Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective June 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
Amplitude-Modulated Radiofrequency Electromagnetic Fields Therapy – (0581)	Updated	**Posted 6/15/2026, Effective 9/15/2026** Important change(s) in coverage criteria/policy: • Title change from "Amplitude-Modulated Radiofrequency Electromagnetic Fields Therapy" to "Electromagnetic Field and Alternating Electric Field Therapy for Cancer Treatment". • Added policy statement for the use of tumor treating fields (TTFields) therapy in supratentorial glioblastoma.
Blepharoplasty, Blepharoptosis Repair and Brow Lift – (0045)	Updates	Minor change(s) in coverage criteria/policy: • Revised policy statement for UPPER eyelid reconstructive blepharoplasty, UPPER eyelid ptosis (blepharoptosis) repair, brow lift and combination procedures for clarity.
Home Ventilators – (0546)	Updated	Important in coverage criteria/policy:

		• Expanded coverage by adding an option to the criteria for when a BPAP trial is not medically appropriate
Miscellaneous Musculoskeletal Procedures – (0515)	Updated	Minor change(s) in coverage criteria/policy: • Revised policy statement for ligament/meniscus allografts to add the words "meniscal" and "knee". • Revised policy statement for in-office diagnostic arthroscopy from "experimental, investigational or unproven" to "not medically necessary due to insufficient evidence of safety and efficacy." • Removed policy statement for intra-articular corticosteroid injections.
Orthotic Devices and Shoes – (0543)	Updated	Important change(s) in coverage criteria/policy: • Revised policy statement for microprocessor/electronically-controlled lower limb orthotics.
Panniculectomy and Abdominoplasty – (0027)	Updated	**Posted 3/15/2026, Effective 6/15/2026** Important changes in coverage criteria/policy: • Revised policy statement for a medically necessary panniculectomy to reorganize criteria into two clearly defined sections • Revised policy statement for abdominoplasty to include mini-abdominoplasty within the policy statement • Added policy statement for suction-assisted lipectomy performed as stand-alone procedure or in conjunction with a not medically necessary panniculectomy is considered cosmetic and not medically necessary • Revised the policy statement to clarify that suction-assisted lipectomy, when performed in conjunction with a medically necessary panniculectomy, is considered integral to the primary procedure and is not separately reimbursable.
Redundant Skin Surgery – (0470)	Updated	**Posted 6/15/2026, Effective 9/15/2026** Important changes in coverage criteria/policy: • Revised the medically necessary policy statement regarding preoperative photographs to remove requirement for sensitive anatomical areas (e.g., genital or buttock regions) • Revised the medically necessary policy statement regarding rhytidectomy to include criteria that the individual is a non-smoker or agree to abstain from all tobacco and nicotine products for at least three (3) weeks before and three (3) weeks after surgery

		• Revised the formatting of the medically necessary policy statement regarding persistent intertriginous dermatitis, cellulitis, or skin ulceration to improve clarity and consistency in policy statements • Revised the medically necessary policy statement regarding procedures performed following significant weight loss to be incorporated clearly as criteria rather than a note below the related policy statement • Revised the medically necessary policy statement regarding procedures performed following significant weight loss to include criteria for weight loss is associated with glucagon-like peptide-1 (GLP-1) agonist therapy • Removed policy statement regarding cosmetic procedure: surgery for glabellar frown lines • Revised policy statement regarding labiaplasty to include description as well as updated title of related Coverage Policy for Gender Dysphoria Treatment
Scar Revision – (0328)	Updated	**Posted 3/15/2026, Effective 6/15/2026** Important changes in coverage criteria/policy: • Revised policy statements on referring to benefit plan documents. • Revised policy statement for medically necessary scar revision treatments • Removed policy statements related to compression/pressure therapy and surgery. • Revised policy statement regarding injectable medications for the treatment of scars to clarify pharmacologic classifications rather than specific medications. • Added policy statement for laser-assisted drug delivery (LADD). • Revised list of cosmetic modalities of treatment for scar revision to include abrasion, update verbiage on injectable fillers, add hair transplantation, and removed punch grafts. • Revised policy statement for not covered or reimbursable treatments to specify for scar revision and clarify dermabrasion.
Surgical Treatments for Obstructive Sleep Apnea - (0158)	Updated	**Posted 3/15/2026, Effective 6/15/2026** Important **changes** in coverage criteria/policy: • Revised policy statement for implantable upper airway hypoglossal nerve stimulation devices in adults by clarifying body mass index (BMI) recommendations.

		• Revised policy statement for implantable upper airway hypoglossal nerve stimulation in pediatric individuals with Down syndrome by clarifying body mass index (BMI) recommendations. • Updated terminology used to describe the Inspire product to match what is currently being used by the FDA and the manufacturer website. Replace 'Inspire II Upper Airway Stimulator' with more current terminology 'Inspire Upper Airway Stimulation System'.
Tissue-Engineered Skin Substitutes - (0068)	Updated	Important change(s) in coverage criteria/policy: • Added Biobrane Glove to existing coverage statement. Added new HCPCS codes A2043 and A2044 that correspond to covered product Biobrane.
Prescription Digital Therapeutics – (0565)	Updated	Important change(s) in coverage criteria/policy: • Added new HCPCS code A9294, which represents FreeSpira to policy and corresponding EIU stem statement.
Vitamin D Testing – (0526)	Updated	**Posted 03/15/2026, Effective 06/15/2026** Important change(s) in coverage criteria/policy: • Revised policy statement to remove mention of "non-pregnant individuals". • Revised policy statement to remove obesity alone as a covered indication for vitamin D testing. • Revised policy statement to include the following as covered indications: exocrine pancreatic insufficiency, chronic pancreatitis, hypoparathyroidism, hypocalcemia, myotonic dystrophy type 2, x-linked hypophosphatemia, and other genetic syndromes. • Revised policy statement to move age greater than or equal to 64, or age 18 or less, into the bulleted list of covered indications. • Added policy statement specifying covered indications for serum 1,25(OH)2D testing (CPT® 82652). • Revised policy statement to allow repeat vitamin D testing every 3 months.
Headache, Occipital, and/or Trigeminal Neuralgia Treatment – (0063)	Updated	• No change in coverage.
Inhaled Nitric Oxide (INO) – (0453)	Updated	• No change in coverage.

Injectable Fillers for Head and Neck Conditions – (0511)	Updated	• No change in coverage.
Pancreatic Islet Cell Transplantation – (0107)	Updated	• No change in coverage.
Pelvic Denervation Procedures – (0368)	Updated	• No change in coverage.
Plasmapheresis – (0153)	Updated	• No change in coverage.
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
Range of Motion Testing – (CPG146)	Updated	• No change in coverage.
Sensory and Auditory Integration Therapy - Facilitated Communication – (CPG149)	Updated	• No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-EviCore Lab Management Guidelines	New / Updated	**Effective 7/1/2026** New guideline: • Hereditary Cancer Syndrome Genetic Testing Substantive changes were made to 21 guidelines: • Amyotrophic Lateral Sclerosis (ALS) Genetic Testing • Cardiomyopathy and Arrhythmia Genetic Testing • Charcot-Marie-Tooth Neuropathy Genetic Testing

		• Early Onset Familial Alzheimer Disease Genetic Testing • Epilepsy Genetic Testing • Experimental, Investigational, or Unproven Laboratory Testing • Familial Hypercholesterolemia Genetic Testing • Hereditary Ataxia Genetic Testing • Hereditary Connective Tissue and Thoracic Aortic Disease Genetic Testing • Hereditary Pancreatitis Genetic Testing • Inherited Bone Marrow Failure Syndrome (IBMFS) Testing • Laboratory Billing and Reimbursement • Limb-Girdle Muscular Dystrophy Genetic Testing • Liquid Biopsy Testing • Maturity-Onset Diabetes of the Young (MODY) Genetic Testing • Mitochondrial Disorders Genetic Testing • Nonsyndromic Hearing Loss and Deafness Genetic Testing • Noonan Spectrum Disorder Genetic Testing • Pharmacogenomic Testing for Drug Toxicity and Response • Primary Ciliary Dyskinesia Genetic Testing • Somatic Mutation Testing
Cobranded Cigna-EviCore Peripheral Vascular Intervention Guidelines	Updated	**Effective 6/1/2026** Guidelines were updated with no clinically impactful changes.
Administrative Policy	**New, Updated, or Retired?**	**Comments**
Wheelchairs/Power Operated Vehicles - (A024)	New	**Effective 6/14/2026 services have moved to an Administrative policy, the Medical CP is being retired 6/14/2026.** • No changes to coverage. • Coverage is dependent only upon standard benefit plan language as DME items. • Medical necessity verbiage has been removed.

Enteral Formula and Supplies - (A022)	Updated	• No changes to content.
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Allergen Immunotherapy – Palforzia (IP0141)	Updated	**Effective 6/1/2026** No criteria changes
Alpha1-Proteinase Inhibitor Products (IP0387)	Updated	**Effective 6/1/2026** **Updated** documentation statement **from** "Documentation: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, claims records, and/or other information." **to** "Documentation: Documentation is required where noted in the criteria as [documentation required]. Documentation may include, but not limited to, chart notes, laboratory tests, claims records, prescription receipts and/or other information. All documentation must include patient-specific identifying information." **Alpha$_1$-Antitrypsin Deficiency with Emphysema (or Chronic Obstructive Pulmonary Disease).** Criteria were divided into initial therapy and continuation of therapy. **For initial therapy: Updated from** "Documentation is provided the patient has a baseline (pretreatment) alpha1-antitrypsin serum concentration of < 11 mcM (11 mcmol/L) [< 80 mg/dL if measured by radial immunodiffusion or < 57 mg/dL if measured by nephelometry]" **to** "Patient has a baseline (pretreatment) alpha$_1$-antitrypsin serum concentration of < 11 micromol/L (< 80 mg/dL if measured by radial immunodiffusion or < 57 mg/dL if measured by nephelometry) [documentation required]." **Updated from** "Documentation is provided that genotyping or phenotyping demonstrates ONE of the following types: ZZ, (null)(null), Z(null), SZ or other rare disease-causing alleles associated with serum alpha1-antitrypsin (AAT) level less than 11 mcmol/L" **to** "Patient had genotyping or phenotyping demonstrating ONE of the following types: PI*ZZ, PI*(null)(null), PI*Z(null), PI*SZ or other rare disease-causing alleles associated with serum alpha$_1$-antitrypsin (AAT) level < 11 micromol/L [documentation required]." **Added** "According to the prescriber, the patient has clinical evidence of emphysema or chronic obstructive pulmonary disease." **Removed** "At baseline, the patient meets ONE of the

		following: Documentation is provided of a forced expiratory volume in 1 second (FEV1) less than 65% of predicted OR Patient meets ONE of the following (1 or 2): 1. Documentation is provided of an accelerated decline in lung function (accelerated decline in lung function includes FEV1 decline greater than 100 mL/year or a decline in diffusing capacity of the lungs for carbon monoxide [DLCO] greater than 15% per year); 2. Documentation is provided that supplemental oxygen required at rest or with exertion." **For Patient is Currently Receiving an Alpha1-Proteinase Inhibitor Product: Added** "Approve for Approve for 1 year if the patient meets ALL of the following (i, ii, and iii): i. Patient is ≥ 18 years of age; ii. According to the prescriber, the patient is a current non-smoker; iii. Preferred product criteria is met for the product(s) as listed in the below table(s)." **Alpha$_1$-Antitrypsin Deficiency-Associated Panniculitis.** Criteria were divided into initial therapy and continuation of therapy. **For initial therapy: Updated from** "Documentation is provided that the diagnosis of panniculitis confirmed by skin biopsy" **to** "Patient has a diagnosis of panniculitis confirmed by skin biopsy [documentation required]." **Updated from** "Documentation is provided of the patient has a baseline alpha1-antitrypsin serum concentration of less than 11 mcmol/L (less than 80 mg/dL if measured by radial immunodiffusion or less than 57 mg/dL if measured by nephelometry)" **to** "Patient has a baseline (pretreatment) alpha1-antitrypsin serum concentration of < 11 micromol/L) (< 80 mg/dL if measured by radial immunodiffusion or < 57 mg/dL if measured by nephelometry) [documentation required]." **Updated from** "Documentation is provided that genotyping or phenotyping demonstrates ONE of the following types: ZZ, (null)(null), Z(null), SZ or other rare disease-causing alleles associated with serum alpha1-antitrypsin (AAT) level less than 11 mcmol/L" **to** "Patient had genotyping or phenotyping demonstrating ONE of the following types: PI*ZZ, PI*(null)(null), PI*Z(null), PI*SZ or other rare disease-causing alleles associated with serum alpha$_1$-antitrypsin (AAT) level < 11 micromol/L [documentation required]." **Removed** "Patient meets ONE of the following (i or ii): i. Documentation is provided of the patient has Mild panniculitis and ONE of the following (a or b):a. Documentation is provided the patient experienced inadequate efficacy or significant intolerance with dapsone OR b. According to the prescriber, dapsone is contraindicated; OR ii. Documentation is provided of the patient has Moderate to severe panniculitis." **For Patient is Currently Receiving an Alpha1-Proteinase Inhibitor Product: Added** "Approve for Approve for 1 year if the patient meets ALL of the following (i and ii): i. Patient is ≥ 18 years of age; ii. Preferred product criteria is met for the product(s) as listed in the below table(s)."

