Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective January 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
Ambulance Services – (0555)	Updated	**Posted 10/15/2025, Effective 1/15/2026** Minor **changes** in coverage criteria/policy: • Title change from Ambulance Services to "Fixed Wing Air Ambulance Transport" • Removal of unmanaged codes and the policy statements associated with those codes • Update and revise the medical necessity policy statement for fixed wing air transport by removing water transport as it is no longer included in this policy and added an additional medical necessity criteria statement. • Revision of the medical necessity statement for fixed wing air ambulance transport • Revision of the not medically necessary statement for fixed wing air ambulance transport.

Breast Implant Removal – (0048)	Updated	**Posted 1/15/2026, Effective 4/15/2026** Important changes in coverage criteria/policy: • Revision to the first 3 policy statements to define surgical management of the implant capsule/ capsular revision • Revision to the medical necessity criteria to policy statement for the removal of either a silicone gel-filled or saline-filled breast implant to change the word "Stage" to "Grade" IV capsular contracture • Revision to the medical necessity criteria to policy statement for the removal of either a silicone gel-filled or saline-filled breast implant to include a "confirmed "diagnosis of either Breast implant -associated anaplastic large cell lymphoma (BIA-ALCL) or breast implant-associated squamous cell carcinoma (BIA-SCC) • Revision of the policy statement for removal of an intact silicone gel-filled implant to include breast implant illness • Addition of an additional medical necessity requirement for procedures that are not medically necessary to include mastopexy following implant removal • Addition of CPT codes 19325, 19330;19342 to coincide with the policy statement for subsequent surgical implantation of a new FDA approved breast implant after removal.
Cardiac Omnibus Codes - (0574)	Updated	**Posted 10/15/2025, Effective 1/15/2026** Minor **changes** in coverage criteria/policy: • No change in coverage • Adding codes to policy statement
Category III Current Procedural Terminology (CPT®) codes – (0558)	Updated	**Posted 1/15/2026, Effective 4/15/2026** • No change in coverage.
COVID-19: In Vitro Diagnostic Testing - (0557)	Updated	• No change in coverage.
Electroencephalo-graphy - (0521)	Updated	**Posted 1/15/2026, Effective 2/15/2026**

		Minor changes in coverage criteria/policy: • Revised policy statement for digital EEG spike analysis performed in conjunction with a specialized EEG for clarity. • Revised policy statement for digital EEG spike analysis performed in conjunction with a sleep study or routine EEG for clarity. • Added policy statement for remote monitoring of sub-scalp implanted EEG monitoring system due to new codes effective 1/1/2026.
Gender Dysphoria Treatment – (CP0266)	Updated	Minor changes in coverage criteria/policy: • Revised Table 2 to add CPT codes 15773 and 15774, and soft tissue grafting (direct excision) (CPT code 15769). • Moved submental skin/subcutaneous tissue excision (CPT code 15838) from Table 3 to Table 2. • Added Appendix to house state-specific information related to the treatment of gender dysphoria; (note: the separate State Specific Guidelines support document will be retired). • Removed Note regarding Tanner stage from informational statement bullet regarding hormonal therapy. • Added Note to informational statement that "Conditions of coverage and/or prior authorization requirements may apply" to other/nonsurgical gender dysphoria treatment services. • Moved "not medically necessary" statement for mastectomy under age 15 from a Note to a bolded statement.
Hyperhidrosis: Surgical Treatments - (0037)	Updated	• No change in coverage.
Mammary Ductoscopy, Aspiration and Lavage – (CP0057)	Updated	**Effective 1/15/2026** • No change in coverage.
Speech Generating Devices - (0049)	Updated	Minor change(s) in coverage criteria/policy: • Revised policy statements on referring to benefit plan documents for clarity. • Revised policy statement on synthesized speech generating devices for clarity.

		• Revised policy statement on not medically necessary devices for clarity of policy statement intent.
Stem Cell Transplantation: Non-cancer Disorders - (0535)	Updated	• No change in coverage.
Stem Cell Transplantation: Solid Tumors - (0534)	Updated	• No change in coverage.
Tissue-Engineered Skin Substitutes – (CP0068)	Updated	**Effective 1/15/2026** • Removed Marigen™ Pacto from coverage statement • Added the following products to EIU policy statement: Absolv3 Membrane, AmchoMatrixDL, AmnioMatrixF4X, CYGNUS Solo, NuForm, Polygon3 Membrane, Summit AC, Summit FX • Differentiated Phasix and Phasix ST in coverage statement and in background
Prosthetic Devices - (0536)	Updated	• No change in coverage.
Vascularized Composite Allograft (VCA) Transplant - (0560)	Updated	• No change in coverage.
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
		• No updates in January 2026

EviCore Guidelines	New, Updated, or Retired?	Comments
Cobranded Cigna-EviCore High-Tech Imaging Guidelines	Updated	**Posted 10/27/2025, Effective 2/3/2026:** Important changes in coverage criteria. Five guidelines were updated with clinical changes which will expand coverage: • Neck Imaging • Pediatric Chest Imaging • Pediatric Musculoskeletal Imaging • Pediatric Neck Imaging • Preface to the Imaging Guidelines Twelve guidelines were updated with clinical changes which will expand and limit coverage: • Abdomen Imaging • Breast Imaging • Cardiac Imaging • Chest Imaging • Head Imaging • Oncology Imaging • Pediatric Abdomen Imaging • Pediatric and Special Populations Oncology Imaging • Pediatric Head Imaging • Pelvis Imaging • Peripheral Vascular Disease (PVD) Imaging • Spine Imaging Six guidelines were updated with no clinically impactful changes: • Pediatric and Special Populations Spine Imaging • Pediatric Cardiac Imaging • Pediatric Pelvis Imaging • Pediatric Peripheral Nerve and Neuromuscular Disorders (PNND) Imaging • Pediatric Peripheral Vascular Disease (PVD) Imaging

		• Peripheral Nerve and Neuromuscular Disorders (PNND) Imaging
Cobranded Cigna-EviCore Lab Management Guidelines	Updated	**Posted 9/26/2025; Effective 1/1/2026** Important changes in coverage criteria. Five new guidelines: • Expanded Carrier Screening Panels • Genomic Prostate Score • Prolaris • Hereditary Ataxia Genetic Testing • Hereditary Connective Tissue and Thoracic Aortic Disease Genetic Testing Eleven guidelines had clinically substantive changes: • Genetic Testing by Multigene Panels • Experimental, Investigational, or Unproven Laboratory Testing • Preimplantation Genetic Testing (Formerly Preimplantation Genetic Screening and Diagnosis) • Chromosomal Microarray Testing For Developmental Disorders (Prenatal and Postnatal) • Lynch Syndrome Genetic Testing • Somatic Mutation Testing • Facioscapulohumeral Muscular Dystrophy Genetic Testing • Exome Sequencing • Decipher Prostate Cancer Classifier • Genome Sequencing • Human Platelet and Red Blood Cell Antigen Genotyping Nine guidelines were retired: • Carrier Screening Panels, Including Targeted, Pan-Ethnic, Universal, and Expanded • Ataxia-Telangiectasia Genetic Testing • Friedreich Ataxia Genetic Testing • Hereditary Ataxia Multigene Panel Testing • Spinocerebellar Ataxia Genetic Testing • Marfan Syndrome Genetic Testing • Thoracic Aortic Aneurysms and Dissections (TAAD) Panel Genetic Testing • Ehlers-Danlos Syndrome Genetic Testing • Hereditary Connective Tissue Disorder Genetic Testing

Cobranded Cigna-EviCore Vascular Intervention Guidelines	Updated	**Posted 12/26/2025; Effective 4/1/2026** Important changes in coverage criteria. Two guidelines were updated with clinical changes which will expand and limit coverage: • Cerebrovascular Intervention • Peripheral Vascular Intervention
Administrative Policy	**New, Updated, or Retired?**	**Comments**
Preventive Care Services - (A004)	Updated	Effective 1/15/2026: • Add new code 87494 (Infectious agent detection by nucleic acid, DNA or RNA, Chlamydia and gonorrhea, multiplex amplified probe) • Add new codes 90482, 90483, 90484 (vaccine counseling on different date of service than administration). • Add new code J7299 (Miudella – intrauterine copper contraceptive) • Add new code G9871 (Behavioral counseling for diabetes prevention, online, 60 minutes) • Add codes G0537, G0538 (ASCVD risk assessment administration & management). • Update CPT, HCPCS, ICD-10 coding for consistency with AMA.
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Attention Deficit Hyperactivity Disorder (ADHD) Stimulants for Employer Group Plans - (IP0477)	Updated	**<Effective 1/1/2026>** **Updated** the Adderall immediate-release tablets and Evekeo immediate-release tablets preferred product requirements.

