Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective March 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
Fecal Calprotectin Testing – (0121)	Updated	Important change in coverage policy: • Title change from Inflammatory Bowel Disease - Testing for the Diagnosis and Management to Fecal Calprotectin Testing • No clinical policy statement changes
Genetic Testing for Reproductive Carrier Screening and Prenatal Diagnosis – (0514)	Updated	**Posted and Effective 4/10/2026** Important changes in coverage criteria/policy: • Removed policy statements for germline carrier testing for familial disease; Fragile X; spinal muscular atrophy; cystic fibrosis; hemoglobinopathies; carrier screening panels ≥ 15 genes; carrier screening based on general population risk; preimplantation testing of an embryo; invasive prenatal testing of a fetus; genetic testing for recurrent pregnancy loss; and genetic testing for infertility.

		• Added policy statements for preconception/prenatal carrier screening panels, and genome sequencing for prenatal diagnosis or pregnancy loss. • Revised policy statements for preconception/prenatal Ashkenazi Jewish carrier screening, and noninvasive prenatal testing.
Intestinal and Multivisceral Transplantation – (0288)	Updated	**Posted 12/15/2025, Effective 3/15/2026** Important **changes** in coverage criteria: • Added policy statements if individual has a history of malignancy • Added policy statement for non-coverage of living-donor intestinal transplantation.
Laboratory Testing Services – (0604)	Updated	No clinical policy statement changes. Minor changes made in policy. • Removed deleted codes from policy: 0167U, 86327, 86490, 88388. • Made minor non-substantive proofreading edits to general background section for improved clarity. • Removed Medicare Coverage Determinations section from policy.
Manipulation Under Anesthesia - (0276)	Updated	**Effective 03/15/2026** Important change(s) in coverage criteria/policy: • Removed CPT code 22505 and related verbiage from policy statements for reduction of a displaced fracture and for reduction of acute/traumatic dislocation, since this will code will be managed by EviCore • Revised third policy statement for clarity
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.

Scar Revision – (0328)	Updated	**Posted 03/15/2026, Effective 06/15/2026** 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 12/15/2025, Effective 3/15/2026** Important **changes** in coverage criteria/policy: • Revised policy statement for drug-induced sleep endoscopy (DISE) in adults, removing the requirement that a mandibular repositioning appliance or tongue-retaining appliance be considered and found to be ineffective or undesirable prior to DISE, making this procedure less restrictive. • Revised policy statement for uvulectomy from experimental, investigational or unproven to not medically necessary. • Revised policy statement for implantable upper airway hypoglossal nerve stimulation devices in adults to include the Genio System, and added the FDA approved, device-specific indications related to age, apnea-hypopnea index on polysomnography • Removed policy statement for tongue implant (e.g., ReVENT® Sleep Apnea System), as this technology is not FDA-approved and does not appear to be under active clinical investigation.
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'.
Total Ankle Arthroplasty/Replacement – (0285)	Updated	Minor changes in coverage criteria/policy: • Added not medically necessary statement for revision total ankle arthroplasty. • Revised policy statement for total talar replacement to note procedure is considered experimental, investigational or unproven when performed alone or in combination with primary or revision total ankle arthroplasty.
Transvaginal Ultrasound, Non-Obstetrical – (0398)v	Update	**Posting 12/15/2025; Effective 03/15/2026.** Important **changes** in coverage criteria: • Removed policy statement regarding screening or surveillance of a woman at increased risk for ovarian or endometrial cancer to align with current recommendations by professional societies. • Revised policy statement regarding screening for cancer for clarity and consistency in policy statements.
Vitamin D Testing – (0526)	Updated	**Posting 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, 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.

Ablative Treatments for Malignant Breast Tumors – (0540)	Updated	**Effective 3/15/2026** • No change in coverage.
Diagnostic Nasal/Sinus Endoscopy, Functional Endoscopic Sinus Surgery (FESS) and Turbinectomy – (0554)	Updated	**Effective 3/15/2026** • No change in coverage.
Lab Testing Services - (0604)	Updated	• No change in coverage.
Molecular and Proteomic Diagnostic Testing for Hematology and Oncology Indications – (0520)	Updated	**Effective 4/10/2026** • No change in coverage.
Peripheral Nerve Stimulation and Peripheral Nerve Field Stimulation – (0539)	Updated	• No change in coverage.
Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM)– (0563)	Updated	• No change in coverage
Site of Care: High-tech Radiology – (0550)v	Updated	• No change in coverage
Transcranial Magnetic Stimulation – (EN0383)	Updated	• No change in coverage.
Drug Testing - (0513)	Retired	**Effective 04/01/2026** • This CP is retired because the codes in the policy will be managed by a reimbursement policy or other medical coverage policies.
Unlisted Procedure Codes - 0583	Retired	**Effective 03/15/2026**

