tumors: The patient meets the ONE of the following (A or B):Note: This includes (but is not limited to) carcinoid tumors, vasoactive intestinal peptide tumors (VIPomas), glucagonomas, gastrinomas, insulinomas.; The patient has tried one of Somatuline Depot subcutaneous injection; OR; Patient has already been started on therapy with Sandostatin LAR.; Patient with pheochromocytoma/paraganglioma: The patient meets the following (A or B): The patient has tried Somatuline Depot; OR Patient has already been started on therapy with Sandostatin LAR; Patient with diarrhea associated with chemotherapy; enterocutaneous fistula; meningioma; pancreatic fistula; Merkel cell carcinoma; thymoma/thymic carcinoma" **to** "ONE of the following: ○ Acromegaly: The patient has tried ONE of octreotide ER injectable suspension, Somatuline Depot or lanreotide subcutaneous injection. NOTE: If requesting a Cipla lanreotide product, the preferred product is J1930, NDC 69097-0906-67; Neuroendocrine Tumor(s) [NETs] of the Gastrointestinal Tract, Lung, Thymus (Carcinoid Tumors), and Pancreas (including glucagonomas, gastrinomas, vasoactive intestinal peptides-secreting tumors [VIPomas], insulinomas): The patient meets the ONE of the following (A or B): The patient has tried ONE of octreotide ER injectable suspension, Somatuline Depot subcutaneous injection or lanreotide subcutaneous injection; OR Note: If requesting a Cipla lanreotide product, the preferred product is J1930, NDC 69097-0906-67, Patient has already been started on therapy with octreotide ER injectable suspension, Sandostatin LAR Depot.; Pheochromocytoma/paraganglioma: The patient meets the following (A or B): The patient has tried ONE of octreotide ER injectable suspension, Somatuline Depot or lanreotide subcutaneous injection; OR Note: If requesting a Cipla lanreotide product, the preferred product is J1930, NDC 69097-0906-67; Patient has already been started on therapy with octreotide ER injectable suspension, Sandostatin LAR; Patient with diarrhea associated with chemotherapy; enterocutaneous fistula; meningioma; pancreatic fistula; Merkel cell carcinoma; thymoma/thymic carcinoma, approve"
Somatostatin Analogs – Signifor LAR (IP0165)	Updated	**Effective 4/1/2026** **Preferred Product Table.** ○ **Updated from** "For a diagnosis of Acromegaly only. Patient has tried Somatuline Depot (lanreotide acetate) injection." **to "**For a diagnosis of Acromegaly, patient has tried ONE of octreotide ER injectable suspension (Sandostatin LAR Depot, generic), Somatuline Depot or lanreotide subcutaneous injection [may require

		prior authorization]. Note: If requesting a Cipla lanreotide product, the preferred product is J1930, NDC 69097-0906-67"
Somatostatin Receptor Agonist – Palsonify (IP0769)	Updated	**Effective 4/1/2026** **Policy Title.** **Updated from** "Somatostatin Receptor Agonist – Palsonify for Individual and Family Plans" **to** "Somatostatin Receptor Agonist – Palsonify" **Preferred Product Table.** **Employer Plans.** **Added** preferred product table for Employer Plans. **Individual and Family Plans.** **Updated from** "Patient has tried octreotide acetate ER (Sandostatin LAR Depot, generic) or lanreotide (Somatuline® Depot, generic) injection. [may require prior authorization]" **to** "Patient has tried ONE of octreotide ER injectable suspension (Sandostatin LAR Depot, generic), Somatuline Depot or lanreotide subcutaneous injection [may require prior authorization]. Note: If requesting a Cipla lanreotide product, the preferred product is J1930, NDC 69097-0906-67"
Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) [1803]	Updated	**Effective 4/1/2026** **Removed** the Non-Steroidal Topical therapeutic category and relocated to a new policy, *Topical Agents for Atopic Dermatitis Step Therapy Policy* (ST005). **Removed** the Overactive Bladder therapeutic category, effective 5/1/2026, and relocated to a new policy, *Overactive Bladder Medications Step Therapy Policy* (ST002). **Removed** the Anti-Parkinsonism Drugs (Carbidopa and Levodopa Products) section effective 4/15/2026 and relocated to a new policy, *Parkinson's Disease – Carbidopa-Levodopa (Oral) Step Therapy Policy for Employer Plans* (ST006).
Step Therapy – Standard and Performance Prescription Drug Lists (Employer Group Plans) [1801]	Updated	**Effective 4/1/2026** **Removed** the Non-Steroidal Topical therapeutic category and relocated to a new policy, *Topical Agents for Atopic Dermatitis Step Therapy Policy* (ST005).