Antiseizure Medications – Clobazam Products - (IP0106)	Updated	**<Effective 1/1/2026>** • **Updated** policy title **from** "Clobazam" **to** "Antiseizure Medications – Clobazam Products." • **Added** Preferred Product Table **to** Employer Plans and Individual and Family Plans **for** Onfi.
Bowel Agents – Opioid-Induced Constipation - (IP0401)	Updated	**<Effective 1/1/2026>** **Added** preferred product requirements for Relistor tablets, Relistor injection, and Symproic tablets for Individual and Family Plans. Updated formatting to match current formatting requirements.
Brands with Bioequivalent Generics - (IP0011)	Updated	**<Effective 1/1/2026>** **Added for Employer Plans:** Actonel, Activella, Arava, Aricept, Cardura, Catapres-TTS, Clarinex (applies to Standard, Performance and Legacy Plans), Daliresp, Effient, Evista, Invega ER, Lovenox, Namenda, Namenda XR, Namzaric, Prevacid capsules (applies to Standard, Performance and Legacy Plans), Proscar, Protonix (applies to Standard, Performance and Legacy Plans), Rapaflo **Added for Individual and Family Plans:** Alcaine, Brilinta, Complera, Mesnex, Rectiv, Xarelto oral suspension, Xarelto 2.5 mg tablets
Brands with Bioequivalent Generics - (IP0011)	Updated	**<Effective 1/15/2026>** **Added for Individual and Family Plans:** Ovide
Bruton's Tyrosine Kinase Inhibitor – Rhapsido (IP0771)	New	**<Effective 1/15/2026>** New policy.
Cardiology – Ivabradine - (IP0286)	Updated	**<Effective 1/1/2026>** • **Added** preferred product table for Employer Plans

Colony Stimulating Factors – Filgrastim - (IP0528)	Updated	**<Effective 1/15/2026>** **Policy Title.** **Updated from** "Filgrastim" **to "**Colony Stimulating Factors – Filgrastim Products" **Updated** policy template. **Coding Information:** **Removed** HCPCS Codes Q5101 & Q5110
Colony Stimulating Factors – Pegfilgrastim - (IP0070)	Updated	**<Effective 1/15/2026>** **Policy Title.** **Updated from** "Pegfilgrastim" **to "**Colony Stimulating Factors – Pegfilgrastim Products" **Updated** policy template. **Cancer in a Patient Receiving Myelosuppressive Chemotherapy**. **Removed "**Has non-myeloid malignancy and is receiving myelosuppressive chemotherapy associated with an increased risk of febrile neutropenia; Non-Covered Product Criteria is met, refer to below table(s)" **Added** "Approve for 6 months if the patient meets ALL of the following (A, B, and C):Patient meets ONE of the following (i, ii, or iii): Patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen); OR Patient meets BOTH of the following (a and b):Patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia, but the risk is less than 20% based on the chemotherapy regimen; AND Patient has at least one risk factor for febrile neutropenia according to the prescriber; OR Note: Examples of risk factors include age > 65 year receiving full chemotherapy dose intensity; prior chemotherapy or radiation therapy; persistent neutropenia; bone marrow involvement by tumor; recent surgery and/or open wounds; liver dysfunction (bilirubin > 2.0 mg/dL); renal dysfunction (creatine clearance < 50 mL/min); poor performance status; human immunodeficiency virus (HIV) infection patients with low CD4 counts.Patient meets BOTH of the following (a and b): Patient has had a neutropenic complication from a prior chemotherapy cycle and did not receive prophylaxis with a colony stimulating factor; AND Note: Examples of colony stimulating factors include filgrastim products, pegfilgrastim products, Ryzneuta (efbemalenograstim alfa-vuxw subcutaneous injection), Rolvedon (eflapegrastim-xnst subcutaneous injection).A reduced dose or frequency of chemotherapy may compromise treatment outcome; AND The medication is prescribed by or in consultation with an oncologist or hematologist.Preferred product criteria is met for the product(s) as listed in the below table(s)

		Updated dosing **Radiation Syndrome (Hematopoietic Syndrome of Acute Radiation Syndrome [H-ARS]).** **Removed** "Has had exposure to myelosuppressive doses of radiation (suspected or confirmed exposure to radiation levels greater than 2 gray (Gy)" **Added** "Medication is prescribed by or in consultation with a physician with expertise in treating acute radiation syndrome." **Updated** dosing **Peripheral Blood Progenitor Cell (PBPC) Collection and Therapy.** **Removed** "Supportive care to reduce the duration of severe neutropenia in individuals post-autologous hematopoietic cell transplant who received high-dose chemotherapy" **Added** "Medication is prescribed by or in consultation with an oncologist, a hematologist, or a physician who specializes in transplantation" **Updated** dosing. **Preferred Product Table.** **Removed** "Individual requires a single dose of the requested colony stimulating factor to complete the current cycle of chemotherapy and will change to a health plan preferred pegfilgrastim product for the next cycle of chemotherapy (if needed)"
Colony Stimulating Factors – Rolvedon - (IP0526)	Updated	**<Effective 1/15/2026>** **Policy Title.** **Updated from** "Eflapegrastim" **to** "Colony Stimulating Factors – Rolvedon" **Cancer in a Patient Receiving Myelosuppressive Chemotherapy**. **Updated from** "Non-myeloid malignancy receiving myelosuppressive chemotherapy associated with an increased risk of febrile neutropenia" **to** "Cancer in a Patient Receiving Myelosuppressive Chemotherapy." **Added "**Patient meets ONE of the following: Patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen); OR Patient meets BOTH of the following (a and b): Patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia, but the risk is less than 20% based on the chemotherapy regimen; AND Patient has at least one risk factor for febrile neutropenia according to the prescriber; OR Note: Examples of risk factors include age > 65 years receiving full chemotherapy dose intensity; prior chemotherapy or radiation therapy; persistent neutropenia; bone marrow involvement by tumor; recent surgery and/or open wounds; liver dysfunction (bilirubin > 2.0

		mg/dL); renal dysfunction (creatine clearance < 50 mL/min); poor performance status; patient with human immunodeficiency virus (HIV) infection and low CD4 counts. Patient meets BOTH of the following (a and b): Patient has had a neutropenic complication from a prior chemotherapy cycle and did not receive prophylaxis with a colony stimulating factor; AND Note: Examples of colony stimulating factors include filgrastim products, pegfilgrastim products, Ryzneuta (efbemalenograstim alfa-vuxw subcutaneous injection). A reduced dose or frequency of chemotherapy may compromise treatment outcome; AND The medication is prescribed by or in consultation with an oncologist or hematologist. **Radiation Syndrome (Hematopoietic Syndrome of Acute Radiation Syndrome):** This Other Use with Supportive Evidence was added as a new condition of approval. A new dosing limitation was added.
Colony Stimulating Factors – Ryzneuta - (IP0745)	Updated	**<Effective 1/15/2026>** **Added** documentation instructions **Cancer in a Patient Receiving Myelosuppressive Chemotherapy**. **Updated from** "Non-myeloid malignancy receiving myelosuppressive chemotherapy associated with an increased risk of febrile neutropenia" **to** "Cancer in a Patient Receiving Myelosuppressive Chemotherapy." **Added** "Patient meets ONE of the following: Patient is receiving myelosuppressive anti-cancer medications that are associated with a high risk of febrile neutropenia (the risk is at least 20% based on the chemotherapy regimen); OR Patient meets BOTH of the following (a and b): Patient is receiving myelosuppressive anti-cancer medications that are associated with a risk of febrile neutropenia, but the risk is less than 20% based on the chemotherapy regimen; AND Patient has at least ONE risk factor for febrile neutropenia according to the prescriber; OR Note: Examples of risk factors include age > 65 year receiving full chemotherapy dose intensity; prior chemotherapy or radiation therapy; persistent neutropenia; bone marrow involvement by tumor; recent surgery and/or open wounds; liver dysfunction (bilirubin > 2.0 mg/dL); renal dysfunction (creatine clearance < 50 mL/min); poor performance status; patient with human immunodeficiency virus (HIV) infection and low CD4 counts. Patient meets BOTH of the following (a and b): Patient has had a neutropenic complication from a prior chemotherapy cycle and did not receive prophylaxis with a colony stimulating factor; AND Note: Examples of colony stimulating factors include filgrastim products, pegfilgrastim products, Rolvedon (eflapegrastim-xnst subcutaneous injection). A reduced dose or frequency of chemotherapy may compromise treatment outcome; AND The medication is prescribed by or in consultation with an oncologist or hematologist"

