Payment Policy & Coding Monthly Policy Updates

Effective August 15, 2026 (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
Breast Reduction – (0152)	Updated	**Posted 8/15/2026, Effective 11/15/2026** • Revise benefit coverage statements to include "to treat macromastia" • Add weight-stabilization criteria when breast reduction is performed following significant weight loss, including weight loss related to bariatric surgery, GLP-1 agonist therapy, or other non-surgical/non-pharmacologic weight loss. • Removing integral procedure/reimbursement statement • Revise not medically necessary policy statement to consolidate procedures performed in conjunction with breast reduction surgery to treat macromastia into one list/policy statement. • Limit coverage as not medically necessary for autologous fat grafting, insertion of breast implants, implantation of mesh products to prevent bottoming out, when performed with breast reduction surgery to treat macromastia

		• Revise suction lipectomy or ultrasonically assisted suction lipectomy as the sole treatment for symptomatic macromastia from unproven to not medically necessary.
Extracorporeal Photopheresis - (0320)	New	**Posted 8/15/2025, Effective 11/15/2026** • New Policy (note: this policy was retired August 2025 and is being reinstated) I. Extracorporeal photopheresis is considered **medically necessary** for **ANY** (a through d) of the following indications: a. erythrodermic cutaneous T-cell lymphoma (CTCL) (e.g., mycosis fungoides and Sézary syndrome) b. acute or chronic graft-versus-host disease (GVHD) c. cardiac transplantation (rejection prophylaxis or cellular/recurrent rejection) d. lung transplantation (bronchiolitis obliterans syndrome, chronic lung allograft dysfunction) II. Extracorporeal photopheresis is considered **not medically necessary** for **ANY** other indication, including the following (a through o): a. solid organ graft rejection, not listed above as covered b. autoimmune diseases (e.g., multiple sclerosis, systemic sclerosis, diabetes mellitus [DM] type 1, rheumatoid arthritis, systemic lupus erythematosus [SLE], psoriasis, and pemphigus) c. atopic dermatitis d. Crohn's disease e. chronic B cell leukemia f. chronic obstructive bronchitis g. eosinophillic fasciitis h. hepatitis C i. human immunodeficiency virus (HIV) j. myasthenia gravis k. nephrogenic fibrosing sclerosis/dermopathy l. nephrogenic peritonitis m. Non-erythrodermic mycosis fungoides

		n. prevention of re-stenosis after percutaneous transluminal coronary angioplasty (PTCA) composite tissue allotransplantation
Laser Interstitial Thermal Therapy – (0528)	Updated	**Posted 08/15/2026, Effective 11/15/2026** Important changes in coverage criteria: • Revised policy language to state "neurosurgeon trained in LITT" instead of "at least two specialists". • Add coverage of newly diagnosed (i.e., primary) glioblastoma or other glioma. • Remove the word "symptomatic" from criteria for malignant brain neoplasms and radiation necrosis. • Update the size criteria of malignant brain neoplasms or radiation necrosis lesions from 30 cc in volume to 3 cm in diameter.
Nucleic Acid Pathogen Testing - (0530)	Updated	**Posted 05/15/2026, Effective 08/15/2026** Important change(s) in coverage criteria/policy: • Added CPT code 87632 (Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus, 6-11 targets) to coding section of policy. Posted 08/15/2026 • Revised policy statement table for nucleic acid pathogen testing for certain STIs in the symptomatic individual. Aligned codes with associated pathogen(s) and removed deleted codes as appropriate, for clarification. No changes to coverage intent. • Removed policy statement for central nervous system pathogens testing.
Site of Care: Outpatient Hospital Setting for Physical and Occupational Therapy - (0600)	Updated	Important changes in coverage criteria/policy: • Clarified what is meant by "specialized" equipment and personnel by expanding upon the examples provided in parentheses. • Expanded criteria to include multidisciplinary clinical expertise. • Expanded criteria by adding a bullet point which allows an outpatient hospital setting when a freestanding PT/OT facility would cause a barrier to care. • Clarified intent by removing the list of specific conditions/indications.

		1. Physical therapy (PT) or occupational therapy (OT) services provided in an outpatient hospital setting is considered **medically necessary** for an adult or pediatric patient when **ANY** of the following criteria (a through e) is met: a. Specialized equipment (e.g., overhead harness system for gait training, exoskeleton for gait, continuous physiologic monitoring [e.g., telemetry/ECG], oxygen titration or cardiopulmonary support equipment, advanced transfer or mobility systems, specialized wound care or burn management equipment) is required for medically necessary PT/OT services not available in a free-standing PT/OT facility. b. Specialized PT/OT personnel (e.g., board certified cardiovascular and pulmonary clinical specialist, wound care certified, expertise in managing medically complex or high-risk individuals) who are not available in a free-standing PT/OT facility are required to provide medically necessary services. c. Coordinated multidisciplinary clinical expertise (e.g., specialized personnel with advanced certification or expertise including but not limited to cardiovascular, pulmonary, wound care), not available in a free-standing PT/OT facility, is required to safely provide medically necessary services. c. A freestanding PT/OT facility is not available within a reasonable geographical location/distance. d. Use of a freestanding PT/OT facility would cause a barrier to equitable delivery of care (e.g., limitations in accessible transportation, lack of language or communication support services, or insufficient accommodations for physical or cognitive impairments).
Thymus Tissue Transplantation - (0561)	Updated	Minor change(s) in coverage criteria/policy: • Add 'partial DiGeorge syndrome' to the list of conditions considered not medically necessary. (This is for clarification; diagnosis is already excluded by T cell parameters listed in policy statement.
Fixed Wing Air Ambulance Transport – (0555)	Updated	• No change in coverage
Anesthesia and Facility Services for Dental Treatment – (0415)	Updated	• No change in coverage.

