Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective August 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
Bariatric Surgery and Procedures – (CP0051)	Updated	Important **changes** in coverage criteria:: • Revised policy statement to lower the body mass index (BMI) criteria for adults. • Revised policy statement to update terminology of nonalcoholic fatty liver disease (NAFLD) and nonalcoholic steatohepatitis (NASH) to include metabolic dysfunction–associated steatotic liver disease (MASLD) and metabolic dysfunction–associated steatohepatitis (MASH). • Added policy statement for coverage of endoscopic sleeve gastrectomy for the adult population. • Removed policy statement for cholecystectomy and prophylactic vena cava filter placement.
Breast Reduction – (CP0152)	Updated	Important **changes** in coverage criteria • Posting 8/15/2015; Effective 11/15/2025 • Addition of policy statement for CPT code 15839- Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area.

Cardiac Omnibus Codes – (CP0574)	Updated	Important **changes** in coverage criteria: • Added policy statement for Inferior vena cava (IVC) sensor (0981T) • Revised policy statement for carotid sinus baroreflex activation device (adding 0268T)
External Counterpulsation – (CP0058)	Updated	Important **changes** in coverage criteria: Posting 05/15/2025, effective date 08/15/2025 • Limited coverage so that individuals need to have clinically severe coronary artery disease with documentation of ischemia on an imaging stress test and obstructive CAD that is not amendable to revascularization by PCI or CABG.
Orthotic Devices and Shoes – (CP0543)	Updated	Posting **8/15/2025**; Effective **11/15/2025** Important **changes** in coverage criteria: • Added "powered exoskeleton orthosis (e.g., ReWalk Personal Exoskeleton)" to policy statement for orthoses considered experimental, investigational, or unproven. • Minor change: Removed "any orthosis used to treat edema" from list of Not Covered or Reimbursable orthoses.
Tissue-Engineered Skin Substitutes – (CP0068)	Updated	Important **changes** in coverage criteria: • Revised policy statement for Phasix to add "ST" to differentiate Phasix™ ST Mesh for hiatal hernia repair • Added policy statement for Allomend and VNEW are considered experimental, investigational, or unproven • Removed policy statement for Derma-gide and Palingen
Treatment of Cutaneous and/or Deep Tissue Hemangioma, Port Wine Stain and Other Vascular Lesions - (CP0313)	Updated	**This is an existing policy that underwent annual review. Posting 5/15/25, Effective 8/15/25.** Minor **changes** in coverage criteria/policy: • Revised coverage statement to align with the benefit language (addition of verbiage related to "functional impairment"). • Due to this update a cascade change was made via addition of a new bullet point to address infantile hemangioma separately.
Laboratory Testing Services – (CP0604)	Updated	Important **changes** in coverage criteria: Posting **8/15/2025**; Effective **11/15/2025** • Expanding scope of CP by adding section on EIU Lab tests, and adding Codes 0247U, 0261U, 0384U, 0558U, and 0559U • Remove codes - Code 0346U retired on 1/1/2025; Codes 00358U and 0412U are not going to be managed • Removed not covered or reimbursable header and changed not covered or reimbursable to not medically necessary in the statement

Ambulance Services – (CP0555)	Updated	• No change in coverage.
Anesthesia and Facility Services for Dental Treatment – (CP0415)	Updated	• No change in coverage.
Category III Current Procedural Terminology (CPT®) codes – (CP0558)	Updated	• No change in coverage.
Continuous Passive Motion (CPM) Devices – (CP0198)	Updated	• No change in coverage.
Gynecomastia Surgery – (CP0195)	Updated	• No change in coverage.
Laser Interstitial Thermal Therapy – (CP0528)	Updated	• No change in coverage.
Male Sexual Dysfunction Treatment: Non-pharmacologic – (CP0403)	Updated	• No change in coverage.
Thymus Tissue Transplantation – (CP0561)	Updated	• No change in coverage.
Extracorporeal Photopheresis – (CP0320)	Updated	• The single code in the policy, 36522, isn't implemented/managed.
Lyme Disease Treatment-Antibiotic Treatment - (CP0400)	Updated	• To be retired effective 08/15/2025. It has been determined that the policy no longer has business value. The associated prepay CWA edit will be retired.

ASH Guidelines	New, Updated, or Retired?	Comments
Electric Stimulation for Pain, Swelling and Function in a Clinic Setting – (CPG272)	Updated	• No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-EviCore High-Tech Imaging Guidelines	Updated	Important **changes** in coverage criteria. • Posted August 1, 2025, Effective November 18, 2025: • One guideline was updated with clinical changes which will expand and limit coverage: • Breast Imaging
Administrative Policy	**New, Updated, or Retired?**	**Comments**
Authorized Generics - (A008)	Updated	Effective: 8/15/2025 • **Added** Umeclidinium and vilanterol inhalation powder authorized generic for Anoro Ellipta as a not covered product for Individual and Family Plans. • **Removed:** Aciphex Sprinkles for Standard Drug List Plan and Performance Drug List Plan
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Anticoagulants – Dabigatran - (IP0033)	Updated	Effective: 8/15/2025 • A note was added to include Eliquis tablets for oral suspension and Eliquis Sprinkle capsules for oral suspension under examples for the **Treatment or**

		Prevention of Other Thromboembolic-Related Conditions under coverage for dabigatran capsules. • A note was also added to include Xarelto for oral suspension, Eliquis tablets for oral suspension and Eliquis Sprinkle capsules for oral suspension under examples for the **Treatment or Prevention of Other Thromboembolic-Related Conditions** under coverage for Pradaxa oral pellets. • Removed documentation requirements from coverage policy criteria.
Belumosudil - (IP0313)	Updated	Effective 8/1/2025 • **Added** Individual and Family Plans to the policy. • **Removed** documentation requirements.
Brands with Bioequivalent Generics - (IP0011)	Updated	Effective 8/1/2025 • Added for Employer Plans: • Climara, Dexilant, Divigel, Nexium DR capsules, Nexium DR packets, Prevacid SoluTabs • Added for Individual and Family Plans: • Climara, Dexilant, Nexium DR capsules, Nexium DR packets • **Added** extended release to generic lamotrigine for Lamictal XR • **Updated** Azopt 1% from solution to suspension
Bone Modifiers – Denosumab Products (Prolia) - (IP0331)	Updated	Effective 8/15/2025 • **Updated** policy title form "Denosemab (Prolia)" to "Bone Modifiers – Denosumab Products (Prolia)" • **Added** Jubbonti and Stoboclo, Prolia biosimilars, to the policy with the same criteria as Prolia. • **Removed** documentation requirements throughout the policy. • Bone Loss (Treatment to Increase Bone Mass) in patients with Breast Cancer at High Risk for Fracture Receiving Adjuvant Aromatase Inhibitor Therapy. • **Added** examples of aromatase inhibitor therapy. • Bone Loss (Treatment to Increase Bone Mass) in Individuals with Nonmetastatic Prostate Cancer at High Risk for Fracture Receiving Androgen Deprivation Therapy. • **Added** examples of androgen deprivation therapy. • Glucocorticoid-Induced Osteoporosis – Treatment. • **Added** an example of a systemic glucocorticoid. • **Added** zoledronic acid intravenous infusion as a prerequisite option. • **Removed** intravenous bisphosphonate products as a prerequisite option. • **Added** oral bisphosphonate-containing products as a prerequisite option. • **Clarified** the oral bisphosphonate or oral bisphosphonate-containing prerequisite trial should be for 12 months.

