Payment Policy & Coding Monthly Policy Updates

Effective July 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
Cardioverter-Defibrillator Devices – (0431)	Updated	Important changes in coverage criteria/policy: • Added our standard benefit plan disclaimer at the start of the criteria. • Clarified the criterion in the primary prevention of SCD, section on hypertrophic cardiomyopathy, regarding "abnormal blood pressure response to exercise" by defining "abnormal". • Consolidated the transvenous ICD criteria in children into one statement. • Clarified the criterion in the ICD in a child section of the policy by defining "massive" left ventricular hypertrophy. • Expanded and clarified criteria for a transvenous ICD in children. • Removed the criteria for wearable cardioverter-defibrillators because the associated CPT and HCPCS codes are not clinically managed.

		• Expanded coverage by removing the criteria under AEDs that states "individual does not meet criteria for a wearable cardioverter-defibrillator" and removing the "pediatric" limitation.
Duplex Scan of Extracranial Arteries – (0542)	Updated	Important change in coverage criteria/policy: • Revised policy statement for duplex scan to evaluate the extracranial arteries by adding new indications to the list of medically necessary conditions.
Infertility Services – (0089)	Updated	**Posted 07/15/2026, Effective 10/15/2026** Important changes in coverage criteria/policy: • Revised policy statement regarding evaluation of the female factor to include sonosalpingography/hysterosalpingo-contrast sonography (HyCoSy), or hysterosalpingo-foam sonography (HyFoSy) and remove clomiphene challenge test. • Revised policy statement regarding female infertility treatment services to remove ovarian wedge resection, tubal embryo transfer (TET), low tubal ovum transfer (LTOT), and pronuclear stage transfer (PROST). • Revised policy statement regarding intracytoplasmic sperm injection (ICSI) and associated services. • Revised policy statement regarding pharmacologic treatment of endocrinopathies for male infertility to remove pulsatile gonadotropin-releasing hormone and androgens • Revised policy statement regarding male infertility treatment services to remove seminal tract washout. • Revised policy statement regarding cryopreservation, storage and thawing to combine mature oocytes or supernumerary embryos generated during a covered assisted reproductive technology cycle. • Revised policy statement regarding cryopreservation, storage and thawing to include sperm obtained through surgical retrieval techniques (e.g., testicular or epididymal sperm retrieval) when ejaculatory sperm are not available. • Revised policy statement regarding cryopreservation, storage and thawing to include mature gametes (oocytes or sperm) or embryos for individuals facing anticipated infertility due to chemotherapy, pelvic radiotherapy, other gonadotoxic therapies, or surgical removal of reproductive organs for treatment of disease.

		• Added a policy statement for mature gametes (oocytes or sperm) or embryos for fertility preservation associated with age-related reproductive decline in otherwise healthy individuals. • Removed policy statements regarding cryopreservation services: embryos when not undergoing covered active infertility treatment; sperm; and oocytes for any indication other than listed above. • Revised policy statement regarding assisted embryo hatching • Added a policy statement regarding sperm DNA integrity testing (e.g., sperm DNA fragmentation testing, TUNEL assay, Comet assay, sperm chromatin structure assay [SCSA]) • Revised policy statement of experimental/investigational/unproven services to remove direct intraperitoneal insemination, intrafollicular insemination, fallopian tube sperm transfusion, laser-assisted necrotic blastomere removal from cryopreserved embryos, SmartJane™ screening test [Biome, Inc], and saline-air infused sono-hysterosalpingogram (e.g., femVue® [Femasys, Inc.]).
Male Sexual Dysfunction Treatment: Non-pharmacologic – (0403)	Updated	Minor changes in coverage criteria/policy: • Added examples of pertinent lab tests. • Removed examples of skin substitutes.
Molecular and Proteomic Diagnostic Testing for Hematology and Oncology Indications – (0520)	Updated	Minor changes in coverage criteria/policy: • Revised policy statement for initial tissue-based broad molecular profile panel testing to add acute lymphoblastic leukemia as an indicated cancer type. • Removed policy statements for circulating tumor cell testing and variant testing in myeloproliferative neoplasms. • Revised not covered or reimbursable section to add PredicineCARE Urine Assay and UGT1A1 gene analysis.
Otoplasty and External Ear Reconstruction – (0335)	Updated	**Posting date 4/15/2026, Effective date 7/15/2026** Important change in coverage criteria/policy: External ear reconstruction surgery: • Add photo documentation requirements for hearing devices, in addition to eyewear. • Add 'oblique' view as an acceptable photo option. • Clearly link medical necessity for all devices to the correction of an active condition by including the phrase 'current hearing or visual deficit' in the policy statement.

		• Clearly communicate that surgery is appropriate to support use of prescription lenses only by adding the word 'prescription' to describe eyewear. • Add 'cochlear implants' to policy statement as an appropriate reason for surgery. Otoplasy: For clarification, add the following examples of indications that apply to the not medically necessary for 'any' indication policy statement: • Psychological symptom treatment with no other indication. • Appearance improvement with no other indication. • Non-prescriptive sunglasses use.
Treatment of Cutaneous and Vascular Lesions – (0313)	Updated	**Posted 7/15/2026, Effective 10/15/2026** Important change in coverage criteria/policy: • Added policy statement for intense pulsed light (IPL)
Athletic Pubalgia Surgery – (0522)	Updated	• No change in coverage
Bariatric Surgery and Procedures – (0051)	Updated	• No change in coverage.
Category III Current Procedural Terminology (CPT®) codes – (0558)	Updated	• No change in coverage.
Diaphragmatic/Phrenic Nerve Stimulation – (0391)	Updated	• No change in coverage
Excimer Laser, Dermabrasion and Chemical Peels for Dermatologic Conditions – (0505)	Updated	• No change in coverage
Fetal Surgery – (0175)	Updated	• No change in coverage.
Genetic Testing for Hereditary and Multifactorial Conditions – (0052)	Updated	• No change in coverage.

Genetic Testing for Reproductive Carrier Screening and Prenatal Diagnosis – (0514)	Updated	• No change in coverage.
Head and Neck Ultrasound – (0549)	Updated	• No policy statement changes
Pharmacogenetic Testing – (0500)	Updated	• No change in coverage.
Scrotal Ultrasound – (0548)	Updated	• No change in coverage.
Ultrasound Guidance for Trigger Point Injections – (0139)	Updated	• No change in coverage.
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
Cognitive Rehabilitation - (CPG270)	Updated	• No change in coverage.
Patient Assessments: Medical Necessity Decision Assist Guideline for Evaluations and Re-evaluations - (CPG111)	Updated	• No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-EviCore	Updated	**Effective 8/4/2026**

Musculoskeletal Management Guidelines		Important **changes** in coverage criteria. Eleven guidelines were updated with clinical changes which will expand coverage: • CMM-211: Spinal Cord and Dorsal Root Ganglion Stimulation • CMM-315: Shoulder Surgery - Arthroscopic and Open Procedures • CMM-600: Preface to Spine Surgery Guidelines • CMM-601: Anterior Cervical Discectomy and Fusion • CMM-602: Cervical Total Disc Arthroplasty • CMM-604: Posterior Cervical Fusion • CMM-606: Lumbar Microdiscectomy (Laminotomy, Laminectomy, or Hemilaminectomy) • CMM-608: Lumbar Decompression • CMM-609: Lumbar Fusion (Arthrodesis) • CMM-611: Sacroiliac Joint Fusion and Stabilization • CMM-614: Thoracic/Thoracolumbar Fusion (Arthrodesis) Two guidelines were updated with clinical changes which will expand and limit coverage: • CMM-200: Epidural Steroid Injections • CMM-318: Shoulder Arthroplasty/Replacement/ Resurfacing/Revision/Arthrodesis One guideline was updated with clinical changes which will limit coverage: • CMM-312: Knee Surgery-Arthroscopic and Open Procedures Twenty guidelines were updated with no change in coverage: • Preface to the Comprehensive Musculoskeletal Management (CMM) Guidelines • CMM-201: Facet Joint Injections/Medial Branch Blocks • CMM-203: Sacroiliac Joint Procedures • CMM-207: Epidural Adhesiolysis • CMM-208: Ablations/Denervations of Facet Joints and Peripheral Nerves • CMM-209: Regional Sympathetic Blocks • CMM-308: Intradiscal Procedures • CMM-310: Spinal Manipulation Under Anesthesia • CMM-311: Knee Replacement/Arthroplasty • CMM-313: Hip Replacement/Arthroplasty • CMM-314: Hip Surgery-Arthroscopic and Open Procedures • CMM-401: Discography