		• This CP is retired because the unlisted CPT codes included will now be managed by the cobranded Cigna-EviCore guideline Management of Unlisted Codes.
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
Low-Level Laser and High-Power Laser Therapy – (CPG030)	Updated	• No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-EviCore Guidelines	Updated	**Effective 4/1/2026** An informational document was updated with no clinically impactful changes: • CMS Policy Hierarchies and Application Guidelines
Cobranded Cigna-EviCore High-Tech Imaging Guidelines	Updated	**Effective 2/3/2026** • Guideline updated with no clinically impactful changes: ○ Musculoskeletal Imaging
Cobranded Cigna-EviCore Musculoskeletal Management Guidelines	New, Updated	**Effective 2/25/2026** The following guidelines were updated with no clinically impactful changes: • CMM-200: Epidural Steroid Injections • CMM-201: Facet Joint Injections/Medial Branch Blocks • CMM-203: Sacroiliac Joint Procedures • CMM-207: Epidural Adhesiolysis • CMM-209: Regional Sympathetic Blocks • CMM-210: Implantable Intrathecal Drug Delivery Systems • CMM-211: Spinal Cord and Dorsal Root Ganglion Stimulation • CMM-401: Discography

		• CMM-600: Preface to Spine Surgery Guidelines • CMM-601: Anterior Cervical Discectomy and Fusion • CMM-602: Cervical Total Disc Arthroplasty • CMM-603: Posterior Cervical Decompression (Laminectomy/Hemilaminectomy/Laminoplasty) • CMM-604: Posterior Cervical Fusion • CMM-605: Cervical Microdiscectomy • CMM-606: Lumbar Microdiscectomy (Laminotomy, Laminectomy, or Hemilaminectomy) • CMM-607: Primary Vertebral Augmentation (Percutaneous Vertebroplasty/Kyphoplasty) and Sacroplasty • CMM-608: Lumbar Decompression • CMM-610: Lumbar Total Disc Arthroplasty • CMM-611: Sacroiliac Joint Fusion and Stabilization • CMM-613: Thoracic Decompression/ Discectomy • CMM-614: Thoracic/Thoracolumbar Fusion (Arthrodesis) • CMM-616: Vertebral Body Tethering for Adolescent Idiopathic Scoliosis **Effective 3/7/2026** New guideline: • CMM-310: Manipulation of the Spine Under Anesthesia
Administrative Policy	**New, Updated, or Retired?**	**Comments**
Authorized Generics (A008)	Updated	**Effective 3/1/2026** • **Removed** umeclidinium and vilanterol inhalation powder for Individual and Family Plans
Cigna Healthcare Drug Coverage Policy	**New, Updated,**	**Comments**

	or Retired?	
Amyloidosis – Tegsedi – (IP0417)	Retired	**Effective 3/1/2026** Important or minor change(s) in coverage criteria/policy: Product coverage policy supports discontinued by manufacturer on 9/27/2024. Policy retired, effective 3/1/2026.
Antibiotics – Xifaxan for Individual and Family Plans – (IP0473)	Updated	**Effective 3/1/2026** **Individual and Family Plans Preferred Product Table:** **Added** Note: A trial of Aemcolo would count towards the requirement.
Benign Prostatic Hyperplasia – Entadfi – (IP0519)	Updated	**Effective 3/1/2026** **Updated** policy title **from** "Entadfi (finasteride and tadalafil)" **to** "Benign Prostatic Hyperplasia – Entadfi" **Updated** approval duration from 12 months to 6 months. **Updated** preferred product table language from "Documented inability to take single agent finasteride 5 mg and tadalafil 5 mg concurrently [may require prior authorization]" **to** "According to the prescriber, the patient has a clinical reason they cannot take finasteride 5 mg and tadalafil 5 mg as separate agents **[may require prior authorization]**."
Bone Modifiers – Denosumab Products (Xgeva) – (IP0332)	Updated	**Effective 3/1/2026** **Added** Bilprevda to the policy with the same criteria as the other denosumab (Xgeva, biosimilars) products. **Added** Xbryk to the policy with a "Note" stating that Xbryk is not covered on the pharmacy and medical benefits for Employer Plans and Individual and Family Plans. Refer to the customer's benefit plan document for details of covered product(s). **Preferred Product Table:** **Added** Bilprevda as a step through product for both Bomyntra and Osenvelt, for both Employer Plans and Individual and Family Plans.
Brands with Bioequivalent Generics – (IP0011)	Updated	**Effective 3/1/2026** **Added for Employer Plans:** Extina, Loprox cream, Dymista

		Added for Individual and Family Plans: Oxistat cream, Naftin 2% gel
California: Weight Loss Medications - Glucagon-Like Peptide-1 Agonists Benefit Exclusion Override Policy BMI ≥ 40 – (INT028)	Updated	**Effective 3/1/2026** Wegovy tablet was added to the policy; new criteria were created.
Cardiology – Camzyos – (IP0480)	Updated	**Effective 3/1/2026** **Obstructive Hypertrophic Cardiomyopathy**. The approval duration for initial therapy was changed to 1 year. Previously, it was 8 months. The Note defining Class II and Class III heart failure was removed. The requirement for a peak left ventricular outflow tract gradient was changed to ≥ 30 mmHg at rest and ≥ 50 mmHg after provocation (Valsalva maneuver or post exercise). For patients currently receiving Camzyos, the requirement regarding patients being established on therapy for at least 8 months was changed to at least 1 year.
Chelating Agents – Trientine Products – (IP0278)	Updated	**Effective 3/1/2026** **Policy Title**: **Updated from** "Trientine Products" **to** "Chelating Agents – Trientine Products" **Added** "**Documentation:** Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information." **Wilson's Disease:** **Updated** the genetic language by replacing "mutations" with "variants". **Updated from** "Failure, contraindication or intolerance to penicillamine therapy (Cuprimine®, Depen®, or generics)" **to** "According to the prescriber, patient has tried one penicillamine product and is intolerant to penicillamine therapy and **added** a Note with examples of penicillamine products. **Added** "According to the prescriber, patient has clinical features indicating the potential for intolerance to penicillamine therapy and **added** a Note with clinical features indicating the potential for intolerance to penicillamine therapy. **Added** "According to the prescriber, patient has a contraindication to penicillamine therapy."