Continuous Passive Motion (CPM) Devices – (0198)	Updated	• No change in coverage.
Gynecomastia Surgery – (0195)	Updated	• No change in coverage.
Stem Cell Transplantation: Blood Cancers - (0533)	Updated	• No change in coverage.
Ultrasound in Pregnancy (including 3D, 4D and 5D Ultrasound) - (0142)	Updated	• No change in coverage
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
Electric Stimulation for Pain, Swelling and Function in a Clinic Setting - (272)	Updated	• No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-EviCore High-Tech Imaging Guidelines	Updated	**Effective 9/1/2026** Two guidelines were updated with clinical changes which will expand coverage: • Cardiac Imaging • Pelvis Imaging Four guidelines were updated with clinical changes which will expand and limit coverage: • Breast Imaging • Musculoskeletal Imaging • Oncology Imaging

		• Pediatric and Special Populations Oncology Imaging Nine guidelines were updated with no clinically impactful changes: • Head Imaging • Pediatric Abdomen Imaging • Pediatric Chest Imaging • Pediatric Head Imaging • Pediatric Musculoskeletal Imaging • Pediatric Peripheral Vascular Disease Imaging • Peripheral Vascular Disease Imaging • Preface to the Imaging Guidelines • Spine Imaging
Cobranded Cigna-EviCore Comprehensive Musculoskeletal Management Guidelines	Updated	**Effective 9/1/2026** One guideline was updated with no clinically impactful changes: • CMM-210: Implantable Intrathecal Drug Delivery Systems
Administrative Policy	**New, Updated, or Retired?**	**Comments**
Authorized Generics (A008)	Updated	**Effective 8/1/2026** **Added** umeclidinium Ellipta (authorized generic for Incruse Ellipta) and umeclidinium and vilanterol inhalation powder (authorized generic for Anoro Ellipta) as a not covered product for Individual and Family Plans. • **Added** umeclidinium Ellipta (authorized generic for Incruse Ellipta) as a not covered product for all Employers Plans.
Non-Participating Laboratory Services - (A001)	Updated	**Effective 8/8/2026** • No changes, annual update.

Midwife, Home Birth and Non-Clinical Maternal Services - (A002)	Updated	**Effective 8/8/2026** • No changes, annual update.
Emergency Services - (A005)	Updated	**Effective 8/8/2026** • No changes, annual update.
Abortion - (A006)	Updated	**Effective 8/8/2026** • No changes, annual update.
Clinical Trials - (A003)	Updated	**Effective 8/15/2026** • No changes, annual update.
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Alzheimer's Disease – Amyloid Beta-Directed Antibodies – Kisunla (IP0697)	Updated	**Effective 8/15/2026** **Documentation statement** was added to the policy. **Alzheimer's Disease:** This condition of approval was added. **Conditions Not Covered:** Removed Alzheimer's Disease.
Alzheimer's Disease – Amyloid Beta-Directed Antibodies – Leqembi Intravenous (IP0547)	Updated	**Effective 8/15/2026** **Policy Name: Updated from** "Neurology - Leqembi" **to** "Alzheimer's Disease – Amyloid Beta-Directed Antibodies – Leqembi Intravenous" Leqembi IQLIK was removed from the policy. **Documentation statement** was added to the policy.

		Alzheimer's Disease: This condition of approval was added. **Conditions Not Covered:** Removed Alzheimer's Disease.
Alzheimer's Disease – Amyloid Beta-Directed Antibodies – Leqembi IQLIK (IP0796)	New	**Effective 8/15/2026** **New Policy.**
Aminocaproic Acid for Individual and Family Plans (IP0463)	Retired	**Effective 8/1/2026** • Prior Authorization removed from aminocaproic acid on all Individual and Family Plans formularies Amicar oral solution and Amicar tablets relocated to Pharmacy and Medical Prior Authorization - (1407)
Anticoagulants – Dabigatran (IP0033)	Updated	**Effective 8/1/2026** **Pradaxa capsules:** **Treatment or Prevention of Other Thromboembolic-Related Conditions.** **Updated from** "Patient has had failure, contraindication or intolerance to ONE of the following: warfarin, fondaparinux, or a low molecular weight heparin product (e.g., enoxaparin, Fragmin [dalteparin injection])" **to** "Patient has tried warfarin, fondaparinux, or a low molecular weight heparin product (e.g., enoxaparin, Fragmin [dalteparin injection])" **Updated from** "Patient has been started on dabigatran capsules for the treatment of an acute thromboembolic condition" **to** "Patient has been started on dabigatran capsules." **Pradaxa oral pellets:** **Treatment or Prevention of Other Thromboembolic-Related Conditions.** **Updated from** "Patient has had failure, contraindication or intolerance to ONE of the following: warfarin, fondaparinux, or a low molecular weight heparin product (e.g., enoxaparin, Fragmin [dalteparin injection])" **to** "Patient has tried warfarin, fondaparinux, or a low molecular weight heparin product (e.g., enoxaparin, Fragmin [dalteparin injection])" **Updated from** "Patient has been started on Pradaxa oral pellets for the treatment of an acute thromboembolic condition" **to** "Patient has been started on Pradaxa oral pellets." **Employer Plans and Individual and Family Plans Preferred Product Table:** **Pradaxa 75 mg, 110 mg, 150 mg:** **Updated from** "The individual has tried dabigatran capsule (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

		dabigatran capsule (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] which, per the prescriber, would result in a significant allergy or serious adverse reaction." **Pradaxa Oral Pellets:** **Removed** documentation requirements. **Updated from** "Currently receiving Pradaxa oral pellets for treatment of thrombosis (for example, deep vein thrombosis [DVT] or pulmonary embolism [PE])" **to** "Patient is currently receiving Pradaxa oral pellets or dabigatran capsules (Pradaxa capsules, generic)." **Added** Note: If the patient has tried the tablet form of the alternative, this meets criteria for Patient is < 8 years of age. **Updated from** "Patient is <2.6 kg and has tried rivaroxaban oral suspension (Xarelto oral suspension, generics) Note: If the patient has tried the tablet form of the alternative, this meets criteria." **to** "Patient is <2.6 kg"
Anticoagulants – Savaysa (IP0034)	Updated	**Effective 8/1/2026** **Treatment or Prevention of Other Thromboembolic-Related Conditions.** **Added** Eliquis tablets for oral suspension, Eliquis Sprinkle and Pradaxa oral pellets to the list of products tried for patients to not be required to try warfarin, fondaparinux, or a low molecular weight heparin. **Updated from** "Patient has been started on Savaysa for the treatment of an acute thromboembolic condition" **to** "Patient has been started on Savaysa" **Employer Plans Preferred Product Table:** **Added** Pradaxa capsules, generic or Pradaxa oral pellets to the dabigatran requirement. **Added** Eliquis tablets, Eliquis tablets for oral suspension, or Eliquis sprinkle capsules for oral suspension to the Eliquis requirement. **Added** Xarelto tablets, Xarelto oral suspension to the Xarelto requirement. **Updated from** "The patient is currently receiving Savaysa. for treatment of thrombosis (e.g., deep vein thrombosis [DVT] or pulmonary embolism [PE])" to "The patient is currently receiving Savaysa" **Removed** "The patient is using Savaysa for the treatment of DVT or PE associated with cancer and has tried Eliquis" **Removed** "The patient is currently receiving Savaysa for prophylaxis of DVT or PE after orthopedic surgery (e.g., hip replacement surgery)" **Individual and Family Plans Preferred Product Table:** **Added** Eliquis tablets, Eliquis tablets for oral suspension, or Eliquis sprinkle capsules for oral suspension to the Eliquis requirement.