		• CMM-603: Posterior Cervical Decompression (Laminectomy/ Hemilaminectomy/ Laminoplasty) • CMM-605: Cervical Microdiscectomy • CMM-607: Primary Vertebral Augmentation (Percutaneous Vertebroplasty/ Kyphoplasty) and Sacroplasty • CMM-610: Lumbar Total Disc Arthroplasty • CMM-612: Grafts • CMM-613: Thoracic Decompression/Discectomy • CMM-615: Electrical and Low Frequency US Bone Growth Stimulation Spine • CMM-616: Vertebral Body Tethering for Adolescent Idiopathic Scoliosis
Administrative Policy	**New, Updated, or Retired?**	**Comments**
		• No updates in July 2026
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Alosetron (IP0012)	Retired	**Effective 7/15/2026** Lotronex relocated to Drugs Requiring Medical Necessity Review for Employer Plans - (1602)
Amyloidosis – Wainua (IP0628)	Updated	**Effective 7/1/2026** **Preferred Product Table.** **Employer Plans** **Added** "For Value, Advantage, Total Savings"
Antiseizure Medications – Vigabatrin (IP0049)	Updated	**Effective 7/15/2026** **Treatment-Refractory Complex Partial Seizures**: In initial therapy criteria, where previously stated "patient has tried and/or is concomitantly receiving at least three other antiseizure medications", the "and/or" was updated to "or". Additionally, under examples of other antiseizure medications, Fycompa was updated to perampanel.

Attention Deficit Hyperactivity Disorder (ADHD) Stimulant Medications for Employer Group Plans (IP0477)	Updated	**Effective 7/1/2026** **Updated** the Adzenys XR-ODT, Cotempla XR-ODT, Mydayis and Xelstrym preferred product requirements.
Attention Deficit Hyperactivity Disorder (ADHD) Stimulant Medications for Individual and Family Plans (IP0584)	Updated	**Effective 7/1/2026** **Updated** the Xelstrym preferred product requirement. **Effective 7/15/2026**
Bone Modifiers Denosumab - (Prolia) (IP0331)	Updated	**Effective 7/1/2026** **Policy Title:** **Updated from** "Bone Modifiers – Denosumab Products (Prolia)" **to** "Bone Modifiers – Denosumab Products (Prolia) Prior Authorization." Enoby was added to the policy with the same criteria as the other denosumab (Prolia, biosimilars) products. Bosaya was added to the policy with the same criteria as the other denosumab (Prolia, biosimilars) products. All Preferred Product Criteria removed from coverage policy. **Conditions Not Recommended for Approval:** The condition "Concurrent Use with Other Denosumab Products" was added. **Coding Information:** **Added HCPCS Codes:** C9399 J3490 J3590 Q5159 Q5161 Q5162 **Added** the following note to C9399 J3490 J3590 "†Note: Considered Medically Necessary when used to report Enoby™ (denosumab-qbde subcutaneous injection – Hikma) and medical necessity criteria outlined in this Coverage Policy are met.
Bone Modifiers – Denosumab (Xgeva) (IP0332)	Updated	**Effective 7/1/2026** **Policy Title:**

		Updated from "Bone Modifiers – Denosumab Products (Xgeva)" **to** "Bone Modifiers – Denosumab Products (Xgeva) Prior Authorization." Xtrenbo was added to the policy with the same criteria as other denosumab (Xgeva, biosimilars) products. Aukelso was added to the policy with the same criteria as other denosumab (Xgeva, biosimilars) products. All Preferred Product Criteria removed from coverage policy. **Conditions Not Recommended for Approval:** The condition "Concurrent Use with Other Denosumab Products" was added. **Dosing**: The verbiage "up to" and "by subcutaneous injection" were replaced with "no more frequently" and "subcutaneously," respectively. **Coding Information:** **Added** HCPCS Code: Q5161 Q5162 & Q5167 **Added** the following note to C9399 J3490 J3590 "†Note: Considered Medically Necessary when used to report Xtrenbo™ (denosumab-qbde subcutaneous injection – Hikma) and medical necessity criteria outlined in this Coverage Policy are met (Codes effective until 6/30/2026)
Bone Modifiers - Denosumab Products (Prolia) Preferred Specialty Management - (PSM033)	New	**Effective 7/1/2026** New policy.
Bone Modifiers - Denosumab Products (Xgeva) Preferred Specialty Management - (PSM034)	New	**Effective 7/1/2026** New policy.
Brands with Bioequivalent Generics (IP0011)	Updated	**Effective 7/1/2026** **Removed for Employer Plans:** Aczone (5% gel pump), Alinia, Aptiom, Dymista, Fycompa, Vimpat

Brands with Bioequivalent Generics (IP0011)	Updated	**Effective 7/15/2026** **Removed for Employer Plans:** Alphagan P 0.15% ophthalmic solution, Zyprexa, Zyprexa Zydis **Removed for Individual and Family Plans:** Pentasa 500 mg, Vimpat
Butalbital Combination Products (IP0025)	Retired	**Effective 7/15/2026** All products are being relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602), except Esgic tablets and capsules, Vanatol LQ, Vanatol S, and Vtol LQ which have been discontinued
Cardiology – Cardamyst (IP0783)	Updated	**Effective 7/1/2026** Policy title changed from "Cardiology – Cardamyst for Individual and Family Plans" to "Cardiology – Cardamyst"
Cardiology – Myqorzo (IP0791)	Updated	**Effective 7/15/2026** **Policy Title**: **Updated from** "Cardiology – Myqorzo for Individual and Family Plans " **to** "Cardiology – Myqorzo" **Obstructive Hypertrophic Cardiomyopathy.** A requirement was added that, for Initial Therapy, a patient has tried or is currently receiving at least one beta-blocker or nondihydropyridine calcium channel blocker for at least 3 months, or, according to the prescriber, the patient has a contraindication or intolerance to a beta-blocker or calcium channel blocker. A Note of Examples of beta blockers and calcium channel blockers was added. Another Note of Examples of contraindications and intolerances was added. **Obstructive Hypertrophic Cardiomyopathy:** For patients currently receiving Myqorzo, the requirement for ejection fraction to be ≥ 50% was removed.
Clomiphene (IP0492)	Retired	**Effective 7/15/2026** Medical Necessity criteria for clomiphene are now supported in BEO002.
Clomiphene Benefit Exclusions Overrides - (BEO002)	New	**Effective 7/15/2026** New policy.

Clotting Factors and Antithrombin (8007)	Retired	**Effective 7/15/2026** • ATryn has been discontinued All other products relocated to Pharmacy and Medical Prior Authorization - (1407) and Drugs Requiring Medical Necessity Review for Employer Plans - (1602)
Citalopram 30 mg Oral Capsule (IP0416)	Retired	**Effective 7/15/2026**
Contraceptives (IP0036)	Updated	**Effective 7/15/2026** No criteria changes.
Cyanocobalamin Nasal Spray (IP0170)	Retired	**Effective 7/15/2026** All products relocated to Pharmacy and Medical Prior Authorization - (1407) and Drugs Requiring Medical Necessity Review for Employer Plans - (1602)
Cystic Fibrosis – Pulmozyme (IP0483)	Updated	**Effective 7/15/2026** ○ No criteria changes.
Cystic Fibrosis Transmembrane Conductance Regulator – Alyftrek (IP0723)	Updated	**Effective 7/15/2026** **Cystic Fibrosis.** The term "mutation" was replaced by "variant" throughout the criteria. Changes to the requirements that the patient has at least ONE variant in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is considered pathogenic or likely pathogenic were made to add that this is according to the prescriber. In addition, the list of specific variants was removed. A requirement was added that, according to the prescriber, the patient either has a variant in the CFTR gene responsive to the medication based on clinical or in vitro data; OR has a variant in the CFTR gene results in the production of CFTR protein. **Conditions Not Recommended for Approval** **Cystic Fibrosis, Patient with Unknown Cystic Fibrosis Transmembrane Conductance Regulator Gene Variant.** The term "mutation" was replaced by "variant" in this condition not recommended for approval. **Employer Plans and Individual and Family Plans Preferred Product Table:** **Updated from** "The patient has at least one variant in the cystic fibrosis transmembrane conductance regulator gene that is considered to be a pathogenic or likely pathogenic variant that is not covered by Trikafta" **to** "According to the prescriber, the patient has a variant in the cystic fibrosis transmembrane conductance regulator gene that is not covered by Trikafta"