		Radiation Syndrome (Hematopoietic Syndrome of Acute Radiation Syndrome): This Other Use with Supportive Evidence was added as a new condition of approval. A new dosing limitation was added. **Preferred Product Table.** **Added** documentation requirements
Dermatology – Anzupgo (IP0759)	New	**<Effective 1/15/2026>** New Policy.
Drugs Requiring Medical Necessity Review for Employer Plans - (1602)	Updated	**<Effective 1/15/2026>** **Added** preferred product step requirement for desloratadine oral solution **Updated preferred product step requirement for the following products:** Zoryve 0.3% cream, Zoryve foam, Firvanq, and vancomycin 25 mg/mL oral solution (authorized generic of Firvanq)
Hepatology – Livdelzi - (IP0711)	Updated	**<Effective 1/15/2026>** **Employer Plans:** **Removed** Preferred Product Table.
Hematology – Rytelo - (IP0693)	Updated	**<Effective 1/15/2026>** **Added** documentation instructions **Myelodysplastic Syndrome:** Regarding the diagnosis of myelodysplastic syndrome, the qualifier of "very" was added to "low" and "intermediate-1" was changed to "intermediate". Also, removed the requirement that the patient does not have deletion 5q [del{5q)] cytogenic abnormality. In the requirement that the patient has responded, lost response, or is ineligible for erythropoiesis-stimulating agents, a Note was added that a patient with a serum erythropoietin level > 500 mU/mL is considered ineligible for erythropoiesis-stimulating agents. **Preferred Product Table.** **Added** documentation requirements **Removed** "Patient does NOT have a deletion 5q; Patient has ring sideroblasts < 15%, patient has tried or has a poor probability to respond to immunosuppressive therapy.

Hepatitis C Virus Direct-Acting Antivirals Preferred Specialty Management Policy for Individual and Family Plans - (PSM026)	Updated	**<Effective 1/1/2026>** **Epclusa (brand) and Harvoni (brand)** were moved from a Preferred Product to a Non-preferred Product. Throughout the policy, exception criteria were updated to remove the Epclusa (brand) and Harvoni (brand) from the list of preferred products and to differentiate between adult and pediatric patients in order to allow exceptions for pediatric patients where applicable due to authorized generic products not being available as oral pellets.
Hereditary Angioedema – Andembry (IP0755)	New	**<Effective 1/1/2026>** New policy.
Hereditary Angioedema – C1 Esterase Inhibitors (Intravenous) – (IP0315)	Updated	**<Effective 1/1/2026>** **Policy Title.** **Updated** from "Hereditary Angioedema – C1 Esterase Inhibitors (IV)" **to** "Hereditary Angioedema – C1 Esterase Inhibitors (Intravenous)" **Updated** documentation requirements throughout the policy where required. **Updated** preferred product requirements for Employer Plans and Individual and Family Plans. **Conditions Not Covered** **Removed** C1-Inhibitor normal (levels and function) episodes of angioedema not related to a documented pathogenic variant in the *F12, ANGPT1, PLG,* or *KNG1* gene. **For Berinert and Cinryze** **Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency – Prophylaxis.** **Added** "Due to C1 Inhibitor (C1-INH) Deficiency" to indication name **Added** "Patient has HAE type I or type II as confirmed by the following diagnostic criteria and **added** "Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement." **Removed** "Confirmed pathogenic variant in the *SERPING1, F12, ANGPT1*, *PLG* or *KNG1* gene" **Removed** "Berinert or Cinryze will not be concomitantly administered with other FDA approved prophylactic treatments for HAE (for example Haegarda, Takhzyro, or Orladeyo)" **Added** "a physician who specializes in the treatment of HAE or related disorders" to specialist requirement. **Added** criteria for "Patient is currently receiving Berinert or Cinryze prophylaxis"

		Berinert and Cinryze Hereditary Angioedema (HAE) With Normal C1 Inhibitor (C1-INH) – Treatment of Acute Attacks. Added new approval condition and requirements under "Other Uses with Supportive Evidence". **Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency - Treatment of Acute Attacks** **Added** "Due to C1 Inhibitor (C1-INH) Deficiency" to indication name **Added** "Patient has HAE type I or type II as confirmed by the following diagnostic criteria (a and b): Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement." **Removed** "Confirmed pathogenic variant in the *SERPING1, F12, ANGPT1*, *PLG* or *KNG1* gene" **Removed** "Berinert or Cinryze will not be concomitantly administered with other FDA-approved treatments for acute HAE attacks (for example Firazyr, icatibant, Kalbitor, Ruconest, or Sajazir)" **Added** "a physician who specializes in the treatment of HAE or related disorders" to specialist requirement. **Added** criteria for "Patient who has treated previous acute HAE attacks with Berinert or Cinryze" **For Ruconest** **Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency - Treatment of Acute Attacks** **Added** "Due to C1 Inhibitor (C1-INH) Deficiency" to indication name **Added** "Patient has HAE type I or type II as confirmed by the following diagnostic criteria (a and b): Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement." **Removed** "Confirmed pathogenic variant in the *SERPING1, F12, ANGPT1*, *PLG* or *KNG1* gene" **Removed** "Ruconest will not be concomitantly administered with other FDA-approved treatments for acute HAE attacks (for example, Berinert, Cinryze, Firazyr, icatibant, Kalbitor, or Sajazir)" **Added** "a physician who specializes in the treatment of HAE or related disorders" to specialist requirement. **Added** criteria for "Patient who has treated previous acute HAE attacks with Ruconest"
Hereditary Angioedema – C1 Esterase Inhibitors	Updated	**<Effective 1/1/2026>** **Policy Title.**

(Subcutaneous) - (IP0316)		**Updated** from "Hereditary Angioedema – C1 Esterase Inhibitors (SC)" **to** "Hereditary Angioedema – C1 Esterase Inhibitors (Subcutaneous)" **Updated** documentation requirements throughout the policy where required. **Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency – Prophylaxis.** **Added** "Due to C1 Inhibitor (C1-INH) Deficiency" to indication name **Added** "Patient has HAE type I or type II as confirmed by the following diagnostic criteria and **added** "Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement." **Removed** "Confirmed pathogenic variant in the *SERPING1, F12, ANGPT1*, *PLG* or *KNG1* gene" **Removed** "Haegarda will not be concomitantly administered with other FDA-approved prophylactic treatments for HAE (for example, Cinryze, Takhzyro, or Orladeyo)". This was duplicative and already present in "Conditions Not Covered". **Added** "a physician who specializes in the treatment of HAE or related disorders" to specialist requirement. **Added** criteria for "Patient is currently receiving Haegarda prophylaxis" **Conditions Not Covered** **Removed** C1-Inhibitor normal (levels and function) episodes of angioedema not related to a documented pathogenic variant in the *F12, ANGPT1, PLG,* or *KNG1* gene.
Hereditary Angioedema – Dawnzera - (IP0761)	New	**<Effective 1/1/2026>** New policy.
Hereditary Angioedema – Ekterly - (IP0756)	New	**<Effective 1/15/2026>** New policy.
Hereditary Angioedema - Icatibant - (IP0335)	Updated	**<Effective 1/1/2026>** **Updated** documentation requirements throughout the policy where required. **For Employer Plans: Updated** Sajazir from Preferred to a Non-Preferred product and now requires documentation that the "patient has tried generic icatibant (the bioequivalent generic product) AND cannot continue to use due to a formulation difference in the inactive ingredient(s) [e.g., differences in stabilizing agent, buffering agent, and/or surfactant] between

