Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective February 15, 2024 (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
Percutaneous Revascularization of the Lower Extremities in Adults – (0537)	Update	Important **changes** in coverage criteria: • Expanded coverage by increasing the threshold for ankle-brachial index from ≤ 0.69 to ≤0.90 for both claudication and Chronic limb-threatening ischemia (CLTI) to align with professional society guidelines. Minor **changes** in coverage criteria/policy: • Added the phrases “presence of” and “documentation of an” to the claudication criteria for clarity and improved readability. • Update the term “Critical/chronic limb ischemia (CLI)” to “Chronic limb-threatening ischemia (CLTI) to align with generally accepted terminology. • Added “present for ≥ two weeks” to the CLTI criteria for nonhealing wound/ulcers to help differentiate from acute limb ischemia. • Added “(< 2 weeks duration)” to the acute limb ischemia criteria to help differentiate from CLTI.

Pharmacogenetic Testing for Non-Cancer Indications – (0500)	Update	Important **changes** in coverage criteria:: • Expanded coverage to allow biomarker testing if Identification of the gene biomarker is noted to be clinically necessary prior to initiating therapy with drug target as noted anywhere within the U.S. Food and Drug Administration (FDA)-approved prescribing label.
Recurrent Pregnancy Loss: Diagnosis and Treatment – (0284)	Update	Important **changes** in coverage criteria: • Removed “antiprothrombin (phospholipid cofactor) antibody, each Ig class” from the not covered or reimbursable diagnostic testing list because CPT 86849 is no longer being managed.
Stem Cell Transplantation: Non-Cancer Disorders – (0535)	Update	Important **changes** in coverage criteria: • Expanded coverage by removing the word “young” from the adult criteria for sickle cell disease because allogenic HSCT is a standard of care for adults and age limits are not applied or mentioned in the ASTCT guidelines.
Transthoracic Echocardiography in Adults – (0510)	Update	Minor **changes** in coverage criteria/policy: • Expanded coverage to include TTE if individual taking CAMZYOSTM (mavacamten) for a FDA-approved indication. • Reformatted policy statement section
Anesthesia Services for Interventional Pain Management Procedures in an Adult – (0551)	Update	• No change in coverage.
Autonomic Nerve Function Testing – (0506)	Update	• No change in coverage.
Bone Graft Substitutes – (0118)	Update	• No change in coverage
Complementary and Alternative Medicine – (EN0086)	Update	• No change in coverage.
Diabetes Equipment and Self-Management – (0106)	Update	• No change in coverage.
Endometrial Ablation – (0013)	Update	• No change in coverage.
Hospice Care – (0462)	Update	• No change in coverage.
Peripheral Nerve Destruction for Pain Conditions – (0525)	Update	• No change in coverage.

Plantar Fasciitis Treatments – (0097)	Update	• No change in coverage.
Total Ankle Arthroplasty/ Replacement – (0285)	Update	• No change in coverage.
Transthoracic Echocardiography in Children – (0523)	Update	• No change in coverage.
Pelvis Imaging Amendment to Cigna-eviCore General Pelvis Imaging Guideline DV001	Retired 2/01/2024	• Addressed in eviCore Pelvis Imaging guideline
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
		• No updates February 2024
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded High-tech Radiology (HTR) / Cardiology Imaging Guidelines	Update	Posted **November 3, 2023**, Effective date **February 1, 2024**: Important **changes** in coverage criteria. **The updated guidelines included:** Informational document: • Preface to the Imaging Guidelines Five guidelines had an expansion of coverage: • Abdomen Imaging Guidelines • Pediatric Abdomen Imaging Guidelines • Pediatric Cardiac Imaging Guidelines • Pediatric Chest Imaging Guidelines • Pediatric Peripheral Vascular Disease Imaging Guidelines One guideline had adverse changes in coverage: • Spine Imaging Guidelines 15 guidelines had positive and adverse changes in coverage:

		• Breast Imaging Guidelines
		• Cardiac Imaging Guidelines
		• Chest Imaging Guidelines
		• Head Imaging Guidelines
		• Musculoskeletal Imaging Guidelines
		• Neck Imaging Guidelines
		• Oncology Imaging Guidelines
		• Pelvis Imaging Guidelines
		• Peripheral Nerve Disorders Imaging Guidelines
		• Peripheral Vascular Disease Imaging Guidelines
		• Pediatric Head Imaging Guidelines
		• Pediatric Musculoskeletal Imaging Guidelines
		• Pediatric Neck Imaging Guidelines
		• Pediatric Oncology Imaging Guidelines
		• Pediatric Spine Imaging Guidelines
		
		The remaining two guidelines had no changes in coverage:
		• Pediatric Pelvis Imaging Guidelines
		• Pediatric Peripheral Nerve Disorders Imaging Guidelines
		
		Posted **January 2, 2024**, Effective date **February 12, 2024**:
		
		Important **change** in coverage criteria:
		• Pelvis Imaging Guidelines
		  • Added coverage for pre-procedure imaging for prostate artery embolization
		
		Posted **January 19, 2024**, Effective date **February 12, 2024**:
		
		Important **change** in coverage criteria:
		• Head Imaging Guidelines
		  ➢ Added coverage for imaging related to Alzheimer's treatment with amyloid reduction medications
		No change to coverage:
		  • Breast Imaging Guidelines
		
		Posted **January 19, 2024**, Effective date **April 1, 2024**:
		
		Informational document; no change to coverage:
		• Preface to the Imaging Guidelines

Administrative Policy	New, Updated, or Retired?	Comments
		• No updates February 2024
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments** **All policy changes effective February 1, 2024, unless otherwise stated**
Abatacept Intravenous - (IP0232)	Update	Important **changes** in coverage criteria: • Added Adalimumab - adbm (CF) as a prerequisite option to the Employer Plans and Individual and Family Plans preferred product approaches. • Updated Hyrimoz to clarify only the Sandoz/Novartis brand is covered. • Effective **2/1/2024**.
Abatacept Subcutaneous – (IP0231)	Update	Important **changes** in coverage criteria: • Added Adalimumab - adbm (CF) as a prerequisite option to the Employer Plans and Individual and Family Plans preferred product approaches. • Updated Hyrimoz to clarify only the Sandoz/Novartis brand is covered. • Effective **2/1/2024**.
Adalimumab – (IP0245)	Update	Important **changes** in coverage criteria: • Added Adalimumab - adbm (CF) to the policy as a preferred product. • Added Abrilada to the policy as a non-preferred product. • Removed expired Amjevita NDC related information and preferred product criteria for Individual and Family Plans that was in effect through 12/31/23. • Updated Hyrimoz entry to clarify only the Sandoz/Novartis brand is covered • Effective date of **2/1/2024**.
Anakinra – (IP0243)	Update	Important **changes** in coverage criteria: • Added Adalimumab - adbm (CF) as a prerequisite option to the Employer Plans and Individual and Family Plans preferred product approaches. • Updated Hyrimoz to clarify only the Sandoz/Novartis brand is covered. • Effective **2/1/2024**.
Antihemophilic Factor (Recombinant) - (IP0564)	Update	Important **changes** to coverage criteria: • The criterion [B], for a negative Factor VIII test within 30 days, was removed. • Effective date **2/15/2024**.