Cystic Fibrosis Transmembrane Conductance Regulator – Trikafta (IP0434)	Updated	**Effective 7/15/2026** **Cystic Fibrosis.** The term "mutation" was replaced by "variant" throughout the criteria. Changes to the requirements that the patient has at least ONE variant in the cystic fibrosis transmembrane conductance regulator (CFTR) gene that is considered pathogenic or likely pathogenic were made to add that this is according to the prescriber. In addition, the list of specific variants was removed. A requirement was added that, according to the prescriber, the patient either has a variant in the CFTR gene responsive to the medication based on clinical or in vitro data; OR has a variant in the CFTR gene results in the production of CFTR protein. **Conditions Not Recommended for Approval** **Cystic Fibrosis, Patient with Unknown Cystic Fibrosis Transmembrane Conductance Regulator Gene Variant.** The term "mutation" was replaced by "variant" in this condition not recommended for approval.
Delafloxacin (IP0373)	Retired	**Effective 7/15/2026** • All products relocated to Pharmacy and Medical Prior Authorization - (1407) and Drugs Requiring Medical Necessity Review for Employer Plans - (1602)
Dermatology – Gene Therapy – Vyjuvek (IP0572)	Updated	**Effective 6/18/2026** No criteria changes.
Dermatology – Gene Therapy – Zevaskyn (IP0747)	Updated	**Effective 6/18/2026** ○ No criteria changes.
Drugs Requiring Medical Necessity Review for Employer Plans (1602)	Updated	**Effective 7/1/2026** **Updated preferred product requirement criteria for the following:** Xigduo XR 2.5/1000 mg tablets
Drugs Requiring Medical Necessity Review for Employer Plans (1602)	Updated	**Effective 7/15/2026** **Added preferred product requirement criteria for the following:** Pivya, insulin glargine-yfgn (by Civica), Desmoda, Byqlovi 0.05% ophthalmic suspension, and halobetasol propionate 0.05% lotion **Updated preferred product requirement criteria for the following:** clobetasol propionate 0.05% ophthalmic suspension **Removed preferred product requirement criteria for the following:** citalopram 30 mg capsules, digoxin 62.5 mcg tablets (effective until 7/30/2026)

Enzyme Replacement Therapy – Elaprase (IP0444)	Updated	**Effective 7/15/2026** **Conditions Not Covered:** Concomitant use of Elaprase with Avlayah™ (tividenofusp alfa-eknm) was added.
Erectile Dysfunction Agents Drug Quantity Management Policy – Per Days - (DQM017)	Updated	**Effective 7/15/2026** **Tadalafil 20 mg tablets (Cialis, generic):** An override was added to approve the requested quantity, not to exceed 60 tablets per 30 days at retail or 180 tablets per 90 days at home delivery, if the patient has a diagnosis of pulmonary arterial hypertension (PAH). • **Vybrique (sildenafil oral film):** Vybrique oral film was added to the policy. For the 25 mg, 50 mg, and 100 mg oral films, the quantity limits and clinical overrides are the same as for the corresponding strengths of sildenafil tablets (Viagra, generic). The new quantity limits for the Vybrique 75 mg oral films are 6 films or 8 films per 30 days at retail and 18 films or 24 films per 90 days at home delivery (exact quantities are based on choice of client plan design). Clinical overrides are provided for up to 30 films per 30 days at retail or 90 films per 90 days at home delivery, if the patient has a diagnosis of benign prostatic hyperplasia (BPH) with or without erectile dysfunction or if the patient is using sildenafil for prevention or treatment of erectile dysfunction after radical prostatectomy.
Fenofibrates (IP0339)	Retired	**Effective 7/15/2026** • Antara, fenofibrate 30mg, and Fenoglide have been discontinued • All other products relocated to Drugs Requiring Medical Necessity Review for Employer Plans - (1602)
Fertility Injectables (1012)	Retired	**Effective 7/15/2026** Medical Necessity criteria for follitropins are now supported in IP0800; menotropins in IP0801; gonadotropin-releasing hormone agonists in IP0803; and chorionic gonadotropins in IP0804.
Glycopyrrolate (IP0388)	Retired	**Effective 7/15/2026** • All products relocated to Drugs Requiring Medical Necessity Review for Employer Plans - (1602)
Graft-Versus-Host-Disease – Rezurock (IP0313)	Updated	**Effective 7/1/2026** **Policy Title.**

		Updated from "Belumosudil" **to** "Graft-Versus-Host Disease – Rezurock" **Graft-Versus-Host-Diesease.** **Updated from** "Failure, contraindication, intolerance" **to** "Tried" for systemic treatments **Added** "Patient is Currently Receiving Rezurock" criteria
Hematology – Fibrinogen Products (IP0357)	Updated	**Effective 7/1/2026** Fesilty was added to the policy. **Congenital Fibrinogen Deficiency (Factor I Deficiency), Including Afibrinogenemia and Hypofibrinogenemia:** Approval of Fesilty was added. **Conditions Not Recommended for Approval:** Fesilty was added to the fibrinogen products that should not be used concomitantly. **Coding Information:** **Added** HCPCS J7176
Hemophilia – Non-Factor Routine Prophylaxis Products – Hemlibra (IP0121)	Updated	**Effective: 7/1/2026** No criteria changes.
Hemophilia – Non-Factor Routine Prophylaxis Products – Alhemo (IP0730)	Updated	**Effective: 7/1/2026** No criteria changes.
Hemophilia – Non-Factor Routine Prophylaxis Products – Hympavzi (IP0731)	Updated	**Effective: 7/1/2026** • No criteria changes.
Hemophilia – Non-Factor Routine Prophylaxis Products – Qfitlia (IP0742)	Updated	**Effective: 7/1/2026** • No criteria changes.
Human Chorionic Gonadotropin for Non-Fertility Uses (IP0327)	Updated	**Effective 7/15/2026** **Treatment of Prepubertal Cryptorchidism.** Removed documentation requirements for this use.

		Added Treatment of Hypogonadotropic Hypogonadism (hypogonadism secondary to a pituitary deficiency) in males as covered condition.
Hyperlipidemia – PCSK9 Inhibitors – Leqvio (IP0380)	Updated	**Effective 7/1/2026** • **Hypercholesterolemia:** The requirement for a patient to have a coronary artery calcium or calcification score ≥300 was replaced with a requirement that, according to the prescriber, the patient to be at risk for atherosclerotic cardiovascular disease (ASCVD), ASCVD event, or major adverse cardiovascular event (MACE). The requirement for a patient to have tried one high-intensity statin therapy along with ezetimibe (as a single-entity or as a combination product) for ≥ 8 continuous weeks was removed.
Hyperlipidemia – PCSK9 Inhibitors – Praluent (IP0250)	Updated	**Effective 7/1/2026** **Hypercholesterolemia:** The requirement for a patient to have a coronary artery calcium or calcification score ≥300 was replaced with a requirement that, according to the prescriber, the patient to be at risk for atherosclerotic cardiovascular disease (ASCVD), ASCVD event, or major adverse cardiovascular event (MACE). The requirement for a patient to have tried one high-intensity statin therapy along with ezetimibe (as a single-entity or as a combination product) for ≥ 8 continuous weeks was removed.
Inflammatory Conditions – Ustekinumab Subcutaneous Prior Authorization Policy - (IP0687)	Updated	**Effective 7/1/2026** **Coding Information:** **Added** HCPCS Q5137 & Q5164 **Updated** the description for C9399, J3490 & J3590 to include the note "Code effective until 6/30/2026" **Removed** the note "Code effective 7/1/2025" from HCPCS code Q5099 & Q5100 (one year post-effective date)
Inflammatory Conditions – Ustekinumab Intravenous Prior Authorization Policy - (IP0686)	Updated	**Effective 7/1/2026** **Coding Information:** **Added** HCPCS Q5164 **Updated** the description for C9399, J3490 & J3590 to include the note "Code effective until 6/30/2026"