		Employer Plans Preferred Product Table **Cuvrior:** **Updated from** "Documentation of failure, contraindication, or intolerance to trientine hydrochloride [may require prior authorization]" **to** "Patient has tried trientine hydrochloride capsules [may require prior authorization][documentation required]" **Syprine:** **Updated from** "Documented trial of trientine hydrochloride (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 [may require prior authorization]" **to** "Patient has tried the bioequivalent generic product trientine hydrochloride [may require prior authorization], AND cannot take due to a formulation difference in the inactive ingredient(s) e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which would result, per the prescriber, in a significant allergy or serious adverse reaction[documentation required]." **Individual and Family Plans Preferred Product Table:** **Updated from** "Documentation of failure, contraindication, or intolerance to penicillamine 250mg tablets [may require prior authorization]" **to** "Patient has tried penicillamine 250mg tablets [may require prior authorization] [documentation required]"
Complement Inhibitors – Zilbrysq PA (IP0622)	Updated	**Effective 3/1/2026** No criteria changes.
Cystic Fibrosis Transmembrane Conductance Regulator – Alyftrek (IP0723)	Updated	**Effective 3/1/2026** **Employer Plans and Individual and Family Plans Preferred Product Table:** **Added** The patient has at least one variant in the cystic fibrosis transmembrane conductance regulator gene that is considered to be a pathogenic or likely pathogenic variant that is not covered by Trikafta.
Desmopressin Products – Nocdurna (IP0127)	Updated	**Effective 3/1/2026** **Nocturia due to Nocturnal Polyuria:** Moved examples of loop diuretics to a Note.
Diuretic – Enbumyst – (IP0784)v	New	**Effective 3/15/2026** **New policy**

Drugs Requiring Medical Necessity Review for Employer Plans – (1602)	Updated	**Effective 3/1/2026** **Added preferred product step requirement for the following products:** opium tincture 10 mg/mL, Ertaczo, Exelderm cream and solution, Jublia, Luzu, oxiconazole nitrate 1% cream, Oxistat cream and lotion, sulconazole nitrate 1% cream and solution (authorized generic of Exelderm), Xolegel, Bevespi Aerosphere, Duaklir Pressair, Ryaltris, Omnaris, Qnasl, Qnasl Children's, Xhance, Zetonna, tavaborole 5% topical solution, miconazole-zinc oxide-petrolatum ointment, and Vusion. **Updated preferred product step requirement for the following products:** Furoscix, dihydroergotamine mesylate nasal spray (generic Migranal), Trudhesa, Lotemax, Vtama, ArmonAir DigiHaler, Arnuity Ellipta, Flovent Diskus, Flovent HFA, fluticasone furoate inhalation powder (authorized generic of Arnuity Ellipta), fluticasone inhalation powder (authorized generic of Flovent Diskus), fluticasone propionate HFA (authorized generic of Flovent HFA), and Pulmicort Flexhaler.
Drugs Requiring Medical Necessity Review for Employer Plans – (1602)	Updated	**Effective 3/15/2026** **Added preferred product step requirement for the following products:** Blujepa, econazole nitrate topical foam, Brekiya, and ciprofloxacin/hydrocortisone 0.2%/1% otic suspension (generic for Cipro HC) **Updated preferred product step requirement for the following products:** desloratadine 0.5 mg/mL oral solution, Lexette, and Cipro HC
Enzyme Replacement Therapy – Revcovi – (IP0399)	Updated	**Effective 3/1/2026** **Updated** "At baseline, individual has had absent or very low (<1% of normal) adenosine deaminase (ADA) catalytic activity" **to** "At baseline (i.e., prior to initiating enzyme replacement therapy), the patient has had absent or very low (<1% of normal) adenosine deaminase (ADA) catalytic activity."
Gonadotropin-Releasing Hormone Agonist – Synarel – (IP0415)	Updated	**Effective 3/15/2026** **Policy Title.** **Updated from** "Nafarelin Acetate" to "Gonadotropin Releasing Hormone Agonist – Synarel" **Central Precocious Puberty.** **Updated** pubertal basal LH from 0.3 to 0.2 mIU/mL **Endometriosis.**