		Preferred Product Criteria – Employer Plans and Individual and Family Plans. **Aralast NP and Zemaira: Updated from "**Documentation is provided that the patient has tried and cannot take BOTH of the following (1 and 2): 1. Glassia AND 2. Prolastin-C (powder or liquid)" to "Patient has tried and cannot take BOTH of the following (1 and 2) [documentation required]: 1. Glassia AND 2. Prolastin-C" **Coding Information** **Removed** HCPCS code: J7699
Alprostadil Products for Individual and Family Plans (IP0425)	Updated	**Effective 6/15/2026** **Policy Title:** **Removed** "Erectile Dysfunction" from policy title. **Added** Caverject®, Caverject Impulse®, and MUSE® to the policy. **Erectile Dysfunction:** **Removed** specialist requirement from criteria **Removed** drug quantity limits from policy **History of Radical Prostatectomy:** **Updated from** "Individual with a History of Radical Prostatectomy who is continuing alprostadil therapy" **to** "History of Radical Prostatectomy" **Updated** authorization duration from 6 months to 1 year. **Added** Note: Alprostadil products for post-radical prostatectomy are Caverject, Caverject Impulse, Edex, and MUSE. **Removed** "has not received 6 months of therapy" **Removed** specialist requirement. **Prophylaxis after Radical Prostatectomy (Early Penile Rehabilitation):** **Updated** authorization duration from 6 months to 1 year.
Antibiotics (Inhaled) – Cayston (IP0485)	Updated	**Effective 6/15/2026** No criteria changes.
Antibiotics (Inhaled) – Tobramycin Inhalation Solution – (IP0094)	Updated	**Effective 6/15/2026** **Bronchiectasis, Non-Cystic Fibrosis.** The requirement that the patient is ≥ 18 years of age was removed.

Antibiotics (Inhaled) – TOBI Podhaler (IP0499)	Updated	**Effective 6/15/2026** No criteria changes.
Attention Deficit Hyperactivity Disorder Non-Stimulant Medications (IP0217)	Updated	**Effective 6/15/2026** **Added** a policy statement. **Updated** the documentation statement. **Onyda XR: Updated** the Attention Deficit Hyperactivity Disorder (ADHD) and Pervasive Developmental Disorders (e.g., autism spectrum disorder, Asperger's disorder) medical necessity requirements. **Qelbree: Updated** the Attention Deficit Hyperactivity Disorder (ADHD) medical necessity requirements. **Updated** the Employer Plans and Individual and Family Plans preferred product requirements for Onyda XR and Qelbree. **Updated** the Conditions Not Covered statement.
Azathioprine (IP0337)	Retired	**Effective 6/1/2026** All products relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602)
Cardiology – Camzyos (IP0480)	Updated	**Effective 6/15/2026** **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 Camzyos, the requirement for ejection fraction to be ≥ 50% was removed. The Note defining Class II versus Class III heart failure symptoms was also removed.
Cardiology – Myqorzo for Individual and Family Plans (IP0791)	Update	**Effective 6/15/2026** **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.
Chelating-Agents Penicillamine Products – (IP0277)	Updated	**Effective 6/15/2026** **Policy Title:** **Updated** from "Penicillamine" to "Chelating Agents – Penicillamine Products." **Cystinuria:** **Removed** documentation requirements from coverage criteria. **Wilson's Disease:** **Removed** documentation requirements from coverage criteria. **Lead Poisoning:** **Removed** "Lead Poisoning" as a covered use. **Individual and Family Plans Preferred Product Table**: **Updated** preferred product criteria for Depen **from** "documentation of failure, contraindication or intolerance to penicillamine tablets" **to** "The patient has tried penicillamine tablets (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction." **Updated** preferred product criteria for Cuprimine and its generic **from** "Documentation of failure, contraindication, or intolerance to penicillamine tablets [prior authorization required]" **to** "One of the following (A or B): A. The patient has tried penicillamine tablets [may require prior authorization]. B. The patient cannot swallow or has difficulty swallowing penicillamine tablets."
Cinacalcet for Individual and Family Plans (IP0464)	Updated	**Effective 6/1/2026** **Updated** the policy statement.
Collagenase for Individual and Family Plans (IP0470)	Retired	**Effective 6/1/2026** Santyl relocated to Pharmacy and Medical Prior Authorization (1407)

Complement Inhibitors – Fabhalta (IP0614)	Updated	**Effective 6/15/2026** **Updated** documentation statement **from** "Documentation: Documentation is required where noted in the criteria as [documentation required]. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information" **to** "Documentation: Documentation is required where noted in the criteria as [documentation required]. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, prescription receipts and/or other information. All documentation must include patient-specific identifying information." **Primary Immunoglobulin A Nephropathy:** The approval duration was changed to 1 year for both initial therapy and patients currently receiving Fabhalta.
Complement System Disorders – WHIM Syndrome – Xolremdi (IP0654)	Updated	**Effective 6/15/2026** No criteria changes.
Contraceptives – Phexx (IP0729)	Updated	**Effective 6/15/2026** No criteria changes.
Corticosteroids (Intraarticular) – Zilretta (IP0140)	Updated	**Effective 6/1/2026** No criteria changes.
Covid-19 Drug & Biologics Therapeutics (2016)	Updated	**Effective 6/15/2026** Important changes in coverage criteria: • **Added** dosing information for Gohibic to policy. • **Removed** Intravenous Immunoglobulin (IVIG) medical necessity criteria from policy. **Coding Information** • **Added** the following HCPCS codes for infliximab and biosimilars: ○ J1745 Q5103 Q5104 Q5121 • **Removed** the following HCPCS codes because they have been deleted by CMS following FDA EUA revocations: ○ **Deleted** effective 4/17/2021 M0239 Q0239 ○ **Deleted** effective 12/14/2023 M0245 M0246

		○ **Deleted** effective 12/13/2024 M0220 M0221 M0222 M0223 M0240 M0241 M0243 M0244 M0247 M0248 Q0220 Q0222 Q0240 Q0243 Q0244 Q0245 Q0247 • **Removed** the ICD-10 diagnosis table **Removed** the Experimental/Investigational/Unproven coding table, as all associated HCPCS codes have been deleted and are no longer billable.
Cushing's – Mifepristone (IP0092)	Updated	**Effective 6/1/2026** **Added** documentation instructions **Added** [documentation required] to: Patient meets ONE of the following (i or ii) [documentation required]: Patient has tried one of ketoconazole tablets, Metopirone (metyrapone capsules), Lysodren (mitotane tablets), Signifor (pasireotide subcutaneous injection), or Signifor LAR (pasireotide intramuscular injection) for the treatment of endogenous Cushing's syndrome; OR Patient is currently receiving mifepristone; AND **Preferred Product Table.** **Updated from** "Trial of" **to** "The patient has tried" **Added** "e.g., differences in dyes, fillers, preservatives] between the Brand and the bioequivalent product" **Added** [documentation required] for Employer Plans and Individual and Family Plans
Diabetes – Diabetic Supplies - (IP0272)	Updated	**Effective 6/15/2026** No criteria changes. **Individual and Family Plans:** **Added** (keywords updated) Contour Next One blood glucose meter to policy.
Diabetes – Glucagon-Like Peptide-1 Agonists for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists (IP0701)	Updated	**Effective 6/15/2026** **Updated** the policy and documentation statements. ○ Throughout the policy, Foundayo was added as an example of a glucagon-like peptide-1 (GLP-1) receptor agonist.

Diabetes – Glucagon-Like Peptide-1 Agonists for Individual and Family Plans (IP0702)	Updated	**Effective 6/15/2026** **Updated** the policy and documentation statements. Throughout the policy, Foundayo was added as an example of a glucagon-like peptide-1 (GLP-1) receptor agonist. Ozempic tablets were added to the Policy. **Policy Statement:** The Note listing the specific glucagon-like peptide-1 (GLP-1) agonists not targeted in this Policy was revised to state that there are other GLP-1 agonists not indicated for the treatment of diabetes that are not targeted in this Policy. **Tye 2 Diabetes Mellitus:** The list of agents was updated to add Ozempic tablets; prior reference to Ozempic was updated to Ozempic injection.
Diabetes – Tzield (IP0537)	Updated	**Effective 6/15/2026** **Type 1 Diabetes (Clinical/Stage 3), Delay of Onset.** **Updated from** "Patient is ≥8 years of age" **to** "Patient is ≥1 year of age" **Removed "**Patient does NOT have type 2 diabetes" (moved to Conditions Not Covered) **Conditions Not Covered** **Added** Type 2 Diabetes as a Condition Not Covered
Drugs Requiring Medical Necessity Review for Employer Plans (1602)	Updated	**Effective 6/1/2026** **Added preferred product requirement criteria for the following product:** levetiracetam orally disintegrating tablet, Brenzavvy, bexagliflozin tablets, Farxiga, Invokana, Invokamet, Invokamet XR, Segluromet, Steglatro, and Xigduo XR. **Added preferred product requirement criteria for the following products (EFFECTIVE 7/1/2026):** Aczone 5% gel, Aczone 7.5% gel pump, Aptiom, Fycompa tablets, Vimpat, penciclovir 1% cream, Zortress, Fexmid, azelastine and fluticasone propionate nasal spray, Dymista, ibuprofen 300 mg tablets, Prolensa, and dexlansoprazole **Added preferred product requirement criteria for the following products (EFFECTIVE 7/15/2026):** Allzital tablet, Bupap tablet, butalbital 50 mg and Acetaminophen 300 mg capsules and tablets, Fioricet capsules, and Fioricet with Codeine **Updated preferred product requirement criteria for the following products (EFFECTIVE 7/1/2026):** Xerese, Gralise, Kristalose, and lactulose (10 gram and 20 gram) packet **Removed preferred product requirement criteria for the following product:** Vtama for Standard/Performance/Legacy Drug List Plans only

Drugs Requiring Medical Necessity Review for Employer Plans (1602)	Update	**Effective 6/15/2026** **Added preferred product requirement criteria for the following:** **EFFECTIVE 7/1/2026:** besifloxacin 0.6% ophthalmic suspension and Vimpat tablets **EFFECTIVE 7/15/2026:** Sdamlo, Baxdela, Humatin 250 mg capsule, Brexafemme, Zyprexa, Zyprexa Zydis, Isordil 40 mg tablets, isosorbide dinitrate 40 mg tablets, Obizur, fenofibrate 90 mg capsules, Dartisla ODT, glycopyrrolate 1.5 mg tablet, Robinul, Robinul Forte, Thrombate III, Lotronex, diclofenac sodium 1.5% topical solution, diclofenac sodium 2% topical solution, Flector Patch, Licart, Pennsaid, Alphagan P 0.15%, citalopram 30 mg capsules, Reltone, ursodiol 200 mg and 400 mg capsules, and Nascobal nasal spray **Updated preferred product requirement criteria for the following:** **EFFECTIVE 6/15/2026:** Zylet. Criteria now applies to all Employer Plans **EFFECTIVE 7/1/2026:** Vimpat oral solution **EFFECTIVE 7/15/2026:** mupirocin 2% cream, Xdemvy, Katerzia, Norliqva, Isordil Titradose, Donnatal Elixir and tablets, Tobrex ointment, Alphagan P 0.1%, and Avar-E **Removed preferred product requirement criteria for the following:** **EFFECTIVE 6/15/2026:** tobramycin 0.3%/loteprednol etabonate 0.5% ophthalmic suspension (generic for Zylet) **EFFECTIVE 7/1/2026:** gabapentin extended-release tablets (generic for Gralise) **EFFECTIVE 7/1/2026: Removed** 'may require prior authorization' from criteria for Fycompa oral suspension **EFFECTIVE 7/15/2026:** Avar-E Green, Pred-G, lidocaine 3% lotion, Lido-K, and Synera
Enzyme Replacement Therapy – Sucraid (IP0447)	Updated	**Effective 6/15/2026** ○ **Congenital Sucrase-Isomaltase Deficiency:** Criteria were divided into initial therapy and continuation of therapy. The approval duration was set at 6 months for initial therapy and the approval duration for continuation of therapy is 1 year; previously, the approval duration was 1 year. For initial therapy, the diagnostic criteria were revised. A breath test with results consistent with congenital sucrase-isomaltase deficiency was added. Also, criteria were simplified that the patient had a biopsy of the small bowel (the word endoscopic before "biopsy" was removed) with disaccharidase levels consistent with congenital sucrase-isomaltase deficiency with the need to meet all of the following requirements related to this criterion removed: decreased (usually absent) sucrase level (normal reference > 25 U/g protein); decreased or normal isomaltase (palatinase) level [normal reference > 5 U/g protein]; decreased maltase level (normal reference > 100 U/g protein); and decreased or normal lactase level (normal reference > 15