Attention Deficit Hyperactivity Disorder (ADHD) Stimulants for Individual and Family Plans – (IP0584)	Update	Important **changes** in coverage criteria: • Retitled the policy • Added criteria for brand Mydayis and the new generic Mydayis. • Effective date **2/15/2024**.
Baricitinib - (IP0225)	Update	Important changes to criteria: • Added Adalimumab - adbm (CF) as a prerequisite option to the Employer Group Plans and Individual and Family Plans PPRC approaches. • Updated Hyrimoz entry to clarify only the Sandoz brand is covered. • Effective **2/1/2024**.
Bexaglifozin - (IP0592)	New	Important **points** for new policy: • This is a new policy supporting pharmacy prior authorization of Brenzavvy and Bexaglifozin tablets for all Employer formularies and Brenzavvy on all Individual and Family Plans formularies. • Effective date **2/1/2024**.
Brodalumab - (IP0246)	Update	Important changes to criteria: • Added Adalimumab - adbm (CF) as a prerequisite option to the Employer Group Plans and Individual and Family Plans PPRC approaches. • Updated Hyrimoz entry to clarify only the Sandoz brand is covered. • Effective **2/1/2024**.
Certolizumab – (IP0244)	Update	Important **changes** in coverage criteria: • Added Adalimumab - adbm (CF) as a prerequisite option to the Employer Plans and Individual and Family Plans preferred product approaches. • Updated Hyrimoz to clarify only the Sandoz/Novartis brand is covered. • Effective **2/1/2024**
Ciltacabtagene autoleucel – (IP0414)	Update	Important **changes** in coverage criteria • Updated medical necessity criteria to include dosing information • Policy aligned to current language and template standards. • Effective date **2/15/2024.**
Collagenase Clostridium Histolyticum – (IP0143)	Update	Important **changes** in coverage criteria: • Clarified criteria for Dupuytren's Contracture to apply to current treatment course. • Updated Conditions Not Covered related to retreatment. • Effective date **2/1/2024**.
Dalfampridine - (IP0024)	Update	Important **changes** in coverage criteria: • *Multiple Sclerosis Walking Scale-12* added as an example of an objective measure to evaluate impaired ambulation (criterion [D]). • Individual and Family Plans approach added to the policy. • Policy aligned to current template and language standards.

		• Effective **2/15/2024**.
Dimethyl fumarate - (IP0266)	Update	**Minor** changes to coverage criteria: • Annual review with no changes to the current criteria approach. • Policy aligned to current template and language standards. • Effective **2/15/2024**.
Drugs/ Biologics Not Covered Unless Approved Under Medical Necessity Review Employer Group Plans: Standard, Performance, or Legacy Prescription Drug List (1601)	Update	**Important** changes to coverage criteria: • Pokonza 10 meq (potassium chloride) packet (effective 3/15/2024), Lidocan II (lidocaine) 5% topical adhesive patch, Airsupra (albuterol / budesonide) inhaler and Fluticasone propionate Diskus 50 mcg, 100 mcg, 250 mcg oral inhalation (generic for Flovent Diskus) added to the policy. • Effective **2/15/2024.**
Drugs/ Biologics Not Covered Unless Approved Under Medical Necessity Review Employer Group Plans: Value, Advantage, or Cigna Total Savings Prescription Drug List (1602)	Update	**Important** changes to coverage criteria: • Pokonza 10 meq (potassium chloride) packet (effective 3/15/2024), Lidocan II (lidocaine) 5% topical adhesive patch, Airsupra (albuterol / budesonide) inhaler and Fluticasone propionate Diskus 50 mcg, 100 mcg, 250 mcg oral inhalation (generic for Flovent Diskus) added to the policy. • Effective **2/15/2024.**
Efgartigimod Intravenous – (IP0376)	Update	Minor **changes** in coverage criteria/policy: • Updated Conditions Not Covered section. • Effective date of **2/15/2024**.
Efgartigimod Subcutaneous Injection – (IP0574)	Update	Minor **changes** in coverage criteria/policy: • Updated Conditions Not Covered section. • Effective date of **2/15/2024**.
Faricimab – (IP0542)	Update	Important **changes** in coverage criteria: • Updated medical necessity criteria to include new FDA-approved indication - Macular Edema Following Retinal Vein Occlusion • Policy aligned to current language and template standards • Effective: **2/15/2024**
Fingolimod - (IP0259)	Update	Minor **changes** to coverage criteria: • Annual review with no changes to the current criteria approach. • Policy aligned to current template and language standards. • Effective **2/15/2024**.
Golimumab Subcutaneous – (IP0237)	Update	Important **changes** in coverage criteria:

		• Added Adalimumab - adbm (CF) as a prerequisite option to the Employer Plans and Individual and Family Plans preferred product approaches. • Updated Hyrimoz to clarify only the Sandoz/Novartis brand is covered. • Effective **2/1/2024**.
Idecabtagene vicleucel – (IP0168)	Update	Important **changes** in coverage criteria • Updated medical necessity criteria to include dosing information • Policy aligned to current language and template standards. • Effective date **2/15/2024**.
Ixekizumab - (IP0225)	Update	Important changes to criteria: • Added Adalimumab - adbm (CF) as a prerequisite option to the Family Plans preferred product approach. • Updated Hyrimoz entry to clarify only the Sandoz brand is covered. • Effective **2/1/2024**.
Migalastat – (IP0400)	Update	Minor **changes** in coverage criteria: • Added concurrent use with Elfabrio as a condition not recommended for approval. • Policy aligned to current language and template standards • Effective: **2/15/2024**
Ophthalmic Glaucoma Agents - Prostaglandin Analogs and Rho Kinase Inhibitors - (IP0027)	Update	Important **changes** in coverage criteria: • Policy title updated to: Ophthalmic Glaucoma Agents - Prostaglandin Analogs and Rho Kinase Inhibitors. • Iyuzeh (latanoprost 0.005% ophthalmic solution) [preservative-free] added to the policy for both Employer and Individual and Family Plans. • Employer Rocklatan approach added to the policy. • Current Xalatan and Xelpros Employer approaches aligned to current P&T guidance. • Current Individual and Family Plans criteria approaches for Lumigan, Rhopressa, Rocklatan, tafluprost 0.0015% ophthalmic solution, Travatan Z, Vyzulta, Xalatan, Xelpros and Zioptan aligned to current P&T guidance and added to the policy. • Effective **2/1/2024**.
Ozanimod - (IP0214)	Update	Important changes to criteria: • Added Adalimumab - adbm (CF) as a prerequisite option to the Employer Group Plans and Individual and Family Plans Ulcerative Colitis preferred product approaches. • The number of preferred product steps for Ulcerative Colitis, was increased from one to two, for both Employer Group Plans and Individual and Family Plans. • Updated Hyrimoz entry to clarify only the Sandoz brand is covered. • Effective **2/1/2024**.

HMG-CoA Reductase Inhibitors (Statins) and Combination Products – (IP0064)	Update	Important **change** in coverage criteria: • Added criteria for pitavastatin tablets for Individual and Family Plans • Effective date: **2/1/2024**
Omalizumab – (IP0487)	Update	Important **changes** in coverage criteria: • Removed criteria for chronic idiopathic urticaria regarding consideration of dosing reduction. • Effective date of **2/15/2024.**
Oncology Medications – (1403)	Update	Important **changes** in coverage criteria • Added step preferred product criteria for Akeega • Effective 2/15/2024
Palovarotene - (IP0596)	Update	Important points for **new policy**: • This is a new policy supporting pharmacy prior authorization of palovarotene capsules [Sohonos]. • Effective date **2/15/2024**.
Pharmacy Prior Authorization – (1407)	Update	Important **changes** in coverage criteria • Added non-coverage of Xdemvy, glipizide 2.5mg IR tablet, Carospir (spironolactone 25 mg/5 mL oral suspension), spironolactone 25 mg/5 mL oral suspension, and Lidocan II (lidocaine) 5% topical adhesive patch for IFP • Effective **2/15/2024**
Prucalopride – (IP0017)	Update	Important **changes** in coverage criteria: • Policy to now contain criteria for both Employer Group Plans and Individual and Family Plans. • Updated criteria to include age and diagnosis for Employer Group Plans. • Updated the preferred alternatives. • Effective date of **2/1/2024**.
Quantity Limitations - (1201)	Update	Important **changes** in coverage criteria: • Extended the current Adalimumab QL to Abrilada and adalimumab – adbm. • Added new QLs for Symbicort and Budesonide / Formoterol 80/4.5 mcg and 160/4.5 mcg inhalation aerosol (generic for Symbicort). • Effective date of **2/1/2024**.
Sarilumab - (IP0233)	Update	Important changes to criteria: • Added Adalimumab - adbm (CF) as a prerequisite option to the Employer Group Plans and Individual and Family Plans PPRC approaches. • Updated Hyrimoz entry to clarify only the Sandoz brand is covered. • Effective **2/1/2024**.