		Added Codes effective until 6/30/2026 to the following dagger note for HCPCS codes C9399, J3490, and J3590: ○ Considered Medically Necessary when used to report Starjemza™ (ustekinumab-hmny intravenous infusion), provided the medical necessity criteria outlined in this Coverage Policy are met (Codes effective until 6/30/2026).
Immune Globulin - (5026)	Updated	**Effective 7/1/2026** **Coding Information** **Added** HCPCS code J1577
Immunologicals - Exdensur - (IP0787)	Updated	**Effective 7/1/2026** **Coding Information:** **Added** HCPCS J2361 **Updated** the description for C9399, J3490 & J3590 to include the note "Code effective until 6/30/2026
Gaucher Disease – Substrate Reduction Therapy – Cerdelga (IP0441)	Updated	**Effective 7/15/2026** **Gaucher Disease Type 1:** "Documenting" was replaced with "showing" for the requirement of a molecular genetic test showing biallelic pathogenic glucocerebrosidase (GBA) gene variants. A requirement was added that the medication is not being used for the management of neurological manifestations.
Gaucher Disease – Substrate Reduction Therapy – Miglustat (IP0446)	Updated	**Effective 7/15/2026** • **Gaucher Disease Type 1:** A requirement was added that the medication is not being used for the management of neurological manifestations.
Gonadotropin-Releasing Hormone Agonists – Lupron Depot (IP0109)	Updated	**Effective 7/15/2026** **Updated cross-reference:** Infertility use of Lupron Depot is now referenced under Infertility – Leuprolide Acetate for Injection (IP0803).
Growth Disorders – Ngenla Prior Authorization Policy (IP0577)	Updated	**Effective 7/15/2026** No criteria changes.

Growth Disorders – Skytrofa Prior Authorization Policy (IP0375)	Updated	**Effective 7/15/2026** No criteria changes.
Growth Disorders – Sogroya Prior Authorization Policy (IP0576)	Updated	**Effective 7/15/2026** • No criteria changes.
Hypoparathyroidism - Natpara (IP0177)	Updated	**Effective 7/15/2026** No criteria changes.
Hypoparathyroidism - Yorvipath (IP0712)	Updated	**Effective 7/15/2026** • No criteria changes.
Ibrexafungerps (IP0301)	Retired	**Effective 7/15/2026** • All products relocated to Pharmacy and Medical Prior Authorization - (1407) and Drugs Requiring Medical Necessity Review for Employer Plans - (1602)
Immune Disorders – Gene Therapy – Waskyra - (IP0812)	New	**Effective 7/1/2026** New policy.
Immunologicals – Cinqair (IP0423)	Updated	**Effective 7/15/2026** Throughout the policy, FEV_1 criteria thresholds were updated to ≥12% and ≥200 mL. Throughout the policy, Exdensur (depemokimab-ulaa subcutaneous injection) was added to notes as an example of monoclonal antibody therapy.
Immunologicals – Fasenra (IP0421)	Updated	**Effective 7/15/2026** **Asthma:** The dosing regimens were updated from if the patient weighs < 35 kg, approve either 10 mg administered subcutaneously once every 4 weeks for the first 3 doses or 10 mg administered subcutaneously once every 8 weeks OR if the patient weighs ≥ 35 kg, approve either 30 mg administered subcutaneously once every 4 weeks for the first 3 doses or 30 mg administered subcutaneously once every 8 weeks to one of the following 3 dosing options: 1) for patients ≥ 12 years of age, approve 30 mg administered subcutaneously once every 4 weeks for the first 3 doses, then every 8 weeks thereafter; 2) for patients 6

		years to 11 years of age who weigh < 35 kg, approve 10 mg administered subcutaneously once every 4 weeks for the first 3 doses, then every 8 weeks thereafter; or 3) for patients 6 years to 11 years of age who weigh ≥ 35 kg, approve 30 mg administered subcutaneously once every 4 weeks for the first 3 doses, then every 8 weeks thereafter. **Conditions Not Recommended for Approval:** Hypereosinophilic syndrome was removed as a Condition Not Recommended for Approval. Throughout the policy, FEV_1 criteria thresholds were updated to ≥12% and ≥200 mL. ○ Throughout the policy, Exdensur (depemokimab-ulaa subcutaneous injection) was added to notes as an example of monoclonal antibody therapy.
Immunologicals – Nucala (IP0422)	Updated	**Effective 7/15/2026** Throughout the policy, FEV_1 criteria thresholds were updated to ≥12% and ≥200 mL.
Immunologicals – Xolair (IP0487)	Updated	**Effective 7/15/2026** Throughout the policy, Exdensur (depemokimab-ulaa subcutaneous injection) was added to notes as an example of monoclonal antibody therapy.
Infectious Disease – Impavido (IP0210)	Updated	**Effective 7/15/2026** No criteria changes.
Infectious Disease – Livtencity (IP0394)	Updated	**Effective 7/15/2026** No criteria changes.
Infertility - Follitropins - (IP0800)	New	**Effective 7/15/2026** New policy. **Coding Information:** **Added** S0126 and S0128
Infertility - Menotropins for Injection - (IP0801)	New	**Effective 7/15/2026** New policy.

Infertility - Leuprolide Acetate for Injection - (IP0803)	New	**Effective 7/15/2026** New policy.
Infertility - Chorionic Gonadotropins - (IP0804)	New	**Effective 7/15/2026** New policy. **Coding Information:** **Added** J0725 & J3490
Infertility – Gonadotropin-Releasing Hormone Antagonists (IP0333)	Updated	**Effective 7/15/2026** ○ No criteria changes.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Value/Advantage Prescription Drug Lists - (PSM035)	New	**Effective 7/1/2026** New policy.
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Employer Plans: Value/Advantage Prescription Drug Lists - (PSM036)	New	**Effective 7/1/2026** New policy.
Inflammatory Conditions – Ilumya Prior Authorization Policy - (IP0659)	Updated	**Effective 7/1/2026.** • No criteria changes.

Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Employer Plans: Value/Advantage Prescription Drug Lists - (PSM037)	New	**Effective 7/1/2026** • New policy.
Inflammatory Conditions – Siliq Prior Authorization Policy (IP0685)	Updated	**Effective 7/1/2026.** • No criteria changes.
Inflammatory Conditions – Simponi Subcutaneous Prior Authorization Policy (IP0667)	Updated	**Effective 7/1/2026.** • No criteria changes.
Inflammatory Conditions – Taltz Prior Authorization Policy (IP0688)	Updated	**Effective 7/1/2026.** No criteria changes.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Value/Advantage Prescription Drug Lists - (PSM038)	New	**Effective 7/1/2026** ○ New policy.
Inflammatory Conditions Preferred	New	**Effective 7/1/2026**

Specialty Management Policy for Employer Plans: Value/Advantage Prescription Drug Lists - (PSM020)		○ New policy.
Metabolic Disorders – Imcivree (IP0104)	Updated	**Effective 7/15/2026** **Acquired Hypothalamic Obesity.** This condition of approval was added to the policy. **Obesity Due to Bardet-Biedl Syndrome.** For initial therapy, patient ≥ 18 years of age was updated to patient ≥ 16 years of age. Patient < 18 years of age was updated to patient 6 to < 16 years of age. A criterion was added for patient 2 to < 6 years of age requiring that the patient currently has a BMI ≥ 97th percentile for age and gender on growth chart assessment. **Obesity Due to Proopiomelanocortin (POMC), Proprotein Convertase Subtilisin/Kexin Type 1 (PCSK1), or Leptin Receptor (LEPR) Deficiency.** For initial therapy, patient 6 to 17 years of age, was broken into patient with LEPR deficiency and patient with POMC or PCSK1. Criterion for patient with POMC or PCSK1 was added as patient currently has a BMI ≥ 95th percentile for age and gender on growth chart assessment OR a body weight ≥ 95th percentile for age and gender on growth chart assessment. Patient 2 to ≤ 5 years of age was updated to patient currently has a BMI ≥ 97th percentile for age and gender on growth chart assessment; previously was patient currently has a body weight ≥ 97th percentile for age on growth chart assessment. For continuation of therapy, the criterion patient has continued growth potential was updated to patient is < 18 years of age
Migraine – Zavzpret (IP0573)	Updated	**Effective 7/15/2026** No criteria changes.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy: Value/Advantage	New	**Effective 7/1/2026** New policy.