		• **Added** examples of inadequate efficacy and intolerance to oral bisphosphonate or oral bisphosphonate-containing products. • **Updated** the contraindication to bisphosphonate therapy statement. • Osteoporosis Treatment for a Postmenopausal Patient • **Added** zoledronic acid intravenous infusion as a prerequisite option. • **Removed** intravenous bisphosphonate products as a prerequisite option. • **Added** oral bisphosphonate-containing products as a prerequisite option. • **Clarified** the oral bisphosphonate or oral bisphosphonate-containing prerequisite trial should be for 12 months. • **Added** examples of inadequate efficacy and intolerance to oral bisphosphonate or oral bisphosphonate-containing products. • **Updated** the contraindication to bisphosphonate therapy statement. • Osteoporosis Treatment (to Increase Bone Mass) for Men. • **Added** zoledronic acid intravenous infusion as a prerequisite option. • **Removed** intravenous bisphosphonate products as a prerequisite option. • **Added** oral bisphosphonate-containing products as a prerequisite option. • **Clarified** the oral bisphosphonate or oral bisphosphonate-containing prerequisite trial should be for 12 months. • **Added** examples of inadequate efficacy and intolerance to oral bisphosphonate or oral bisphosphonate-containing products. • **Updated** the contraindication to bisphosphonate therapy statement. • Conditions Not Covered. • Updated the Concurrent Use with Other Medications for Osteoporosis statement. • Updated the Giant Cell Tumor of Bone statement. • Updated the Osteoporosis Prevention statement. • Coding Information • **Added** Codes: C9399, J3490, J3590, Q5136
Bone Modifiers – Denosumab Products (Xgeva) - (IP0332)	Updated	Effective: 8/15/2025 • Osenvelt and Wyost was added to the policy with the same criteria as Xgeva. The Policy name was changed from "Bone Modifiers – Xgeva" to "Bone Modifiers – Denosumab Products (Xgeva)." • Preferred Product Criteria Table for Employer and Individual and Family plans. • **Added** step requirement criteria for Osenvelt and Wyost • **Updated** Xgeva criteria from "failure, contraindication or intolerance" to "tried" zoledronic acid injection (Zometa). • Coding Information: • Added HCPCS: Q5136, C9399, J3490, J3590

Complement Inhibitors – Eculizumab Products - (IP0549)	Updated	Effective 8/15/2025 • Policy title updated from Eculizumab to Complement Inhibitors – Eculizumab Products • Documentation requirements were updated throughout the policy. • **Atypical Hemolytic Uremic Syndrome. Updated** approval duration from 6 months to 1 year. **Removed** "Diagnosis of thrombocytopenic purpura (TTP) has been excluded (for example, normal ADAMTS 13 activity) OR a trial of plasma exchange did not result in clinical improvement". **Removed** "Has been vaccinated against meningococcal infection (at least 2 weeks prior to treatment, if not previously vaccinated), where and when clinically appropriate". **Updated** dosing. • **Neuromyelitis Optica Spectrum Disorder. Removed** "Has been vaccinated against meningococcal infection (at least 2 weeks prior to treatment, if not previously vaccinated) where and when clinically appropriate" • **Paroxysmal Nocturnal Hemoglobinuria. Updated** "Flow cytometry demonstrates one of the following: At least 10% PNH type III red cells; or Greater than 50% of glycosylphosphatidylinositol-anchored proteins (GPI-AP)- deficient polymorphonuclear cells (PMNs)" **to** now read "Diagnosis was confirmed by peripheral blood flow cytometry results showing the absence or deficiency of glycosylphosphatidylinositol (GPI)-anchored proteins on at least two cell lineages." **Removed** "At least one transfusion related to anemia secondary to PNH OR occurrence of a thromboembolic event and "Has been vaccinated against meningococcal infection (at least 2 weeks prior to treatment, if not previously vaccinated) where and when clinically appropriate." • **Conditions Not Covered. Removed** the following from the listing of specific conditions: Acute antibody mediated rejection; Chronic antibody-mediated rejection in recipients with persistently high B flow crossmatch after positive crossmatch kidney transplantation; Geographic atrophy in age-related macular degeneration; Prevention of delayed graft function; Systemic lupus erythematosus; Stem cell transplant-associated thrombotic microangiopathy; and Typical hemolytic uremic syndrome (HUS). There is no change in coverage for these conditions.
Complement Inhibitors – Empaveli - (IP0194)	Updated	Effective 8/15/2025 • **Paroxysmal Nocturnal Hemoglobinuria:** Biosimilars to Soliris were added to the criteria where only Soliris was previously noted. Added documentation requirements for confirmation of diagnosis. • **Conditions Not Recommended for Approval:** Biosimilars to Soliris were added to the criteria where only Soliris was previously noted. PiaSky was added to the list of medications that should not be used concomitantly with Empaveli.
Complement Inhibitors – Fabhalta - (IP0614)	Updated	Effective 8/15/2025 • **Paroxysmal Nocturnal Hemoglobinuria.** • Initial Therapy

		• **Added** documentation to the diagnostic statement. • Patient is Currently Receiving Fabhalta. • **Added** documentation to the beneficial response statement.
Complement Inhibitors – PiaSky - (IP0694)	Updated	Effective: 8/15/2025 • **Paroxysmal Nocturnal Hemoglobinuria:** For patients who are currently receiving PiaSky, the Note regarding examples of benefit of PiaSky is updated to include "improvement in Functional Assessment of Chronic Illness Therapy (FACIT)-Fatigue score." Dosing section was separated to provide dosing information for Initial Therapy and for a Patient who is Currently Receiving PiaSky. Previously the dosing section included information on loading doses and maintenance doses without separation.
Complement Inhibitors – Ultomiris - (IP0550)	Updated	Effective 8/15/2025 • Policy title updated from *Ravulizumab-cwvz Intravenous* to *Complement Inhibitors – Ultomiris* • Documentation requirements were updated throughout the policy. • **Atypical Hemolytic Uremic Syndrome. Updated** approval duration from 6 months to 1 year. **Removed** "Diagnosis of thrombocytopenic purpura (TTP) has been excluded (for example, normal ADAMTS 13 activity) OR a trial of plasma exchange did not result in clinical improvement." **Removed** "Has been vaccinated against meningococcal infection (at least 2 weeks prior to treatment, if not previously vaccinated), where and when clinically appropriate." **Updated** dosing. • **Generalized Myasthenia Gravis. Updated** dosing. • **Paroxysmal Nocturnal Hemoglobinuria. Updated** "Flow cytometry demonstrates one of the following: At least 10% PNH type III red cells; or Greater than 50% of glycosylphosphatidylinositol-anchored proteins (GPI-AP)- deficient polymorphonuclear cells (PMNs)" **to** now read "Diagnosis was confirmed by peripheral blood flow cytometry results showing the absence or deficiency of glycosylphosphatidylinositol (GPI)-anchored proteins on at least two cell lineages." **Removed** "At least one transfusion related to anemia secondary to PNH OR occurrence of a thromboembolic event and "Has been vaccinated against meningococcal infection (at least 2 weeks prior to treatment, if not previously vaccinated) where and when clinically appropriate." • **Updated** dosing.
Complement Inhibitors – Voydeya - (IP0647)	Updated	Effective: 8/15/2025 • **Paroxysmal Nocturnal Hemoglobinuria:** Biosimilars to Soliris were added to the criteria where only Soliris was previously noted; Ultomiris subcutaneous injection was removed from criteria since the manufacturer has decided not to market the product. Added documentation requirements for confirmation of diagnosis.