		Added Xarelto tablets, Xarelto oral suspension [may require prior authorization] to the Xarelto requirement. **Added** "Note: A trial of any dabigatran product (Pradaxa capsules, generic or Pradaxa oral pellets) would count towards meeting the requirement." **Updated from** "The patient is currently receiving Savaysa. for treatment of thrombosis (e.g., deep vein thrombosis [DVT] or pulmonary embolism [PE])" **to** "The patient is currently receiving Savaysa" **Removed** "The patient is using Savaysa for the treatment of DVT or PE associated with cancer and has tried Eliquis" **Removed** "The patient is currently receiving Savaysa for prophylaxis of DVT or PE after orthopedic surgery (e.g., hip replacement surgery)"
Antiseizure Medications (IP0031)	Retired	**Effective 8/1/2026** All products relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602) for Employer Plans
Attention Deficit Hyperactivity Disorder Non-Stimulant Medications (IP0217)	Updated	**Effective 8/15/2026** **Employer Plans and Individual and Family Plans** **Preferred Product Tables:** **Added** The patient has already been started on therapy with Onyda XR. **Added** The patient has already been started on therapy with Qelbree.
Attention Deficit Hyperactivity Disorder (ADHD) Stimulant Medications for Employer Group Plans (IP0477)	Updated	**Effective 8/15/2026** **Arynta:** Arynta (lisdexamfetamine dimesylate oral solution) was added to the policy. **Added** preferred product requirements for Arynta. **Updated** the amphetamine ER ODT tablets (generic for Adzenys XR ODT) preferred product requirements.
Attention Deficit Hyperactivity Disorder (ADHD) Stimulant Medications for Individual and Family Plans (IP0584)	Updated	**Effective 8/1/2026** **Arynta:** Arynta (lisdexamfetamine dimesylate oral solution) was added to the policy with the same approval criteria as lisdexamfetamine capsules (Vyvanse, generic).
Bone Modifiers – Evenity (IP0179)	Updated	**Effective 8/1/2026** **Osteoporosis – Treatment of a Postmenopausal Patient:** Added an exception allowing bypass of bisphosphonate trial for a patient with a very low T-score < -3.0. The Note

		providing examples of significant intolerance to an oral bisphosphonate was updated to remove femoral fractures.
Bone Modifiers – Denosumab Products (Prolia) (IP0331)	Updated	**Effective 8/1/2026** **Osteoporosis – Treatment of a Postmenopausal Patient**: Added an exception allowing bypass of bisphosphonate trial for a patient with a very low T-score < -3.0. **Conditions Not Recommended for Approval**: For Concurrent Use with Other Medications for Osteoporosis, it was clarified this criterion applies only to osteoporosis-related indications. **Coding Information:** **Added** HCPCS Q5167 **Updated** the description for C9399, J3490 & J3590 to include the note "Code effective until 6/30/2026" **Added** the note "Codes effective until 6/30/2026" to the following dagger note for HCPCS codes C9399, J3490, and J3590: †Note: Considered Medically Necessary when used to report Enoby™ (denosumab-qbde subcutaneous injection – Hikma) and medical necessity criteria outlined in this Coverage Policy are met (Codes effective until 6/30/2026).
Bone Modifiers – Teriparatide (IP0330)	Updated	**Effective 8/1/2026** **Osteoporosis – Treatment of a Postmenopausal Patient:** Added an exception allowing bypass of bisphosphonate trial for a patient with a very low T-score < -3.0.
Bone Modifiers – Tymlos (IP0329)	Updated	**Effective 8/1/2026** **Osteoporosis – Treatment of a Postmenopausal Patient:** Added an exception allowing bypass of bisphosphonate trial for a patient with a very low T-score < -3.0.
Brands with Bioequivalent Generics (IP0011)	Updated	**Effective 8/15/2026** **Removed for Employer Plans:** Sulfatrim
Complement Inhibitors – Empaveli (IP0194)	Updated	**Effective 8/1/2026** **No criteria changes**
Complement Inhibitors – Voydeya (IP0647)	Updated	**Effective 8/1/2026**

		No criteria changes
Complement System Disorders-WHIM Syndrome-Xolremdi (IP0654)	Updated	**Effective 8/1/2026** **WHIM syndrome:** Updated to require submission of supporting documentation for genetic testing results and documentation of neutrophil and white blood cell (WBC) counts.
Crysvita (IP0285)	Updated	**Effective 8/1/2026** **X-Linked Hypophosphatemia:** Dosing criteria were updated to approve up to 90 mg administered subcutaneously not more frequently than once every 2 weeks, regardless of the patient's age. Previously, these criteria approved the above dosing for a patient < 18 years of age. For a patient ≥ 18 years of age, criteria previously approved up to a maximum of 90 mg administered subcutaneously not more frequently than once every 4 weeks.
Dermatology – Hyaftor (IP0511)	Updated	**Effective 8/15/2026** No criteria changes.
Dermatology – Vtama Drug Quantity Management Policy – Per Days (DQM024)	Updated	**Effective 8/15/2026** ○ No criteria changes.
Drugs Requiring Medical Necessity Review for Employer Plans (1602)	Updated	**Effective 8/1/2026** **Added preferred product requirement criteria for the following:** **EFFECTIVE 8/1/2026:** clonidine 0.05 mg tablet (brand), Briviact (tablets and oral solution), Elepsia XR, Eprontia, Lamictal XR Starter Kit, Motpoly XR, oxcarbazepine extended-release tablets, Oxtellar XR, Spritam, Xcopri, Zonisade, Edurant, Atmeksi, Savella, Coxanto, diclofenac potassium 25 mg capsules and tablets, fenoprofen 200 mg capsules (brand), fenoprofen 400 mg capsules, Indocin suspension, Indocin suppository, ketoprofen 25 mg capsules, Lofena, mefenamic acid 250 mg capsules, meloxicam capsules and suspension, Nalfon, Naprelan, naproxen sodium CR tablets, naproxen sodium ER tablets, Naprosyn, naproxen 125 mg/5 mL oral suspension, oxaprozin 300 mg capsules (brand), Relafen DS, Sprix, Tivorbex, Tolectin, Vivlodex, Zipsor, and Zorvolex **EFFECTIVE 8/15/2026:** Verquvo **Updated preferred product requirement criteria for the following:** **EFFECTIVE 8/1/2026:** topiramate 50 mg oral sprinkle capsules (brand), Emrosi, and Afrezza