Prescription Drug List Plans - (PSM039)		
Muscular Dystrophy – Gene Therapy – Elevidys – (IP0571)	Updated	**Effective 7/1/2026** **Duchenne Muscular Dystrophy – Treatment:** This condition of approval was added. **Conditions Not Recommended for Approval:** Removed Duchenne Muscular Dystrophy. Added Becker Muscular Dystrophy, Patients with Duchenne Muscular Dystrophy Who are Non-Ambulatory, Concurrent Use with Anti-Sense Oligonucleotide (Exon-Skipping) Therapies, Prior Receipt of Gene Therapy, and Prior Hematopoietic Stem Cell Transplantation.
Inflammatory Conditions – Tocilizumab Intravenous Products Preferred Specialty Management Policy - PSM012	Updated	**Effective 7/1/2026** Actemra intravenous was moved from Preferred to Non- Preferred. For Non-Preferred products, documentation of a trial of both Avtozma intravenous and Tyenne intravenous is required in addition to documentation of a difference in formulation of inactive ingredients.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy: Standard/Performance and Total Savings Prescription Drug Lists - (PSM013)	Updated	**Effective 7/1/2026** **Value/Advantage Drug List Plans:** Removed "Value/Advantage" from the policy title and criteria relocated to a new policy *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Value/Advantage Prescription Drug Lists – (PSM035)* to be effective 7/1/2026. **Non-Preferred Products**: An option of approval was added in a patient meeting all of the following: Patient requires a dose < 20 mg; patient has tried one preferred product with documentation requirement; and the patient cannot continue to use the preferred product with documentation requirement. **Appendix A.** **Non-Adalimumab Preferred Products:** Icotyde was added as a Preferred product for plaque psoriasis. **Non-Preferred Adalimumab products:** The requirement the patient has tried and cannot continue to use three Preferred adalimumab products was updated to now require a trial of ALL Preferred adalimumab products (adalimumab-aaty, Cyltezo/adalimumab-adbm, Humira (NDCs starting with 00074), and Simlandi/adalimumab-ryvk (NDCs starting with 82009) with documentation

		requirements. An exception will still be allowed for those requiring a dose <20mg to try two Preferred adalimumab products, rather than all Preferred adalimumab products.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Individual and Family Plans - (PSM014)	Updated	**Effective 7/1/2026** **Non-Preferred Products**: An option of approval was added in a patient meeting all of the following: Patient requires a dose < 20 mg; patient has tried one preferred product with documentation requirement; and the patient cannot continue to use the preferred product with documentation requirement. **Appendix A.** **Non-Adalimumab Preferred Products:** Icotyde was added as a Preferred product for plaque psoriasis.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Legacy Drug List Plans - (PSM003)	Updated	**Effective 7/1/2026** **Non-Preferred Products**: An option of approval was added in a patient meeting all of the following: Patient requires a dose < 20 mg; patient has tried two preferred products with documentation requirement; and the patient cannot continue to use the preferred products with documentation requirement. **Appendix A.** **Non-Adalimumab Preferred Products:** Icotyde was added as a Preferred product for plaque psoriasis. **Non-Preferred Adalimumab products:** The requirement the patient has tried and cannot continue to use three Preferred adalimumab products was updated to now require a trial of ALL Preferred adalimumab products (adalimumab-aaty, Cyltezo/adalimumab-adbm, Humira (NDCs starting with 00074), and Simlandi/adalimumab-ryvk (NDCs starting with 82009) with documentation requirements. An exception will still be allowed for those requiring a dose <20mg to try two Preferred adalimumab products, rather than all Preferred adalimumab products.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance and Total Savings	Updated	**Effective 7/1/2026** **Value/Advantage Drug List Plans:** Removed "Value/Advantage" from the policy title and criteria relocated to a new policy *Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Employer Plans: Value/Advantage Prescription Drug Lists - (PSM037)* to be effective 7/1/2026.

Prescription Drug Lists - (PSM006)		
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, and Total Savings Prescription Drug Lists - (PSM001)	Updated	**Effective 7/1/2026** **Value/Advantage Drug List Plans:** Removed "Value/Advantage" from the policy title and criteria relocated to a new policy, *Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Value/Advantage Prescription Drug Lists - (PSM020),* to be effective 7/1/2026. ○ **Icotyde:** For **Plaque Psoriasis**, Icotyde was added as a Step 1 Preferred agent. Criteria for Bimzelx, Cimzia, Cosentyx, Ilumya, and Siliq were updated to include Icotyde as a Preferred Product. Icotyde was added to Appendix A, Table 2.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Legacy Prescription Drug Lists - (PSM017)	Updated	**Effective 7/1/2026** **Icotyde:** For **Plaque Psoriasis**, Icotyde was added as a Step 1 Preferred agent. Criteria for Bimzelx, Cimzia, Cosentyx, Ilumya, and Siliq were updated to include Icotyde as a Preferred Product. Icotyde was added to Appendix A, Table 2. ○
Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)	Updated	**Effective 7/1/2026** **Icotyde:** For **Plaque Psoriasis**, Icotyde was added as a Step 1 Preferred agent. Criteria for Bimzelx, Cimzia, Ilumya, Siliq, and Taltz were updated to include Icotyde as a Preferred Product. Icotyde was added to Appendix A, Table 2.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Standard/Performance and Total Savings	Updated	**Effective 7/1/2026** **Value/Advantage Drug List Plans:** Removed "Value/Advantage" from the policy title and criteria relocated to a new policy *Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Value/Advantage Prescription Drug Lists - (PSM038)* to be effective 7/1/2026. **Stelara SC 45mg vial and ustekinumab SC 45mg vial:** For medical and pharmacy benefit coverage, moved to a Step 3 product with criteria to direct to a trial of all the Preferred Products with documentation requirements. Documentation is also required to

Prescription Drug Lists - (PSM021)		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. **Stelara SC 45mg syringe, 90mg syringe:** Continue to remain as Step 2 products and direct to a trial of one Preferred Product with documentation requirements. **Non-Preferred Products**: An option of approval was added in a patient meeting all of the following: Patient is <18 years of age; patient weighs < 60 kg; patient has tried two preferred products with documentation requirement; and the patient cannot continue to use the preferred product with documentation requirement. ○ **Appendix: Non-Ustekinumab Preferred Products:** Icotyde was added as a Preferred product for plaque psoriasis.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Legacy Prescription Drug List Plans - (PSM022)	Updated	**Effective 7/1/2026** **Stelara SC 45mg vial and ustekinumab SC 45mg vial:** Updated criteria to share the same exception criteria as the other Non-Preferred ustekinumab products which direct to a trial of all the 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. All Non-Preferred products were combined into Step 2 with the same criteria and Step 3 was removed. **Non-Preferred Products**: An option of approval was added in a patient meeting all of the following: Patient is <18 years of age; patient weighs < 60 kg; patient has tried two preferred products with documentation requirement; and the patient cannot continue to use the preferred product with documentation requirement. **Appendix: Non-Ustekinumab Preferred Products:** Icotyde was added as a Preferred product for plaque psoriasis.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Individual and Family Plans - (PSM023)	Updated	**Effective 7/1/2026** **Stelara SC 45mg vial and ustekinumab SC 45mg vial:** For medical and pharmacy benefit coverage, moved to a Step 3 product with criteria to direct to a trial of all the 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. **Stelara SC 45mg syringe, 90mg syringe:** Continue to remain as Step 2 products and direct to a trial of one Preferred Product with documentation requirements.