		the brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction". **Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency - Treatment of Acute Attacks** **Added** "Due to C1 Inhibitor (C1-INH) Deficiency" to indication name **Added** "Patient has HAE type I or type II as confirmed by the following diagnostic criteria" and also **added** "Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement." **Removed** "Confirmed pathogenic variant in the *SERPING1, F12, ANGPT1*, *PLG* or *KNG1* gene" **Removed** "Icatibant will not be concomitantly administered with other FDA-approved treatments for acute HAE attacks (for example Berinert, Cinryze, Kalbitor, or Ruconest)" **Added** "a physician who specializes in the treatment of HAE or related disorders" to specialist requirement. **Added** criteria for "Patient who has treated previous acute HAE attacks with icatibant" **Updated** preferred product criteria to include the following examples of formulation differences in the inactive ingredient(s) "[e.g., differences in stabilizing agent, buffering agent, and/or surfactant] between the brand and the bioequivalent generic product". **Hereditary Angioedema (HAE) With Normal C1 Inhibitor (C1-INH) – Treatment of Acute Attacks**. Added new approval condition and requirements under "Other Uses with Supportive Evidence". **Conditions Not Covered** **Removed** C1-Inhibitor normal (levels and function) episodes of angioedema not related to a documented pathogenic variant in the *F12, ANGPT1, PLG,* or *KNG1* gene.
Hereditary Angioedema – Kalbitor - (IP0336)	Updated	**<Effective 1/1/2026>** **Policy Title.** **Updated** from "Hereditary Angioedema - Ecallantide" **to** "Hereditary Angioedema - Kalbitor" **Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency - Treatment of Acute Attacks** **Added** "Due to C1 Inhibitor (C1-INH) Deficiency" to indication name **Added** "Patient has HAE type I or type II as confirmed by the following diagnostic criteria (a and b): Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement." **Removed** "Confirmed pathogenic variant in the SERPING1, F12, ANGPT1, PLG or KNG1 gene"

		Removed "Has low C1-INH antigenic levels (less than 50% of normal) at baseline, as documented by laboratory reference values" **Removed** "Kalbitor will not be concomitantly administered with other FDA-approved treatments for acute HAE attacks (for example, Berinert®, Cinryze®, icatibant, or Ruconest®)" **Added** "a physician who specializes in the treatment of HAE or related disorders" to specialist requirement. **Added** criteria for Patient who has treated previous acute HAE attacks with Kalbitor **Updated** preferred product tables for Employer Plans and Individual and Family Plans **Conditions Not Covered** **Removed** C1-Inhibitor normal (levels and function) episodes of angioedema not related to a documented pathogenic variant in the F12, ANGPT1, PLG, or KNG1 gene.
Hereditary Angioedema – Orladeyo - (IP0096)	Updated	**<Effective 1/1/2026>** **Policy Title.** **Updated** from "Hereditary Angioedema - Berotralstat" **to** "Hereditary Angioedema - Orladeyo" **Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency - Prophylaxis** **Added** "Due to C1 Inhibitor (C1-INH) Deficiency" to indication name **Added** "Patient has HAE type I or type II as confirmed by the following diagnostic criteria (a and b): Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement." **Removed** "Confirmed pathogenic variant in the *SERPING1, F12, ANGPT1*, *PLG* or *KNG1* gene" **Removed** "Has low C1-INH antigenic levels (less than 50% of normal) at baseline, as documented by laboratory reference values" **Added** "a physician who specializes in the treatment of HAE or related disorders" to specialist requirement. **Added** criteria for Patients currently receiving Orladeyo
Hereditary Angioedema – Takhzyro - (IP0334)	Updated	**<Effective 1/1/2026>** **Policy Title.** **Updated** from "Hereditary Angioedema - Lanadelumab-flyo" **to** "Hereditary Angioedema - Takhzyro" **Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency - Prophylaxis**

		Added "Due to C1 Inhibitor (C1-INH) Deficiency" to indication name **Added** "Patient has HAE type I or type II as confirmed by the following diagnostic criteria (a and b): Note: A diagnosis of HAE with normal C1-INH (also known as HAE type III) does NOT satisfy this requirement." **Removed** "Confirmed pathogenic variant in the *SERPING1, F12, ANGPT1*, *PLG* or *KNG1* gene" **Removed** "Has low C1-INH antigenic levels (less than 50% of normal) at baseline, as documented by laboratory reference values" **Removed** "Takhzyro will not be concomitantly administered with other FDA-approved prophylactic treatments for HAE (for example, Cinryze®, Haegarda®, or Orladeyo®)" **Added** "a physician who specializes in the treatment of HAE or related disorders" to specialist requirement. **Added** criteria for Patient is currently receiving Takhzyro prophylaxis **Conditions Not Covered** **Removed** C1-Inhibitor normal (levels and function) episodes of angioedema not related to a documented pathogenic variant in the F12, ANGPT1, PLG, or KNG1 gene.
Human Immunodeficiency Virus – Apretude - (IP0435)	Retired	**<Effective 1/1/2026>**
Immunologicals – Dupixent - (IP0453)	Updated	**<Effective 1/15/2026>** **Chronic Rhinosinusitis with Nasal Polyps:** Criteria were updated to require the patient has experienced symptoms for at least 8 weeks. Previously, criteria required the patient to have experienced symptoms for at least 6 months. A requirement that the patient has had the diagnosis of chronic rhinosinusitis with nasal polyps for at least 6 months was added. The requirement that the patient has received at least one course of treatment with a systemic corticosteroid was updated to require that the course of treatment has been within the previous year. Previously, criteria required that the course of treatment was for 5 days or more within the previous 2 years. A "Note" was added to clarify that one course of a systemic corticosteroid is ≥ 3 consecutive days of treatment or one long-acting injectable dose. **Chronic Spontaneous Urticaria:** This condition for approval was updated from "Chronic Spontaneous Urticaria (Chronic Idiopathic Urticaria)" to "Chronic Spontaneous Urticaria." Criteria were clarified to require that the patient has/had urticaria for ≥ 6 weeks (previously required > 6 weeks). The requirement that the patient have urticaria symptoms that have been present for > 3 days per week despite daily non-sedating H_1 antihistamine therapy with

		doses that have been titrated up to a maximum of four times the standard FDA-approved dose was removed. This was replaced with a requirement that the patient has tried high-dose oral second-generation H_1 antihistamine therapy, according to the prescriber. A "Note" was added to clarify that high-dose oral second-generation H_1 antihistamine therapy is the highest dose tolerated by the patient and can be up to four times the FDA-approved dose.
Immunologicals – Nucala - (IP0422)	Updated	**<Effective 1/15/2026>** **Chronic Rhinosinusitis with Nasal Polyps:** Criteria were updated to require the patient has experienced symptoms for at least 8 weeks. Previously, criteria required the patient to have experienced symptoms for at least 6 months. A requirement that the patient has had the diagnosis of chronic rhinosinusitis with nasal polyps for at least 6 months was added. The requirement that the patient has received at least one course of treatment with a systemic corticosteroid was updated to require that the course of treatment has been within the previous year. Previously, criteria required that the course of treatment was for 5 days or more within the previous 2 years. A "Note" was added to clarify that one course of a systemic corticosteroid is ≥ 3 consecutive days of treatment or one long-acting injectable dose.
Immunologicals – Tezspire - (IP0412)	Updated	**<Effective 1/15/2026>** **Chronic Rhinosinusitis with Nasal Polyps:** This new indication was added to the policy. **Conditions Not Recommended for Approval:** "Chronic Rhinosinusitis with Nasal Polyps" was removed as a Condition Not Recommended for Approval.
Immunologicals – Xolair - (IP0487)	Updated	**<Effective 1/15/2026>** **Chronic Rhinosinusitis with Nasal Polyps:** Criteria were updated to require the patient has experienced symptoms for at least 8 weeks. Previously, criteria required the patient to have experienced symptoms for at least 6 months. A requirement that the patient has had the diagnosis of chronic rhinosinusitis with nasal polyps for at least 6 months was added. The requirement that the patient has received at least one course of treatment with a systemic corticosteroid was updated to require that the course of treatment has been within the previous year. Previously, criteria required that the course of treatment was for 5 days or more within the previous 2 years. A "Note" was added to clarify that one course of a systemic corticosteroid is ≥ 3 consecutive days of treatment or one long-acting injectable dose. **Chronic Spontaneous Urticaria:** This condition for approval was updated from "Chronic Spontaneous Urticaria (Chronic Idiopathic Urticaria)" to "Chronic Spontaneous Urticaria." Criteria were clarified to require that the patient has/had urticaria for ≥ 6 weeks (previously