		• **Conditions Not Recommended for Approval:** PiaSky was added to the list of medications that should not be used concomitantly with Voydeya.
Complement Inhibitors – Zilbrysq - (IP0622)	Updated	Effective: 8/15/2025 • **Generalized Myasthenia Gravis:** Updated documentation requirements. • **Concurrent Use with Another Complement Inhibitor, a Neonatal Fc Receptor Blocker, or a Rituximab Product.** Removed Ultomiris subcutaneous injection from the Note of examples of complement inhibitors.
Colony Stimulating Factors – Ryzneuta - (IP0745)	New	Effective: 8/1/2025 • New policy.
Cushing's – Isturisa - (IP0044)	Updated	Effective 8/1/2025 • **Endogenous Cushing's Syndrome:** This condition was moved from "other uses with supportive evidence" to "FDA-approved indication". Removed criterion for trial of previous therapies. • **Cushing's Disease:** This condition was removed from the policy as it is no longer an FDA approved indication and falls under the broader term, Cushing's Syndrome. • **Added** a requirement for a patient to have a documented diagnosis of Cushing's syndrome. • **Removed** prerequisite step for Endogenous Cushing's Syndrome. • **Updated** the Employer Plans preferred product requirements. • **Added** Individual and Family Plans preferred product requirements. • **Reworded** the conditions not covered statement.
Dermatology – Gene Therapy – Vyjuvek - (IP0572)	Updated	Effective: **7/10/2025** • **Dystrophic Epidermolysis Bullosa:** The criterion was modified to "Squamous cell carcinoma has been considered for the target wound(s)." Previously, "Squamous cell carcinoma has been ruled out for the target wound(s)."
Dermatology – Gene Therapy – Zevaskyn - (IP0747)	New	Effective 8/15/2025 • New policy.
Dermatology – Hyftor - (IP0511)	Updated	Effective: 8/15/2025 • Added "[documentation required]" throughout policy.
Diabetes – Glucagon-Like Peptide-1 Agonists for Individual	Updated	Effective 8/15/2025 • Conditions Not Covered • **Prediabetes/Diabetes Prevention.** • **Updated** the statement with information from the 2025 American Diabetes Association Standards of Care.

and Family Plans - (IP0702)		
Diabetes – Glucagon-Like Peptide-1 Agonists for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (IP0701)	Updated	Effective 8/15/2025 • Conditions Not Covered • **Prediabetes/Diabetes Prevention.** • **Updated** the statement with information from the 2025 American Diabetes Association Standards of Care.
Drugs Requiring Medical Necessity Review for Employer Plans - (1602)	Updated	Effective: 8/1/2025 • **Added preferred product step requirement for the following products:** • Zunveyl, halcinonide 0.1% cream, Afrezza, Climara Pro, Elestrin, metaxalone 640 mg tablet, Konvomep, omeprazole/sodium bicarbonate capsules, omeprazole/sodium bicarbonate powder for oral suspension, Voquezna, Zegerid capsules, Zegerid powder for oral suspension, Siklos, Xromi, Inzirqo, and Thalitone. • **Updated preferred product step requirement for the following products:** • Halog Cream, Halog Ointment, Furoscix, Veozah, and Yosprala.
Eflapegrastim - (IP0526)	Updated	Effective 8/1/2025 • **Removed** the specialist prescribing requirement. • **Updated** the authorization and reauthorization durations from 6 months to 12 months.
Enspryng - (IP0078)	Updated	Effective: 8/15/2025 • **Added "Documentation:** 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, and/or other information." • **Added "[documentation required]"** to the following criteria: Diagnosis was confirmed by a positive blood serum test for anti-aquaporin-4 antibody
Filgrastim - (IP0528)	Updated	Effective Date 8/1/2025 • **Coding Information** • **Added** HCPCS: Q5148 (Code effective 4/1/2025) • **Updated** the description for C9173 to include the note "Code effective until 6/30/2025"

Gout – Krystexxa - (IP0269)	Updated	Effective: 8/1/2025 • **Gout, Chronic**: The previous requirement "Patient has a contraindication or has had an intolerance to a trial of allopurinol, as determined by the prescriber." was updated to "According to the prescriber, patient has a contraindication or has had an intolerance to a trial of allopurinol." Also, the requirement "Krystexxa is not being used in combination with another uric acid lowering drug" was updated to "Krystexxa is not being used in combination with an oral urate-lowering drug for the treatment of gout".
Graft-Versus-Host Disease – Niktimvo - (IP0722)	Updated	Effective 8/1/2025 • **Added:** Graft-Versus-Host Disease to the header. • **Graft-Versus-Host Disease**, For initial therapy, for the requirement that a patient tried two systemic treatments, the descriptor "conventional" was removed and the word "therapies" was changed to "medications." Also, an etanercept product was listed in the Note that cites examples of systemic therapy for chronic graft-versus-host disease. • **Removed** "for 1 year" under both Initial Therapy and Patient currently receiving Niktimvo sections.
Hemophilia – Non-Factor Routine Prophylaxis Products – Alhemo - (IP0730)	Updated	Effective 8/15/2025 • **"Non-Factor Routine Prophylaxis Products**" was added to the title of the Policy. In addition, the following changes were made: • **Hemophilia A with Factor VIII Inhibitors:** In Initial Therapy and for a Patient Currently Receiving Alhemo, a requirement was added that according to the prescriber, prophylactic use of bypassing agents will be discontinued (for Initial Therapy) or will not occur while receiving Alhemo (for a Patient Currently Receiving Alhemo). A Note was added that use of bypassing agents for the treatment of breakthrough bleeding is permitted and examples of bypassing agents were listed in a Note. Previously, use of bypassing agents for routine prophylaxis was addressed in the Conditions Not Recommended for Approval. Also, a requirement was added that the patient is not undergoing immune tolerance induction therapy. Previously, this was addressed in Conditions Not Recommended for Approval. • **Hemophilia B with Factor IX Inhibitors:** In Initial Therapy and for a Patient Currently Receiving Alhemo, a requirement was added that according to the prescriber, prophylactic use of bypassing agents will be discontinued (for Initial Therapy) or will not occur while receiving Alhemo (for a Patient Currently Receiving Alhemo). A Note was added that use of bypassing agents for the treatment of breakthrough bleeding is permitted and examples of bypassing agents were listed in a Note. Previously, use of bypassing agents for routine prophylaxis was addressed in the Conditions Not Recommended for Approval. Also, a requirement was added that