		Non-Preferred Products: An option of approval was added in a patient meeting all of the following: Patient is <18 years of age; patient weighs < 60 kg; patient has tried two preferred products with documentation requirement; and the patient cannot continue to use the preferred product with documentation requirement. **Appendix: Non-Ustekinumab Preferred Products:** Icotyde was added as a Preferred product for plaque psoriasis.
Inflammatory Conditions - Tocilizumab Subcutaneous Products Prior Authorization Policy – (IP0657)	Updated	**Effective 7/1/2026** No criteria changes. **Appendix:** Icotyde (icotrokinra tablet) was added under Oral Therapies/Targeted Synthetic Oral Small Molecule Drugs.
Lupus – Saphnelo Intravenous (IP0280)	Updated	**Effective 7/15/2026** **Title:** The policy name was updated to add Intravenous. Throughout the policy, it was clarified the target is Saphnelo intravenous.
Lupus – Saphnelo Subcutaneous for Individual and Family Plans - (IP0810)	New	**Effective 7/15/2026** New policy.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy: Standard/Performance and Total Savings Prescription Drug List Plans - (PSM015)	Updated	**Effective 7/1/2026** **Value/Advantage Drug List Plans:** Removed "Value/Advantage" from the policy title and criteria relocated to a new policy, Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy: Value/Advantage Prescription Drug List Plans - (PSM039), to be effective 7/1/2026.
Inflammatory Conditions – Cosentyx Intravenous Preferred	Updated	**Effective 7/1/2026** **Value/Advantage Drug List Plans:** Removed "Value/Advantage" from the policy title and criteria relocated to a new policy *Inflammatory Conditions – Cosentyx Intravenous*

Specialty Management Policy for Employer Plans: Standard/Performance and Total Savings Prescription Drug Lists - (PSM009)		*Preferred Specialty Management Policy for Employer Plans: Value/Advantage Prescription Drug Lists – (PSM036)* to be effective 7/1/2026.
Muscular Dystrophy – Exondys 51 (IP0135)	Updated	**Effective 7/15/2026** **Added** documentation statement. **Updated** template format.
Nephrology – Filspari (IP0565)	Updated	**Effective 7/15/2026** **Focal Segmental Glomerulosclerosis:** This was added as a new condition of approval. • **Primary Immunoglobulin A Nephropathy:** The criterion requiring that the patient is at high risk of disease progression, defined by ONE of the following: urine protein-to-creatinine ratio ≥ 0.8 g/g OR proteinuria ≥ 0.5 g/day was modified to require that the patient is at high risk of disease progression, defined by urine protein-to-creatinine ratio ≥ 0.5 g/g OR proteinuria ≥ 0.5 g/day. The Note of examples of angiotensin converting enzyme inhibitors or angiotensin receptor blockers was modified to examples include but are not limited to lisinopril, fosinopril, enalapril, benazepril, irbesartan, losartan, candesartan, valsartan, ambrisentan, bosentan.
Nephrology – Korsuva (IP0436)	Updated	**Effective 7/15/2026** **Policy Title:** **Updated from "**Difelikefalin**" to "**Nephrology – Korsuva**"** **Chronic Kidney Disease Associated Pruritus in Hemodialysis:** • **Updated** "individual" with "patient" throughout criteria. • **Updated** "documented failure, contraindication, or intolerance" **to** "Patient has tried" ONE of the following therapies for chronic kidney disease-associated pruritus... **Coverage Policy**:

		• **Removed** "When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.". • **Removed** "Receipt of sample product does not satisfy any criteria requirements for coverage.".
Nephrology - Voyxact - (IP0788)	Updated	**Effective 7/15/2026** **Primary Immunoglobulin A Nephropathy:** The criterion requiring that the patient is at high risk of disease progression, defined by ONE of the following: urine-to-protein-creatinine ratio ≥ 0.8 g/g OR proteinuria ≥ 0.5 g/day was modified to require that the patient is at high risk of disease progression, defined by urine-to-protein-creatinine ratio ≥ 0.5 g/g OR proteinuria ≥ 0.5 g/day.
Neurology – Brineura (IP0175)	Updated	**Effective 7/15/2026** **Documentation:** Documentation requirements were added to the medical necessity criteria. **Neuronal Ceroid Lipofuscinosis Type 2 (CLN2), Dosing:** The dosing was simplified to allow maximum approved dosing and now reads as follows: "approve up to 300 mg via intracerebroventricular infusion administered not more frequently than once every other week". ○ **Conditions Not Recommended for Approval:** Under Neuronal Ceroid Lipofuscinoses (NCLs) other than neuronal ceroid lipofuscinosis type 2 (CLN2), examples of NCLs were moved to a Note.
Neurology – Rystiggo (IP0575)	Updated	**Effective 7/15/2026** ○ No criteria changes**.**
Ophthalmology – Oxervate (IP0302)	Updated	**Effective 7/15/2026** No criteria changes**.**
Overactive Bladder Medications Step Therapy Policy for Employer Plans:	Updated	**Effective 7/15/2026** **Updated** the policy title from "Overactive Bladder Medications Step Therapy Policy for Employer Plans: Value/Advantage/Legacy Drug Lists" to "Overactive Bladder Medications Step Therapy Policy for Employer Plans: Legacy Drug List.

Legacy Drug List (ST002)		**Removed** Gemtesa from the policy.
Overactive Bladder Medications Step Therapy Policy for Employer Plans: Value/Advantage Drug List - (ST007)	New	**Effective 7/15/2026** New policy.
Wakefulness-Promoting Agents – Oxybate Products (IP0103)	Updated	**Effective 7/15/2026** **The policy name was changed from "Neurology – Oxybate Products" to "Wakefulness-Promoting Agents – Oxybate Products"** **Cataplexy Treatment in a Patient with Narcolepsy:** The phrase "if the patient is ≥ 18 years of age" was added to the dextroamphetamine trial requirement, such that patients < 18 years of age are not required to try dextroamphetamine. Additionally, an exception was added to allow continuation for a patient currently receiving the requested product. **Excessive Daytime Sleepiness in a Patient with Narcolepsy:** For the requirement to try a central nervous system stimulant, modafinil, or armodafinil, an exception was added to allow continuation for a patient currently receiving the requested product. **Idiopathic Hypersomnia:** For the requirement to try modafinil, armodafinil, or methylphenidate, an exception was added to allow continuation for a patient currently receiving Xywav. **Updated the preferred product criteria for Employer Plans:** **Xyrem:** **Updated from** "Inability to obtain sodium oxybate oral solution due to market availability" **to** "The patient has tried sodium oxybate oral solution (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction [documentation required]" **Updated the preferred product criteria for Individual and Family Plans:** **Lumryz:** **Removed** "Patient is ≥ 18" for Cataplexy Treatment in Patients with Narcolepsy **Added** "Patient has already been started on therapy with Lumryz."

		Sodium Oxybate oral solution: **Removed** "Patient is ≥ 18" for Cataplexy Treatment in Patients with Narcolepsy **Added** "Patient has already been started on therapy with sodium oxybate oral solution**"** **Xyrem:** **Removed** "Patient is ≥ 18" for Cataplexy Treatment in Patients with Narcolepsy **Added** "Patient has already been started on therapy with Xyrem" **Xywav:** **Removed** "Patient is ≥ 18" for Cataplexy Treatment in Patients with Narcolepsy **Added** "Patient has already been started on therapy with Xywav."
Non-Infertility - Progesterone (Vaginal) Benefit Exclusions Override Policy for Employer Plans - (BEO003)	New	**Effective 7/15/2026** New policy.
Oncology Medications (1403)	Updated	**Effective 7/1/2026** **Akeega.** For BRCA-mutated prostate cancer **Added** "Note: If the patient has already tried any of the following: Rubraca, Talzeena, or Zejula, this would satisfy the requirement for an approval. **Braftovi.** Removed preferencing criteria for Employer Plans **Ibrance.** For breast cancer: **Added "**Note: Phesgo (pertuzumab, trastuzumab, and hyaluronidase-zzxf SC inj) may be substituted wherever IV pertuzumab and IV trastuzumab are used." **Mektovi.** Removed preferencing criteria for Employer Plans **Onivyde.** Removed preferencing criteria for Employer Plans and Individual and Family Plans