		Added "Note: An exception to the requirement for a trial of the above therapies can be made if the patient has previously used a gonadotropin-releasing hormone (GnRH) agonist (e.g., Lupron Depot) or antagonist (e.g., Orilissa) for endometriosis." **Removed** "Documentation of failure, contraindication or intolerance to a gonadotropin-releasing hormone agonist (for example, Lupron Depot) or antagonist (for example, Orilissa) for endometriosis **Gender-Dysphoric/Gender-Incongruent Persons; Persons Undergoing Gender Reassignment (Female-To-Male or Male-To-Female).** Added new criterion under Other Uses with Supportive Evidence for gender dysphoric/gender-incongruent persons; persons undergoing gender reassignment (female-to-male or male-to-female).
Growth Disorders – Increlex – (IP0310)	Updated	**Effective 3/15/2026** **No criteria changes**
Hematology – Adzynma – (IP0606)	Updated	**Effective 3/1/2026** **Added** documentation instructions. **Added** documentation requirements to: At baseline (prior to therapy) ADAMTS13 activity is < 10% (< 10 IU/dL); Patient does not have anti-ADAMTS13 autoantibodies as determined by a diagnostic test; Patient has a pathogenic variant or a mutation in the ADAMTS13 gene
Hematology – Cablivi – (IP0161)	Updated	**Effective 3/1/2026** ○ **Acquired Thrombotic Thrombocytopenic Purpura:** The age of approval was changed from ≥ 18 years of age to ≥ 12 years of age.
Hematology – Ceprotin – (IP0342)	Updated	**Effective 3/1/2026** **Removed** "documented/documentation" from diagnosis of protein C deficiency criteria **Added** "According to the prescriber" to criteria for current or prior history of symptoms associated with severe protein C deficiency
Hematology -Coagadex – (IP0554)	Updated	**Effective 3/1/2026** **Hereditary Factor X Deficiency.** **Removed** "Documentation of **ONE** of the following: Routine prophylaxis to reduce the frequency of bleeding episodes; Treatment of bleeding episodes; Perioperative

		management of bleeding in individuals with mild, moderate, and severe hereditary Factor X deficiency
Hematology – Corifact – (IP0552)	Updated	**Effective 3/1/2026** **Congenital Factor XIII Deficiency.** **Removed** ONE of the following conditions is met: Peri-operative management of bleeding; Routine prophylaxis to reduce the frequency of bleeding episodes' Treatment of bleeding episodes
Hematology – Gene Therapy – Casgevy – (IP0615)	Updated	**Effective 2/19/2026** **Sickle Cell Disease: Added** The recommended dose of Casgevy is a one-time (per lifetime) single intravenous infusion of a minimum of 3 x 106 CD34+ cells/kg of body weight. **Transfusion-Dependent Beta-Thalassemia: Added** The recommended dose of Casgevy is a one-time (per lifetime) single intravenous infusion of a minimum of 3 x 106 CD34+ cells/kg of body weight. **Conditions Not Covered**, the condition "Concurrent Use with Reblozyl (luspartercept-aamt subcutaneous injection)" was revised to "Concomitant Use with Aqvesme (mitapivat tablets) or Reblozyl (luspatercept-aamt subcutaneous injection)". **Coding Information Removed** HCPCS codes C9399 & J3590 **Removed** "Code effective 1/1/2025" from HCPCS J3392
Hematology – Gene Therapy – Lyfgenia – (IP0167)	Updated	**Effective 3/5/2026** ○ **Sickle Cell Disease:** The dosing was clarified that the recommended dose is a minimum of 3 x 10^6 CD34+ cells/kg. Also, the qualifier regarding body weight "within the past 30 days" was removed. Previously, the dosing was: The recommended dose of Lyfgenia is a one-time (per lifetime) single intravenous infusion of 3 x 10^6 CD34+ cells/kg based on current body weight in kg (within the past 30 days). The new dosing reads: The recommended dose of Lyfgenia is a one-time (per lifetime) single intravenous infusion of a minimum of 3 x 10^6 CD34+ cells/kg of body weight.
Hematology – Gene Therapy – Zynteglo – (IP0486)	Updated	**Effective 2/19/2026** **Transfusion-Dependent Beta Thalassemia**. A Note was added that a single dose of Zynteglo is composed of one or more infusion bag(s).

		Conditions Not Covered , the condition "Concurrent Use with Reblozyl (luspartercept-aamt subcutaneous injection)" was revised to "Concomitant Use with Aqvesme (mitapivat tablets) or Reblozyl (luspatercept-aamt subcutaneous injection)".
Hematology – Tretten – (IP0553)	Updated	**Effective 3/1/2026** **Congenital Factor XIII A-Subunit Deficiency.** **Removed** ONE of the following conditions is met: Peri-operative management of bleeding; Routine prophylaxis to reduce the frequency of bleeding episodes; Treatment of bleeding episodes
Hemophilia – FEIBA – (IP0354)	Updated	**Effective 3/1/2026** **Hemophilia A with inhibitors.** **Added** documentation requirements. **Hemophilia B with inhibitors.** **Added** documentation requirements.
Hemophilia – Eptacog Products - Sevenfact – (IP0355)	Updated	**Effective 3/1/2026** **Hemophilia A with inhibitors.** **Added** documentation requirements. **Hemophilia B with inhibitors.** • **Added** documentation requirements.
Hemophilia – Eptacog Products – NovoSeven RT – (IP0356)	Updated	**Effective 3/1/2026** **Updated** policy title **from** "NovoSeven RT" **to** "Hemophilia – Eptacog Products – NovoSeven RT"
Hepatitis C – Sovaldi Prior Authorization Policy – (IP0157)	Updated	**Effective 3/1/2026** No criteria changes.
Hepatology – Metabolic Dysfunction-Associated Steatohepatitis – Wegovy Benefit Exclusion Overrides Policy for	New	**Effective 3/15/2026** New policy.