Rozanolixizumab – (IP0575)	Update	Minor **changes** in coverage criteria: • Updated Conditions Not Covered section. • Effective date of **2/15/2024**.
Secukinumab Intravenous - (IP0594)	New	Important points for new policy • New policy supporting medical precertification of secukinumab intravenous infusion [Cosentyx]. A. Effective **2/1/2024.**
Secukinumab Subcutaneous - (IP0223)	Update	Important **changes** in coverage criteria: • Policy renamed to Secukinumab Subcutaneous. • Added Adalimumab - adbm (CF) as a prerequisite option to the Employer Group Plans preferred product approach. • Updated Hyrimoz entry to clarify only the Sandoz brand is covered. • Effective date of **2/1/2024**.
Skeletal Muscle Relaxants – (IP0211)	Update	Important **changes** in coverage criteria: • Added new strength baclofen 10 mg/5 mL (AG for Ozobax DS) and Ozobax DS to coverage policy • Added a generic step requirement for both baclofen 10 mg/5mL and Ozobax DS to Employer Group and Individual and Family Plans. • Effective date: **2/1/2024**.
Tegaserod – (IP0019)	Update	Important **changes** in coverage criteria: • Policy to now contain criteria for both Employer Group Plans and Individual and Family Plans. • Updated criteria to include age and diagnosis for Employer Group Plans. • Updated the preferred alternatives. • Effective date of **2/1/2024**.
Tenapanor – (IP0455)	Update	Important **changes** in coverage criteria: • Policy to now contain criteria for both Employer Group Plans and Individual and Family Plans. • Updated the preferred alternatives. • Effective date of **2/1/2024**.
Tofacitinib - (IP0246)	Update	Important changes to criteria: • Added Adalimumab - adbm (CF) as a prerequisite option to the Employer Group Plans and Individual and Family Plans PPRC approaches. • Updated Hyrimoz entry to clarify only the Sandoz brand is covered. • Effective **2/1/2024**.
Tralokinumab – (IP0386)	Update	Minor **changes** in coverage criteria/policy:

		• Updated criteria to apply to individuals age 12 years and older based on FDA label expansion. • Effective date of **2/15/2024**.
Tofacitinib - (IP0246)	Update	Important changes to criteria: • Added Adalimumab - adbm (CF) as a prerequisite option to the Employer Group Plans and Individual and Family Plans PPRC approaches. • Updated Hyrimoz entry to clarify only the Sandoz brand is covered. • Effective **2/1/2024**.
Tralokinumab – (IP0386)	Update	Minor **changes** in coverage criteria/policy: • Updated criteria to apply to individuals age 12 years and older based on FDA label expansion. • Effective date of **2/15/2024**.
Tofacitinib - (IP0246)	Update	Important changes to criteria: • Added Adalimumab - adbm (CF) as a prerequisite option to the Employer Group Plans and Individual and Family Plans PPRC approaches. • Updated Hyrimoz entry to clarify only the Sandoz brand is covered. • Effective **2/1/2024**.
Tralokinumab – (IP0386)	Update	Minor **changes** in coverage criteria/policy: • Updated criteria to apply to individuals age 12 years and older based on FDA label expansion. • Effective date of **2/15/2024**.
Tofacitinib - (IP0246)	Update	Important changes to criteria: • Added Adalimumab - adbm (CF) as a prerequisite option to the Employer Group Plans and Individual and Family Plans PPRC approaches. • Updated Hyrimoz entry to clarify only the Sandoz brand is covered. • Effective **2/1/2024**.
Tralokinumab – (IP0386)	Update	Minor **changes** in coverage criteria/policy: • Updated criteria to apply to individuals age 12 years and older based on FDA label expansion. • Effective date of **2/15/2024**.
Tofacitinib - (IP0246)	Update	Important changes to criteria: • Added Adalimumab - adbm (CF) as a prerequisite option to the Employer Group Plans and Individual and Family Plans PPRC approaches. • Updated Hyrimoz entry to clarify only the Sandoz brand is covered. • Effective **2/1/2024**.
Tralokinumab – (IP0386)	Update	Minor **changes** in coverage criteria/policy:

		• Updated criteria to apply to individuals age 12 years and older based on FDA label expansion. • Effective date of **2/15/2024**.
Trientine Products – (IP0278)	Update	Minor **changes** in coverage criteria • Added generic step requirement for trientine 250 mg and 500 mg capsules for IFP. • Policy aligned to current language and template standards • Effective 2/15/2024.
Unassigned Drug and Biologic Medical Precertification – (1701)	Update	Important changes to criteria: • Added DefenCath to coverage policy • Effective **1/15/2024**. Important changes to criteria: • Updated medical necessity criteria language • Effective **2/1/2024**
Upadacitinib - (IP0229)	Update	Important changes to criteria: • Added Adalimumab - adbm (CF) as a prerequisite option to the Employer Group Plans and Individual and Family Plans PPRC approaches. • Updated Hyrimoz entry to clarify only the Sandoz brand is covered. • Effective **2/1/2024**.
Weight Loss – Liraglutide (Saxenda) - (IP0206)	Update	Important **changes** in coverage criteria: • Baseline body mass index defined as “prior to therapy with Saxenda, Wegovy or Zepbound”. • Policy aligned to current template and language standards. • Policy effective **2/15/2024**.
Weight Loss – Semaglutide - (Wegovy™) (IP0521)	Update	Important **changes** in coverage criteria: • Baseline body mass index defined as “prior to therapy with Saxenda, Wegovy or Zepbound”. • Policy aligned to current template and language standards. • Policy effective **2/15/2024**.
Amikacin Liposome – (IP0383)	Update	No change in coverage. • Effective: 2/15/2024
Anifrolumab-fnia – (IP0280)	Update	No change in coverage. • Effective: 2/15/2024

Denosumab (Prolia®) – (IP0331)	Update	• No change in coverage.
Etanercept – (IP0241)	Update	No change in coverage. • Effective: 2/15/2024
Filgrastim – (IP0528)	Update	• No change in coverage.
Gabapentin Extended-Release – (IP0317)	Update	No change in coverage. • Effective: 2/15/2024
Human Chorionic Gonadotropin (hCG) for Non-fertility Uses – (IP0327)	Update	No change in coverage. • Effective: 2/15/2024
NovoSeven RT – (IP0356)	Update	No change in coverage • Effective: 2/15/2024
Nusinersen – (IP0182)	Update	No change in coverage. • Effective: 2/15/2024
Sapropterin – (IP0295)	Update	No change in coverage. • Effective: 2/15/2024
Sedative Hypnotic Medications – (IP0023)	Update	No change in coverage. • Effective: 2/15/2024
Sildenafil – (IP0098)	Update	No change in coverage. • Effective: 2/15/2024
Spesolimab – (IP0501)	Update	No change in coverage. • Effective: 2/15/2024
Tadalafil for Emp – (IP0097)	Update	No change in coverage. • Effective: 2/15/2024
Tadalafil for IFP – (IP0101)	Update	No change in coverage.

		• Effective: 2/15/2024
Topical Diclofenac Sodium Gel 3% - (IP0282)	Update	No change in coverage. • Effective: 2/15/2024
Topical Ruxolitinib – (IP0369)	Update	No change in coverage. • Effective: 2/15/2024
Topical Tazarotene Products – (IP0174)	Update	No change in coverage. • Effective: 2/15/2024
Metyrosine – (IP0450)	Update	No change in coverage. • Effective: 2/15/2024
CareAllies Medical Necessity Guideline	**New, Updated, or Retired?**	**Comments**
		• No updates in February 2024
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
		• No updates in February 2024
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
Omnibus Reimbursement Policy (R24)	Update	• Policy updated

ClaimsXten Documents*	New, Updated, or Retired?	Comments
Code Editing Policy and Guidelines	Update	• Updates made in February 2024