		Removed the Anti-Parkinsonism Drugs (Carbidopa and Levodopa Products) section effective 4/15/2026 and relocated to a new policy, *Parkinson's Disease – Carbidopa-Levodopa (Oral) Step Therapy Policy for Employer Plans* (ST006).
Step Therapy – Value and Advantage Prescription Drug Lists (Employer Group Plans) [1802]	Updated	**Effective 4/1/2026** **Removed** the Non-Steroidal Topical therapeutic category and relocated to a new policy, *Topical Agents for Atopic Dermatitis Step Therapy Policy* (ST005). **Removed** the Anti-Parkinsonism Drugs (Carbidopa and Levodopa Products) section effective 4/15/2026 and relocated to a new policy, *Parkinson's Disease – Carbidopa-Levodopa (Oral) Step Therapy Policy for Employer Plans* (ST006).
Tobramycin/loteprednol etabonate (Zylet) Ophthalmic Suspension for Individual and Family Plans (IP0474)	Retired	**Effective 4/15/2026** Zylet relocated to Pharmacy and Medical Prior Authorization (1407)
Topical Agents for Atopic Dermatitis Step Therapy Policy for Employer Plans - (ST005)	New	**Effective 4/1/2026** New policy.
Transplantation - Yartemlea - (IP0789)	New	**Effective 4/1/2026** New policy
Wakefulness-Promoting Agents – Armodafinil, Modafinil (IP0075)	Updated	**Effective 4/1/2026** **Policy Statement:** A note was added that for certain indications, because of the specialized skills required for evaluation and diagnosis of patients treated with modafinil and armodafinil as well as the monitoring required for adverse events and efficacy, approval requires modafinil and armodafinil to be prescribed by or in consultation with a physician who specializes in the condition being treated. **Idiopathic Hypersomnia:** Diagnostic criteria were added to confirm the patient has been evaluated using polysomnography and a multiple sleep latency test, and results of the polysomnography and multiple sleep latency test are congruent with a diagnosis of idiopathic hypersomnia. In addition, the previous specialist criterion which stated, "the diagnosis is confirmed by a sleep specialist physician or at an institution that specializes

		in sleep disorders (i.e., sleep center)" was revised to "the medication has been prescribed by or in consultation with a sleep specialist or a neurologist."
Zokinvy (IP0107)	Updated	**Effective 4/15/2026** • No criteria changes
Precertification Policy	**New, Updated, or Retired?**	**Comments**
Master Outpatient Precertification List	New or Updated	Updated prior authorization requirements are available on our websites, CignaforHCP.com and Cigna.com. Additions consist of new codes released by CMS and the AMA that have been selected for our prior authorization program. Updates include existing codes that have been added to prior authorization. **New Codes:** • For April 1, 2026, Cigna added 0 CPT, and 24 HCPCS newly released codes to prior authorization. **Updates:** • For April 10, 2026, Cigna added 9 CPT, and 0 HCPCS existing codes to prior authorization. **Terminations:** • For March 31, 2026, CMS/AMA deleted/terminated 2 codes, 0 CPT and 2 HCPCS.
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
Covid Interim Billing Guidelines – (R33)	Updated	**Effective 03/06/2026** • Renamed policy to "Services Not Reimbursable" • Updated
Laboratory Services - (R17)	Updated	**Effective 03/05/2026** • Updated

Drug Testing Billing Requirements – (R25)	Update	**Effective 03/15/2026** • Updated
Modifier - Bilateral Procedures – (M50)	Update	**Effective 03/27/2026** • Updated
Omnibus Reimbursement Policy - (R24)	Update	**Effective 02/23/2026** • Updated
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		• No updates for Apri 2026
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**
Code Editing Policy and Guidelines	Update	• Updated