		Removed preferred product requirement criteria for the following: **EFFECTIVE 8/1/2026:** brivaracetam (oral solution and tablets) and Dxevo 11 Day Dose Pack
Drugs Requiring Medical Necessity Review for Employer Plans (1602)	Updated	**Effective 8/15/2026** **Added preferred product requirement criteria for the following:** **EFFECTIVE 8/15/2026:** butalbital 25 mg and acetaminophen 325 mg tablet, Auvelity titration pack, Granisol oral solution, Januvia, Janumet, Astagraf XL, Cafergot, cyclobenzaprine ER 15 mg and 30 mg capsules, Relgaabi 200 mg capsule (brand) **EFFECTIVE 9/1/2026:** Emend oral suspension, Altoprev, Atorvaliq, Crestor, Ezallor Sprinkle, FloLipid, Lescol XL, Lipitor, Livalo, Roszet, rosuvastatin and ezetimibe tablets, Vytorin, Zocor, Zypitamag, calcipotriene 0.005% foam, Sorilux, Vectical, Enstilar, Taclonex ointment, Taclonex topical suspension, Wynzora **Updated preferred product requirement criteria for the following:** **EFFECTIVE 8/15/2026:** Auvelity, Ibsrela, alogliptin tablets, Brynovin, Nesina, sitagliptin 25 mg, 50 mg, and 100 mg tablets, Tradjenta, Zituvio, alogliptin and metformin tablets, alogliptin and pioglitazone tablets, Jentadueto, Jentadueto XR, Kazano, Oseni, sitagliptin and metformin tablets, Zituvimet, Admelog, Afrezza, Apidra, Fiasp, insulin aspart, Kirsty, NovoLog, Brenzavvy, bexagliflozin tablets, Invokana, Steglatro, Cipro HC Otic Suspension, Myrbetriq granules, Ermeza, levothyroxine capsules, Thyquidity, Tirosint, Tirosint-SOL **EFFECTIVE 9/1/2026:** valsartan oral solution, Edarbi, Edarbyclor **Removed preferred product requirement criteria for the following:** **EFFECTIVE 8/15/2026:** Onglyza, Merilog, GlucaGen HypoKit, ciprofloxacin/hydrocortisone 0.2%/1% otic suspension
Enzyme Replacement Therapy – Avlayah (IP0807)	New	**Effective 8/1/2026** New policy.
Growth Disorders – Yuviwel (IP0799)	New	**Effective 8/15/2026** New policy.
Gout - Krystexxa (IP0269)	Updated	**Effective 8/1/2026** ○ **Gout, Chronic:** The requirement that a patient has had two previous gout flares was clarified to add "at least" two previous flares. The term "drug" was updated to "therapy" throughout. Also, the dosing was clarified to add "no more frequently than."

Hematology – Omisirge (IP0817)	New	**Effective 8/1/2026** New Policy.
Hepatology – Iqirvo (IP0710)	Updated	**Effective 8/1/2026** **Conditions Not Covered**: Concomitant use with Livdelzi (seladelpar capsules) or Lynavoy (linerixibat tablets) was added.
Hepatology – Livdelzi (IP0711)	Updated	**Effective 8/1/2026** **Conditions Not Covered:** Concomitant use with Ocaliva (obeticholic acid tablets) was removed while concomitant use with Lynavoy (linerixibat tablets) was added
Hereditary Angioedema – Ekterly (IP0756)	Updated	**Effective 8/15/2026** • No criteria changes.
HIV Products (P0050)	Updated	**Effective 8/1/2026** **Removed** Edurant from the policy.
Hyperlipidemia – Nexletol – (IP0248)	Updated	**Effective 8/1/2026** **Reduce Major Adverse Cardiovascular Events in Patients at Increased Risk:** The diagnosis was changed to as listed; previously, it was "Established Cardiovascular Disease". A Note was added that this includes only patients with established cardiovascular disease. The Note in the asterisk at the end of the criteria was changed to reflect this modification. **Heterozygous Familial Hypercholesterolemia (HeFH):** **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]**; **Hypercholesterolemia**: The name of this indication was changed to as listed (Previously "Primary Hyperlipidemia."). The Note in the asterisk at the end of the criteria was changed to reflect this modification.

		The requirement for a patient to have a coronary artery calcium or calcification score ≥ 300 was replaced with a requirement that, according to the prescriber, the patient is at risk for atherosclerotic cardiovascular disease (ASCVD), an ASCVD event, or a major adverse cardiovascular event (MACE). **Preferred Product Table.** **Updated from** "Approve if the patient has tried a Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) inhibitor [e.g., Praluent or Repatha]." **To** "Approve if the patient has met the following: If the patient is considered to be statin intolerant, the patient has tried ezetimibe, an ezetimibe (Zetia)-containing product OR a Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) inhibitor product [e.g., Leqvio, Praluent, or Repatha"
Hyperlipidemia – Nexlizet – (IP0249)	Updated	**Effective 8/1/2026** **Reduce Major Adverse Cardiovascular Events in Patients at Increased Risk:** The diagnosis was changed to as listed; previously, it was "Established Cardiovascular Disease". A Note was added that this includes only patients with established cardiovascular disease. The Note in the asterisk at the end of the criteria was changed to reflect this modification. **Heterozygous Familial Hypercholesterolemia (HeFH):** **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]**; **Hypercholesterolemia**: The name of this indication was changed to as listed (Previously "Primary Hyperlipidemia."). The Note in the asterisk at the end of the criteria was changed to reflect this modification. The requirement for a patient to have a coronary artery calcium or calcification score ≥ 300 was replaced with a requirement that, according to the prescriber, a patient is at risk for atherosclerotic cardiovascular disease (ASCVD), an ASCVD event, or a major adverse cardiovascular event (MACE). **Preferred Product Table.** **Updated from** "Approve if the patient has tried a Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) inhibitor product [e.g., Praluent or Repatha]." **To "**Approve if the patient has met the following: If the patient is considered to be statin intolerant, the patient has

		tried ezetimibe, an ezetimibe (Zetia)-containing product OR a Proprotein Convertase Subtilisin Kexin Type 9 (PCSK9) inhibitor product [e.g., Leqvio, Praluent, or Repatha].”
Hyperlipidemia – PCSK9 Inhibitors – Lerochol (IP0811)	New	**Effective 8/1/2026** New policy.
Immune Globulin (5026)	Retired	**Effective 8/15/2026** Criteria relocated to IP0776 & IP0777
Immune Globulin – Intravenous (IP0776)	New	**Effective 8/15/2026** New Policy.
Immune Globulin – Subcutaneous (IP0777)	New	**Effective 8/15/2026** New Policy.
Immunologicals – Fasenra (IP0421)	Updated	**Effective 8/1/2026** • **Hypereosinophilic Syndrome:** New approval criteria for this indication were added.
Immunologicals – Nucala (IP0422)	Updated	**Effective 8/1/2026** • **Hypereosinophilic Syndrome:** Initial approval duration was changed from 8 months to 6 months. The requirement that the patient has had hypereosinophilic syndrome for 6 months was removed.
Inflammatory Conditions – Adalimumab Products Drug Quantity Management Policy – Per Days – (DQM005)	Updated	**Effective 8/15/2026** No criteria changes.
Inflammatory Conditions – Infliximab Intravenous Products Preferred Specialty	Updated	**Effective 8/15/2026** No criteria changes.