Individual and Family Plans - (IP0781)		
Hereditary Angioedema - Dawnzera (IP0761)	Updated	**Effective 3/1/2026** **Added** Employer Plans preferred product requirements.
Hereditary Angioedema – Orladeyo - (IP0096)	Updated	**Effective 3/1/2026** **Added** Orladeyo oral pellets (new formulation) to the policy with the same requirements applied as the tablets. **Hereditary Angioedema (HAE) Due to C1 Inhibitor (C1-INH) Deficiency – Prophylaxis:** Under Initial Therapy, patient age requirement was changed from ≥ 12 years of age to ≥ 2 years of age.
Human Immunodeficiency Virus – Sunlenca (IP0546)	Updated	**Effective 3/15/2026** **No criteria changes.**
Immune Globulin – (5026)	Updated	**Effective 3/15/2026** **Employer Plans and Individual and Family Plans Preferred Product Table:** **Gammagard Liquid:** removed preferred product requirements for Gammagard Liquid **Gammagard S/D IgA ≤ 1 mcg/mL:** updated criteria for the exception of "Patient requires an IVIG product with the lowest IgA content"
Immunologicals – Nemluvio – (IP0714)	Updated	**Effective 3/15/2026** • **No criteria changes.**
Infectious Disease – Pretomanid – (IP0384)	Updated	**Effective 3/1/2026** **Policy Title:** **Updated from** "Pretomanid" **to** "Infectious Disease – Pretomanid" **Tuberculosis** **Updated** indication name **from** "Treatment of Pulmonary Tuberculosis" **to "Tuberculosis"** **Updated** approval duration **from** 9 months **to** 6 months.

		Updated criteria related to type of resistant or nonresponsive tuberculosis **from** "Documentation of ONE of the following" **to** "Patient meets ONE of the following (i, ii, or iii)" **Added** linezolid oral suspension to medications prescribed in combination with pretomanid. **Added** pulmonologist to specialist requirement. • **Removed** reauthorization criteria
Infectious Disease – Pyrimethamine PA – (IP0348)	Updated	**Effective 3/1/2026** **Cystoisosporiasis (formerly known as isosporiasis) – Secondary Prophylaxis (Chronic Maintenance Treatment), Cystoisosporiasis (formerly known as isosporiasis) – Treatment, Pneumocystis Pneumonia – Primary Prophylaxis, Pneumocystis Pneumonia – Secondary Prophylaxis (Chronic Maintenance Therapy), Toxoplasma gondii Encephalitis – Primary Prophylaxis**. For these conditions of approval, the criterion requiring patients to try an alternative therapy was clarified to state that this was required unless contraindicated. A corresponding Note was added to give examples of contraindications such as allergies or intolerances.
Infectious Disease – Sirturo – (IP0494)	Updated	**Effective 3/1/2026** • **Tuberculosis.** The specialist requirement was updated to include pulmonologist.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Individual and Family Plans – (PSM014)	Updated	**Effective 3/1/2026** **Adalimumab-bwwd, adalimumab-ryvk (NDCs starting with 51759), Amjevita (NDCs starting with 84612), Humira (NDCs starting with 83457), Hyrimoz (NDCs starting with 83457)**: Added to the policy as Non-Covered products and directing to Preferred Products. **Adalimumab-ryvk:** In the note, it was specified that NDCs starting with 51759 also count toward the trial of the preferred -ryvk product.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Legacy Drug List Plans – (PSM003)	Updated	**Effective 3/1/2026** **Adalimumab-bwwd, adalimumab-ryvk (NDCs starting with 51759), Amjevita (NDCs starting with 84612), Humira (NDCs starting with 83457), Hyrimoz (NDCs starting with 83457)**: Added to the policy as Non-Covered products and directing to Preferred Products.

		Adalimumab-ryvk: In the note, it was specified that NDCs starting with 51759 also count toward the trial of the preferred -ryvk. **Humira:** In the note, it was specified that NDCs starting with 83457 also count toward the trial of the preferred Humira.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy: Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists – (PSM013)	Updated	**Effective 3/1/2026** **Adalimumab-bwwd, adalimumab-ryvk (NDCs starting with 51759), Amjevita (NDCs starting with 84612), Humira (NDCs starting with 83457), Hyrimoz (NDCs starting with 83457)**: Added to the policy as Non-Covered products and directing to Preferred Products. • **Adalimumab-ryvk:** In the note, it was specified that NDCs starting with 51759 also count toward the trial of the preferred -ryvk product.
Inflammatory Conditions – Adalimumab Products Prior Authorization Policy – (IP0652)	Updated	**Effective 3/1/2026** **Added** Adalimumab-bwwd to the policy. **Added** a note for adalimumab-bwwd, adalimumab-ryvk (-ryvk NDCs starting with 51759), Amjevita (NDCs starting with 84612), Humira (NDCs starting with 83457), Hyrimoz (NDCs starting with 83457) to designate them as Non-Covered products for Employer Plans and Individual and Family Plans.
Inflammatory Conditions – Infliximab Intravenous Products PA – (IP0660)	Updated	**Effective 3/1/2026** **No criteria changes.**
Inflammatory Conditions – Omvoh Intravenous PA - (IP0662)	Updated	**Effective 3/1/2026** **No criteria changes.**
Inflammatory Conditions – Omvoh Subcutaneous PA - (IP0663)	Updated	**Effective 3/1/2026** • **No criteria changes.**
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for	Updated	**Effective 3/1/2026** **For Psoriatic Arthritis**, Xeljanz oral solution was added as a Step 2a agent. Criteria were updated to remove "tablets" from Xeljanz in the preferred products. Updated the