		U/g protein). For the requirement that the patient had symptomatic congenital sucrase-isomaltase deficiency, the phrase "prior to starting therapy with Sucraid" was deleted. For continuation of therapy, criteria were added that according to the prescriber, the patient has experienced a beneficial clinical response from baseline (prior to initiating Sucraid). A Note was added that examples of beneficial clinical response include reduced symptoms (e.g., bloating, abdominal cramping, diarrhea). It was added that the medication is prescribed by or in consultation with a geneticist, gastroenterologist, a metabolic disorder sub-specialist, or a physician who specializes in the treatment of congenital diarrheal disorder.
Erectile Dysfunction Agents Drug Quantity Management Policy – Per Days (DQM017)	New	**Effective 6/15/2026** New Policy.
Enzyme Replacement Therapy – Naglazyme (IP0443)	Updated	**Effective 6/1/2026** No criteria changes.
Enzyme Replacement Therapy – Vimizim (IP0442)	Updated	**Effective 6/1/2026** No criteria changes.
Familial Chylomicronemia Syndrome – Redemplo (IP0773)	New	**Effective 6/1/2026** • New policy.
Gastroenterology – Gimoti (IP0085)	Updated	**Effective 6/15/2026** **Conditions Not Covered: Added** Gastroesophageal reflux
Gaucher Disease – Enzyme Replacement Therapy – Elelyso (IP0163)	Updated	**Effective 6/15/2026** **Gaucher Disease – Type 1:** A requirement was added that the medication is not being used for the management of neurological manifestations. **Gaucher Disease – Type 3:** The requirement that the medication is being used for the management of impaired growth, hepatologic, or visceral symptoms was removed. Dosing for Gaucher Disease Type 3 was revised such that each individual dose must not

		exceed 60 U/kg administered intravenously no more frequently than once every 2 weeks.
Gaucher Disease – Enzyme Replacement Therapy – Vpriv (IP0164)	Updated	**Effective 6/15/2026** **Gaucher Disease – Type 1:** A requirement was added that the medication is not being used for the management of neurological manifestations. **Gaucher Disease – Type 3:** The requirement that the medication is being used for the management of impaired growth, hepatologic, or visceral symptoms was removed. Dosing for Gaucher Disease Type 3 was revised such that each individual dose must not exceed 60 U/kg administered intravenously no more frequently than once every 2 weeks.
Gonadotropin-Releasing Hormone Agonists – Implants for Non-Oncology Indications (IP0620)	Updated	**Effective 6/1/2026** **Added** dosing to: Gender-Dysphoric/ Gender-Incongruent Persons; Persons Undergoing Gender Reassignment (Female-to-Male or Male-to-Female). **Supprelin LA.** **Central Precocious Puberty.** **Preferred Product Table. Removed** 'Patient is < 2 years of age' **Zoladex.** **Preservation of Ovarian Function/Fertility in Patients undergoing Chemotherapy**. **Added** dosing **Prophylaxis or Treatment of Uterine Bleeding or Menstrual Suppression in Patients with Hematologic Malignancy, or Undergoing Cancer Treatment, or Prior to Bone Marrow/Stem Cell Transplantation.** **Added** new Use with Supportive Evidence.
Gonadotropin-Releasing Hormone Antagonists – Myfembree (IP0205)	Updated	**Effective 6/1/2026** No criteria changes.
Gonadotropin-Releasing Hormone Antagonists – Oriahnn (IP0087)	Updated	**Effective 6/1/2026** No criteria changes.
Gonadotropin-Releasing Hormone Antagonists – Orilissa (IP0196)	Updated	**Effective 6/1/2026** No criteria changes.

Graft-Versus-Host-Disease – Niktimvo (IP0722)	Updated	**Effective 6/1/2026** • No criteria changes.
Growth Disorders - Growth Hormone Long-Acting Products Preferred Specialty Management Policy for Individual and Family Plans (PSM028)	New	**Effective 6/15/2026** • New Policy (criteria relocated from IP0375, IP0576, and IP0577)
Growth Disorders - Growth Hormone Long-Acting Products Preferred Specialty Management Policy for Standard and Performance Prescription Drug List Plans (PSM029)	New	**Effective 6/15/2026** New Policy (criteria relocated from IP0375 and IP0576)
Growth Disorders - Growth Hormone Long-Acting Products Preferred Specialty Management Policy for Value/Advantage and Total Savings Prescription Drug List Plans (PSM030)	New	**Effective 6/15/2026** • New Policy (criteria relocated from IP0375, IP0576, and IP0577)
Growth Disorders - Growth Hormone Long-Acting Products	New	**Effective 6/15/2026** New Policy (criteria relocated from IP0576)

Preferred Specialty Management Policy for Legacy Prescription Drug List Plans (PSM031)		
Growth Disorders - Growth Hormone Short-Acting Products Preferred Specialty Management Policy (PSM027)	New	**Effective 6/15/2026** New Policy (criteria relocated from IP0452)
Growth Disorders - Growth Hormone Prior Authorization Policy (IP0452)	Update	**Effective 6/15/2026** **Policy Title** **Updated from** "Somatropin" **to** "Growth Disorders – Growth Hormone Prior Authorization Policy" **Added** Preferred Specialty Management Statement **Added** documentation requirements throughout policy **Growth Hormone Deficiency in a Child or Adolescent** **Removed** "Other pituitary hormone deficiencies (for example, thyroid, cortisol or sex steroids) have been ruled out and/or corrected prior to time of testing **Added** criteria to include at least one growth hormone stimulation test AND the peak growth hormone response to at least one test is < 10 ng/mL AND at least one risk factor for growth hormone deficiency **Removed** "Defined central nervous system pathology (for example, empty sella syndrome, interruption of pituitary stalk, hypoplasia of the pituitary gland, craniofacial developmental defects, pituitary or hypothalamic tumors)" **Added** criteria for congenital hypopituitarism to include at least one growth hormone stimulation test AND the peak growth hormone response to at least one test is < 10 ng/mL or Patient has a deficiency in at least one other pituitary hormone or Patient has the imaging triad of ectopic posterior pituitary and pituitary hypoplasia with abnormal pituitary stalk

		Added "Note: Growth hormone deficiency may occur in combination with other pituitary hormone deficiencies and is referred to as hypopituitarism, panhypopituitarism, or multiple pituitary hormone deficiency." To multiple pituitary hormone deficiencies **Removed** "Note: If the individual has had one growth hormone stimulation test and the peak growth hormone response was less than 10 ng/mL, this would satisfy criteria for an approval." **Added** criteria for Patients continuing somatropin therapy **Non-Growth Hormone Deficient Short Stature (Idiopathic Short Stature) in a Child or Adolescent** **Updated** initial therapy approval **from** up to 12 months **to** 6 months **Added** "Note: Height velocity percentile is NOT the same as height for age percentile." **Added** criteria for patients continuing somatropin therapy. **Growth Hormone Deficiency in an Adult or Transition Adolescent** **Added** criteria for adult insulin tolerance test, glucagon stimulation tests, and macrilien test peal response requirements **Removed** for adult "growth hormone response of less than 5 ng/mL when measured by polyclonal antibody (RIA) or less than 2.5 ng/mL when measured by monoclonal antibody (IRMA)" **Added** "Note: The following formula can be used to calculate BMI: BMI equals body weight in kg divided by height meters squared (m2) [i.e., BMI = kg/m2]" **Added** criteria for transition adolescents **Chronic Kidney Disease in a Child or Adolescent** **Removed** "Renal function at stage 2 or more advanced Chronic Kidney Disease" **Removed** "Individual's 6 to 12 month height velocity is more than two SD below the mean for age and sex" **Removed** "Individual's height velocity is more than 1.5 SD below the mean sustained over two years" **Added** "Patient's baseline height velocity is below the 25th percentile over a period of 3 months in infants (≤ 1 year of age) or 6 months in children and adolescents" **Added** criteria for Patients continuing somatropin therapy (i.e., established on somatropin for ≥ 10 months). **Noonan Syndrome in a Child or Adolescent** **Updated from** "Baseline height is less than the 5th percentile for age and gender" **to** "Patient's baseline height is less than the 5th percentile using a growth chart for children without Noonan syndrome"

		Removed "Individual's 1 year height velocity is more than two SD below the mean for age and sex" **Removed** "Individual's height velocity is more than 1.5 SD below the mean sustained over two years" **Added** criteria for Patients continuing somatropin therapy (i.e., established on somatropin for ≥ 10 months). **Prader-Willi Syndrome** **Added** criteria for Patients continuing somatropin therapy (i.e., established on somatropin for ≥ 10 months). **Short Stature Homeobox-Containing Gene Deficiency in a Child or Adolescent** **Removed** "Individual's 1 year height velocity is more than two SD below the mean for age and sex" **Removed** "Individual's height velocity is more than 1.5 SD below the mean sustained over two years" **Added** criteria for Patients continuing somatropin therapy (i.e., established on somatropin for ≥ 10 months). **Child Born Small for Gestational Age or with Intrauterine Growth Restriction Including a Child with Silver-Russell Syndrome** **Added** criteria for Patients continuing somatropin therapy (i.e., established on somatropin for ≥ 10 months). **Turner Syndrome** **Updated from** "Diagnosis of Turner Syndrome is confirmed by genetic testing" **to** "The diagnosis of Turner's syndrome has been confirmed by karyotype analysis (i.e., chromosome analysis)" **Removed** "Individual's 1 year height velocity is more than two SD below the mean for age and sex" **Removed** "Individual's height velocity is more than 1.5 SD below the mean sustained over two years" **Added** criteria for Patients continuing somatropin therapy (i.e., established on somatropin for ≥ 10 months). **Short Bowel Syndrome** Added use and criteria **Human Immunodeficiency Virus Infection with Wasting or Cachexia in an Adult**

		Updated from "Wasting or cachexia that is due to malabsorption, poor diet, opportunistic infection, or depression, and other causes have been addressed prior to starting somatropin" **to** "Other causes of wasting or cachexia (e.g., due to malabsorption, poor diet, opportunistic infection, or depression) have been addressed prior to starting somatropin" ○
Growth Disorders – Ngenla Prior Authorization Policy (IP0577)	Update	**Effective 6/15/2026** **Policy Title**: **Updated from** "Growth Disorders - Ngenla" **to** "Growth Disorders – Ngenla Prior Authorization Policy" **Added** Preferred Specialty Management Statement **Growth Hormone Deficiency in a Pediatric Patient (≥ 3 years of age to < 18 years of age)** **Removed** "Other pituitary hormone deficiencies (for example, thyroid, cortisol or sex steroids) have been ruled out and/or corrected prior to time of testing **Added** criteria to include the option to require at least one growth hormone stimulation test AND the peak growth hormone response to at least one test is < 10 ng/mL AND at least one risk factor for growth hormone deficiency. **Removed** "Defined central nervous system pathology (for example, empty sella syndrome, interruption of pituitary stalk, hypoplasia of the pituitary gland, craniofacial developmental defects, pituitary or hypothalamic tumors)" for patients who have undergone brain radiation or tumor resection. **Added** criteria for congenital hypopituitarism to include at least one growth hormone stimulation test AND the peak growth hormone response to at least one test is < 10 ng/mL or Patient has a deficiency in at least one other pituitary hormone or Patient has the imaging triad of ectopic posterior pituitary and pituitary hypoplasia with abnormal pituitary stalk **Added** "Note: Growth hormone deficiency may occur in combination with other pituitary hormone deficiencies and is referred to as hypopituitarism, panhypopituitarism, or multiple pituitary hormone deficiency" to multiple pituitary hormone deficiencies **Removed** "Note: If the individual has had one growth hormone stimulation test and the peak growth hormone response was less than 10 ng/mL, this would satisfy criteria for an approval" from multiple hormone deficiencies. **Updated** criteria for Patients Currently Receiving Ngenla or is switching to Ngenla from another Growth Hormone Agent (Patient has been established on either therapy for ≥ 10 months). **Removed** preferred product tables for Employer Plans and Individual and Family Plans