Management Policy (PSM005)		
Inflammatory Conditions - Spevigo Intravenous Prior Authorization Policy (IP0501)	Updated	**Effective 8/1/2026** The Policy Statement was revised to note that this policy applies to the Spevigo intravenous formulation. **Generalized Pustular Psoriasis Flare:** The approval duration was changed to 1 month; previously, it was up to two doses. Regarding the requirement that the patient is experiencing a flare of moderate to severe intensity, the phase "according to the prescriber" was added; the phrase "experiencing" a flare was changed to "treating a current" flare. Regarding previous receipt of Spevigo intravenous, the requirements were divided into separate criterion. Regarding treatment of the current flare, the wording that the "patient has not already received two doses of Spevigo intravenous" was changed to "two or more doses of Spevigo intravenous." The requirement that if the patient has previously received two doses of Spevigo intravenous at least 12 weeks have elapsed since the last dose of Spevigo was reworded to state "if the patient has received Spevigo intravenous for the treatment of a previous flare, at least 12 weeks have elapsed since the last dose of Spevigo intravenous." Regarding Dosing, the following requirements were removed: 1) if a second doses is administered, 7 days elapse between the doses; and 2) if this is a new flare, at least 12 weeks have elapsed since the last dose of Spevigo. Also, regarding the approval of 900 mg per dose administered by intravenous infusion, the qualifier "for up to two doses per flare" was added.
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance and Total Savings Prescription Drug Lists - (PSM009)	Updated	**Effective 8/20/2026** For **Ankylosing Spondylitis, Non-radiographic Axial Spondyloarthritis, and Psoriatic Arthritis:** Cosentyx subcutaneous was added as a Step 1 Preferred Product. **Preferred and Non-Preferred Products Table:** Updated table to clarify that Xeljanz brand is a Step 3c Non-Preferred Product directing to one Step 1 Product AND generic tofacitinib. It previously was a Step 1 TNFi AND generic tofacitinib.
Inflammatory Conditions – Cosentyx Intravenous Preferred	Updated	**Effective 8/20/2026**

Specialty Management Policy for Employer Plans: Value/Advantage Prescription Drug Lists - (PSM036)		For **Ankylosing Spondylitis, Non-radiographic Axial Spondyloarthritis, and Psoriatic Arthritis:** Cosentyx subcutaneous was added as a Step 1 Preferred Product. **Preferred and Non-Preferred Products Table:** Updated table to clarify that Xeljanz brand is a Step 3c Non-Preferred Product directing to one Step 1 Product AND generic tofacitinib. It previously was a Step 1 TNFi AND generic tofacitinib.
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Legacy Prescription Drug List Plans - (PSM016)	Updated	**Effective 8/20/2026** For **Ankylosing Spondylitis, Non-radiographic Axial Spondyloarthritis, and Psoriatic Arthritis:** Cosentyx subcutaneous was added as a Step 1 Preferred Product. **Preferred and Non-Preferred Products Table:** Updated table to clarify that Xeljanz brand is a Step 3c Non-Preferred Product directing to one Step 1 Product AND generic tofacitinib. It previously was a Step 1 TNFi AND generic tofacitinib.
Inflammatory Conditions – Tofacitinib Products Preferred Specialty Management Policy for Legacy Prescription Drug List Plans - (PSM041)	Updated	**Effective 8/20/2026** **Cosentyx SC**: **For Ankylosing Spondylitis** and **Psoriatic Arthritis** moved Cosentyx SC from Step 3a to Step 1. Xeljanz/XR and generic tofacitinib/XR criteria for these indications were updated to add Cosentyx SC amongst the preferred products. **Xeljanz/XR**: The step was modified so that a patient is directed to one Step 1 agent and generic tofacitinib. Previously, a patient was directed to one Step 1 TNF inhibitor and generic tofacitinib. The **Ankylosing Spondylitis, Psoriatic Arthritis,** and **Ulcerative Colitis** criteria were updated accordingly to revise the agents that count toward this requirement.
Inflammatory Conditions – Tofacitinib Products Preferred Specialty Management Policy for Standard/Performance and Total Savings Prescription Drug List Plans - (PSM040)	Updated	**Effective 8/20/2026** **Cosentyx SC**: **For Ankylosing Spondylitis** and **Psoriatic Arthritis** moved Cosentyx SC from Step 3a to Step 1. Xeljanz/XR and generic tofacitinib/XR criteria for these indications were updated to add Cosentyx SC amongst the preferred products. **Xeljanz/XR**: The step was modified so that a patient is directed to one Step 1 agent and generic tofacitinib. Previously, a patient was directed to one Step 1 TNF inhibitor and generic tofacitinib. The **Ankylosing Spondylitis, Psoriatic Arthritis,** and **Ulcerative Colitis** criteria were updated accordingly to revise the agents that count toward this requirement.
Inflammatory Conditions – Tofacitinib Products	Updated	**Effective 8/20/2026**