		the patient is not undergoing immune tolerance induction therapy. Previously, this was addressed in Conditions Not Recommended for Approval. • **Conditions Not Recommended for Approval:** Regarding Concurrent Use of Non-Factor Routine Prophylaxis Products, all agents are now listed together in one criterion, which now includes Qfitlia. The condition of Concurrent Use of Bypassing Agents for Routine Prophylaxis was removed as this is now addressed in the approval criteria. The condition of Patient Receiving Immune Tolerance Induction Therapy was removed as this is now addressed in the approval criteria.
Hemophilia – Non-Factor Routine Prophylaxis Products – Hemlibra - (IP0121)	Updated	Effective 8/15/2025 • **"Non-Factor Routine Prophylaxis Products"** was added to the title of the Policy. In addition, the following changes were made: • **Hemophilia A with Factor VIII Inhibitors:** In Initial Therapy, requirements were added that Factor VIII inhibitor titer testing has been performed within the past 30 days and that the patient has a positive test for Factor VIII inhibitors of ≥ 0.6 Bethesda units/mL. The requirement was deleted that the patient has had a positive Factor VIII inhibitor titer > than 5 Bethesda Units or that the patient has had a positive Factor VIII inhibitor titer ≤ to 5 Bethesda units and either has had an anamnestic response (current or past) to Factor VIII product dosing or that the patient experienced an inadequate clinical response (current or past) to increased Factor VIII product dosing. The requirement that the prescriber attests that if the patient is currently receiving a bypassing agent for prophylaxis, that the bypassing agent therapy will be discontinued the day prior to initiation of Hemlibra was changed to "according to the prescriber, prophylactic use of bypassing agents will be discontinued." The requirement that prophylactic use of bypassing agents will not occur while using Hemlibra was removed. The requirement that the prescriber attests that the patient will not be undergoing immune tolerance induction therapy while receiving Hemlibra was changed to "the patient is not undergoing immune tolerance induction therapy." The requirement that the prescriber attests the following regarding Factor VIII product was deleted: 1) that if the patient is currently receiving a Factor VIII product for prophylactic use, the Factor VIII product will be discontinued within the initial 4-week loading dose period with Hemlibra and 2) prophylactic use of Factor VIII products will not occur while using Hemlibra; the related Note was also removed. For a Patient Currently Receiving Hemlibra, the requirement that the "prescriber attests that prophylactic use of bypassing agents will not occur while using Hemlibra" was changed to "according to the prescriber, prophylactic use of bypassing agents will not occur while receiving Hemlibra." The requirement that the "prescriber attests that the patient will not be undergoing immune tolerance induction while receiving Hemlibra" was changed to "Patient is not undergoing immune tolerance induction therapy." The requirement was deleted that the prescriber attests that prophylactic use of Factor VIII products will not occur

		while using Hemlibra; the related Note was also removed. In the Note regarding examples of a beneficial response, the phrase "to therapy" was added and "spontaneous bleeding events" was changed to "spontaneous bleeds." • **Hemophilia A without Factor VIII Inhibitors**: In Initial Therapy, it was added that the patient either had Factor VIII inhibitor titer testing performed within the past 30 days and the patient does not have a positive test for Factor VIII inhibitors of ≥ 1.0 Bethesda units/mL or the patient has not received Factor VIII therapy in the past. The requirement was deleted that the patient either has severe to moderate severe disease as defined by pretreatment Factor VIII levels ≤ 2% of normal or that the patient has moderate to mild disease as defined by pretreatment Factor VIII levels > 2% to < 40% of normal and meets one of the following: 1) patient has experienced a severe, traumatic, or spontaneous bleeding episode as determined by the prescriber, 2) patient has hemophilia related joint damage, has experienced a joint bleed, or has a specific joint that is subject to recurrent bleeding (presence of a target joint), or 3) patient is in a perioperative situation and/or has an additional clinical scenario regarding bleeding/bleeding risk in which the prescriber determines the use of Hemlibra is warranted. Also, Notes related to these requirements were deleted. The requirement was removed that the prescriber attests that prophylactic use of bypassing agents will not occur while using Hemlibra (along with the related Note). The requirement regarding use of Factor VIII products was changed to state that "according to the prescriber, prophylactic use of Factor VIII products will be discontinued no later than 4 weeks following the initial Hemlibra dose". Previously, the requirement was that the prescriber attested that if the patient was receiving a Factor VIII product for prophylactic use, that therapy will be discontinued within the initial 4-week loading dose period with Hemlibra and that prophylactic use of Factor VIII products will not occur while using Hemlibra. For a Patient Currently Receiving Hemlibra, the requirement that the prescriber attests that prophylactic use of bypassing agents will not occur while using Hemlibra was deleted, along with the related Note. Regarding prophylactic use of Factor VIII products, the phrase "prescriber attests" was changed to "according to the prescriber" and the word "using" was changed to "receiving." In the Note regarding examples of a beneficial response, the phrase "to therapy" was added and "spontaneous bleeding events" was changed to "spontaneous bleeds." • **Conditions Not Recommended for Approval:** It was added that Concurrent Use of Alhemo, Hympavzi, or Qfitlia is not permitted.
Hemophilia – Non-Factor Routine Prophylaxis Products – Hympavzi - (IP0731)	Updated	Effective 8/15/2025 • **"Non-Factor Routine Prophylaxis Products"** was added to the title of the Policy. In addition, the following changes were made: • **Hemophilia A without Factor VIII Inhibitors:** In Initial Therapy, the requirement that "Patient has severe hemophilia A as evidence by a baseline

		(without Factor VIII replacement therapy) Factor VIII level of < 1%" was changed to "Patient has moderate to severe hemophilia A as evidenced by a baseline (without Factor VIII replacement therapy) Factor VIII level of ≤ 2%". Regarding prophylactic use of Factor VIII products, the phrase "will not occur while using Hympavzi" was changed to "will be discontinued." For a Patient Currently Receiving Hympavzi, for the criteria regarding prophylactic use of Factor VIII products, the word "using" was changed to "receiving." • **Hemophilia B without Factor IX Inhibitors**: In Initial Therapy, the wording "moderately severe or severe hemophilia B" was changed to "moderately severe to severe hemophilia B." Regarding prophylactic use of Factor IX products, the phrase "will not occur while using Hympavzi" was changed to "will be discontinued." For a Patient Currently Receiving Hympavzi, for the criteria regarding prophylactic use of Factor IX products, the word "using" was changed to "receiving." In the Note regarding examples of a beneficial response, the phrase "to therapy" was added and "spontaneous bleeding events" was changed to "spontaneous bleeds." • **Conditions Not Recommended for Approval:** Qfitlia was added as a medication that should not be used concurrently with Hympavzi. • **Coding Information** **Added** HCPCS Coding Table **Added** Code: J1712
Hemophilia – Non-Factor Routine Prophylaxis Products – Qfitlia - (IP0742)	Updated	Effective 8/15/2025 • **"Non-Factor Routine Prophylaxis Products**" was added to the title of the Policy. In addition, the following changes were made: • **Hemophilia A without Factor VIII Inhibitors:** For Initial Therapy, the requirement that "Patient has severe hemophilia A as evidenced by a baseline (without Factor VIII replacement therapy) Factor VIII level of < 1%" was changed to "Patient has moderately severe to severe hemophilia A as evidence by a baseline (without Factor VIII replacement therapy) Factor VIII level of ≤ 2%". The requirement regarding prophylactic use of Factor VIII products was changed from "will not occur 7 days after the initiation of Qfitlia therapy" to "will be discontinued no later than 7 days following the initial Qfitlia dose". For a Patient Currently Receiving Qfitlia, regarding prophylactic use of Factor VIII products, the word "using" was changed to "receiving." • **Hemophilia A with Factor VIII Inhibitors**: For Initial Therapy, regarding prophylactic use of bypassing agents, the phrase "will not occur 7 days after the initiation of Qfitlia therapy" was changed to "will be discontinued no later than 7 days following the initial Qfitlia dose". For a Patient Currently Receiving Qfitlia, the word "products" was removed after "bypassing agents" and "using" was changed to "receiving" regarding prophylactic use. For both Initial Therapy and for a Patient Currently Receiving Qfiltia, a requirement was added that the patient is not