		Conditions Not Covered **Removed** Acute Critical Illness Due to Complications Following Surgery, Multiple Accidental Trauma, or with Acute Respiratory Failure, Aging (i.e., Antiaging); To Improve Functional Status in Elderly Patients; and Somatopause, Chronic Fatigue Syndrome, Corticosteroid-Induced Short Stature, Fibromyalgia, Human Immunodeficiency Virus (HIV)-Infected Patients with Alterations in Body Fat Distribution, Infertility, Obesity, Osteoporosis, Other Off-label Uses [for example, celiac disease, chromosomal anomalies unless otherwise specified as covered (for example, but not limited to, deletion of chromosome 18q), Crohn's disease, cystic fibrosis, Down syndrome, hypophosphatemic rickets, juvenile rheumatoid arthritis, muscular dystrophy, primary or idiopathic IGF-1 deficiency, skeletal dysplasias, spinal cord defects].
Growth Disorders – Skytrofa Prior Authorization Policy (IP0375)	Update	**Effective 6/15/2026** **Policy Title:** **Updated from** "Growth Disorders - Skytrofa" **to** "Growth Disorders – Skytrofa Prior Authorization Policy" **Added** Preferred Specialty Management Statement **Growth Hormone Deficiency in a Pediatric Patient (≥ 1 year of age)** **Removed** "Other pituitary hormone deficiencies (for example, thyroid, cortisol or sex steroids) have been ruled out and/or corrected prior to time of testing **Added** criteria to include the option to require at least one growth hormone stimulation test AND the peak growth hormone response to at least one test is < 10 ng/mL AND at least one risk factor for growth hormone deficiency. **Removed** "Defined central nervous system pathology (for example, empty sella syndrome, interruption of pituitary stalk, hypoplasia of the pituitary gland, craniofacial developmental defects, pituitary or hypothalamic tumors)" for patients who have undergone brain radiation or tumor resection. **Added** criteria for congenital hypopituitarism to include at least one growth hormone stimulation test AND the peak growth hormone response to at least one test is < 10 ng/mL or Patient has a deficiency in at least one other pituitary hormone or Patient has the imaging triad of ectopic posterior pituitary and pituitary hypoplasia with abnormal pituitary stalk **Added** "Note: Growth hormone deficiency may occur in combination with other pituitary hormone deficiencies and is referred to as hypopituitarism, panhypopituitarism, or multiple pituitary hormone deficiency" to multiple pituitary hormone deficiencies

		Removed "Note: If the individual has had one growth hormone stimulation test and the peak growth hormone response was less than 10 ng/mL, this would satisfy criteria for an approval" from multiple hormone deficiencies. **Updated** criteria for Patients Currently Receiving Skytrofa or switching to Skytrofa from another Growth Hormone Agent (Patient has been established on either therapy for ≥ 10 months). **Removed** preferred product tables for Employer Plans and Individual and Family Plans **Conditions Not Covered** **Removed** Corticosteroid-Induced Short Stature, Human Immunodeficiency Virus (HIV)-Infected Patients with Alterations in Body Fat Distribution, and Other Off-label Uses [for example, celiac disease, chromosomal anomalies unless otherwise specified as covered (for example, but not limited to, deletion of chromosome 18q), Crohn's disease, cystic fibrosis, Down syndrome, hypophosphatemic rickets, juvenile rheumatoid arthritis, muscular dystrophy, primary or idiopathic IGF-1 deficiency, skeletal dysplasias, spinal cord defects].
Growth Disorders – Sogroya Prior Authorization Policy (IP0576)	Update	**Effective 6/15/2026** **Policy Title**: **Updated from** "somapacitan" **to** "Growth Disorders – Sogroya Prior Authorization Policy" **Added** Preferred Specialty Management Statement **Growth Hormone Deficiency in a Pediatric Patient (≥ 2.5 years of age)** **Removed** "Other pituitary hormone deficiencies (for example, thyroid, cortisol or sex steroids) have been ruled out and/or corrected prior to time of testing **Added** criteria to include the option to require at least one growth hormone stimulation test AND the peak growth hormone response to at least one test is < 10 ng/mL AND at least one risk factor for growth hormone deficiency. **Removed** "Defined central nervous system pathology (for example, empty sella syndrome, interruption of pituitary stalk, hypoplasia of the pituitary gland, craniofacial developmental defects, pituitary or hypothalamic tumors)" for patients who have undergone brain radiation or tumor resection. **Added** criteria for congenital hypopituitarism to include at least one growth hormone stimulation test AND the peak growth hormone response to at least one test is < 10 ng/mL or Patient has a deficiency in at least one other pituitary hormone or Patient has the imaging triad of ectopic posterior pituitary and pituitary hypoplasia with abnormal pituitary stalk

		Added "Note: Growth hormone deficiency may occur in combination with other pituitary hormone deficiencies and is referred to as hypopituitarism, panhypopituitarism, or multiple pituitary hormone deficiency" to multiple pituitary hormone deficiencies **Removed** "Note: If the individual has had one growth hormone stimulation test and the peak growth hormone response was less than 10 ng/mL, this would satisfy criteria for an approval" from multiple hormone deficiencies. **Updated** criteria for Patients Currently Receiving Sogroya or switching to Sogroya from another Growth Hormone Agent (Patient has been established on either therapy for ≥ 10 months). **Growth Hormone Deficiency in an Adult or Transition Adolescent** **Added** documentation requirements throughout criteria. **Added** criteria for growth hormone stimulation testing and response requirements for adults and transition adolescents. **Removed** preferred product tables for Employer Plans and Individual and Family Plans **Added the following indications: Non-Growth Hormone Deficient Short Stature (Idiopathic Short Stature) in a Child or Adolescent, Noonan Syndrome in a Child or Adolescent, Small for Gestational Age or with Intrauterine Growth Restriction Including a Child with Silver-Russel Syndrome** **Conditions Not Covered** **Removed** Corticosteroid-Induced Short Stature, Human Immunodeficiency Virus (HIV)-Infected Patients with Alterations in Body Fat Distribution, and Other Off-label Uses [for example, celiac disease, chromosomal anomalies unless otherwise specified as covered (for example, but not limited to, deletion of chromosome 18q), Crohn's disease, cystic fibrosis, Down syndrome, hypophosphatemic rickets, juvenile rheumatoid arthritis, muscular dystrophy, primary or idiopathic IGF-1 deficiency, skeletal dysplasias, spinal cord defects]. **Updated** data for Acute Critical Illness Due to Complications Following Surgery, Multiple Accidental Trauma, or with Acute Respiratory Failure and Athletic Ability Enhancement
Gout – Krystexxa (IP0269)	Updated	**Effective 6/1/2026** • No criteria changes.
Hematology – Aqvesme - (IP0782)	New	**Effective 6/1/2026** New Policy.

Hepatology – Metabolic Dysfunction-Associated Steatohepatitis – Wegovy Benefit Exclusion Overrides Policy for Employer Plans (INT032)v	Updated	**Effective 6/1/2026** Wegovy HD injection was added to the policy; approval criteria are the same as for Wegovy injection (see below). **Policy statement:** Wegovy HD injection was added throughout this statement. **Documentation:** Wegovy HD injection was added to the documentation statement. **Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH):** For initial therapy, Wegovy HD injection was added to the requirements related to identification of stage F2 or F3 fibrosis prior to initiating treatment with Rezdiffra, Wegovy injection, or Wegovy tablet **[documentation required]**. Wegovy HD injection was added to the requirements and corresponding Note that apply to a patient who is currently receiving Wegovy injection or Wegovy tablet.
Hepatology – Metabolic Dysfunction-Associated Steatohepatitis – Wegovy Benefit Exclusion Overrides Policy for Individual and Family Plans (BEO004)	Updated	**Effective 6/1/2026** **Updated** the policy number. Wegovy HD injection was added to the policy; approval criteria are the same as for Wegovy injection. **Policy Statement:** Wegovy HD injection was added throughout this statement. **Documentation:** Wegovy HD injection was added to the documentation statement. **Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH):** For initial therapy, Wegovy HD injection was added to the requirements related to identification of stage F2 or F3 fibrosis prior to initiating treatment with Rezdiffra, Wegovy injection, or Wegovy tablet **[documentation required]**. Wegovy HD injection was added to the requirements and corresponding Note that apply to a patient who is currently receiving Wegovy injection or Wegovy tablet.
Hepatology – Rezdiffra (IP0642)	Updated	**Effective 6/1/2026** **Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH).** • Initial Therapy. Reference to Wegovy was updated to specify Wegovy injection throughout. Wegovy tablet and Wegovy HD injection were added to the requirements related to identification of stage F2 or F3 fibrosis prior to initiating treatment with Rezdiffra, Wegovy injection, Wegovy HD injection, or Wegovy tablet **[documentation required]**. Patient is Currently Receiving Rezdiffra. The

		requirement that the patient does not have cirrhosis (F4) was removed. This is already addressed as a Condition Not Covered.
Hereditary Angioedema – Andembry (IP0755)	Updated	**Effective 6/1/2026** No criteria changes.
Homozygous Familial Hypercholesterolemia – Juxtapid (IP0221)	Updated	**Effective 6/1/2026** • **Homozygous Familial Hypercholesterolemia:** For Initial Therapy, the age of approval was changed to ≥ 2 years of age. The requirement for a patient to try a Proprotein Convertase Subtilisn Kexin Type 9 (PCSK9) inhibitor was updated for patients ≥ 10 years of age. A patient who is 2 years to 10 years of age is not required to try a PCSK9.
Hyperhidrosis – Qbrexza (IP0074)	Updated	**Effective 6/15/2026** No criteria changes.
Hyperhidrosis – Sofdra (IP0703)	Updated	**Effective 6/15/2026** No criteria changes.
Immune Globulin (5026)	Updated	**Effective 6/15/2026** **Added** Gammagard Liquid ERC® and Qivigy® to the policy **Added** documentation statement to the policy. **Employer Plans and Individual and Family Plans Preferred Product Table:** **Added** documentation requirements to "Patient has tried THREE of the following products" for all products**.** **Added** preferred product requirements for Qivigy. **Added** Gammagard Liquid ERC to the list of preferred products for all non-covered products.
Immunologicals – Adbry Prior Authorization Policy - (IP0653)	Updated	**Effective 6/15/2026** ○ **Conditions not Recommended for Approval, Concurrent Use of Adbry with another Monoclonal Antibody Therapy:** Exdensur (depemokimab-

		ulaa subcutaneous injection) was added as an example of monoclonal antibody therapy.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Legacy Drug List Plans - (PSM003)	Updated	**Effective 6/1/2026** **Adalimumab-aaty** was moved from a Non-Preferred Product to a Preferred product. **Non-Preferred Adalimumab products:** Adalimumab- aaty was added to the list of preferred products throughout the criteria. In the note, it was specified that a trial of Yuflyma counts toward a trial of adalimumab-aaty.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy: Standard/Performance, Value/Advantage, Total Savings Drug List Plans - (PSM013)	Updated	**Effective 6/1/2026** **Adalimumab-aaty** was moved from a Non-Preferred Product to a Preferred product. **Non-Preferred Adalimumab products:** Adalimumab- aaty was added to the list of preferred products throughout the criteria. In the note, it was specified that a trial of Yuflyma counts toward a trial of adalimumab-aaty.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Individual and Family Plans - (PSM014)	Updated	**Effective 6/1/2026** **Adalimumab-aaty** was moved from a Non-Preferred Product to a Preferred product. **Non-Preferred Adalimumab products:** Adalimumab-aaty was added to the list of preferred products throughout the criteria. In the note, it was specified that a trial of Yuflyma counts toward a trial of adalimumab-aaty.
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance,	Updated	**Effective 6/4/2026** **Ankylosing Spondylitis and Psoriatic Arthritis:** adalimumab-aaty was added as a Preferred Product.

Value/Advantage, Total Savings Prescription Drug Lists Plans - (PSM009)		
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Legacy Prescription Drug Lists Plans - (PSM016)	Updated	**Effective 6/4/2026** **Ankylosing Spondylitis and Psoriatic Arthritis:** adalimumab-aaty was added as a Preferred Product.
Inflammatory Conditions – Cosentyx Subcutaneous Prior Authorization Policy – (IP0678)	Updated	**Effective 6/1/2026** **Ankylosing Spondylitis:** For initial therapy, the requirement that the patient is ≥ 18 years of age was changed to the patient is ≥ 12 years of age. In the Appendix, Icotyde (icotrokinra tablets) was added under the Oral Therapies/Targeted Synthetic Oral Small Molecule Drugs.
Inflammatory Conditions – Icotyde Prior Authorization Policy - (IP0805)	New	**Effective 6/1/2026** New policy
Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy for Individual and Family Plan Prescription Drug Lists - (PSM011)	Updated	**Effective 6/4/2026** **Adalimumab-aaty** was added as a Preferred Product throughout the policy.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management	Updated	**Effective 6/4/2026** **For All Conditions,** adalimumab-aaty was added as a preferred product. ○

Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists - (PSM006)		
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Individual and Family Plans - (PSM010)	Updated	**Effective 6/4/2026** **For All Conditions,** adalimumab-aaty was added as a preferred product.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Legacy Prescription Drug Lists - (PSM018)	Updated	**Effective 6/4/2026** **For All Conditions,** adalimumab-aaty was added as a preferred product.
Inflammatory Conditions – Rinvoq/Rinvoq LQ Prior Authorization Policy - (IP0682)	Updated	**Effective 6/1/2026** **Crohn's disease:** Added the following options of approval: (1) According to the prescriber, a tumor necrosis factor inhibitor is not clinically advisable; (2) The patient has had a 3-month trial of at least one other advanced therapy, unless intolerant. A note defining advanced therapies was included. For both options of approval, documentation is required. **Ulcerative Colitis:** Added the following options of approval: (1) According to the prescriber, a tumor necrosis factor inhibitor is not clinically advisable; (2) The patient has had a 3-month trial of at least one other advanced therapy, unless intolerant. A note defining advanced therapies was included. For both options of approval, documentation is required. **Conditions Not Recommended for Approval**: Exdensur (depemokimab-ulaa subcutaneous injection) was added as an example of a biologic immunomodulator. • **Appendix:** Icotyde (icotrokinra tablets) was added.