Legacy Prescription Drug Lists - (PSM018)		Preferred and Non-Preferred Products table to include Bimzelx as a Step 2b agent. Cosentyx was added as an agent that also counts towards a trial of a Preferred Product.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists - (PSM006)	Updated	**Effective 3/1/2026** **For Psoriatic Arthritis**, Xeljanz oral solution was added as a Step 2a agent. Criteria were updated to remove "tablets" from Xeljanz in the preferred products. Updated the Preferred and Non-Preferred Products table to include Bimzelx as a Step 2b agent. Cosentyx was added as an agent that also counts towards a trial of a Preferred Product.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Individual and Family Plans - (PSM010)	Updated	**Effective 3/1/2026** **For Psoriatic Arthritis**, Xeljanz oral solution was added as a Step 2 agent. Criteria were updated to remove "tablets" from Xeljanz in the preferred products. Taltz was added as an agent that also counts towards a trial of a Preferred Product.
Inflammatory Conditions – Otezla/Otezla XR Prior Authorization Policy – (IP0666)	Updated	**Effective 3/1/2026** • **Plaque Psoriasis and Psoriatic Arthritis:** Specified that the weight requirement of ≥ 20 kg for Otezla and ≥ 50 kg for Otezla XR only applies to patients < 18 years of age.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists - (PSM001)	Updated	**Effective 3/1/2026** **Xeljanz oral solution:** For Psoriatic Arthritis, Xeljanz oral solution was added as a Step 2a agent. Criteria for Cimzia, Cosentyx, Orencia, and Simponi were updated to remove "tablets" from Xeljanz in the preferred products.
Inflammatory Conditions Preferred Specialty	Updated	**Effective 3/1/2026**

Management Policy for Employer Plans: Legacy Prescription Drug Lists - (PSM017)		• **Xeljanz oral solution:** For Psoriatic Arthritis, Xeljanz oral solution was added as a Step 2a agent. Criteria for Cimzia, Cosentyx, Orencia, and Simponi were updated to remove "tablets" from Xeljanz in the preferred products.
Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)	Updated	**Effective 3/1/2026** **Xeljanz oral solution**: For Psoriatic Arthritis, Xeljanz oral solution was added as a Step 2 agent. Criteria for Cimzia, Orencia, and Simponi were updated to remove "tablets" from Xeljanz in the preferred products.
Inflammatory Conditions – Simponi Aria Prior Authorization Policy – (IP0668)	Updated	**Effective 3/1/2026** **No criteria changes.**
Inflammatory Conditions – Ustekinumab Intravenous Products Preferred Specialty Management Policy – (PSM024)	Updated	**Effective 3/1/2026** **Starjemza intravenous:** Added to the policy as a Non-Preferred product. The same exception criteria apply as the other Non-Preferred products. **Imuldosa IV (NDCs starting with 51407) and Wezlana**: Added to the policy as Non-Covered products and directing to Preferred Products.
Inflammatory Conditions – Ustekinumab Intravenous Products Prior Authorization Policy – (IP0686)	Updated	**Effective 3/1/2026** Starjemza intravenous injection was added to the policy; the same criteria apply as the other ustekinumab intravenous products. ○ A "Note" was added to the policy stating that "The following products are not covered on the pharmacy and medical benefits for Employer Plans and Individual and Family Plans: Imuldosa intravenous (NDCs starting with 51407), Wezlana intravenous. Refer to the customer's benefit plan document for details of covered product(s)."
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for	Updated	**Effective 3/1/2026** **Starjemza SC:** Added as a Non-Preferred ustekinumab product and will share the same exception criteria as the other Non-Preferred products.

Individual and Family Plans – (PSM023)		**Imuldosa SC (NDCs starting with 51407), Pyzchiva SC (NDCs starting with 83457), Ustekinumab-aauz SC, and Wezlana SC:** Added to the policy as Non-Covered ustekinumab products with criteria directing to Preferred Products.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Legacy Prescription Drug List Plans – (PSM022)	Updated	**Effective 3/1/2026** It was clarified throughout the policy that Stelara syringes (45mg, 90mg) are the preferred Stelara SC products. **Starjemza SC:** Added as a Non-Preferred ustekinumab product and will share the same exception criteria as the other Non-Preferred products. **Imuldosa SC (NDCs starting with 51407), Pyzchiva SC (NDCs starting with 83457), Ustekinumab-aauz SC, and Wezlana SC:** Added to the policy as Non-Covered ustekinumab products with criteria directing to Preferred Products. **Stelara SC 45mg vial:** Updated list of Preferred Products in criteria to also include the Stelara syringe. Stelara syringe was already listed as a Step 1 Preferred Product in the table. **Ustekinumab SC 45mg vial:** Updated list of Preferred Products in criteria to also include the Stelara syringe. Stelara syringe was already listed as a Step 1 Preferred Product in the table.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists – (PSM021)	Updated	**Effective 3/1/2026** **Starjemza SC:** Added as a Non-Preferred ustekinumab product and will share the same exception criteria as the other Non-Preferred products. **Imuldosa SC (NDCs starting with 51407), Pyzchiva SC (NDCs starting with 83457), Ustekinumab-aauz SC, and Wezlana SC:** Added to the policy as Non-Covered ustekinumab products with criteria directing to Preferred Products.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Prior Authorization Policy – (IP0687)	Updated	**Effective 3/1/2026** Starjemza subcutaneous injection was added to the policy; the same criteria apply as the other ustekinumab subcutaneous products. Ustekinumab-aauz was added to the policy. A "Note" was also added for Imuldosa subcutaneous (NDCs starting with 51407), Pyzchiva subcutaneous (NDCs starting with