		Talzenna. Removed preferencing criteria for Employer Plans For BRCA-mutated prostate cancer: **Added** "Note: If the patient has already tried any of the following: Akeega, Rubraca, or Zejula, this would satisfy the requirement for an approval. **Pomalyst.** Added preferencing criteria for Employer Plans **Zykadia.** Removed preferencing criteria for Employer Plans
Oncology (Oral – Anaplastic Lymphoma Kinase [ALK]-Positive Agent) – Xalkori Drug Quantity Management Policy – Per Days - (DQM026)	New	**Effective 7/1/2026** New policy.
Ophthalmic – Glaucoma – Prostaglandins (IP0027)	Updated	**Effective 7/1/2026** **For Employer Plans** **Added** Bimatoprost 0.03% ophthalmic solution – generic only, latanoprost 0.005% ophthalmic solution (generic for Xalatan), tafluprost 0.0015% ophthalmic solution, and tafluprost 0.0015% ophthalmic solution to the policy. **Individual and family Plans** **Updated** Rhopressa preferred product requirements **Updated** Rocklatan preferred product requirements
Ophthalmology – Qlosi (IP0738)	Updated	**Effective 7/15/2026** **Policy Title:** Updated from "Qlosi" to "Opthalmology – Qlosi" **Conditions Not Covered:** Updated supporting information for Presbyopia.

Ophthalmology – Vascular Endothelial Growth Factor Inhibitors – Vabysmo (IP0542)	Updated	**Effective 7/15/2026** **Policy Statement:** The word "prescribed" in the statement that "approval requires Vabysmo to be prescribed by or in consultation with a physician who specializes in the condition being treated" was changed to "administered". **Macular Edema Following Retinal Vein Occlusion:** Approval duration was changed from 6 months to 1 year.
Opioid Therapy for Employer Group Benefit Plans - (IP0561)	Updated	**Effective 7/1/2026** **Preferred Product Requirement Table** **Hysingla ER (brand):** Updated to move Hysingla ER from a preferred product to a non-preferred product with criteria directing to the bioequivalent generic product unless the patient cannot take due to a formulation difference in the inactive ingredient(s) [for example, difference in dyes, fillers, preservatives] between the brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction.. **Levorphanol:** Added Xyvona to the policy as another levorphanol product with the same criteria applying as for generic levorphanol. Removed brand Hysingla ER as a preferred alternative in the preferred product criteria. Updated criteria to require three medications (each from a different group) of the following: a morphine-containing product, a hydrocodone-containing product, a hydromorphone-containing product, an oxycodone-containing product, an oxymorphone-containing product, a fentanyl-containing product, a methadone-containing product, or a tapentadol-containing product and allowing an exception for those patients currently receiving levorphanol for chronic pain (cancer or non-cancer pain) **MS Contin:** Updated preferred product criteria to direct to the bioequivalent generic product unless the patient cannot take due to a formulation difference in the inactive ingredient(s) [for example, difference in dyes, fillers, preservatives] between the brand and the bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction. **Nucynta ER:** Removed brand Hysingla ER as a preferred alternative in the preferred product criteria. Updated preferred product criteria to require the patient has tried three other oral long-acting opioid products; OR if intolerant or allergic to morphine: has tried one of hydrocodone ER tablets or capsules, or Xtampza ER; OR has renal insufficiency and has tried one of hydrocodone ER tablets or capsules, or Xtampza ER; An exception to the preferred product requirements is provided if the patient is currently receiving Nucynta ER AND is using the requested medication for chronic pain (cancer or non-cancer pain).

		Oxycontin: Removed brand Hysingla ER as a preferred alternative in the preferred product criteria. Updated preferred product criteria to require the patient has tried three other oral long-acting opioid products; OR if intolerant or allergic to morphine: has tried one of hydrocodone ER tablets or capsules, or Xtampza ER; OR has renal insufficiency and has tried one of hydrocodone ER tablets or capsules, or Xtampza ER; OR the patients ≥ 11 years and < 18 years of age; OR if the patient is currently receiving Oxycontin or oxycodone ER AND is using the requested medication for chronic pain (cancer or non-cancer pain) and the patient has tried Xtampza ER. **Seglentis, Qdolo (brand):** Removed from the policy, discontinued by the manufacturer. **Tapentadol extended-release tablets:** added to the policy with the same criteria as Nucynta ER. **Appendix 1:** Added tapentadol immediate-release tablet and Xyvona. Removed benzydrocodone/acetaminophen (generic for Apadaz), it has been discontinued by the manufacturer. **Appendix 2:** Added Tapentadol extended-release tablets and Xyvona. Removed MorphaBond ER, it has been discontinued by the manufacturer.
Opioid Therapy for Employer Group Benefit Plans - (IP0561)	Updated	**Effective 7/15/2026** **Added** Butalbital/acetaminophen/caffeine/codeine capsule to Appendix 1
Opioid Therapy – Individual and Family Plans (IP0562)	Updated	**Effective 7/15/2026** **Added** Butalbital/acetaminophen/caffeine/codeine capsule to Appendix 1
Pain – Journavx Drug Quantity Management Policy – Per Days (DQM004)	Updated	**Effective 7/1/2026** **Updated** the policy statement.
Paromomycin (IP0520)	Retired	**Effective 7/15/2026** • All products relocated to Pharmacy and Medical Prior Authorization - (1407) and Drugs Requiring Medical Necessity Review for Employer Plans - (1602)
Pharmacy and Medical Prior Authorization (1407)	Updated	**Effective 7/15/2026** **Added Individual and Family Plan product-specific medical necessity criteria for the following:** **EFFECTIVE 7/15/2026:** Baxdela, Humatin 250 mg capsule, Brexafemme, Vimpat oral solution and tablets, Isordil Titradose, Isordil 40 mg tablets, isosorbide dinitrate 40 mg

		tablets, Obizur, fenofibrate 90 mg capsules, Fibricor, Lipofen, Tricor, Dartisla ODT, Glycate, glycopyrrolate 1.5 mg tablet, Robinul, Robinul Forte, Thrombate III, Pentasa 500 mg capsules, Lotronex, diclofenac epolamine 1.3% topical patch, diclofenac sodium 2% topical solution, Flector Patch, Licart, Pennsaid, Alphagan P 0.1% and 0.15% ophthalmic solution, Tobrex ointment, citalopram 30 mg capsules, Reltone, and ursodiol 200 mg and 400 mg capsules, cyanocobalamin nasal spray, Nascobal, Pivya, levetiracetam orally disintegrating tablets (authorized generic of Spritam), Sdamlo, Atmeksi, Ontralfy, Pokonza solution, ipratropium bromide inhalation aerosol (generic of Atrovent HFA), and Atrovent HFA **EFFECTIVE 8/1/2026:** Amicar oral solution, Amicar tablet, and Alinia tablets **Updated Individual and Family Plan product-specific medical necessity criteria for the following:** **EFFECTIVE 7/15/2026:** Xdemvy, topiramate extended-release capsules, Trokendi XR, Spritam and Pokonza powder for oral solution **Removed Individual and Family Plan product-specific medical necessity criteria for the following:** **EFFECTIVE 7/15/2026:** dapagliflozin tablets (authorized generic of Farxiga) and dapagliflozin and metformin extended-release tablets (authorized generic of Xigduo XR)
Phosphodiesterase Type 5 Inhibitors - Non-Erectile Dysfunction Benefit Exclusion Override Policy for Employer Plans (BEO001)	Updated	**Effective 7/15/2026** Vybrique (sildenafil oral film) was added to the policy with the same authorization criteria and exclusions as other Phosphodiesterase Type 5 Inhibitors - Non-Erectile Dysfunction products.
Phosphodiesterase Type 5 Inhibitors - Sildenafil (Viagra®, Vybrique™) for Individual and Family Plans (IP0098)	Updated	**Effective 7/15/2026** **Policy Title:** **Updated from** "Phosphodiesterase Type 5 Inhibitors - Sildenafil (Viagra®) for Individual and Family Plans" **to** "Phosphodiesterase Type 5 Inhibitors - Sildenafil (Viagra®, Vybrique™) for Individual and Family Plans" Vybrique (sildenafil oral film) was added to the policy with the same authorization criteria and exclusions as other sildenafil products.
Phosphodiesterase Type 5 Inhibitors - Vybrique for Employer Plans (IP0809)	New	**Effective 7/15/2026** New Policy.