Hepatology – Rezdiffra (IP0642)	Updated	**Effective 6/1/2026** **Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH).** • Initial Therapy. Reference to Wegovy was updated to specify Wegovy injection throughout. Wegovy tablet and Wegovy HD injection were added to the requirements related to identification of stage F2 or F3 fibrosis prior to initiating treatment with Rezdiffra, Wegovy injection, Wegovy HD injection, or Wegovy tablet **[documentation required]**. Patient is Currently Receiving Rezdiffra. The requirement that the patient does not have cirrhosis (F4) was removed. This is already addressed as a Condition Not Covered.
Inflammatory Conditions – Spevigo Intravenous Prior Authorization Policy (IP0501)	Updated	**Effective 6/1/2026** No criteria. • Appendix updated to only include biologics FDA approved for the treatment of plaque psoriasis.
Inflammatory Conditions – Spevigo Subcutaneous (IP0649)	Updated	**Effective 6/1/2026** No criteria. • Appendix updated to only include biologics FDA approved for the treatment of plaque psoriasis.
Inflammatory Conditions – Tocilizumab Intravenous Products Prior Authorization Policy - (IP0656)	Updated	**Effective 6/1/2026** **Systemic Juvenile Idiopathic Arthritis:** The dosing interval was changed from at least 1 week to at least 2 weeks between doses. **Cytokine Release Syndrome Associated with Bispecific CD3 T-Cell Engager Therapy:** This was changed from Cytokine Release Syndrome Associated with Bispecific Antibodies. Under the Note, Blincyto (blinatumomab intravenous infusion) was added as an example of a bispecific CD3 T-cell engager therapy. **Immune Checkpoint Inhibitor Therapy-Related Toxicities:** This was reworded from Immunotherapy-Related Toxicities Associated with Checkpoint Inhibitor Therapy. **Polymyalgia Rheumatica:** The dosing was changed from 6 mg/kg (maximum of 600 mg per dose) to 8 mg/kg (maximum of 800 mg per dose). **Appendix:** Icotyde (icotrokinra tablet) was added under Targeted Oral Therapies.

Immunologicals – Dupixent (IP0453)	Updated	**Effective 6/1/2026** **Allergic Fungal Rhinosinusitis:** This new condition for approval was added to the policy. **Updated** the Asthma diagnostic requirements. ○ Throughout the policy, Exdensur (depemokimab-ulaa subcutaneous injection) was added to notes as an example of monoclonal antibody therapy.
Immunologicals – Dupixent (IP0453)	Updated	**Effective 6/15/2026** ○ **Chronic Spontaneous Urticaria:** The age of approval was changed from ≥ 12 years of age to ≥ 2 years of age.
Immunologicals - Exdensur - (IP0787)	New	**Effective 6/1/2026** New policy.
Immunologicals – Tezspire (IP0412)	Updated	**Effective 6/1/2026** **Updated** the Asthma diagnostic requirements.
Immunologicals – Xolair (IP0487)	Updated	**Effective 6/1/2026** **Updated** the Asthma diagnostic requirements.
Interferon – Actimmune (IP0201)	Updated	**Effective 6/15/2026** No criteria changes.
Kygevvi for Individual and Family Plans - (IP0780)	New	**Effective 6/1/2026** New policy.
Lupus – Benlysta Intravenous (IP0429)	Updated	**Effective 6/1/2026** The requirement "as determined by the prescriber" was updated to "according to the prescriber" throughout the Policy. **Systemic Lupus Erythematosus (SLE):** The initial approval duration was changed from 4 to 6 months. The requirement for autoantibody-positive SLE was updated to include anti-Smith antibodies. The term "standard therapy" was clarified to "standard therapy for SLE".

		Coding Information: **Added** HCPCS J0490
Lupus – Benlysta Subcutaneous (IP0430)	Updated	**Effective 6/1/2026** The requirement "as determined by the prescriber" was updated to "according to the prescriber" throughout the Policy. **Systemic Lupus Erythematosus (SLE):** The initial approval duration was changed from 4 to 6 months. The requirement for autoantibody-positive SLE was updated to include anti-Smith antibodies. The term "standard therapy" was clarified to "standard therapy for SLE".
Lupus – Lupkynis (IP0122)	Updated	**Effective 6/1/2026** **Lupus Nephritis** The requirement "as determined by the prescriber" was updated to "according to the prescriber". The Note providing examples of an immunosuppressive regimen was updated to include leflunomide, methotrexate. Estimated glomerular filtration rate (eGFR) was updated to state > 45 mL/min/1.73 m2 **Conditions Not Covered:** **Updated from** "any other use is considered experimental, investigational, or unproven" **to** "Lupkynis for any other use is considered not medically necessary"
Lupus – Saphnelo (IP0280)	Updated	**Effective 6/1/2026** **Systemic Lupus Erythematosus** The term "standard therapy" was clarified to "standard therapy for systemic lupus erythematosus (SLE)". The requirement "as determined by the prescriber" was updated to "according to the prescriber". **Employer Plans Preferred Product Table:** **Updated from** "Failure, contraindication, or intolerance to Benlysta (belimumab) [may require prior authorization] intravenous infusion or subcutaneous injection" **to** "Patient has tried Benlysta (belimumab) intravenous or subcutaneous. [may require prior authorization]." **Updated from** "Depression or suicidality, according to the prescriber" to "Per the prescriber, the patient has depression or suicidality." **Updated from** "Treatment with Saphnelo has been started" **to** "Patient has already been started on therapy with Saphnelo" **Conditions Not Covered:**

		Updated from "any other use is considered experimental, investigational, or unproven" **to** "Saphnelo for any other use is considered not medically necessary"
Medication Administration Site of Care (1605)	Updated	**Effective 6/15/2026** **Updated from "**A documented history of anadverse event warranting a more intense level of care during or following infusion of the prescribed medication unless the adverse event can be appropriately managed by the use of pre-medication(s) or other preventive actions" **to** "Patient has a history of an adverse event warranting a more intense level of care during or following infusion of the prescribed medication unless the adverse event can be appropriately managed by the use of pre-medication(s) or other preventive actions" **Updated** from "A documented history of a significant comorbidity (e.g., cardiopulmonary disorder) or concerns regarding fluid overload status that precludes treatment at an alternative less intensive site of care" **to** "Patient has a history of a significant comorbidity (e.g., cardiopulmonary disorder) or concerns regarding fluid overload status that precludes treatment at an alternative less intensive site of care" ○
Metabolic Disorders – Phenylbutyrate Products (IP0169)	Updated	**Effective 6/1/2026** **Updated** the policy statement. **Employer Group Plans:** ○ **Updated** preferred product criteria for Olpruva and Ravicti.
Migraine – Calcitonin Gene-Related Peptide Inhibitors – Aimovig (IP0503)	Updated	**Effective 6/1/2026** **Migraine Headache Prevention:** Existing requirements were reformatted into separate sets of requirements for Initial Therapy and Continuation of Therapy.
Migraine – Calcitonin Gene-Related Peptide Inhibitors – Ajovy (IP0504)	Updated	**Effective 6/1/2026** **Migraine Headache Prevention in Adults:** Existing requirements were reformatted into separate sets of requirements for Initial Therapy and Continuation of Therapy. ○ **Preventive Treatment of Episodic Migraine in Pediatric Patients:** Existing requirements were reformatted into separate sets of requirements for Initial Therapy and Continuation of Therapy.
Migraine – Calcitonin Gene-Related Peptide	Updated	**Effective 6/1/2026**

Inhibitors – Emgality (IP0505)		**Migraine Headache Prevention:** Existing requirements were reformatted into separate sets of requirements for Initial Therapy and Continuation of Therapy.
Migraine – Calcitonin Gene-Related Peptide Inhibitors – Vyepti (IP0506)	Updated	**Effective 6/1/2026** **Migraine Headache Prevention:** Existing requirements were reformatted into separate sets of requirements for Initial Therapy and Continuation of Therapy.
Migraine – Elyxyb (IP0640)	Updated	**Effective 6/15/2026** No criteria changes.
Muscular Dystrophy – Duvyzat (IP0651)	Updated	**Effective 6/1/2026** No criteria changes.
Nephrology - Voyxact - (IP0788)	New	**Effective 6/1/2026** New policy.
Neurology – Daybue (IP0578)	Updated	**Effective 6/15/2026** **Product List:** Daybue Stix added to policy. **Documentation Statement updated from** "Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, claims records, and/or other information" **to** "Documentation is required where noted in the criteria as [documentation required]. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, prescription receipts and/or other information. All documentation must include patient-specific identifying information." **Rett Syndrome:** **Initial Therapy:** Approval duration updated from 1 year to 6 months. **Updated from** "Documentation is provided of a pathogenic variant in the MECP2 gene" **to** "Patient has a pathogenic variant in the MECP2 gene [documentation required]" **Updated from** "Documentation is provided of classic/ typical Rett Syndrome, according to the Rett Syndrome Diagnostic Criteria" **to** "Patient has classic/typical Rett Syndrome, according to the Rett Syndrome Diagnostic Criteria [documentation required]"

		Updated from "According to the prescriber, the patient is past the initial period of regression and has reached the plateau phase (for example, no additional loss or degradation in ambulation, hand function, speech, or nonverbal communicative or social skills within 6 months of initial period of regression)" **to** "According to the prescriber, the patient is past the initial period of regression Note: Being past the initial period of regression is defined as no additional loss or degradation in ambulation, hand function, speech, or nonverbal communicative or social skills within 6 months of initial period of regression" **Patient is Currently Receiving Daybue:** Criteria added to policy.
Neurology – Edaravone Oral (IP0176)	Updated	**Effective 6/15/2026** **Policy Title:** **Updated from** "Neurology – Edaravone Products" **to** "Neurology – Edaravone" **Removed** Radicava (edaravone intravenous infusion) from policy. **Removed** documentation requirements from policy. **Amyotrophic Lateral Sclerosis (ALS):** **Updated from** "Documentation provided that the patient has a "definite" or "probable" diagnosis of amyotrophic lateral sclerosis (ALS) based on the application of the El Escorial or the revised Airlie House diagnostic criteria" **to** "According to the prescriber, the patient has a "definite" or "probable" diagnosis of amyotrophic lateral sclerosis (ALS) based on the application of the El Escorial or the revised Airlie House diagnostic criteria" **Updated from** "Patient has received or is currently receiving riluzole tablets, Tiglutik (riluzole oral suspension), or Exservan (riluzole oral film)" **to** "Patient is currently receiving a riluzole product"; specific products were moved to a Note as examples. Teglutik (riluzole oral suspension) was added to the list of examples of riluzole products. **Added** Appendix **Coding Information**

		Removed coding table & HCPCS codes
Neurology – Edaravone Intravenous (IP0806)	New	**Effective 6/15/2026** New Policy (IV product separated from oral suspension – criteria relocated from IP0176 to new standalone policy)
Neurology – Gene Therapy – Lenmeldy (IP0695)	Updated	**Effective 5/14/2026** No criteria changes. •
Neurology – Imaavy (IP0743)	Updated	**Effective 6/1/2026** • No criteria changes.
Neurology – Qalsody (IP0567)	Updated	**Effective 6/15/2026** **Removed "**except for the criterion requiring documentation of response or benefit to Qalsody therapy" from Documentation Statement **Amyotrophic Lateral Sclerosis (ALS):** **Added** "Patient has a confirmed SOD1 pathogenic variant **[documentation required]"** **Updated from** "Patient has weakness associated with ALS" **to** "Patient has weakness attributable to ALS" **Added** "According to the prescriber, the patient has adequate respiratory function and does not require invasive ventilation" **Removed** "Patient has one of the following pathogenic or likely pathogenic variants of the superoxide dismutase 1 (*SOD1*) gene [documentation required]: p.Ala5Val, p.Ala5Thr, p.Leu39Val, p.Gly42Ser, p.His44Arg, p.Leu85Val, p.Gly94Ala, p.Leu107Val, and p.Val149Gly" **Removed** "Patient has a baseline Amyotrophic Lateral Sclerosis Functional Rating Scale – Revised (ALSFRS-R) slope decline ≥ 0.2 per month [documentation required]" Removed "Patient has a SOD1 genetic variant which is not listed here [documentation required]: p.Ala5Val, p.Ala5Thr, p.Leu39Val, p.Gly42Ser, p.His44Arg, p.Leu85Val, p.Gly94Ala, p.Leu107Val, and p.Val149Gly" **Removed** "Patient has a baseline ALSFRS-R slope decline ≥ 0.9 per month [documentation required] Note: ALSFRS-R slope decline is calculated as ([48 minus baseline ALSFRS-R total score]/time since symptom onset)"