		undergoing immune tolerance induction therapy. Previously, this was addressed in Conditions Not Recommended for Approval. • **Hemophilia B without Factor IX Inhibitors:** For Initial Therapy, the requirement that patients have "moderately severe or severe hemophilia B" was changed to "moderately severe to severe hemophilia B." The requirement regarding prophylactic use of Factor IX products was changed from "will not occur 7 days after the initiation of Qfitlia therapy" to "will be discontinued no later than 7 days following the initial Qfitlia dose". For a Patient Currently Receiving Qfitlia, regarding prophylactic use of Factor IX products, the word "using" was changed to "receiving." In the Note that addresses a beneficial response, the phrase "to therapy" was added and "spontaneous bleeding events" was changed to "spontaneous bleeds." • **Hemophilia B with Factor IX Inhibitors:** In Initial Therapy, regarding prophylactic use of bypassing agents, the phrase "will not occur 7 days after the initiation of Qfitlia therapy" was changed to "will be discontinued no later than 7 days following the initial Qfitlia dose". For a Patient Currently Receiving Qfitlia, the word "products" was removed after "bypassing agents" and "using" was changed to "receiving" regarding prophylactic use. For both Initial Therapy and for a Patient Currently Receiving Qfiltia, a requirement was added that the patient is not undergoing immune tolerance induction therapy while receiving Qfitlia. Previously, this was addressed in Conditions Not Recommended for Approval. • **Conditions Not Recommended for Approval:** Regarding Concurrent Use of Non-Factor Routine Prophylaxis Products, all agents are now listed together in one criterion. Patient Receiving Immune Tolerance Induction Therapy was removed as this is now addressed in approval criteria in patients with inhibitors.
Hepatology – Rezdiffra - (IP0642)	Updated	Effective: 8/15/2025 • **Metabolic-Dysfunction Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH). Updated** to remove "with moderate to advanced liver fibrosis"
HIV Products - (P0050)	Updated	Effective: 8/1/2025 • **Added** generic emtricitabline/rilpivirine/tenofovir disoproxil fumarate tablet to Appendix 1.
Homozygous Familial Hypercholesterolemia – Evkeeza (IP0128)	Updated	Effective: 8/15/2025 • **Homozygous Familial Hypercholesterolemia:** For Initial Therapy, the phrase "phenotypic confirmation of" was replaced with "had genetic testing confirming." Also, "apo B" was changed to "APOB." • **Added** "documentation required" to initial therapy criteria screening for genetic or physical findings to confirm HoFH diagnosis.

Homozygous Familial Hypercholesterolemia – Juxtapid - (IP0221)	Updated	Effective: 8/15/2025 • **Homozygous Familial Hypercholesterolemia:** For Initial Therapy, the phrase "phenotypic confirmation of" was replaced with "had genetic testing confirming." Also, "apo B" was changed to "APOB." • **Added** "documentation required" to initial therapy criteria screening for genetic or physical findings to confirm HoFH diagnosis. • **Updated HCPCS coding** • **Added** HCPCS C9399 & J3490
Hyperhidrosis – Qbrexza - (IP0074)	Updated	Effective 8/1/2025 • **Employer Plans Preferred Product Table:** • **Added** Documentation required under Criteria 1 and 2
Immunologicals – Dupixent - (IP0453)	Updated	Effective: 8/1/2025 • **Chronic Obstructive Pulmonary Disease:** Criteria requiring the patient to have signs and symptoms of chronic bronchitis were removed. Exacerbation criteria were simplified to require the patient to have experienced two or more COPD exacerbations requiring treatment with a systemic corticosteroid with or without an antibiotic in the previous 12 months or one or more COPD exacerbations requiring a hospitalization in the previous 12 months. Previously, these criteria required that the patient experienced two or more COPD exacerbations requiring treatment with a systemic corticosteroid and/or an antibiotic in the previous 12 months and one or more of these exacerbations required treatment with a systemic steroid and one or more of these exacerbations occurred while the patient was receiving combination inhaled therapy. Previous criteria also required that one or more COPD exacerbations requiring a hospitalization in the previous 12 months had occurred while the patient was receiving combination inhaled therapy.
Immunologicals – Nucala - (IP0422)	Updated	Effective: 8/1/2025 • **Chronic Obstructive Pulmonary Disease (COPD):** This condition and criteria for approval were added to the policy. New approval criteria for this indication were added that include an age requirement, an eosinophil requirement, a trial of inhaled therapies, a history of COPD exacerbations, and specialist involvement. • **Conditions Not Recommended for Approval, Chronic Obstructive Pulmonary Disease:** Chronic Obstructive Pulmonary Disease was removed from the "Conditions Not Recommended for Approval."
Inflammatory Conditions – Adalimumab Products Drug Quantity	New	Effective 8/15/2025 • New policy

Management Policy – Per Days - (DQM005)		
Inflammatory Conditions – Infliximab Intravenous Products Preferred Specialty Management Policy - (PSM005)	Updated	Effective 8/15/2025 • **Removed** the following option of approval for a non-preferred product, "Patient is currently receiving the requested agent for a condition other than plaque psoriasis."
Lipodystrophy – Egrifta - (IP0209)	Updated	Effective 8/1/2025 • **Added** Egrifta WR to the policy with the same criteria as Egrifta SV.
Metabolic Disorders – Cysteamine (Oral) Products for Employer Plans - (IP0046)	Updated	Effective 8/15/2025 • **Added** "for Employer Plans" to policy title. • **Added** documentation requirements
Metabolic Disorders – Cysteamine (Oral) Products for Individual and Family Plans - (IP0466)	Updated	Effective 8/15/2025 • **Added** documentation requirements • **Added** preferred product table for Individual and Family Plans effective 1/1/2026
Migraine – Calcitonin Gene-Related Peptide Inhibitors – Emgality - (IP0505)	Updated	Effective 8/1/2025 • **Episodic Cluster Headache Treatment**: Approval duration was changed from 6 months to 1 year. • **Preferred Product Table: Added** "A trial of nasal sumatriptan also counts towards this requirement" and "Patient has a contraindication to triptans"
Muscular Dystrophy – Gene Therapy – Elevidys - (IP0571)	Updated	Effective 8/1/2025 • **Updated** experimental, investigational or unproven statement with the addition of "regardless of U.S. Food and Drug Administration (FDA) approval status. Criteria will be updated as new published data are available." • **Conditions Not Covered** • **Updated** Duchenne Muscular Dystrophy (DMD)
Neurology – Imaavy – (IP0743)	New	Effective 8/15/2025 • **New Policy**
Neurology – Rystiggo - (IP0575)	Updated	Effective 8/15/2025 • **Conditions Not Recommended for Approval, Concomitant Use with Another Neonatal Fc Receptor Blocker, a Complement Inhibitor, or a Rituximab**