Pompe Disease – Enzyme Replacement Therapy – Lumizyme (IP0440)	Updated	**Effective 7/15/2026** No criteria changes.
Pompe Disease – Enzyme Replacement Therapy – Nexviazyme (IP0279)	Updated	**Effective 7/15/2026** No criteria changes.
Pompe Disease – Enzyme Stabilization Therapy – Opfolda (IP0598)	Updated	**Effective 7/15/2026** No criteria changes.
Pompe Disease – Enzyme Replacement Therapy – Pombiliti (IP0591)	Updated	**Effective 7/15/2026** **Updated** the policy statement.
Progesterone (Vaginal) for Individual and Family Plans (IP0091)	Updated	**Effective 7/15/2026** **Added** generic to policy.
Psychiatry – Zulresso (IP0270)	Updated	**Effective 7/15/2026** No criteria changes.
Spinal Muscular Atrophy – Gene Therapy – Itvisma - (IP0790)	Updated	**Effective 7/1/2026** **Coding Information:** **Added** HCPCS J3405 **Updated** the description for C9309 to include the note "Code effective until 6/30/2026" **Removed** HCPCS J3590
Thrombocytopenia – Doptelet (IP0152)	Updated	**Effective 7/15/2026** **Immune Thrombocytopenia, Chronic or Persistent:** For Doptelet tablets, added Walrilz (rilzabrutinib tablets) as an example of a medication used for this condition.
Thrombocytopenia – Eltrombopag Products (IP0153)	Updated	**Effective 7/15/2026** **Immune Thrombocytopenia:** For Promacta, the examples of Doptelet Sprinkle (avatrombopag oral granules) and Wayrilz (rilzabrutinib tablets) were added as medications

		used for this condition. For Alvaiz, Wayrilz (rilzabrutinib tablets) was added as a medication used for this condition. **Hematologic Toxicity in a Patient Receiving Immune Effector Cell Therapies:** This was added as a new condition of approval for Promacta and Alvaiz. **Thrombocytopenia in a Patient with Myelodysplastic Syndrome:** For Promacta and Alvaiz, the criterion that stated referred to risk was changed from low- to intermediate-risk to very low, low, or intermediate-risk. **Preferred Product Table.** **Alvaiz. Employer Plans** **Updated from** "Patient meets ONE of the following: Patient has tried eltrombopag olamine (tablets/oral suspension, generic Promacta); OR Patient is currently receiving Alvaiz" **to** "ONE of the following: For Immune Thrombocytopenia, patient meets ONE of the following: Patient has tried eltrombopag olamine (Promacta, tablets, generics) or Doptelet tablets; OR Note: If the patient has tried eltrombopag olamine oral suspension (Promacta oral suspension) or Doptelet Sprinkle this counts toward an approval. Patient has already been started on therapy with Alvaiz; For Aplastic Anemia; Hematologic Toxicity in a Patient Receiving Immune Effector Cell Therapies Thrombocytopenia in a Patient with Chronic Hepatitis C; Thrombocytopenia in a Patient with Myelodysplastic Syndrome; Thrombocytopenia in a Patient Post-Allogeneic Transplantation; Thrombocytopenia due to Immune Checkpoint Inhibitor Therapy, patient meets ONE of the following: Patient has tried eltrombopag olamine (Promacta tablets, generics); Note: If the patient has tried eltrombopag olamine oral suspension (Promacta oral suspension) this counts toward an approval. OR Patient has already been started on therapy with Alvaiz" **Alvaiz. Individual and Family Plans** **Updated from** "Patient meets ONE of the following: Patient has tried eltrombopag olamine (tablets/oral suspension, generic Promacta); OR Patient is currently receiving Alvaiz" **to** "ONE of the following: For Immune Thrombocytopenia, patient meets ONE of the following: Patient has tried eltrombopag olamine (Promacta, tablets, generics); OR Note: If the patient has tried eltrombopag olamine oral suspension (Promacta oral suspension) this counts toward an approval. Patient has already been started on therapy with Alvaiz; For Aplastic Anemia; Hematologic Toxicity in a Patient Receiving Immune Effector Cell Therapies Thrombocytopenia in a Patient with Chronic Hepatitis C; Thrombocytopenia in a Patient with Myelodysplastic Syndrome; Thrombocytopenia in a Patient Post-Allogeneic Transplantation; Thrombocytopenia due to Immune Checkpoint Inhibitor Therapy, patient meets ONE of the following: Patient has tried eltrombopag olamine (Promacta tablets, generics); Note: If the patient has tried eltrombopag olamine oral suspension (Promacta oral suspension) this counts toward an approval. OR Patient has already been started on therapy with Alvaiz"

Thrombocytopenia – Nplate (IP0155)	Updated	**Effective 7/15/2026** **Immune Thrombocytopenia:** The examples of Alvaiz (eltrombopag choline tablets), Doptelet Sprinkle (avatrombopag oral granules), and Wayrilz (rilzabrutinib tablets) were added as medications used for this condition. It was noted that Promacta (eltrombopag choline tablets and oral suspension) is available as a generic in both formulations. **Thrombocytopenia in a Patient with Myelodysplastic Syndrome:** The criterion that referred to risk was changed from low- to intermediate-risk to very low, low, or intermediate-risk. **Coding Information** **Deleted** HCPCS code J2796 was removed from the policy (one-year post-deletion)
Thrombocytopenia – Tavalisse (IP0154)	Updated	**Effective 7/15/2026** **Chronic Immune Thrombocytopenia:** Regarding the Note that cited medications used for this condition, Walrilz (rilzabrutinib tablets) and Alvaiz (eltrombopag choline tablets) were added. The listing of Promacta (eltrombopag tablets and oral suspension) was changed to recognize generic availability and is cited as eltrombopag olamine tablets and oral suspension (Promacta, generic).
Topical Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) (IP0021)	Retired	**Effective 7/15/2026** • Voltaren has been discontinued All other products relocated to Drugs Requiring Medical Necessity Review for Employer Plans - (1602)
Transplantation - Yartemlea - (IP0789)	Updated	**Effective 7/1/2026** **Coding Information:** **Added HCPCS** J1289 with a note "Code effective 7/1/2026" **Updated** the description for C9399, J3490 & J3590 to include the note "Code effective until 6/30/2026"
Ursodiol (IP0299)	Retired	**Effective 7/15/2026** All products relocated to Drugs Requiring Medical Necessity Review for Employer Plans - (1602)
Vesicular Monoamine Transporter Type 2 Inhibitors – Austedo (IP0079)	Updated	**Effective 7/15/2026** **Updated** policy template. **Tardive Dyskinesia.**

		Removed "Patient has a history of use of dopamine receptor blocking agent and note listing examples of dopamine receptor blocking agents which include dopamine agonists (e.g., pramipexole, ropinirole), antipsychotics, metoclopramide, prochlorperazine."
Vesicular Monoamine Transporter Type 2 Inhibitors – Ingrezza Products (IP0080)	Updated	**Effective 7/15/2026** **Updated** policy template. **Tardive Dyskinesia.** **Removed** "Patient has a history of use of dopamine receptor blocking agent and note listing examples of dopamine receptor blocking agents which include dopamine agonists (e.g., pramipexole, ropinirole), antipsychotics, metoclopramide, prochlorperazine."
Vijoice (IP0481)	Updated	**Effective 7/15/2026** No criteria changes.
Weight Loss –Appetite Suppressants and Orlistat (IP0420)	Updated	**Effective 7/1/2026** **Added** benzphetamine immediate-release tablets (generic only), diethylpropion hydrochloride immediate-release and controlled-release tablets (generic only), phendimetrazine tartrate tablets and extended-release capsules (generic only), phentermine hydrochloride orally disintegrating tablets (generic only) and phentermine/topiramate extended-release to the policy.
Inflammatory Conditions – Bimzelx Drug Quantity Management – Per Days for Employer Plans - DQM020)	New	**Effective 7/1/2026** New Policy.
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
		• No updates in July 2026
Reimbursement Policy*	**New, Updated,**	**Comments**

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