		required > 6 weeks). The requirement that the patient have urticaria symptoms that have been present for > 3 days per week despite daily non-sedating H_1 antihistamine therapy with doses that have been titrated up to a maximum of four times the standard FDA-approved dose was removed. This was replaced with a requirement that the patient has tried high-dose oral second-generation H_1 antihistamine therapy, according to the prescriber. A "Note" was added to clarify that high-dose oral second-generation H_1 antihistamine therapy is the highest dose tolerated by the patient and can be up to four times the FDA-approved dose.
Inflammatory Conditions – Adalimumab Products Prior Authorization Policy – (IP0652)	Updated	**<Effective 1/1/2026>** **Plaque Psoriasis:** For initial therapy, in the Note, a 3-month trial or prior intolerance to Otezla/Otezla XR (apremilast tablets/extended-release tablets) or Sotyktu (deucravacitinib tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis. For initial therapy, the requirement "patient has a contraindication to methotrexate, as determined by the prescriber" was modified to "according to the prescriber, the patient has a contraindication to methotrexate". In the Appendix, Otezla XR (apremilast extended-release tablets) was added under the Oral Therapies/Targeted Synthetic Oral Small Molecular Drugs.
Inflammatory Conditions – Tocilizumab Intravenous Products Prior Authorization Policy – (IP0656)	Updated	**<Effective 1/1/2026>** **Castleman Disease:** For initial therapy, the requirements that the patient is negative for human immunodeficiency virus (HIV) and human herpesvirus-8 (HHV-8) and that the medication is being used for relapsed or refractory disease are modified to apply for those patients with unicentric disease and will not apply for those patients with multicentric disease. "Relapsed or refractory" was modified to "relapsed/refractory or progressive" disease. **Appendix:** Otezla XR (apremilast extended-release tablet) was added under the Oral Therapies/Targeted Synthetic Oral Small Molecular Drugs.
Inflammatory Conditions – Ilumya Prior Authorization Policy – (IP0659)	Updated	**<Effective 1/1/2026>** **Plaque Psoriasis:** For initial therapy, in the Note, a 3-month trial or prior intolerance to Otezla/Otezla XR (apremilast tablets/extended-release tablets) or Sotyktu (deucravacitinib tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis. For initial therapy, the requirement "patient has a contraindication to methotrexate, as determined by the prescriber" was modified to "according to the prescriber, the patient has a contraindication to methotrexate". In the Appendix, Otezla XR (apremilast extended-release tablets) was added under the Oral Therapies/Targeted Synthetic Oral Small Molecular Drugs.

Inflammatory Conditions – Infliximab Intravenous Products Prior Authorization Policy – (IP0660)	Updated	**<Effective 1/1/2026>** **Plaque Psoriasis:** For initial therapy, in the Note, a 3-month trial or prior intolerance to Otezla/Otezla XR (apremilast tablets/extended-release tablets), or Sotyktu (deucravacitinib tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis. For initial therapy, the requirement "patient has a contraindication to methotrexate, as determined by the prescriber" was modified to "according to the prescriber, the patient has a contraindication to methotrexate". In the Appendix, Otezla XR (apremilast extended-release tablets) was added under the Oral Therapies/Targeted Synthetic Oral Small Molecular Drugs.
Inflammatory Conditions – Kineret PA - (IP0661)	Updated	**<Effective 1/1/2026>** **Immunotherapy-Related Toxicities associated with Chimeric Antigen Receptor (CAR) T-cell Therapy:** The following note was added "Examples of immunotherapy-related toxicities associated with CAR T-cell therapy include cytokine release syndrome, Immune Effector Cell-Associated Neurotoxicity Syndrome (ICANS), and other toxicities." **Pericarditis**: This condition was added to Other Uses with Supportive Evidence.
Inflammatory Conditions – Otezla/Otezla XR Prior Authorization Policy – (IP0666)	Updated	**<Effective 1/1/2026>** **Plaque Psoriasis:** For initial therapy, in the Note, a 3-month trial or prior intolerance to Sotyktu (deucravacitinib tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis. For initial therapy, the requirement "patient has a contraindication to methotrexate, as determined by the prescriber" was modified to "according to the prescriber, the patient has a contraindication to methotrexate". In the Appendix, Otezla XR (apremilast extended-release tablets) was added under the Oral Therapies/Targeted Synthetic Oral Small Molecular Drugs.
Inflammatory Conditions – Skyrizi Subcutaneous Prior Authorization Policy – (IP0670)	Updated	**<Effective 1/1/2026>** **Plaque Psoriasis:** For initial therapy, in the Note, a 3-month trial or prior intolerance to Otezla/Otezla XR (apremilast tablets/extended-release tablets), or Sotyktu (deucravacitinib tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis. For initial therapy, the requirement "patient has a contraindication to methotrexate, as determined by the prescriber" was modified to "according to the prescriber, the patient has a contraindication to methotrexate". In the Appendix, Otezla XR (apremilast extended-release tablets) was added under the Oral Therapies/Targeted Synthetic Oral Small Molecular Drugs.

Inflammatory Conditions – Cimzia Prior Authorization Policy – (IP0672)	Updated	**<Effective 1/1/2026>** **Plaque Psoriasis:** For initial therapy, in the Note, a 3-month trial or prior intolerance to Otezla/Otezla XR (apremilast tablets/extended-release tablets) or Sotyktu (deucravacitinib tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis. For initial therapy, the requirement "patient has a contraindication to methotrexate, as determined by the prescriber" was modified to "according to the prescriber, the patient has a contraindication to methotrexate". In the Appendix, Otezla XR (apremilast extended-release tablets) was added under the Oral Therapies/Targeted Synthetic Oral Small Molecular Drugs.
Inflammatory Conditions – Inflammatory Conditions – Etanercept Products Prior Authorization Policy – (IP0673)	Updated	**<Effective 1/1/2026>** **Plaque Psoriasis:** For initial therapy, in the Note, a 3-month trial or prior intolerance to Otezla/Otezla XR (apremilast tablets/extended-release tablets), or Sotyktu (deucravacitinib tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis. For initial therapy, the requirement "patient has a contraindication to methotrexate, as determined by the prescriber" was modified to "according to the prescriber, the patient has a contraindication to methotrexate". In the Appendix, Otezla XR (apremilast extended-release tablets) was added under the Oral Therapies/Targeted Synthetic Oral Small Molecular Drugs.
Inflammatory Conditions – Cosentyx Subcutaneous Prior Authorization Policy – (IP0678)	Updated	**<Effective 1/1/2026>** **Plaque Psoriasis:** For initial therapy, in the Note, a 3-month trial or prior intolerance to Otezla/Otezla XR (apremilast tablets/extended-release tablets) or Sotyktu (deucravacitinib tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis. For initial therapy, the requirement "patient has a contraindication to methotrexate, as determined by the prescriber" was modified to "according to the prescriber, the patient has a contraindication to methotrexate". In the Appendix, Otezla XR (apremilast extended-release tablets) was added under the Oral Therapies/Targeted Synthetic Oral Small Molecular Drugs.
Inflammatory Conditions – Cosentyx Intravenous Prior Authorization Policy – (IP0683)	Updated	**<Effective 1/1/2026>** **Conditions Not Recommended for Approval:** Hidradenitis suppurativa was added. **Appendix:** Otezla XR (apremilast extended-release tablet) was added under Targeted Synthetic Oral Small Molecule drugs.

Inflammatory Conditions – Siliq Prior Authorization Policy – (IP0685)	Updated	**<Effective 1/1/2026>** **Plaque Psoriasis:** For initial therapy, in the Note, a 3-month trial or prior intolerance to Otezla/Otezla XR (apremilast tablets/extended-release tablets) or Sotyktu (deucravacitinib tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis. For initial therapy, the requirement "patient has a contraindication to methotrexate, as determined by the prescriber" was modified to "according to the prescriber, the patient has a contraindication to methotrexate". In the Appendix, Otezla XR (apremilast extended-release tablets) was added under the Oral Therapies/Targeted Synthetic Oral Small Molecular Drugs.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Prior Authorization Policy – (IP0687)	Updated	**<Effective 1/1/2026>** **Plaque Psoriasis:** For initial therapy, in the Note, a 3-month trial or prior intolerance to Otezla/Otezla XR (apremilast tablets/extended-release tablets), or Sotyktu (deucravacitinib tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis. For initial therapy, the requirement "patient has a contraindication to methotrexate, as determined by the prescriber" was modified to "according to the prescriber, the patient has a contraindication to methotrexate". In the Appendix, Otezla XR (apremilast extended-release tablets) was added under the Oral Therapies/Targeted Synthetic Oral Small Molecular Drugs.
Inflammatory Conditions – Taltz Prior Authorization Policy – (IP0688)	Updated	**<Effective 1/1/2026>** **Plaque Psoriasis:** For initial therapy, in the Note, a 3-month trial or prior intolerance to Otezla/Otezla XR (apremilast tablets/extended-release tablets), or Sotyktu (deucravacitinib tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis. For initial therapy, the requirement "patient has a contraindication to methotrexate, as determined by the prescriber" was modified to "according to the prescriber, the patient has a contraindication to methotrexate". In the Appendix, Otezla XR (apremilast extended-release tablets) was added under the Oral Therapies/Targeted Synthetic Oral Small Molecular Drugs.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance,	Updated	**<Effective 1/1/2026>** Throughout the policy, adalimumab-aacf was added as an example of an adalimumab product. For all **rheumatology, dermatology,** and **gastroenterology** it was specified that adalimumab-ryvk NDCs starting with 82009 are the Preferred product.