		Product: Imaavy was added to the Note of examples of neonatal Fc receptor blockers. Biosimilars to Soliris were added to the Note of examples of complement inhibitors, where only Soliris was previously noted. • **Added** documentation requirements throughout policy.
Neurology – Vyvgart Hytrulo - (IP0574)	Updated	Effective: 8/15/2025 • **Added** documentation instructions • **Chronic Inflammatory Dymelinating Polyneuropathy (CIDP):** For a patient who is currently receiving Vyvgart Hytrulo, the requirement that the medication be prescribed by or in consultation with a neurologist was added. Dosing information for the Vyvgart Hytrulo prefilled syringe was added to the dosing section. • **Generalized myasthenia gravis:** Dosing information for the Vyvgart Hytrulo prefilled syringe was added to the dosing section. • **Updated from** "Documentation that the patient has confirmed anti-acetylcholine receptor antiboy positive generalized myasthenia gravis" **to** "patient has confirmed anti-acetylcholine receptor antiboy positive generalized myasthenia gravis **[documentation required**]" • **Conditions Not Covered, Concomitant Use with Another Neonatal Fc Receptor Blocker, a Complement Inhibitor, or a Rituximab Product:** Imaavy was added to the Note of examples of neonatal Fc receptor blockers. Biosimilars to Soliris were added to the Note of examples of complement inhibitors, where only Soliris was previously noted.
Neurology – Vyvgart Intravenous - (IP0376)	Updated	Effective: 8/15/2025 • **Added** documentation instructions • **Chronic Inflammatory Dymelinating Polyneuropathy (CIDP):** For a patient who is currently receiving Vyvgart Hytrulo, the requirement that the patient is ≥ 18 years of age was added and the requirement that the medication be prescribed by or in consultation with a neurologist was added. Dosing information for the Vyvgart Hytrulo prefilled syringe was added to the dosing section. • **Generalized myasthenia gravis:** Dosing information for the Vyvgart Hytrulo prefilled syringe was added to the dosing section. • **Updated from** "Documentation that the patient has confirmed anti-acetylcholine receptor antiboy positive generalized myasthenia gravis" **to** "patient has confirmed anti-acetylcholine receptor antiboy positive generalized myasthenia gravis **[documentation required**]" • **Conditions Not Covered, Concomitant Use with Another Neonatal Fc Receptor Blocker, a Complement Inhibitor, or a Rituximab Product:** Imaavy was added to the Note of examples of neonatal Fc receptor blockers. Biosimilars to Soliris were added to the Note of examples of complement inhibitors, where only Soliris was previously noted.

Oncology – Thalomid - (IP0493)	Updated	Effective: 8/15/2025 • **Policy Title.** • **Updated from** "Oncology – Thalomid for Non-Oncology Uses" **to** "Oncology – Thalomid" • **FDA Approved Indications.** • **Added** criteria for Multiple Myeloma • **Other Uses with Supportive Evidence.** • **Added** criteria for Castleman Disease, Histiocytic Neoplasms, Kaposi Sarcoma, Medulloblastoma • **Conditions Not Covered.** • **Crohn's Disease.** • **Updated from "**Guidelines from the American College of Gastroenterology (2018) for the management of Crohn's disease in adults do not mention Thalomid as a therapeutic alternative" **to** "Guidelines from the American College of Gastroenterology (2018) for the management of Crohn's disease in adults mention that thalidomide may be effective in severe Crohn's disease, but should be used only in exceptional circumstances, given the high risk of serious adverse effects that include sedation, constipation, peripheral neuropathy, and severe birth defects."
Ophthalmology – Dry Eye Disease Cyclosporine Ophthalmic Products - (IP0026)	Updated	Effective 8/1/2025 • **Employer Plan Preferred Product Table.** • **Restasis Multidose: Added** preferred product step requirements for when patient is unable to use generic cyclosporine 0.05% ophthalmic emulsion single use vials
Ophthalmic – Glaucoma – Prostaglandins - (IP0027)	Updated	Effective: 8/1/2025 • **Preferred Product Table:** • **Lumigan and Vyzulta** • **For Employer Plans and Individual and Family Plans:** • **Updated** from "Failure, contraindication, or intolerance **to**…" to "Patient has tried…" • **Added** "Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement." • **Rhopressa** • **For Individual and Family Plans:** • **Removed** trial of a parasympathomimetic, topical or oral carbonic anhydrase inhibitor, and a second prostaglandin analog. • **Added** trial of an ophthalmic carbonic anhydrase inhibitor • **Added** Notes with examples of ophthalmic beta-blockers products, ophthalmic alpha-adrenergic agonists, and ophthalmic carbonic anhydrase inhibitors

Ophthalmology – Vascular Endothelial Growth Factor Inhibitors – Susvimo - (IP0349)	Updated	Effective: 8/15/2025 • **Diabetic Retinopathy:** This condition was added to the Conditions Not Recommended for Approval section.
Pharmacy and Medical Prior Authorization - (1407)	Updated	Effective: 8/1/2025 • **Added** Individual and Family Plan product-specific medical necessity criteria: clocortolone 0.1% pump, clocortolone pivalate 0.1% cream, doxepin 5% cream, doxepin 5% cream, prudoxin 5% cream, Afrezza, Climara Pro, Elestrin, Evamist, halcinonide 0.1% cream, Halog 0.1% cream, sumatriptan/ naproxen sodium tablets, Treximet, Konvomep, omeprazole/sodium bicarbonate capsules, omeprazole/sodium bicarbonate suspension, Voquezna tablets, Zegerid capsules, Zegerid packets, Vowst capsules, clemastine syrup, Thalitone, Siklos • **Updated** Individual and Family Plan product-specific medical necessity criteria: Veozah, carbinoxamine maleate 4 mg/5 mL, Karbinal ER
Proprotein Convertase Subtilisin Kexin Type 9 Inhibitors – Praluent - (IP0250)	Updated	Effective: 8/15/2025 • **Heterozygous Familial Hypercholesterolemia:** For Initial Therapy, the phrase "phenotypic confirmation of heterozygous familial hypercholesterolemia" was replaced with "The diagnosis has been confirmed by genetic testing". Also, "apo B" was changed to "APOB". • **Homozygous Familial Hypercholesterolemia:** For Initial Therapy, the phrase "phenotypic confirmation of homozygous familial hypercholesterolemia" was replaced with "The diagnosis has been confirmed by genetic testing". Also, "apo B" was changed to "APOB".
Proprotein Convertase Subtilisin Kexin Type 9 Inhibitors – Repatha - (IP0195)	Updated	Effective: 8/15/2025 • **Heterozygous Familial Hypercholesterolemia:** For Initial Therapy, the phrase "phenotypic confirmation of heterozygous familial hypercholesterolemia" was replaced with "The diagnosis has been confirmed by genetic testing". Also, "apo B" was changed to "APOB". • **Homozygous Familial Hypercholesterolemia:** For Initial Therapy, the phrase "phenotypic confirmation of homozygous familial hypercholesterolemia" was replaced with "The diagnosis has been confirmed by genetic testing". Also, "apo B" was changed to "APOB".
Proprotein Convertase Subtilisin Kexin Type 9 Related Products – Leqvio - (IP0380)	Updated	Effective: 8/15/2025 • **Added "Documentation:** 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, and/or other information."