Preferred Specialty Management Policy for Value/Advantage Prescription Drug List Plans -(PSM042)		**Cosentyx SC**: **For Ankylosing Spondylitis** and **Psoriatic Arthritis** moved Cosentyx SC from Step 3a to Step 1. Xeljanz/XR and generic tofacitinib/XR criteria for these indications were updated to add Cosentyx SC amongst the preferred products. • **Xeljanz/XR**: The step was modified so that a patient is directed to one Step 1 agent and generic tofacitinib. Previously, a patient was directed to one Step 1 TNF inhibitor and generic tofacitinib. The **Ankylosing Spondylitis, Psoriatic Arthritis,** and **Ulcerative Colitis** criteria were updated accordingly to revise the agents that count toward this requirement.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Legacy Drug List Plans - (PSM003)	Updated	**Effective 8/20/2026** **Appendix A.** **Non-Adalimumab Preferred Products:** Cosentyx SC was added as a Preferred product for ankylosing spondylitis, non-radiographic axial spondyloarthritis, psoriatic arthritis, and psoriasis.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Value/Advantage Prescription Drug Lists - (PSM035)	Updated	**Effective 8/20/2026** **Appendix A.** **Non-Adalimumab Preferred Products:** Cosentyx SC was added as a Preferred product for ankylosing spondylitis, non-radiographic axial spondyloarthritis, psoriatic arthritis, and psoriasis.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy: Standard/Performance, and Total Savings Prescription Drug Lists - (PSM013)	Updated	**Effective 8/20/2026** **Appendix A.** **Non-Adalimumab Preferred Products:** Cosentyx SC was added as a Preferred product for ankylosing spondylitis, non-radiographic axial spondyloarthritis, psoriatic arthritis, and psoriasis.

Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Legacy Prescription Drug List Plans - (PSM022)	Updated	**Effective 8/20/2026** **Appendix: Non-Ustekinumab Preferred Products:** Cosentyx SC was added as a Preferred product for psoriatic arthritis and psoriasis.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Standard/Performance and Total Savings Prescription Drug Lists - (PSM021)	Updated	**Effective 8/20/2026** **Appendix: Non-Ustekinumab Preferred Products:** Cosentyx SC was added as a Preferred product for psoriatic arthritis and psoriasis.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Value/Advantage Prescription Drug Lists - (PSM038)	Updated	**Effective 8/20/2026** **Appendix: Non-Ustekinumab Preferred Products:** Cosentyx SC was added as a Preferred product for psoriatic arthritis and psoriasis.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management	Updated	**Effective 8/20/2026** **For Psoriatic Arthritis:** Cosentyx subcutaneous was added as a Step 1 Preferred Product. A trial of Cosentyx intravenous also counts.

Policy for Employer Plans: Standard/Performance and Total Savings Prescription Drug Lists - (PSM006)		**Preferred and Non-Preferred Products Table:** Updated table to clarify that Xeljanz brand is a Step 3c Non-Preferred Product directing to one Step 1 Product AND generic tofacitinib. It previously was a Step 1 TNFi AND generic tofacitinib.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Employer Plans: Value/Advantage Prescription Drug Lists - (PSM037)	Updated	**Effective 8/20/2026** **For Psoriatic Arthritis:** Cosentyx subcutaneous was added as a Step 1 Preferred Product. A trial of Cosentyx intravenous also counts. **Preferred and Non-Preferred Products Table:** Updated table to clarify that Xeljanz brand is a Step 3c Non-Preferred Product directing to one Step 1 Product AND generic tofacitinib. It previously was a Step 1 TNFi AND generic tofacitinib.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Legacy Prescription Drug Lists - (PSM018)	Updated	**Effective 8/20/2026** **For Psoriatic Arthritis:** Cosentyx subcutaneous was added as a Step 1 Preferred Product. A trial of Cosentyx intravenous also counts. **Preferred and Non-Preferred Products Table:** Updated table to clarify that Xeljanz brand is a Step 3c Non-Preferred Product directing to one Step 1 Product AND generic tofacitinib. It previously was a Step 1 TNFi AND generic tofacitinib.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Legacy Prescription Drug Lists - (PSM017)	Updated	**Effective 8/20/2026** **Cosentyx SC:** For **Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis**, and **Plaque Psoriasis,** moved Cosentyx SC from Step 3a to Step 1. For all indications except plaque psoriasis, a trial of Cosentyx intravenous also counts. Criteria for Cimzia, Bimzelx, Simponi, Orencia, Ilumya, Siliq, and Rinvoq/LQ were updated to include Cosentyx SC as a Preferred Product. **Rinvoq:** For **Crohn's disease** and **Ulcerative Colitis,** added a note stating if a TNF inhibitor is not clinically advisable according to the prescriber, a trial of adalimumab is not required. ○ **Xeljanz/XR**: The step was modified so that a patient is directed to one Step 1 agent and generic tofacitinib. Previously, a patient was directed to one Step 1 TNF inhibitor and generic tofacitinib.

Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance and Total Savings Prescription Drug Lists - (PSM001)	Updated	**Effective 8/20/2026** **Cosentyx SC:** For **Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis**, and **Plaque Psoriasis,** moved Cosentyx SC from Step 3a to Step 1. For all indications except plaque psoriasis, a trial of Cosentyx intravenous also counts. Criteria for Cimzia, Bimzelx, Simponi, Orencia, Ilumya, Siliq, and Rinvoq/LQ were updated to include Cosentyx SC as a Preferred Product. **Rinvoq:** For **Crohn's disease** and **Ulcerative Colitis,** added a note stating if a TNF inhibitor is not clinically advisable according to the prescriber, a trial of adalimumab is not required. **Xeljanz/XR**: The step was modified so that a patient is directed to one Step 1 agent and generic tofacitinib. Previously, a patient was directed to one Step 1 TNF inhibitor and generic tofacitinib.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Value/Advantage Prescription Drug Lists - (PSM020)	Updated	**Effective 8/20/2026** **Cosentyx SC:** For **Ankylosing Spondylitis, Non-Radiographic Axial Spondyloarthritis, Psoriatic Arthritis**, and **Plaque Psoriasis,** moved Cosentyx SC from Step 3a to Step 1. For all indications except plaque psoriasis, a trial of Cosentyx intravenous also counts. Criteria for Cimzia, Bimzelx, Simponi, Orencia, Ilumya, Siliq, and Rinvoq/LQ were updated to include Cosentyx SC as a Preferred Product. **Rinvoq:** For **Crohn's disease** and **Ulcerative Colitis,** added a note stating if a TNF inhibitor is not clinically advisable according to the prescriber, a trial of adalimumab is not required. **Xeljanz/XR**: The step was modified so that a patient is directed to one Step 1 agent and generic tofacitinib. Previously, a patient was directed to one Step 1 TNF inhibitor and generic tofacitinib.
Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)	Updated	**Effective 8/20/2026** **Rinvoq:** For **Crohn's disease** and **Ulcerative Colitis,** added a note stating if a TNF inhibitor is not clinically advisable according to the prescriber, a trial of adalimumab is not required.
Inpefa (IP0582)	Updated	**Effective 8/15/2026** **Conditions Not Covered** **Type 1 Diabetes:** **Updated** supporting data for this condition.