Value/Advantage, Total Savings Prescription Drug Lists - (PSM001)		For **Psoriatic Arthritis, Plaque Psoriasis, Crohn's Disease,** and **Ulcerative Colitis,** Stelara SC was removed as a Preferred ustekinumab SC product. **Otezla XR:** For **Psoriatic Arthritis** and **Plaque Psoriasis**, Otezla XR was added amongst the Step 1 Preferred Products. A trial of either or both Otezla products (Otezla and Otezla XR) collectively counts as one product. **Cosentyx SC**: • For **Psoriatic Arthritis,** Tremfya SC was added as an agent that counts towards a trial of a Preferred Product for a patient < 18 years of age. • For **Ankylosing Spondylitis, Non-radiographic Axial Spondyloarthritis, and Psoriatic Arthritis,** Bimzelx was added as an agent that counts towards a trial of a Preferred Product. **Orencia SC**: For **Psoriatic Arthritis,** Tremfya SC was added as an agent that counts towards a trial of a Preferred Product for a patient < 18 years of age. **Cimzia:** For **Crohn's disease**, Entyvio was added as an agent that counts towards a trial of a Preferred Product. **Simponi SC:** For **Ulcerative colitis**, Entyvio was added as an agent that counts towards a trial of a Preferred Product. **Bimzelx:** For **Ankylosing Spondylitis, Non-radiographic Axial Spondyloarthritis, and Psoriatic Arthritis,** Cosentyx was added as an agent that counts towards a trial of a Preferred Product.
Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)	Updated	**<Effective 1/1/2026>** **Adalimumab-adaz** was removed as a Preferred Product throughout the policy. Throughout the policy, adalimumab-aacf was added as an example of an adalimumab product. For all **rheumatology, dermatology,** and **gastroenterology** it was specified that adalimumab-ryvk NDCs starting with 82009 are the Preferred product. For **Psoriatic Arthritis, Plaque Psoriasis, Crohn's Disease,** and **Ulcerative Colitis,** Stelara SC was removed as a Preferred ustekinumab SC product. **Otezla XR:** For **Psoriatic Arthritis** and **Plaque Psoriasis**, Otezla XR was added amongst the Step 1 Preferred Products. A trial of either or both Otezla products (Otezla and Otezla XR) collectively counts as one product. • For **Ankylosing Spondylitis, Non-radiographic Axial Spondyloarthritis, and Psoriatic Arthritis,** Bimzelx was added as an agent that counts towards a trial of a Preferred Product. **Orencia SC**: For **Psoriatic Arthritis,** Tremfya SC was added as an agent that counts towards a trial of a Preferred Product for a patient < 18 years of age. **Cimzia:** For **Crohn's disease**, Entyvio and Omvoh were added as agents that counts towards a trial of a Preferred Product.

		Simponi SC: For **Ulcerative colitis**, Entyvio and Omvoh were added as agents that count towards a trial of a Preferred Product. **Bimzelx:** For **Ankylosing Spondylitis, Non-radiographic Axial Spondyloarthritis, and Psoriatic Arthritis,** Cosentyx was added as an agent that counts towards a trial of a Preferred Product.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Legacy Drug List Plans – (PSM003)	Updated	**<Effective 1/1/2026>** **Adalimumab-ryvk:** It was specified that NDCs starting with 82009 are a Preferred product. **Non-Adalimumab Preferred Products:** • For psoriatic arthritis and psoriasis, Otezla XR was added as a Preferred product.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists - (PSM006)	Updated	**<Effective 1/1/2026>** Throughout the policy, adalimumab-aacf was added as an example of an adalimumab product. Throughout the policy, it was specified that adalimumab-ryvk NDCs starting with 82009 are the Preferred product. For **Psoriatic Arthritis**, Otezla XR was added amongst the Step 1 Preferred Products. A trial of either or both Otezla products (Otezla and Otezla XR) collectively counts as one product. For **Psoriatic Arthritis,** Bimzelx was added as an agent that counts towards a trial of a Preferred Product. **For Psoriatic Arthritis,** Stelara subcutaneous was removed as a Preferred Product.
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage,	Updated	**<Effective 1/1/2026>** Throughout the policy, adalimumab-aacf was added as an example of an adalimumab product. Throughout the policy, it was specified that adalimumab-ryvk NDCs starting with 82009 are the Preferred product. For **Psoriatic Arthritis**, Stelara SC was removed as a Preferred ustekinumab SC product.

Total Savings Prescription Drug Lists Plans - (PSM009)		**Otezla XR:** For **Psoriatic Arthritis**, Otezla XR was added amongst the Step 1 Preferred Products. A trial of either or both Otezla products (Otezla and Otezla XR) collectively counts as one product. For **Ankylosing Spondylitis, Non-radiographic Axial Spondyloarthritis, and Psoriatic Arthritis,** Bimzelx was added as a Step 2 agent that counts towards a trial of a Preferred Product.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Individual and Family Plans - (PSM010)	Updated	**<Effective 1/1/2026>** **Adalimumab-adaz** was removed as a Preferred Product throughout the policy. Throughout the policy, adalimumab-aacf was added as an example of an adalimumab product. Throughout the policy, it was specified that adalimumab-ryvk NDCs starting with 82009 are the Preferred product. For **Psoriatic Arthritis**, Otezla XR was added amongst the Step 1 Preferred Products. A trial of either or both Otezla products (Otezla and Otezla XR) collectively counts as one product. For **Psoriatic Arthritis,** Bimzelx was added as an agent that counts towards a trial of a Preferred Product. **For Psoriatic Arthritis,** Stelara subcutaneous was removed as a Preferred Product.
Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy for Individual and Family Plan Prescription Drug Lists – (PSM011)	Updated	**<Effective 1/1/2026>** **Adalimumab-adaz** was removed as a Preferred Product throughout the policy. Throughout the policy, it was specified that adalimumab-ryvk NDCs starting with 82009 are the Preferred product. For **Crohn's Disease** and **Ulcerative Colitis,** Stelara IV/ustekinumab IV were removed as a Preferred ustekinumab IV product.
Inflammatory Conditions – Adalimumab Products	Updated	**<Effective 1/1/2026>** **Adalimumab-ryvk:** It was specified that NDCs starting with 82009 are a Preferred product.

Preferred Specialty Management Policy: Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists - (PSM013)		**Non-Adalimumab Preferred Products:** • For psoriatic arthritis and psoriasis, Otezla XR was added as a Preferred product. For psoriatic arthritis, psoriasis, Crohn's disease, and ulcerative colitis, Stelara subcutaneous was removed from the Preferred products.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Individual and Family Plans - (PSM014)	Updated	**<Effective 1/1/2026>** **Adalimumab-adaz** was moved from a Preferred Product to a Step 3 Non-Preferred product. A patient is directed to a trial of Preferred Products with documentation requirements. Documentation is also required to support the requirement that formulation difference(s) in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction. **Hyrimoz:** Removed the provision directing all requests for Hyrimoz to adalimumab-adaz. Hyrimoz now shares the same exception criteria as the other Step 3 Non-Preferred agents. **Non-Adalimumab Preferred Products:** • For psoriatic arthritis and psoriasis, Otezla XR was added as a Preferred product. For psoriatic arthritis, psoriasis, Crohn's disease, and ulcerative colitis, Stelara subcutaneous was removed from the Preferred products.
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Legacy Prescription Drug Lists Plans - (PSM016)	Updated	**<Effective 1/1/2026>** Throughout the policy, adalimumab-aacf was added as an example of an adalimumab product. Throughout the policy, it was specified that adalimumab-ryvk NDCs starting with 82009 are the Preferred product. **Otezla XR:** For **Psoriatic Arthritis**, Otezla XR was added amongst the Step 1 Preferred Products. A trial of either or both Otezla products (Otezla and Otezla XR) collectively counts as one product. For **Ankylosing Spondylitis, Non-radiographic Axial Spondyloarthritis, and Psoriatic Arthritis,** Bimzelx was added as a Step 2 agent that counts towards a trial of a Preferred Product.

Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Legacy Prescription Drug Lists - (PSM017)	Updated	**<Effective 1/1/2026>** Throughout the policy, adalimumab-aacf was added as an example of an adalimumab product. For all **rheumatology, dermatology,** and **gastroenterology** it was specified that adalimumab-ryvk NDCs starting with 82009 are the Preferred product. **Otezla XR:** For **Psoriatic Arthritis** and **Plaque Psoriasis**, Otezla XR was added amongst the Step 1 Preferred Products. A trial of either or both Otezla products (Otezla and Otezla XR) collectively counts as one product. **Cosentyx SC**: • For **Psoriatic Arthritis,** Tremfya SC was added as an agent that counts towards a trial of a Preferred Product for a patient < 18 years of age. • For **Ankylosing Spondylitis, Non-radiographic Axial Spondyloarthritis, and Psoriatic Arthritis,** Bimzelx was added as an agent that counts towards a trial of a Preferred Product. **Orencia SC**: For **Psoriatic Arthritis,** Tremfya SC was added as an agent that counts towards a trial of a Preferred Product for a patient < 18 years of age. **Cimzia:** For **Crohn's disease**, Entyvio was added as an agent that counts towards a trial of a Preferred Product. **Simponi SC:** For **Ulcerative colitis**, Entyvio was added as an agent that counts towards a trial of a Preferred Product. **Bimzelx:** For **Ankylosing Spondylitis, Non-radiographic Axial Spondyloarthritis, and Psoriatic Arthritis,** Cosentyx was added as an agent that counts towards a trial of a Preferred Product.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Legacy Prescription Drug Lists - (PSM018)	Updated	**<Effective 1/1/2026>** Throughout the policy, adalimumab-aacf was added as an example of an adalimumab product. Throughout the policy, it was specified that adalimumab-ryvk NDCs starting with 82009 are the Preferred product. For **Psoriatic Arthritis**, Otezla XR was added amongst the Step 1 Preferred Products. A trial of either or both Otezla products (Otezla and Otezla XR) collectively counts as one product. For **Psoriatic Arthritis,** Bimzelx was added as an agent that counts towards a trial of a Preferred Product.
Inflammatory Conditions –	Updated	**<Effective 1/1/2026>**

Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists – (PSM021)		The existing Non-Preferred Products were given a designation of Step 3. **Stelara SC:** Stelara was moved from Preferred to a newly created Step 2 Non-Preferred category. A patient is directed to a trial of one Preferred Product with documentation requirements. Documentation is also required to support the requirement that formulation difference(s) in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Additionally, an option for approval was added in a patient continuing therapy with Stelara. **Pyzchiva SC:** Removed the provision directing all requests for Pyzchiva to ustekinumab-ttwe. Pyzchiva now shares the same exception criteria as the other Non-Preferred agents. **Ustekinumab-aekn:** Removed the provision directing all requests for ustekinumab-aekn to Selarsdi. Ustekinumab-aekn now shares the same exception criteria as the other Non-Preferred agents. **Ustekinumab SC:** Added differentiation in criteria for the 45mg vial subcutaneous injection (Janssen Biotech) when requested for medical benefit coverage, as a Step 2 agent. All other ustekinumab SC (Janssen Biotech) will share the same exception criteria as the other Step 3 Non-Preferred agents. **Non-Ustekinumab Preferred Products:** • For psoriatic arthritis and psoriasis, Otezla XR was added as a Preferred product. It was also specified that adalimumab-ryvk NDCs starting with 82009 are a Preferred product.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Legacy Prescription Drug List Plans - (PSM022)	Updated	**<Effective 1/1/2026>** **Pyzchiva SC:** Removed the provision directing all requests for Pyzchiva to ustekinumab-ttwe. Pyzchiva now shares the same exception criteria as the other Non-Preferred agents. **Ustekinumab SC:** Added differentiation in criteria for the 45mg vial subcutaneous injection (Janssen Biotech) when requested for medical benefit coverage, as a Step 2 agent. All other ustekinumab SC (Janssen Biotech) will share the same exception criteria as the other Step 3 Non-Preferred agents. **Stelara SC 45mg vial:** was added to a newly created Step 2 Non-Preferred category. A patient is directed to a trial of one Preferred Product with documentation requirements. Documentation is also required to support the requirement that formulation difference(s) in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Additionally, an option for approval was added in a patient continuing therapy with Stelara. Stelara 45mg and 90mg syringes remain a Step 1 Preferred Product. **Ustekinumab-aekn:** Removed the provision directing all requests for ustekinumab-aekn to Selarsdi. Ustekinumab-aekn now shares the same exception criteria as the other Non-Preferred agents.

		Non-Ustekinumab Preferred Products: • For psoriatic arthritis and psoriasis, Otezla XR was added as a Preferred product. It was also specified that adalimumab-ryvk NDCs starting with 82009 are a Preferred product.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Individual and Family Plans - (PSM023)	Updated	**<Effective 1/1/2026>** The existing Non-Preferred Products were given a designation of Step 3. **Stelara SC:** Stelara was moved from Preferred to a newly created Step 2 Non-Preferred category. A patient is directed to a trial of one Preferred Product with documentation requirements. Documentation is also required to support the requirement that formulation difference(s) in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Additionally, an option for approval was added in a patient continuing therapy with Stelara. **Pyzchiva SC:** Removed the provision directing all requests for Pyzchiva to ustekinumab-ttwe. Pyzchiva now shares the same exception criteria as the other Non-Preferred agents. **Ustekinumab-aekn:** Removed the provision directing all requests for ustekinumab-aekn to Selarsdi. Ustekinumab-aekn now shares the same exception criteria as the other Non-Preferred agents. **Ustekinumab SC:** Added differentiation in criteria for the 45mg vial subcutaneous injection (Janssen Biotech) when requested for medical benefit coverage, as a Step 2 agent. All other ustekinumab SC (Janssen Biotech) will share the same exception criteria as the other Step 3 Non-Preferred agents. **Non-Ustekinumab Preferred Products:** • For psoriatic arthritis and psoriasis, Otezla XR was added as a Preferred product. • It was also specified that adalimumab-ryvk NDCs starting with 82009 are a Preferred product. Adalimumab-adaz was removed as a preferred adalimumab product.
Inflammatory Conditions – Ustekinumab Intravenous Products Preferred Specialty Management Policy - (PSM024)	Updated	**<Effective 1/1/2026>** **Stelara/Ustekinumab intravenous** was moved from a Preferred product to a Non-Preferred product and now shares the same exception criteria as the other Non-Preferred agents.

Metabolic Disorders – Nitisinone Products - (IP0146)	Updated	**<Effective 1/1/2026>** Harliku was added to the policy. The criteria was divided based on the specific agent intended for approval. **Harliku.** Alkaptonuria was added as a condition of approval.**Updated** preferred product table for Employer Plans to now require two preferred products: nitisinone 2 mg capsules and Nityr 2 mg tablets. **Conditions Not Recommended for Approval:** For concomitant therapy with nitisinone products, Harliku was added to the Note of examples.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy for Individual and Family Plans - (PSM008)	Updated	**<Effective 1/1/2026>** **Ulcerative Colitis:** It was specified that adalimumab-ryvk NDCs starting with 82009 are a Preferred product. Stelara was removed as a Preferred ustekinumab product. Adalimumab-adaz was removed as a Preferred adalimumab product.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy for Legacy Prescription Drug List Plans – (PSM004)	Updated	**<Effective 1/1/2026>** **Ulcerative Colitis:** It was specified that adalimumab-ryvk NDCs starting with 82009 are a Preferred product.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy: Standard/Performance, Value/Advantage, Total Savings Prescription Drug List Plans - (PSM015)	Updated	**<Effective 1/1/2026>** **Ulcerative Colitis:** It was specified that adalimumab-ryvk NDCs starting with 82009 are a Preferred product. Stelara was removed as a Preferred ustekinumab product.