		• **Heterozygous Familial Hypercholesterolemia (HeFH):** For Initial Therapy, the phrase "phenotypic confirmation of heterozygous familial hypercholesterolemia" was replaced with "The diagnosis has been confirmed by genetic testing". Also, "apo B" was changed to "APOB". • **Added "[documentation required]"** to the following criteria: Patient has an untreated low-density lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL (prior to treatment with antihyperlipidemic agents) **[documentation required];** The diagnosis has been confirmed by genetic testing **[documentation required]**; Prescriber confirms that the Dutch Lipid Network criteria score was > 5 **[documentation required]**; Prescriber confirms that Simon Broome criteria met the threshold for "definite" or "possible (or probable)" familial hypercholesterolemia **[documentation required]**
Psychiatry – Zulresso - (IP0270)	Updated	Effective: 8/1/2025 • **Added "Documentation:** 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, and/or other information."
Pulmonary Arterial Hypertension – Winrevair - (IP0645)	Updated	Effective: 8/1/2025 • **Pulmonary Arterial Hypertension (PAH) [World Health Organization {WHO} Group 1:** To the requirement of Functional Class PAH, Class IV was added; previously, only Functional Class II and III were listed. Additionally, documentation required was added to the policy to align with ESI policy.
Quantity Limitations - (1201)	Updated	Effective 8/1/2025 • **Added** quantity limits for Xifaxan 200 mg. • **Updated** quantity limits for Xifaxan 550 mg.
Quantity Limitations – (1201)	Updated	Effective 8/15/2025 • **Removed** Adalimumab quantity limit exception criteria and relocated to a new policy, Inflammatory Conditions – Adalimumab Products Drug Quantity Management Policy – Per Days – (DQM005)
Rebyota – (IP0556)	Updated	Effective 8/1/2025 • **Prevention of recurrence of Clostridioides difficile infection (CDI).** • **Updated** positive stool test criteria with addition of "for current episode" and **removed** "within the previous 30 days". • **Removed** documentation requirements
Rituximab for Non-Oncology Indications - (IP0319)	Updated	Effective: 8/15/2025 • **Added** documentation instructions • **Neuromyelitis Optica Spectrum Disorder**

		• **Updated from** "Documented diagnosis of neuromyelitis optica spectrum disorder" **to** "diagnosis was confirmed by a positive blood serum test for anti-aquaporin-4 antibody **[documentation required]"**
Spinal Muscular Atrophy – Evrysdi - (IP0063)	Update	Effective 8/15/2025 • **Policy Title: Updated** from "Risdiplam" to "Spinal Muscular Atrophy – Evrysdi". • **Added** Evrysdi oral tablets to the policy. • **Spinal Muscular Atrophy – Treatment:** • **Updated** documentation requirements throughout the policy. • For Initial Therapy - **Updated** the initial authorization duration from "6 months" to "4 months". **Removed** the 6 Minute Walk Test from the list of baseline motor ability assessment options. **Updated** the genetic testing language from "Bi-allelic mutation" to "bi-allelic pathogenic variants". **Added** "patient has not received Zolgensma" criteria. **Removed** follow-on Evrysdi criteria in those who were previously treated with Zolgensma. **Removed** "individual is of childbearing potential, individual is not currently pregnant and has been counseled to use effective contraception during treatment and up until 1 month after the last Evrysdi dose". **Removed** "individual does not have hepatic impairment" criterion. • For Patient Currently Receiving - **Updated** authorization duration from "6 months" to "4 months". **Updated** criteria for a patient currently receiving Evrysdi. **Removed** the 6 Minute Walk Test from the list of baseline motor ability assessment options. • **Conditions Not Covered: Updated** the conditions not covered statement. **Updated** "Concurrent use of Spinraza" statement.
Spinal Muscular Atrophy – Gene Therapy – Zolgensma - (IP0185)	Update	Effective 8/1/2025 • **Updated** the Conditions Not Covered statement. • **Updated** formatting.
Spinal Muscular Atrophy – Spinraza - (IP0182)	Update	Effective 8/15/2025 • **Policy Title:** From "Nusinersen" to "Spinal Muscular Atrophy – Spinraza". • **Spinal Muscular Atrophy – Treatment:** • **Updated** documentation requirements throughout the policy. • For Initial Therapy **–** • **Updated** the initial authorization duration from "6 months" to "3 months". **Removed** criterion requiring the "onset of clinical signs and symptoms consistent with SMA occur at age 15 years or younger". **Removed** the 6 Minute Walk Test from the list of baseline motor ability assessment options. **Updated** the genetic testing language

		from "Bi-allelic mutation" to "bi-allelic pathogenic variants". **Added** "patient has not received Zolgensma". **Removed** follow-on Spinraza criteria in those who were previously treated with Zolgensma. • For Patient Currently Receiving **-** • **Updated** the reauthorization duration from "12 months" to "4 months". **Added** criteria for a patient currently receiving Spinraza. • **Conditions Not Covered:** • **Updated** the Conditions Not Covered statement. **Updated** "Concurrent use of Evrysdi" statement.
Teriparatide - (IP0330)	Update	Effective: 8/15/2025 • **Added** Bonsity to coverage policy. • **Updated** product availability of Forteo and Teriparatide **from** "600 mcg/2.4 mL" **to** "560 mcg/2.24 mL" throughout policy. • **Employer Plans Preferred Product Table.** • **Bonsity: Added** Bonsity preferred product criteria • **Forteo 560 mcg/2.22 mL, Teriparatide 620 mcg/2.48 mL: Added** inactive ingredient examples. • **Individual and Family Plans Preferred Product Table.** • **Bonsity: Added** Bonsity preferred product criteria • **Forteo 560 mcg/2.22 mL, Teriparatide 560 mcg/2.24 mL, Teriparatide 620 mcg/2.48 mL:** • **Updated** "documented failure, contraindication, or intolerance" **to** "tried and cannot take" • **Added** "patient with glucocorticoid-induced osteoporosis (GIO)" exception.
Topical Acne – Winlevi - (IP0173)	Update	Effective 8/1/2025 • **Acne Vulgaris**: The requirement for previous trials of prescription medications was updated to add "for the treatment of acne vulgaris" throughout the Policy. The Note providing examples of prescription topical retinoids was updated to add Arazlo (tazarotene 0.045% lotion) and Fabior (tazarotene 0.1% foam). The Note providing examples of prescription non-retinoid topical therapies was updated to include benzoyl peroxide.
Transplantation – Grafapex - (IP0727)	Update	Effective Date: 8/1/2025 • **Coding Information** • **Added:** HCPCS code C9175 (Code effective date 7/1/2025) • **Updated** the description for J9999 include the note "Code effective until 6/30/2025"
Uplizna - (IP0062)	Update	Effective: 8/15/2025