		Employer Plans and Individual and Family Plans Preferred Product Table: **Added** generic dapagliflozin to available Farxiga products.
Lipodystrophy – Egrifta (IP0209)	Updated	**Effective 8/1/2026** No criteria changes.
Menkes Disease – Zycubo - (IP0794)	Updated	**Effective 8/1/2026** **Updated** the policy title from "Zycubo for Individual and Family Plans" to "Menkes Disease – Zycubo."
Metabolic Disorders – Cysteamine (Oral) Products for Employer Plans (IP0046)	Updated	**Effective 8/15/2026** No criteria changes.
Metabolic Disorders – Cysteamine (Oral) Products for Individual and Family Plans (IP0466)	Updated	**Effective 8/15/2026** No criteria changes.
Multiple Sclerosis (Injectable – CD20-Directed Cytolytic Antibody) – Ocrevus Intravenous (IP0212)	Updated	**Effective 8/15/2026** The policy name was changed to add the word "intravenous" such that it now reads *Multiple Sclerosis (Injectable – CD20-Directed Cytolytic Antibody) – Ocrevus Intravenous Utilization Management Medical Policy.* ○ **Multiple Sclerosis, Relapsing Forms:** The age requirement was lowered from ≥ 18 years of age to ≥ 10 years of age. For a patient < 18 years of age, the patient must also weigh ≥ 25 kg. In **Dosing,** the phrase "up to" was added to the initial and maintenance dosing prior to the milligram quantity.
Muscular Dystrophy – Deflazacort (IP0131)	Updated	**Effective 8/1/2026** Kymbee™ (deflazacort) oral suspension was added to the coverage policy; no changes were made to the clinical criteria.
Nephrology – Filspari IP0565	Updated	**Effective 8/1/2026**

		Focal Segmental Glomerulosclerosis: The requirement that the patient has received the maximum or maximally tolerated dose of an angiotensin converting enzyme inhibitor or angiotensin receptor blocker for ≥ 6 months prior to starting the medication was added.
Nephrology – Vafseo (IP0706)	Updated	**Effective 8/15/2026** • No criteria changes.
Neurology – Lyrica CR (IP0183)	Updated	**Effective 8/1/2026** **Policy Statement:** In the statement that the patient is directed to try gabapentin immediate-release, the word "Neurontin" was removed**.** **Neuropathic Pain Associated with Diabetic Peripheral Neuropathy:** In the requirement for a trial of gabapentin immediate-release, the word "Neurontin" was removed. • **Postherpetic Neuralgia:** In the requirement for a trial of gabapentin immediate-release, the word "Neurontin" was removed.
Neurology – Vyvgart Hytrulo - IP0574	Updated	**Effective 8/1/2026** **Generalized Myasthenia Gravis.** **Removed** the criterion that the patient has confirmed anti-acetylcholine receptor antibody-positive generalized myasthenia gravis **[documentation required]**. • **Added [documentation required] to** patient meets Myasthenia Gravis Foundation of America classification of II to IV AND Myasthenia Gravis Activities of Daily Living (MG-ADL) score of ≥ 5
Neurology – Vyvgart Intravenous - IP0376	Updated	**Effective 8/1/2026** **Generalized Myasthenia Gravis.** **Removed** the criterion that the patient has confirmed anti-acetylcholine receptor antibody-positive generalized myasthenia gravis **[documentation required]**. • **Added [documentation required] to** patient meets Myasthenia Gravis Foundation of America classification of II to IV AND Myasthenia Gravis Activities of Daily Living (MG-ADL) score of ≥ 5

Nitazoxanide for Individual and Family Plans (IP0467)	Retired	**Effective 8/1/2026** • Prior Authorization removed from nitazoxanide tablets on all Individual and Family Plans formularies • Alinia tablets relocated to Pharmacy and Medical Prior Authorization - (1407)
Nonsteroidal Anti-inflammatory Drugs (IP0457)	Retired	**Effective 8/1/2026** • For Employer Plans: Fenothro, indomethacin 20 mg capsules, Kiprofen, Nalfon 200 mg capsules and Relafen have been discontinued; All other products relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602) ○ For Individual and Family Plans: Coxanto, oxaprozin 300 mg capsules (brand), and Tolectin relocated to Pharmacy and Medical Prior Authorization (1407)
Ophthalmic – Glaucoma – Prostaglandins (IP0027)	Updated	**Effective 8/15/2026** **Employer Plans** **Updated** the Lumigan preferred product requirements. **Individual and Family Plans** ○ **Added** new preferred product requirements for bimatoprost 0.01% ophthalmic solution.
Ophthalmology – Yuvezzi (IP0808)	New	**Effective 8/1/2026** New Policy.
Pharmacy and Medical Prior Authorization (1407)	Updated	**Effective 8/1/2026** **Added Individual and Family Plan product-specific medical necessity criteria for the following:** **EFFECTIVE 8/1/2026:** dapagliflozin and saxagliptin tablets (generic of Qtern), Byqlovi, Tolectin DS, Zybic, beclomethasone HFA inhalation aerosol, milnacipran (tablets and titration pack), Savella (tablets and titration pack), halobetasol propionate 0.05% lotion, Ultravate, clonidine 0.05 mg tablet (brand), azilsartan tablets, Widaplik, Granisol oral solution, Zyprexa Zydis, Desmoda, Quiofic, Relgaabi 200 mg capsule (brand), Idvynso, meclizine 25 mg chewable tablet, Coxanto, oxaprozin, and Tolectin **EFFECTIVE 8/15/2026:** Lanoxin tablets, Coreg, Verquvo, niacin 500 mg tablets, Niacor, Anaprox DS, Arthrotec, Cambia, Daypro, diclofenac potassium 25mg capsules, diclofenac potassium 25mg tablets, diclofenac potassium 50 mg powder packet (generic of Cambia), diclofenac submicronized capsules (authorized generic of Zorvolex), Feldene, indomethacin