		83457), ustekinumab-aauz subcutaneous, and Wezlana subcutaneous stating they are not covered on the pharmacy and medical benefits for Employer Plans and Individual and Family Plans. Refer to the customer's benefit plan document for details of covered product(s).
Inflammatory Conditions – Zymfentra PA - (IP0646)	Updated	**Effective 3/1/2026** **No criteria changes.**
Inflammatory Conditions – Adalimumab Products Prior Authorization Policy - (IP0652)	Updated	**Effective 3/15/2026** **Crohn's Disease:** For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one conventional systemic therapy for Crohn's disease along with the associated note; patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence).
Inflammatory Conditions – Cimzia Prior Authorization Policy - (IP0672)	Updated	**Effective 3/15/2026** **Crohn's Disease:** For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one conventional systemic therapy for Crohn's disease along with the associated note; patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence).
Inflammatory Conditions – Entyvio Intravenous Prior Authorization Policy - (IP0674)	Updated	**Effective 3/15/2026** **Crohn's Disease:** For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one conventional systemic therapy for Crohn's disease along with the associated note; patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence).
Inflammatory Conditions – Entyvio Subcutaneous Prior Authorization Policy - (IP0675)	Updated	**Effective 3/15/2026** ○ **Crohn's Disease:** For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one

		conventional systemic therapy for Crohn's disease along with the associated note; patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence).
Inflammatory Conditions – Infliximab Intravenous Products Prior Authorization Policy - (IP0660)	Updated	**Effective 3/15/2026** **Crohn's Disease:** For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one conventional systemic therapy for Crohn's disease along with the associated Note; patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence). **Still's Disease:** Removed this condition of approval from Other Uses with Supportive Evidence.
Inflammatory Conditions – Omvoh Intravenous Prior Authorization - (IP0662)	Updated	**Effective 3/15/2026** **Crohn's Disease:** For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one conventional systemic therapy for Crohn's disease along with the associated note; patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence).
Inflammatory Conditions – Omvoh Subcutaneous Prior Authorization Policy - (IP0663)	Updated	**Effective 3/15/2026** • **Crohn's Disease:** For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one conventional systemic therapy for Crohn's disease along with the associated note; patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence).
Inflammatory Conditions – Skyrizi Intravenous Prior Authorization Policy - (IP0669)	Updated	**Effective 3/15/2026** • **Crohn's Disease:** For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one conventional systemic therapy for Crohn's disease along with the associated note; patient has

		enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence).
Inflammatory Conditions – Skyrizi Subcutaneous Prior Authorization Policy - (IP0670)	Updated	**Effective 3/15/2026** • **Crohn's Disease:** For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one conventional systemic therapy for Crohn's disease along with the associated note; patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence).
Inflammatory Conditions – Tremfya Intravenous Prior Authorization Policy - (IP0704)	Updated	**Effective 3/15/2026** • **Crohn's Disease:** For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one conventional systemic therapy for Crohn's disease along with the associated note; patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence).
Inflammatory Conditions – Tremfya Subcutaneous Prior Authorization Policy - (IP0689)	Updated	**Effective 3/15/2026** **Crohn's Disease:** For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one conventional systemic therapy for Crohn's disease along with the associated note; patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence).
Inflammatory Conditions – Ustekinumab Intravenous Products Prior Authorization Policy - (IP0686)	Updated	**Effective 3/15/2026** ○ **Crohn's Disease:** For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one conventional systemic therapy for Crohn's disease along with the associated note; patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence).