		• **Immunoglobulin G4-Related Disease:** This condition and criteria for approval were added to the policy. • **Neuromyelitis Optica Spectrum Disorder:** The dosing section was revised to clarify dosing recommendations for initial treatment and for patients continuing treatment. • **Conditions Not Recommended for Approval:** Soliris (eculizumab intravenous infusion) changed to add biosimilars; updated language reads "eculizumab intravenous infusion (Soliris, biosimilars)". • **Added** documentation requirement to NMOSD diagnosis.
Weight Loss –Appetite Suppressants and Orlistat - (IP0420)	Update	Effective 8/1/2025 • Phentermine/topiramate extended-release (generic to Qsymia) was added to the policy. • Conditions Not Recommended for Approval: • **Concomitant Use with Other Medications FDA-Approved for Weight Loss.** This condition not recommended for approval was clarified to state that concomitant use with other medications FDA-approved for weight loss is not recommended. Previously, the requirement did not specify medications were "FDA-approved" for weight loss. The note with examples of weight loss medications was updated to reflect product availability for medications FDA-approved for weight loss.
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 30 - (IP0206)	Update	Effective 8/1/2025 • Wegovy: • **Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease who is Either Obese or Overweight.** Initial Therapy. For the requirement that a patient has had a prior stroke, a note was added that a to clarify that this does not include a transient ischemic attack (TIA). • Zepbound: **Obstructive Sleep Apnea, Moderate to Severe, in a Patient with Obesity.** Initial Therapy. The requirement that a patient had a sleep study was modified to remove the timeframe that the sleep study was within the past 1 year. A patient is still required to have a sleep study. • Conditions Not Recommended for Approval: • **Concomitant Use with Other Medications FDA-Approved for Weight Loss.** This condition not recommended for approval was clarified to state that concomitant use with other medications FDA-approved for weight loss is not recommended. Previously, the requirement did not specify medications were "FDA-approved" for weight loss. The note with examples of weight loss medications was updated to reflect product availability for medications FDA-approved for weight loss.

		• **Concomitant Use with Glucagon-Like Peptide-1 (GLP-1) Agonists or GLP-1/ Glucose-Dependent Insulinotropic Polypeptide (GIP) Agonists.** The note was updated to reflect availability for other GLP-1 or GLP-1/GIP agonists.
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 32 - (IP0621)	Update	Effective 8/1/2025 • **Policy Statement:** The Policy Statement was updated to remove reference for approval of Wegovy to reduce the risk of major adverse cardiovascular events in a patient with established cardiovascular disease who is either overweight or obese, as this indication has been removed from the policy. • Wegovy: • **Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease who is Either Obese or Overweight.** This indication and accompanying requirements were removed from the policy. • Conditions Not Recommended for Approval: • **Concomitant Use with Other Medications FDA-Approved for Weight Loss.** This condition not recommended for approval was clarified to state that concomitant use with other medications FDA-approved for weight loss is not recommended. Previously, the requirement did not specify medications were "FDA-approved" for weight loss. The note with examples of weight loss medications was updated to reflect product availability for medications FDA-approved for weight loss. • **Concomitant Use with Glucagon-Like Peptide-1 (GLP-1) Agonists or GLP-1/ Glucose-Dependent Insulinotropic Polypeptide (GIP) Agonists.** The note was updated to reflect availability for other GLP-1 or GLP-1/GIP agonists.
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 35 - (IP0739)	Update	Effective 8/1/2025 • Wegovy • **Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease who is Either Obese or Overweight.** Initial Therapy. For the requirement that a patient has had a prior stroke, a note was added that a to clarify that this does not include a transient ischemic attack (TIA). • Zepbound **Obstructive Sleep Apnea, Moderate to Severe, in a Patient with Obesity.** Initial Therapy. The requirement that a patient had a sleep study was modified to remove the timeframe that the sleep study was within the past 1 year. A patient is still required to have a sleep study. • Conditions Not Recommended for Approval: • **Concomitant Use with Other Medications FDA-Approved for Weight Loss.** This condition not recommended for approval was clarified to state that concomitant use with other medications FDA-approved for weight loss is not recommended. Previously, the requirement did not specify medications were "FDA-approved" for

		weight loss. The note with examples of weight loss medications was updated to reflect product availability for medications FDA-approved for weight loss. • **Concomitant Use with Glucagon-Like Peptide-1 (GLP-1) Agonists or GLP-1/ Glucose-Dependent Insulinotropic Polypeptide (GIP) Agonists.** The note was updated to reflect availability for other GLP-1 or GLP-1/GIP agonists.
Anticoagulants – Savaysa - (IP0034)	Update	Effective: 8/1/2025 • No criteria changes.
Complement System Disorders – WHIM Syndrome – Xolremdi - (IP0654)	Update	Effective: 8/1/2025 • No criteria changes.
Corticosteroids (Intraarticular) – Zilretta - (IP0140)	Update	Effective: 8/1/2025 • No criteria changes.
Pompe Disease – Enzyme Replacement Therapy – Pombiliti - (IP0591)	Update	Effective: 8/1/2025 • No criteria changes.
Inflammatory Conditions – Skyrizi Intravenous Prior Authorization Policy - (IP0669)	Update	Effective: 8/1/2025 • No criteria changes.
Inflammatory Conditions – Skyrizi Subcutaneous Prior Authorization Policy - (IP0670)	Update	Effective: 8/1/2025 • No criteria changes.
Afrezza – (IP0533)	Retired	Effective: 8/1/2025 • Relocated to Pharmacy Prior Authorization (1407), Drugs Requiring Medical Necessity Review for Employer Plans (1602)
Estrogen – Transdermal - (IP0590)	Retired	Effective: 8/1/2025 • Products have been relocated to Pharmacy Prior Authorization (1407), Drugs Requiring Medical Necessity Review for Employer Plans (1602), and Brands with Bioequivalent Generics (IP0011)

Hydroxyurea Tablet - (IP0325)	Retired	Effective: 8/1/2025 ▪ Relocated to Pharmacy Prior Authorization (1407), Drugs Requiring Medical Necessity Review for Employer Plans (1602)
Proton Pump Inhibitors (PPIs) – (IP0061)	Retired	Effective: 8/1/2025 • Relocated to Pharmacy Prior Authorization (1407), Drugs Requiring Medical Necessity Review for Employer Plans (1602) and Brands with Bioequivalent Generics (IP0011)
Thalitone – (IP0365)	Retired	Effective: 8/1/2025 • Relocated to Pharmacy Prior Authorization (1407), Drugs Requiring Medical Necessity Review for Employer Plans (1602)
CareAllies Medical Necessity Guideline	**New, Updated, or Retired?**	**Comments**
		• All above updates apply
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
August 2025 Prior Authorization Requirements Commercial	New/ Updates	• No precertification adds or changes were made in the month of August 2025.
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
		• No updates for August 2025
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**

		• No updates for August 2025
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**
Code Editing Policy and Guidelines	Updated	• On August 16, 2025, ClaimsXten will be updated to Third Quarter Knowledge Base content and NCCI Version 31.2 for all medical and behavioral claims we process