		Removed "Patient has elevated plasma (serum) neurofilament light chain levels at baseline" **Removed** "Patient has a slow vital capacity (SVC) of ≥ 65% of predicted value for sex, age, and height (from the sitting position)" **Removed** "Patient has received or is currently receiving riluzole tablets, Tiglutik (riluzole oral suspension), or Exservan (riluzole oral film)" **Patient is Currently Receiving Qalsody:** **Removed** "Patient is ≥ 18 years of age" **Removed** "Patient has weakness associated with ALS" **Updated from** "Patient has a superoxide dismutase 1 (SOD1) genetic variant" to "Patient has a confirmed SOD1 pathogenic variant" **Dosing:** Removed initial loading dose and maintenance dose qualifiers.
Neurology – Skyclarys (IP0566)	Updated	**Effective 6/15/2026** ○ No criteria changes.
Oncology – Everolimus Products (IP0408)	Updated	**Effective 6/15/2026** **Preferred Product Table.** **Updated from** "Trial of" **to** "The patient has tried" ○ **Added** Torpenz to the alternatives for Afinitor
Oncology (Oral – Immunomodulators) – Thalomid (IP0493)	Updated	**Effective 6/15/2026** The policy name was changed from "Oncology – Thalomid" to "Oncology (Oral – Immunomodulator) – Thalomid". **Castleman Disease**: The option for approval which stated that patient is negative for the human immunodeficiency virus and human herpesvirus-8 was removed. **Kaposi Sarcoma:** The requirement that the patient is ≥ 18 years of age was added. The requirement that the patient has immune reconstitution inflammatory syndrome (IRIS) was added. The requirement that the patient has relapsed or refractory disease was removed. Sirolimus, Opdivo (nivolumab intravenous infusion), and Keytruda (pembrolizumab intravenous infusion) were added to the Note with examples of other medications. The following option for approval was added "patient has Kaposi sarcoma-associated herpesvirus (KSHV)-associated inflammatory cytokine syndrome" along with a Note which states that

		KSHV-associated inflammatory cytokine syndrome is also known as Kaposi sarcoma inflammatory cytokine syndrome (KICS). **Cancer Cachexia and Crohn's disease** were removed from Conditions Not Recommended For Approval.
Opioid Therapy – Individual and Family Plans - (IP0562)	Updated	**Effective 6/1/2026** **Nucynta:** Updated preferred product criteria to require the patient has tried three other oral immediate-release (NOT long-acting) centrally acting/opioid analgesics; OR if the patient is ≥ 6 years of age to < 18 years of age, ONE of the following: has tried one of morphine sulfate immediate-release tablets or morphine sulfate immediate-release oral solution; OR has renal insufficiency; OR is intolerant or allergic to morphine. An exception to the preferred product requirement is allowed for a patient established on therapy who are in hospice or end of life care or active cancer treatment. **Nucynta ER:** 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). **Tapentadol immediate-release tablets:** added to the policy with the same criteria as Nucynta. **Tapentadol extended-release tablets:** added to the policy with the same criteria as Nucynta ER. **Apadaz, Seglentis, Qdolo (brand):** Removed from the policy, discontinued by the manufacturer. **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 tablet and Xyvona. Removed MorphaBond ER, it has been discontinued by the manufacturer.
Oncology (Injectable – CAR-T) – Kymriah (IP0197)	Update	**Effective 6/1/2026** **Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma:** Added new condition of approval.

Oncology (Injectable – CAR-T) – Yescarta (IP0198)	Updated	**Effective 6/1/2026** **Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma:** This new condition of approval was added to the policy.
Oncology (Intravesicular) – Adstiladrin (IP0579)	Updated	**Effective 6/1/2026** **Non-Muscle Invasive Bladder Cancer**: The option for approval "patient has high-grade papillary Ta/T1 tumors without CIS" was reworded to "patient has Ta/T1 papillary tumors without CIS."
Oncology Medications (1403)	Updated	**Effective 6/1/2026** **Ibrance.** **Removed** "For premenopausal patients using in combination with fulvestrant as subsequent therapy (not initial therapy), approve if the patient has tried Verzenio" **Added "**Patient has human epidermal growth factor receptor 2 (HER2)-positive breast cancer; AND Ibrance is used in combination with an aromatase inhibitor, trastuzumab, and Perjeta (pertuzumab intravenous infusion)" **Lymphir.** **Added** criteria for Lymphir for Employer Plans and Individual and Family Plans **Effective 7/1/2026** **Purixan suspension.** **Added** criteria for Purixan suspension for Employer Plans
Ophthalmology – Dry Eye Disease – Cyclosporine Products (IP0026)	Updated	**Effective 6/15/2026** No criteria changes.
Parkinson's Disease - Amantadine Extended-Release (IP0403)	Updated	**Effective 6/15/2026** Policy title updated from "*Amantadine Extended-Release*" to "*Parkinson's Disease – Amantadine Extended-Releas*e" **Added** a policy statement. **Added** a documentation statement. **Parkinson's Disease:**

		Added a note providing examples of "off" episodes. **Updated** the prerequisite requirement, limiting to previous use of immediate-release amantadine only. **Added** criteria for a patient currently receiving Gocovri. **Updated** the Conditions Not Covered statement.
Parkinson's Disease – Apomorphine Subcutaneous (Apokyn) (IP0530)	Updated	**Effective 6/15/2026** **Updated** the policy statement. **Parkinson's Disease:** The list of examples of treatments for Parkinson's disease was updated to remove cabergoline and to add Neupro (rotigotine transdermal system), Nourianz (istradefylline tablets), or amantadine.
Parkinson's Disease – Carbidopa (IP0523)	Updated	**Effective 6/15/2026** No criteria changes.
Parkinson's Disease - Duopa (IP0303)	Updated	**Effective 6/15/2026** **Updated** the policy statement. **Parkinson's Disease:** The list of examples of treatments for Parkinson's disease off episodes was updated to remove cabergoline and to add Neupro (rotigotine transdermal system), apomorphine, Nourianz (istradefylline tablets), and amantadine.
Parkinson's Disease – Inbrija (IP0522)	Updated	**Effective 6/15/2026** No criteria changes.
Parkinson's Disease – Nourianz (IP0524)	Updated	**Effective 6/15/2026** No criteria changes.
Parkinson's Disease – Onapgo (IP0746)	Updated	**Effective 6/15/2026** **Policy Statement:** In the statement "approval requires Onapgo to be prescribed by or in consultation with a physician who specializes in the condition being treated", the preceding word "initial" was removed to clarify that all approvals (initial and reauthorization) require that Onapgo is prescribed by or in consultation with a specialist.

		Parkinson's Disease: The list of examples of treatments for Parkinson's disease off episodes was updated to remove cabergoline and to add Neupro (rotigotine transdermal system), apomorphine, Nourianz (istradefylline tablets), and amantadine. **Coding Information** **Added** HCPCS Code: C9399
Parkinson's Disease – Vyalev (IP0717)	Updated	**Effective 6/15/2026** **Parkinson's Disease:** Examples of off episodes were moved to a Note. The list of examples of treatments for Parkinson's disease off episodes was updated to remove cabergoline and to add Neupro (rotigotine transdermal system), apomorphine, Nourianz (istradefylline tablets), and amantadine.
Parkinson's Disease – Zelapar (IP0525)	Updated	**Effective 6/1/2026** **Parkinson's Disease:** The phrase "has difficulty swallowing tablets or capsules" was revised to "cannot swallow or has difficulty swallowing tablets or capsules". For a patient who meets this criterion, they are no longer required to have tried selegiline tablets, selegiline capsules, or rasagiline tablets.
Pharmacy and Medical Prior Authorization (1407)	Updated	**Effective 6/1/2026** **Added Individual and Family Plan product-specific medical necessity criteria for the following products:** Corphena, brivaracetam oral solution and tablets, Brenzavvy, dapagliflozin tablets (authorized generic of Farxiga), dapagliflozin and metformin extended-release tablets, Invokana, Invokamet, Invokamet XR, Segluromet, Steglatro, Orudis, tobramycin 0.3%/loteprednol etabonate 0.5% ophthalmic suspension, Evexithroid, Rytary, Xadago, Lopressor (12.5 mg, 50 mg, and 100 mg) tablets, Consensi, Ibsrela, Zelnorm, Apriso ER, Asacol HD, Azulfidine, Azulfidine EN-tabs, Colazal, Dipentum, Pentasa 250 mg capsules, Azasan, azathioprine 75 mg and 100 mg tablets, Sprix, Zerviate, timolol 0.25% and 0.5% ophthalmic solution, Timoptic 0.25% and 0.5% ophthalmic solution, Timoptic Ocudose, Vesicare LS, oxybutynin chloride 2.5mg tablet (brand), Drizalma Sprinkle, venlafaxine besylate extended-release 112.5mg tablets (formerly Venbysi XR), albuterol sulfate inhalation powder (Prasco manufacturer), ProAir Respiclick, Ventolin HFA, Xopenex HFA, Intrarosa, and Santyl **Added Individual and Family Plan product-specific medical necessity criteria for the following products (EFFECTIVE 7/15/2026):** Allzital tablet, Bupap tablet, butalbital 25 mg and acetaminophen 325 mg tablet, butalbital 50 mg and Acetaminophen 300 mg capsules and tablets, Fioricet capsules, and Fioricet with Codeine

		Updated Individual and Family Plan product-specific medical necessity criteria for the following products: carbidopa and levodopa extended-release capsules, Aptiom, Briviact oral solution and tablets, eslicarbazepine acetate tablets, Vowst, Trudhesa, Betimol ophthalmic solution, and timolol hemihydrates 0.25% and 0.5% ophthalmic solution **Removed Individual and Family Plan product-specific medical necessity criteria for the following products:** Twiist and Symjepi
Phosphodiesterase Type 5 Inhibitors – Avanafil (Stendra™) for Individual and Family Plans (IP0100)	Updated	**Effective 6/15/2026** **Policy Title:** **Updated from** "Erectile Dysfunction - Avanafil" **to** "Phosphodiesterase Type 5 Inhibitors - Avanafil (Stendra™) for Individual and Family Plans" **Added** generic avanafil to the policy **Erectile Dysfunction:** **Removed** drug quantity limits throughout policy. **Removed** reauthorization criteria.
Phosphodiesterase Type 5 Inhibitors - Non-Erectile Dysfunction Benefit Exclusion Override Policy for Employer Plans (BEO001)v	New	**Effective 6/15/2026** New Policy
Phosphodiesterase Type 5 Inhibitors - Sildenafil (Viagra®) for Individual and Family Plans (IP0098)	Updated	**Effective 6/15/2026** **Policy Title:** **Updated from** "Sildenafil (Viagra®)" **to** "Phosphodiesterase Type 5 Inhibitors – Sildenafil (Viagra®) for Individual and Family Plans" **Added** documentation policy statement. **Erectile Dysfunction:** **Added** Note: For men with erectile dysfunction and benign prostatic hyperplasia, use criterion 2 below. **Removed** drug quantity limits throughout policy. **Removed** reauthorization criteria.