		submicronized capsules (authorized generic of Tivorbex), Indocin suspension, indomethacin oral suspension, ketoprofen 25mg capsules, Lofena, meloxicam capsules and oral suspension, Nalfon, Naprelan, naproxen sodium CR tablets, naproxen sodium ER tablets, Naprosyn EC, Naprosyn, Relafen DS, Tivorbex, Vivlodex, Zipsor, and Zorvolex **Updated Individual and Family Plan product-specific medical necessity criteria for the following:** **EFFECTIVE 8/1/2026:** clobetasol propionate 0.05% ophthalmic suspension, Auryxia, ferric citrate tablets (authorized generic of Auryxia), Crinone 4% gel and Crinone 8% gel **Removed Individual and Family Plan product-specific medical necessity criteria for the following:** **EFFECTIVE 8/1/2026:** Qtern and umeclidinium/vilanterol inhalation powder(authorized generic of Anoro Ellipta)
Pharmacy and Medical Prior Authorization (1407)	Updated	**Effective 8/15/2026** **Added preferred product requirement criteria for the following: EFFECTIVE 8/15/2026:** Auvelity Titration Pack, Bysanti tablets and titration pack, glipizide 15 mg (brand), folic acid oral solution, gabapentin 200 mg capsules, Astagraf XL, fenoprofen capsules, Tolmetin 200 mg tablets, mirabegron for extended-release oral suspension, Dyrenium capsules, triamterene capsules, cyclobenzaprine ER 15 mg and 30 mg capsules **EFFECTIVE 9/1/2026:** albendazole tablets, Edarbyclor, Abilify, Clozaril, Geodon, Invega, Risperdal, Saphris, Secuado, Seroquel, Seroquel XR, Versacloz, Zyprexa, Vigamox, Zymaxid, calcipotriene 0.005% foam, Sorilux, Vectical, calcipotriene 0.005%/ betamethasone 0.064% topical suspension, Enstilar, Taclonex ointment, Taclonex topical suspension, Wynzora, Emend oral suspension, pitavastatin tablets **Updated preferred product requirement criteria for the following: EFFECTIVE 8/15/2026:** azilsartan tablets, Edarbi, labetalol 400 mg tablets, oxybutynin 2.5 mg tablets, Auvelity, Motegrity, prucalopride tablets, Trulance, Ibsrela, glipizide 2.5 mg tablet (brand), Myrbetriq granules, Breztri Aerosphere, Ermeza, levothyroxine capsules, Thyquidity, Tirosint, Tirosint-SOL **EFFECTIVE 9/1/2026:** valsartan oral solution **Removed preferred product requirement criteria for the following: EFFECTIVE 8/15/2026:** Semglee (non YFGN), GlucaGen/GlucaGen HypoKit, Adthyza
Progesterone (Vaginal) Benefit Exclusion Override (BEO003)	Update	**Effective 8/1/2026** Added generic Endometrin vaginal inserts to the policy. No criteria changes.
Progesterone (Vaginal) for Individual and Family Plans (IP0091)	Update	**Effective 8/1/2026**

		Clarified references to the generic product by adding specificity throughout the policy; updated all mentions of "progesterone" to "progesterone vaginal insert (tablet)."
Pulmonary – Antifibrotics – Jascayd (IP0772)	Updated	**Effective 8/1/2026** **Added** generic nintedanib, where relevant, throughout the policy. **Employer Plans Preferred Product Table:** **Idiopathic Pulmonary Fibrosis:** **Added "**or is currently receiving" to pirfenidone requirement for patients who are pregnant or has or is at risk of coronary artery disease, bleeding events, or gastrointestinal perforation.
Pulmonary – Antifibrotics – Nintedanib (IP0312)	Updated	**Effective 8/1/2026** **Added Preferred Product Table for Employer Plans.** **Added** criteria for Ofev.
Pulmonary Arterial Hypertension – Endothelin Receptor Antagonists (IP0631)	Updated	**Effective 8/15/2026** Generic macitentan tablets were added to the policy. The same criteria apply as those for the brand. **Added** preferred product criteria for Opsumit.
Rebyota (IP0556)	Updated	**Effective 8/1/2026** **Prevention of recurrence of Clostridioides difficile infection (CDI).** Updated recurrence threshold from ≥ 3 total CDI episodes to ≥ 2 total CDI episodes (≥ 1 recurrence) to align with FDA labeling and Phase 3 trial population. **Coding Information** **Removed** CPT codes 44705 0780T, coding table, and CPT disclaimer **Removed** HCPCS codes C9399 G0455 J3490 J3590 **Removed** the note "Code effective 7/1/2023" from HCPCS code J1440
Spinal Muscular Atrophy – Itvisma (IP0790) [Embarc]	Updated	**Effective 8/13/2026** ○ No criteria changes.

Spinal Muscular Atrophy – Zolgensma (IP0185) [Embarc]	Updated	**Effective 8/13/2026** ○ No criteria changes.
Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) [1803]	Updated	**Effective 8/15/2026** **Removed** Januvia and Janumet from the Diabetes Care therapeutic category.
Step Therapy – Standard and Performance Prescription Drug Lists (Employer Group Plans) [1801]	Updated	**Effective 8/15/2026** ○ **Removed** Januvia and Janumet from the Diabetes Care therapeutic category.
Step Therapy – Value and Advantage Prescription Drug Lists (Employer Group Plans) [1802]	Updated	**Effective 8/15/2026** **Removed** Januvia and Janumet from the Diabetes Care therapeutic category.
Tolvaptan Products – Tolvaptan (Jynarque) (IP0287)	Updated	**Effective 8/1/2026** No criteria changes.
Tolvaptan Products – Tolvaptan (Samsca) for Individual and Family Plans (IP0471)	Updated	**Effective 8/1/2026** **Hyponatremia.** Throughout the criteria, 30 days was changed to 1 month. Additionally, throughout the criteria, a Note was added to define that baseline is prior to treatment with any tolvaptan product.
Topical Acne - Non-Retinoid Products (IP0166)	Updated	**Effective 8/15/2026** No criteria changes.
Topical Acne – Winlevi (IP0173)	Updated	**Effective 8/1/2026** No criteria changes.

Vasculitis – Tavneos (IP0398)	Updated	**Effective 8/1/2026** No criteria changes.
Vericiguat (IP0125)	Retired	**Effective 8/15/2026** Relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602) for Employer Plans
California: Weight Loss Medications – Other Appetite Suppressants and Orlistat Benefit Exclusion Override Policy (INT029)	Updated	**Effective 8/1/2026** No criteria changes.
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
		• No updates for August 2026
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
Pharmacy and Infusion Services - (R14)	Updated	**Effective 08/07/2026** • Clarified language regarding non-reimbursable infusion-related supplies and equipment in the office setting, including infusion-related equipment associated with HCPCS codes E0776 and E0791 • Added age-based criteria for HCPCS code J7050 excluding patients less than 3 years of age

Facility Services, Supplies and Equipment – (R12)	Updated	**Effective 08/15/2026** • Additional diagnostic radiopharmaceutical and contrast material codes assigned a CMS NPFS Status Indicator X are subject to the existing policy provision for services that are not separately reimbursed when reported with a facility place of service.
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		• No updates for August 2026
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**
Code Editing Policy and Guidelines		• No updates for August 2026