Neurology - Gene Therapy – Skysona - (IP0529)	Updated	**<Effective 1/8/2026>** **Updated policy template.** **Coding Information** **Removed** "Code effective 1/1/2026" from HCPCS J3397
Neurology – Oxybate Products - (IP0103)	Updated	**<Effective 1/1/2026>** **Individual and Family Plans** **Added** preferred product requirements for Sodium Oxybate oral solution.
Neurology – Vyvgart Hytrulo - (IP0574)	Updated	**<Effective 1/15/2026>** **Chronic Inflammatory Demyelinating Polyneuropathy (CIDP).** **Added** Note: Chronic inflammatory demyelinating polyneuropathy can also be referred to as chronic relapsing polyneuropathy or chronic inflammatory demyelinating polyradiculoneuropathy. **Added** Note: Examples of intravenous or subcutaneous immune globulin include: Gammagard Liquid, Gammaked, Gamunex-C, Panzyga, Privigen, Hizentra, and HyQvia. **Generalized Myasthenia Gravis.** **Initial Therapy and Patient is Currently Receiving Vyvgart Hytrulo (or Vyvgart Intravenous [efgartigimod alfa intravenous infusion]):** Removed the requirement that treatment cycles are no more frequent than every 50 days from the start of the previous treatment cycle; this stipulation was removed from the prescribing information. **Dosing:** Removed the requirement that treatment cycles are no more frequent than every 50 days from the start of the previous treatment cycle; this stipulation was removed from the prescribing information. Added a Note that subsequent treatment cycles are administered based on clinical evaluation**.**
Neurology – Vyvgart Intravenous - (IP0376)	Updated	**<Effective 1/15/2026>** **Generalized Myasthenia Gravis.** **Initial Therapy and Patient is Currently Receiving Vyvgart Intravenous (or Vyvgart Hytrulo [efgartigimod alfa and hyaluronidase-qvfc subcutaneous injection]):** Removed the requirement that treatment cycles are no more frequent than every 50 days from the start of the previous treatment cycle; this stipulation was removed from the prescribing information. **Dosing:** Removed the requirement that treatment cycles are no more frequent than every 50 days from the start of the previous treatment cycle; this stipulation was removed from the

		prescribing information. Added a Note that subsequent treatment cycles are administered based on clinical evaluation.
Oncology Medications - (1403)	Updated	**<Effective 1/1/2026>** **Bosulif.** **Added** capsules **Docivyx.** **Added** "Patients with hypersensitivities to polysorbate 80" **Vabrinty.** **Added** criteria for Vabrinty.
Pharmacy and Medical Prior Authorization - (1407)	Updated	**<Effective 1/1/2026>** **Added Individual and Family Plan product-specific medical necessity criteria for the following products:** Firvanq, vancomycin 25 mg/mL oral solution, Ertaczo, amcinonide 0.1% cream and lotion, Apexicon E 0.05% cream, diflorasone 0.05% cream and ointment, Phospholine Iodide and Crotan. **Updated Individual and Family Plan product-specific medical necessity criteria for the following products:** clocortolone pivalate 0.1% cream, halcinonide 0.1% cream, Creon, Pertzye, and Zenpep (effective until 12/31/2025).
Phenylketonuria - Palynziq - (IP0294)	Updated	**<Effective 1/15/2026>** **Phenylketonuria:** For Initial Therapy, Zelvysia (sapropterin powder for oral solution) and Sephience (sepiapterin oral powder) were added to the Note as examples of treatment modalities. For a patient continuing therapy with Palynziq, "patient is continuing to titrate Palynziq to an effective maintenance dose, per the prescriber" was changed to "according to the prescriber, the patient is continuing to titrate Palynziq to a stable maintenance dose". Clarified that the response criteria apply to a patient on stable maintenance dosing of Palynziq with no concurrent use of sapropterin; Zelvysia was added as an example of a sapropterin product and Sephience was added.
Phenylketonuria - Sapropterin - (IP0295)	Updated	**<Effective 1/15/2026>**

		Phenylketonuria: For a patient currently receiving Sapropterin, "patient has achieved a blood phenylalanine concentration ≤ 360 micromol/L" was added as an option for the requirement of having had a clinical response.
Phenylketonuria – Sephience - (IP0764)	Updated	**<Effective 1/15/2026>** Policy title updated from "Phenylketonuria – Sephience for Individual and Family Plans" to "Phenylketonuria – Sephience" **Phenylketonuria:** For a patient currently receiving Sephience, "patient has achieved a blood phenylalanine concentration < 360 micromol/L" was added as an option for the requirement of having had a clinical response. **Added** Employer Plans preferred product requirements.
Sickle Cell Disease – L-glutamine for Individual and Family Plans - (IP0475)	Updated	**<Effective 1/1/2026>** • **Updated** Preferred Product Table for Individual and Family Plans **from** requiring a trial of hydroxyurea or Droxia **to** requiring a trial of the generic product.
Somatostatin Receptor Agonist – Palsonify for Individual and Family Plans - (IP0769)	New	**<Effective 1/15/2026>** New Policy
Step Therapy Individual and Family Plans - (1603)	Updated	**<Effective 1/1/2026>** **Added** Pulmicort as an Inhaled Corticosteroid (single entity) Step 2 Medication. **Added** inhaled Corticosteroid (single entity) exceptions. **Removed** Myrbetriq as an Over Active Bladder (OAB) Step 2 Medication.
Step Therapy – Standard and Performance Prescription Drug Lists (Employer Group Plans) – (1801)	Updated	**<Effective 1/1/2026>** **Added** Auvelity as an Antidepressant Step 3 Medication. **Removed** Actonel, Adderall**,** Avalide, Evekeo, Fetzima, Hyzaar, Invega, Micardis, Prevacid and Protonix from Step 3 Medications.

Step Therapy – Value and Advantage Prescription Drug Lists (Employer Group Plans) – (1802)	Updated	**<Effective 1/1/2026>** **Added** Auvelity as an Antidepressant Step 3 Medication. **Removed** Actonel, Adderall, Evekeo, Fetzima and Invega as Step 3 Medications.
Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) – (1803)	Updated	**<Effective 1/1/2026>** **Added** Auvelity as an Antidepressant Step 3 Medication. **Removed** Actonel, Adderall, Avalide, Evekeo, Fetzima, Hyzaar, Invega, Micardis, Prevacid and Protonix from Step 3 Medications.
Tasimelteon Products - (IP0428)	Updated	**<Effective 1/1/2026>** Important or minor change(s) in coverage criteria/policy: • Updated Coverage Policy Title: Changed from "Tasimelteon" to "Tasimelteon Products." Content from policy: • Non-24-Hour Sleep-Wake Disorder (Non-24): Removed Hetlioz LQ. • Employer Plans: Added Preferred Products box table with medical necessity criteria for coverage of brand Hetlioz.
Thrombocytopenia-Eltrombopag Products - (IP0153)	Updated	**<Effective 1/1/2026>** Important or minor change(s) in coverage criteria/policy: • Not applicable. Content from policy: • Individual and Family Plans Preferred Product Table: Added Promacta tablets and oral suspension.
Topical Corticosteroids-Hydrocortisone Butyrate Drug	New	**<Effective 1/1/2026>** Important or minor change(s) in coverage criteria/policy: • Not applicable.

Quantity Management Policy-Per Days - (DQM013)		Content from policy: • New policy.
Precertification Policy Commercial	**New, Updated, & Deleted**	**Comments:**
Master Precertification List	Updated	**Comments:** • Updated prior authorization requirements are available on our websites, CignaforHCP.com and Cigna.com. Additions consist of new codes released by CMS and the AMA that have been selected for our prior authorization program. Updates include existing codes that have been added and removed from prior authorization. **New Codes:** • For January 1, 2026, Cigna added 75 CPT, and 20 HCPCS newly released codes to prior authorization. • For December 31, 2025, CMS/AMA deleted/terminated 71 codes, 30 CPT and 41 HCPCS. **Updates:** • For January 28, 2026, Cigna added 1 CPT, and 1 HCPCS existing codes to prior authorization. • For January 28, 2026, 2 codes were removed from prior authorization, 1 CPT and 1 HCPCS.
Reimbursement Policy	**New, Updated, or Retired?**	**Comments**
		• No updates in January 2026

Other Coding and Reimbursement Documents	New, Updated, or Retired?	Comments
		• No updates in January 2026
ClaimsXten Documents	**New, Updated, or Retired?**	**ClaimsXten Documents**
Code Editing Policy and Guidelines	Updated	• No updates in January 2026