		Benign Prostatic Hyperplasia: **Updated from** "Treatment of Benign Prostatic Hyperplasia (BPH)" **to "**Benign Prostatic Hyperplasia" **Updated from** "Documentation of failure, contraindication, or intolerance to ONE of the following: Alpha1-blocker, 5 alpha-reductase inhibitor, or 5 alpha-reductase inhibitor/alpha1-blocker combination product" **to** "Patient has tried an alpha-1 (α1) blocker; OR Patient has tried a 5- alpha-reductase inhibitor" **Added:** Note: Examples of alpha-1 (α1) blockers include doxazosin, terazosin, tamsulosin, alfuzosin **Added:** Note: Examples of a 5-alpha-reductase inhibitor include finasteride and dutasteride. **Added** "Patient has a diagnosis of benign prostatic hyperplasia AND erectile dysfunction" **Removed** reauthorization criteria. **High-Altitude Pulmonary Edema (HAPE):** **Removed** "documented" from diagnosis of HAPE or history of HAPE. **Updated from** "Documentation of failure, contraindication, or intolerance to ONE other pharmacologic therapy for the treatment or prevention of HAPE" **to** "Patient has tried one other pharmacologic therapy for the treatment or prevention of HAPE." **Added:** Note: Examples of other pharmacologic therapy for the treatment or prevention of HAPE are nifedipine, dexamethasone, Cialis (tadalafil tablets). **Removed** reauthorization criteria. **Prophylaxis after Radical Prostatectomy (Early Penile Rehabilitation):** **Updated from** "Documentation of radical prostatectomy within the previous 12 months" **to** "Patient had radical prostatectomy within the previous 12 months" **Removed** reauthorization criteria. **Pulmonary Arterial Hypertension:** Use and criteria added to policy. **Raynaud's Phenomenon:** **Updated from** "Treatment of Raynaud's Phenomenon" **to** "Raynaud's Phenomenon" **Updated from** "Documentation of failure, contraindication, or intolerance to ONE calcium channel blocker" **to** "Patient has tried one calcium channel blocker" **Added:** Note: Examples of calcium channel blockers include amlodipine, felodipine, nifedipine. **Added:** According to the prescriber, use of a calcium channel blocker is contraindicated.

		Added: Note: Examples of reasons a patient cannot take calcium channel blocker therapy include right heart failure or decreased cardiac output. **Removed** reauthorization criteria.
Phosphodiesterase Type 5 Inhibitors Step Therapy Policy for Employer Plans (ST008)	New	**Effective 6/15/2026** New Policy.
Phosphodiesterase Type 5 Inhibitors - Tadalafil (Cialis®) for Individual and Family Plans (IP0101)	Updated	**Effective 6/15/2026** **Policy Title:** **Updated from** "Tadalafil (Cialis®) for Individual and Family Plans" **to** "Phosphodiesterase Type 5 Inhibitors –Tadalafil (Cialis®) for Individual and Family Plans" **Added** documentation policy statement. **Benign Prostatic Hyperplasia:** **Updated from** "Treatment of Benign Prostatic Hyperplasia (BPH)" **to "**Benign Prostatic Hyperplasia" **Updated from** "Documentation of failure, contraindication, or intolerance to BOTH of the following: Alpha1-blocker and 5-alpha-reductase inhibitor" **to** "Patient has tried an alpha-1 (α1) blocker; OR Patient has tried a 5-alpha-reductase inhibitor" **Added** "Patient has a diagnosis of benign prostatic hyperplasia AND erectile dysfunction" **Removed**: Dosage of tadalafil used will be 5mg once daily **Removed:** Dosage of tadalafil used will be 2.5mg once daily, if significant clinical concern such that the individual is unable to use the 5mg daily dosage (for example, creatinine clearance of 30-50 ml/min or concomitant potent inhibitors of CYP3A4, such as ketoconazole or ritonavir) **Added:** Note: Examples of alpha-1 (α1) blockers include doxazosin, terazosin, tamsulosin, alfuzosin **Added:** Note: Examples of a 5-alpha-reductase inhibitor include finasteride and dutasteride. **Removed** drug quantity limits throughout policy. **Removed** reauthorization criteria. **Erectile Dysfunction:** **Added** Note: For men with erectile dysfunction and benign prostatic hyperplasia, use criterion 1 above. **Removed** drug quantity limits throughout policy.

		Removed reauthorization criteria. **High-Altitude Pulmonary Edema (HAPE):** **Removed** "documented" from diagnosis of HAPE or history of HAPE criteria. **Updated from** "Documentation of failure, contraindication, or intolerance to ONE other pharmacologic therapy for the treatment or prevention of HAPE" **to** "Patient has tried one other pharmacologic therapy for the treatment or prevention of HAPE." **Added:** Note: Examples of other pharmacologic therapy for the treatment or prevention of HAPE are nifedipine, dexamethasone, sildenafil. **Removed** reauthorization criteria. **Prophylaxis after Radical Prostatectomy (Early Penile Rehabilitation):** **Updated from** "Documentation of radical prostatectomy within the previous 12 months" **to** "Patient had radical prostatectomy within the previous 12 months" **Removed** reauthorization criteria. **Pulmonary Arterial Hypertension (PAH):** Use and criteria added to policy. **Raynaud's Phenomenon:** **Updated from** "Treatment of Raynaud's Phenomenon" **to** "Raynaud's Phenomenon" **Updated from** "Documentation of failure, contraindication, or intolerance to ONE calcium channel blocker" **to** "Patient has tried one calcium channel blocker" **Added:** Note: Examples of calcium channel blockers include amlodipine, felodipine, nifedipine. **Added:** According to the prescriber, use of a calcium channel blocker is contraindicated. **Added:** Note: Examples of reasons a patient cannot take calcium channel blocker therapy include right heart failure or decreased cardiac output. **Removed** reauthorization criteria. **Updated** preferred product table for Individual and Family Plans to include Cialis 2.5 mg and 5 mg strengths.
Phosphodiesterase Type 5 Inhibitors – Vardenafil for Individual and Family Plans (IP0099)	Updated	**Effective 6/15/2026** **Policy Title:** **Updated from** "Erectile Dysfunction - Vardenafil" **to** "Phosphodiesterase Type 5 Inhibitors – Vardenafil for Individual and Family Plans" **Removed** brand Levitra and Staxyn from policy.

		Erectile Dysfunction: **Added** Note: For men with erectile dysfunction and benign prostatic hyperplasia, use criterion 2 below. **Removed** drug quantity limits throughout policy. **Removed** reauthorization criteria. **Benign Prostatic Hyperplasia:** **Updated from** "Inadequate response to ONE of the following: Alpha1-blocker, 5 alpha-reductase inhibitor, or 5 alpha-reductase inhibitor/alpha1-blocker combination product" **to** "Patient has tried an alpha-1 (α1) blocker; OR Patient has tried a 5- alpha-reductase inhibitor" **Added** "Patient has a diagnosis of benign prostatic hyperplasia AND erectile dysfunction" **Added:** Note: Examples of alpha-1 (α1) blockers include doxazosin, terazosin, tamsulosin, alfuzosin **Added:** Note: Examples of a 5-alpha-reductase inhibitor include finasteride and dutasteride. **Removed** "Failure, contraindication, intolerance to BOTH alpha$_1$-blockers and 5-alpha-reductase inhibitors" **Removed** reauthorization criteria. **Prophylaxis after Radical Prostatectomy (Early Penile Rehabilitation):** **Updated from** "Documentation of radical prostatectomy within the previous 12 months" **to** "Patient had radical prostatectomy within the previous 12 months" **Removed** reauthorization criteria. **Raynaud's Phenomenon:** **Updated from** "Documentation of failure, contraindication, or intolerance to **ONE** calcium channel blocker" **to** "Patient has tried one calcium channel blocker" **Added:** Note: Examples of calcium channel blockers include amlodipine, felodipine, nifedipine. **Added:** According to the prescriber, use of a calcium channel blocker is contraindicated. **Added:** Note: Examples of reasons a patient cannot take calcium channel blocker therapy include right heart failure or decreased cardiac output. **Removed** reauthorization criteria.
Pulmonary – Antifibrotics – Nintedanib (IP0312)	Updated	**Effective 6/15/2026** **Policy Title:** The policy name was changed to as listed. Previously, it was Pulmonary – Antifibrotics – Ofev.

		Added generic nintedanib, where relevant, throughout the policy. **Idiopathic Pulmonary Fibrosis:** **Updated from** "Forced vital capacity is ≥ 40% of the predicted value" **to** "Forced vital capacity is ≥ 40% of the predicted value at baseline." **Conditions Not Covered:** Added generic pirfenidone capsules and film coated tablets where relevant. **Preferred Products Table for Individual and Family Plans:** Added criteria for Nintedanib (generic Ofev)
Pulmonary Arterial Hypertension and Related Lung Disease – Inhaled Prostacyclin Products (IP0753)	Updated	**Effective 6/15/2026** **Pulmonary Arterial Hypertension (PAH) World Health Organization (WHO) Group 1:** The requirement that the patient is in Functional Class II, III, or IV was removed. A requirement that, according to the prescriber, the patient is intermediate or high-risk or is low-risk or intermediate-low risk was added. For a patient with low-risk or intermediate-low risk, a requirement and associated Note was added that the patient has tried or is currently receiving one or more agents from the following different categories (either alone or in combination with another therpay) for ≥ 60 days: PDE5 inhibitors, ERAs, Adempas, Winrevair, or prostacyclin analogs/mimetics. The previous requirement for systemic therapy that applied to all patients was removed.
Pulmonary Arterial Hypertension – Epoprostenol Products (IP0762)	Updated	**Effective 6/15/2026** **Pulmonary Arterial Hypertension (PAH) World Health Organization (WHO) Group 1:** The requirement that the patient is in Functional Class II, III, or IV was removed. A requirement that, according to the prescriber, the patient is intermediate or high-risk or is low-risk or intermediate-low risk was added. For a patient with low-risk or intermediate-low risk, a requirement and associated Note was added that the patient has tried or is currently receiving one or more agents from the following different categories (either alone or in combination with another therapy) for ≥ 60 days: phosphodiesterase type 5 (PDE5) inhibitors, endothelin receptor antagonists (ERAs), Adempas, Winrevair, or prostacyclin analogs/mimetics. The previous requirement for systemic therapy that applied to all patients with Class II disease was removed.

		Conditions Not Recommended for Approval: Ventavis was removed from the Note that lists examples of medications that should not be taken in combination with epoprostenol products.
Pulmonary Arterial Hypertension – Orenitram (IP0616)	Updated	**Effective 6/15/2026** **Pulmonary Arterial Hypertension (PAH) World Health Organization (WHO) Group 1:** A requirement that, according to the prescriber, the patient is intermediate or high-risk or is low-risk or intermediate-low risk was added. For a patient with low-risk or intermediate-low risk, a requirement and associated Note was added that the patient has tried or is currently receiving one or more agents from the following different categories (either alone or in combination with another therapy) for ≥ 60 days: phosphodiesterase type 5 (PDE5) inhibitors, endothelin receptor antagonists (ERAs), Adempas, Winrevair, or prostacyclin analogs/mimetics. The previous requirement for systemic therapy that applied to all patients was removed. **Conditions Not Covered:** Ventavis was removed from the Note that lists examples of medications that should not be taken in combination with Orenitram.
Pulmonary Arterial Hypertension – Treprostinil Injection (IP0757)	Updated	**Effective 6/15/2026** **Pulmonary Arterial Hypertension (PAH) World Health Organization (WHO) Group 1:** For initial therapy, the requirements regarding Functional Class were removed and replaced with risk categories. The requirement for patients in Functional Class III or IV was replaced with intermediate-high risk or high-risk, according to the prescriber. The requirement for patients in Functional Class II was modified to low-risk or intermediate-low risk, according to the prescriber. Patients in low-risk or intermediate-low risk categories are required to try or currently be receiving one or more agnets for PAH from the following different categories (either alone or in combination) for ≥ 60 days: phosphodiesterase type 5 (PDE5) inhibitors, endothelin receptor antagonists (ERAs), Adempas (riociguat tablets), Winrevair (sotatercept-csrk subcutaneous injection), or prostacyclin analogs/mimetics. A Note of examples of PDE5 inhibitors, ERAs, and prostacyclin analogs/mimetics was added. Dosing. Approve up to 100 ng/kg/minute given subcutaneously or intravenously was added to the policy. **Chronic Thromboembolic Pulmonary Hypertension (CTEPH).** Dosing. Approve up to 50 ng/kg/minute subcutaneously or intravenously was added to the policy. **Conditions Not Recommended for Approval:** Concurrent Use with Parenteral Epoprostenol Products, Oral Prostacyclin Products, or Inhaled Prostacyclin Agents Used for Pulmonary Hypertension. Ventavis was removed from the Note of examples.

Pulmonary Arterial Hypertension – Uptravi (IP0627)	Updated	**Effective 6/15/2026** **Pulmonary Arterial Hypertesion (PAH) World Health Organization (WHO) Group 1:** A requirement that, according to the prescriber, the patient is intermediate or high-risk or is low-risk or intermediate-low risk was added. For a patient with low-risk or intermediate-low risk, a requirement and associated Note was added that the patient has tried or is currently receiving one or more agents from the following different categories (either alone or in combination with another therapy) for ≥ 60 days: PDE5 inhibitors, ERAs, Adempas, Winrevair, or prostacyclin analogs/mimetics. The previous requirement for systemic therapy that applied to all patients was removed. **Conditions Not Covered:** Ventavis was removed from the Note that lists examples of medications that should not be taken in combination with Uptravi.
Pulmonary Arterial Hypertension – Winrevair (IP0645)	Updated	**Effective 6/15/2026** **Pulmonary Arterial Hypertension (PAH) World Health Organization (WHO) Group 1:** The requirement that the patient is in Functional Class II, III, or IV was removed. A requirement that, according to the prescriber, the patient is intermediate or high-risk or is low-risk or intermediate-low risk was added. For a patient with low-risk or intermediate-low risk, a requirement and associated Note was added for documentation that the patient has tried or is currently receiving one or more agents from the following different categories (either alone or in combination with another therapy) for ≥ 60 days: PDE5 inhibitors, ERAs, Adempas, or prostacyclin analogs/mimetics. The previous requirement for systemic therapy that applied to all patients was removed.
Psychiatry – Spravato (IP0220)	Updated	**Effective 6/1/2026** **Treatment-Resistant Depression:** Continuation requirements were added to the policy for patients who have already received at least 6 months of therapy with Spravato. For these patients, a 1-year approval duration will be authorized if the patient
Repository Corticotropin – Acthar Gel - IP0178	Updated	**Effective 6/1/2026** No criteria changes.
Repository Corticotropin – Cortrophin Gel - IP0374	Updated	**Effective 6/1/2026** No criteria changes.

Short-Acting Beta2-Agonist Inhalers (IP0040)	Retired	**Effective 6/1/2026** All products relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602) except the following discontinued products: ProAir Digihaler, ProAir HFA, and Proventil HFA
Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors and SGLT-2 / Metformin Combinations (IP0592)	Retired	**Effective 6/1/2026** All products relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602) and Pharmacy and Medical Prior Authorization (1407)
Spinal Muscular Atrophy – Spinraza (IP0182)	Updated	**Effective 7/15/2026** **Spinal Muscular Atrophy – Treatment:** Dosing was revised to divided dosing into three sections: 1) Low-Dose Regimen, 2) Transitioning from the Low-Dose Regimen to the High-Dose Regimen, and 3) High-Dose Regimen.
Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) [1803]	Updated	**Effective 6/1/2026** **Removed** Farxiga and Xigduo XR from the Diabetes Care therapeutic category. **Effective 6/15/2026** **Clarified** the strengths of Zenzedi that are subject to step therapy in the Attention Deficit Hyperactive Disorder (ADHD) therapeutic category.
Step Therapy – Standard and Performance Prescription Drug Lists (Employer Group Plans) [1801]	Updated	**Effective 6/1/2026** **Removed** Farxiga and Xigduo XR from the Diabetes Care therapeutic category. **Effective 6/15/2026** **Clarified** the strengths of Zenzedi that are subject to step therapy in the Attention Deficit Hyperactive Disorder (ADHD) therapeutic category.
Step Therapy – Value and Advantage Prescription Drug Lists (Employer Group Plans) [1802]	Updated	**Effective 6/1/2026** **Removed** Farxiga and Xigduo XR from the Diabetes Care therapeutic category. **Effective 6/15/2026**

		Clarified the strengths of Zenzedi that are subject to step therapy in the Attention Deficit Hyperactive Disorder (ADHD) therapeutic category
Tadalafil (Cialis®) for Employer Group Plans (IP0097)	Retired	**Effective 6/15/2026** Criteria relocated to ST008, BEO001, and DQM017
Tegaserod (IP0019)	Retired	**Effective 6/1/2026** Zelnorm relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602) and Pharmacy and Medical Prior Authorization (1407)
Tenapanor (IP0455)	Retired	**Effective 6/1/2026** Ibsrela relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602) and Pharmacy and Medical Prior Authorization (1407)
Testosterone (Oral, Topical, and Nasal) Products (IP0350)	Updated	**Effective 6/15/2026** **Updated** the Jatenzo, Kyzatrex and Tlando Employer Plans preferred product requirements.
Testosterone (Undecatrex) (IP0724)	Retired	**Effective 6/15/2026** Policy retired. Product no longer available commercially.
Topical Products – Vtama Step Therapy Policy for Employer Plans: Standard / Performance / Legacy Drug Lists (ST004)	New	**Effective 6/1/2026** New policy
Unassigned Drug Code Outpatient Medical Precertification (1701)	Updated	**Effective 6/15/2026** No criteria changes.
Nephrology - Vanrafia – (IP0740)	Updated	**Effective 6/15/2026** **Documentation:** **Added "**All documentation must include patient-specific identifying information."

		Primary Immunoglobulin A Nephropathy: **Updated** the approval duration to 1 year for both initial therapy and patients currently receiving Vanrafia.
Neurology – Brineura (IP0175)	Updated	**Effective 6/15/2026** No criteria changes.
Vesicular Monoamine Transporter Type 2 Inhibitors – Tetrabenazine (IP0208)	Updated	**Effective 6/15/2026** No criteria changes.
Wakefulness-Promoting Agents – Sunosi (IP0102)	Updated	**Effective 6/15/2026** **Updated** the documentation statement. **Excessive Daytime Sleepiness Associated with Narcolepsy:** An exception was added such that a patient who is currently receiving Sunosi does not need to try a central nervous system stimulant, modafinil, or armodafinil. **Excessive Daytime Sleepiness Associated with Obstructive Sleep Apnea**: An exception was added such that a patient who is currently receiving Sunosi does not need to try modafinil or armodafinil.
Wakefulness-Promoting Agents – Wakix (IP0292)	Updated	**Effective 6/15/2026** **Updated** the policy statement. **Cataplexy Treatment in a Patient with Narcolepsy:** The age requirement was updated from ≥ 18 years of age to ≥ 6 years of age in line with expanded labeling. The step component was updated to only direct to dextroamphetamine if the patient is ≥ 18 years of age. An exception was added such that a patient who is currently receiving Wakix does not need to try dextroamphetamine. **Excessive Daytime Sleepiness Associated with Narcolepsy:** An exception was added such that a patient who is currently receiving Wakix does not need to try a central nervous system stimulant, modafinil, or armodafinil.
Weight Loss Medications - Glucagon-Like Peptide-1 Agonists Benefit	Updated	**Effective 6/1/2026** Wegovy HD injection was added to the policy; approval criteria are the same as for Wegovy injection.

Exclusion Override Policy BMI ≥ 35 (INT030)		
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 30 (IP0206)	Updated	**Effective 6/1/2026** Wegovy HD injection was added to the policy; approval criteria are the same as for Wegovy injection. **Policy statement:** Wegovy HD injection was added to the Policy Statement. The statement was also updated to reflect the availability of Wegovy tablet and Wegovy injection. **Documentation:** Wegovy HD injection was added to the documentation statement. Wegovy injection Wegovy HD injection was added to the criteria as previously applied to Wegovy injection. In addition, the following changes were made to the Wegovy injection criteria previously in place. **Weight Loss in an Adult with Overweight or Obesity:** The corresponding Note for a patient currently receiving Wegovy tablet or Wegovy injection was updated to reflect the change to initial approval. Wegovy HD injection was added to the requirements and corresponding Note that apply to a patient who is currently receiving Wegovy injection or Wegovy tablet. **Weight Loss in a Pediatric Patient with Obesity:** The corresponding Note for a patient currently receiving Wegovy tablet or Wegovy injection was updated to reflect the change to initial approval. Wegovy HD injection was added to the requirements and corresponding Note that apply to a patient who is currently receiving Wegovy injection or Wegovy tablet. **Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH):** For initial therapy, Wegovy HD injection was added to the requirements related to identification of stage F2 or F3 fibrosis prior to initiating treatment with Rezdiffra, Wegovy injection, or Wegovy tablet **[documentation required]**. Wegovy HD injection was added to the requirements and corresponding Note that apply to a patient who is currently receiving Wegovy injection or Wegovy tablet. Wegovy tablet **Weight Loss in an Adult with Overweight or Obesity:** The corresponding Note for a patient currently receiving Wegovy tablet or Wegovy injection was updated to reflect the change to initial approval. Wegovy HD injection was added to the requirements and corresponding Note that apply to a patient who is currently receiving Wegovy injection or Wegovy tablet.

Weight Loss – Glucagon-Like Peptide-1 Agonists Benefit Exclusion Overrides Policy BMI ≥ 32 (BEO005)	Updated	**Effective 6/1/2026** **Updated** policy title and policy number. Wegovy HD injection was added to the policy; approval criteria are the same as for Wegovy injection. **Policy statement:** Wegovy HD injection was added to the Policy Statement. The statement was also updated to reflect the availability of Wegovy tablet and Wegovy injection. **Documentation:** Wegovy HD injection was added to the documentation statement. Wegovy injection Wegovy HD injection was added to the criteria as previously applied to Wegovy injection. In addition, the following changes were made to the Wegovy injection criteria previously in place. **Weight Loss in an Adult with Overweight or Obesity:** The corresponding Note for a patient currently receiving Wegovy tablet or Wegovy injection was updated to reflect the change to initial approval. Wegovy HD injection was added to the requirements and corresponding Note that apply to a patient who is currently receiving Wegovy injection or Wegovy tablet. **Weight Loss in a Pediatric Patient with Obesity:** The corresponding Note for a patient currently receiving Wegovy tablet or Wegovy injection was updated to reflect the change to initial approval. Wegovy HD injection was added to the requirements and corresponding Note that apply to a patient who is currently receiving Wegovy injection or Wegovy tablet. **Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH):** For initial therapy, Wegovy HD injection was added to the requirements related to identification of stage F2 or F3 fibrosis prior to initiating treatment with Rezdiffra, Wegovy injection, or Wegovy tablet **[documentation required]**. Wegovy HD injection was added to the requirements and corresponding Note that apply to a patient who is currently receiving Wegovy injection or Wegovy tablet. Wegovy tablet **Weight Loss in an Adult with Overweight or Obesity:** The corresponding Note for a patient currently receiving Wegovy tablet or Wegovy injection was updated to reflect the change to initial approval. Wegovy HD injection was added to the requirements and corresponding Note that apply to a patient who is currently receiving Wegovy injection or Wegovy tablet.
Weight Loss – Glucagon-Like Peptide-	Updated	**Effective 6/1/2026**

1 Agonists Benefit Exclusion Overrides Policy BMI ≥ 35 (BEO006)		**Updated** policy title and policy number. Wegovy HD injection was added to the policy; approval criteria are the same as for Wegovy injection. **Policy statement:** Wegovy HD injection was added to the Policy Statement. The statement was also updated to reflect the availability of Wegovy tablet and Wegovy injection. **Documentation:** Wegovy HD injection was added to the documentation statement. Wegovy injection Wegovy HD injection was added to the criteria as previously applied to Wegovy injection. In addition, the following changes were made to the Wegovy injection criteria previously in place. **Weight Loss in an Adult with Overweight or Obesity:** The corresponding Note for a patient currently receiving Wegovy tablet or Wegovy injection was updated to reflect the change to initial approval. Wegovy HD injection was added to the requirements and corresponding Note that apply to a patient who is currently receiving Wegovy injection or Wegovy tablet. **Weight Loss in a Pediatric Patient with Obesity:** The corresponding Note for a patient currently receiving Wegovy tablet or Wegovy injection was updated to reflect the change to initial approval. Wegovy HD injection was added to the requirements and corresponding Note that apply to a patient who is currently receiving Wegovy injection or Wegovy tablet. **Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH):** For initial therapy, Wegovy HD injection was added to the requirements related to identification of stage F2 or F3 fibrosis prior to initiating treatment with Rezdiffra, Wegovy injection, or Wegovy tablet **[documentation required]**. Wegovy HD injection was added to the requirements and corresponding Note that apply to a patient who is currently receiving Wegovy injection or Wegovy tablet. Wegovy tablet **Weight Loss in an Adult with Overweight or Obesity:** The corresponding Note for a patient currently receiving Wegovy tablet or Wegovy injection was updated to reflect the change to initial approval. Wegovy HD injection was added to the requirements and corresponding Note that apply to a patient who is currently receiving Wegovy injection or Wegovy tablet.
Precertification Policy*	**New, Updated,**	**Comments**

	or Retired?	
Precertification Policies	Updates	• No updates for June 2026
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
Robotic Assisted Surgery - (R04)	Updated	• Updates made June 2026
Services Not Reimbursable - (R33)	Updated	• Updates made June 2026
Modifier - Bilateral Procedures - (M50)	Updated	• Updates made June 2026
Modifier - Healthcare Common Procedure Coding System (HCPCS) National Level II Modifiers - (MHCPCS)	Updated	• Updates made June 2026
Modifier - Modifier Reference Guide - (MRG)	Updated	• Updates made June 2026
Facility Services Supplies and Equipment - (R12)	Updated	• Updates made June 2026
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		• No updates for June 2026

ClaimsXten Documents*	New, Updated, or Retired?	Comments
Code Editing Policy and Guidelines	Update	• No changes in June 2026