Inflammatory Conditions – Ustekinumab Subcutaneous Products Prior Authorization Policy - (IP0687)	Updated	**Effective 3/15/2026** ○ **Crohn's Disease:** For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one conventional systemic therapy for Crohn's disease along with the associated note; patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence).
Inflammatory Conditions – Zymfentra Prior Authorization Policy - (IP0646)	Updated	**Effective 3/15/2026** **Crohn's Disease:** For initial therapy, the following options of approval were removed: The patient has tried or is currently taking systemic corticosteroids, or corticosteroids are contraindicated; patient has tried one conventional systemic therapy for Crohn's disease along with the associated note; patient has enterocutaneous (perianal or abdominal) or rectovaginal fistulas; patient had ileocolonic resection (to reduce the chance of Crohn's disease recurrence).
Inflammatory Conditions – Etanercept Products Prior Authorization Policy - (IP0673)	Updated	**Effective 3/15/2026** **Still's Disease:** This condition of approval was removed from Other Uses with Supportive Evidence.
Inflammatory Conditions – Ustekinumab Subcutaneous Drug Quantity Management Policy – Per Days - (DQM001)	Updated	**Effective 3/15/2026** **Starjemza 45 mg vials, 45 mg prefilled syringes, and 90 mg prefilled syringes:** New quantity limits were added to the policy. The same quantity limits and overrides apply to Starjemza as have previously applied to the other ustekinumab products. Added the following statement to clarify and differentiate non-covered ustekinumab products. "The following products are not covered on the pharmacy and medical benefits for Employer Plans and Individual and Family Plans: Imuldosa subcutaneous (NDCs starting with 51407), Pyzchiva subcutaneous (NDCs starting with 83457), ustekinumab-aauz subcutaneous, Wezlana subcutaneous. Refer to the customer's benefit plan document for details of covered product(s)." Updated the Drug Quantity Limits table to reflect the non-covered products with NDCs where applicable and a note that no exceptions apply for non-covered products

Inflammatory Conditions – Rinvoq/Rinvoq LQ Prior Authorization Policy - (IP0682)	Updated	**Effective 3/15/2026** **No criteria changes.**
Intraarticular Hyaluronic Acid Derivatives – (IP0322)	Updated	**Effective 3/01/2026** **Initial Therapy:** **Added "**Note: Examples of radiographic evidence includes x-ray, magnetic resonance imaging (MRI), computed tomography (CT) scan, ultrasound" to "Diagnosis of affected knee to be treated is confirmed by radiologic evidence of knee osteoarthritis." **Updated** criterion **from** requiring "At least six weeks of provider-directed conservative management program consisting of physical therapy or home exercises" **to** "At least one course of physical therapy for affected knee osteoarthritis." **Updated** criterion **from** requiring "At least ONE injection of intraarticular corticosteroids to the affected knee" **to** requiring "At least TWO injections of intraarticular corticosteroids to the affected knee." **Added** Note: Examples of oral NSAIDs include naproxen, ibuprofen, celecoxib. Examples of topical NSAIDs include diclofenac solution or diclofenac gel. A trial of two or more NSAIDs (oral and/or topical) counts as one pharmacologic therapy. **Removed** criterion "Documented contraindication or intolerance to ALL of the following modalities of therapy for osteoarthritis: 1. Provider-directed conservative management program consisting of physical therapy or home exercises 2. Pharmacologic therapies for knee osteoarthritis 3. Intraarticular corticosteroids." **Added** criterion requiring "The product is administered by or under the supervision of a physician specializing in rheumatology, orthopedic surgery, or physical medicine and rehabilitation (physiatrist)." **Reauthorization Criteria:** **Replaced** reauthorization criteria **with** "Patient Has Already Received One or More Courses of Therapy With a Hyaluronic Acid Derivative (Intraarticular) in the Same Knee." **Added** criterion "At least 6 months have elapsed since the last injection with any hyaluronic acid derivative in affected knee."

		Added criterion "According to the prescriber, the patient had a response to the previous course of hyaluronic acid derivative therapy for osteoarthritis of the affected knee and now requires additional therapy for osteoarthritis symptoms; AND Note: Examples of a response include reduced joint pain, tenderness, morning stiffness, or improved mobility." **Added** criterion "the product is administered by or under the supervision of a physician specializing in rheumatology, orthopedic surgery, or physical medicine and rehabilitation (physiatrist)." **Hymovis One**: This product was added to the policy. **Dosing: Added** Hymovis One to "Approve one injection" dosing criteria. **Preferred Product Tables:** **Added** documentation requirements **to** Euflexxa and Durolane. **Added** "Note: Examples of products that are given as more than one injection to complete a course include, GenVisc 850, Hyalgan, Hymovis, Orthovisc, Supartz FX, Sodium hyaluronate injection, SynoJoynt, Synvisc, Triluron, TriVisc, Visco-3" **to** "The request is for product that requires more than one injection to complete a course." **Added** "Note: If a course of therapy has already been started, the patient can continue with the same product to complete the entire course. After completing this course, if further therapy is required with an intraarticular hyaluronic acid derivative, then a Preferred Product must be tried" **to** "Patient has already started a course of injections with one of these agents." **Added** Hymovis One **to** Preferred Product Table with the same criteria as the other drug products. **Removed** the following note: "In these cases, the individual can continue with the same product to complete the entire course. After completing this course, if further therapy is required with a hyaluronic acid derivative, then a Preferred Product (Durolane, Euflexxa or Gelsyn-3) must be tried." **Conditions Not Covered** **Osteoarthritis and Other Pathologic Conditions Involving Joints Other than the Knee**

		Updated note **from** "(e.g., hand, hip, ankle, shoulder osteoarthritis, temporomandibular joint [TMJ], adhesive capsulitis of the shoulder, subacromial impingement)" **to** "Note: Examples of other pathologic conditions involving joints other than the knee include hand, hip, ankle, and shoulder osteoarthritis, temporomandibular joint [TMJ] disorder, adhesive capsulitis of the shoulder, subacromial impingement." **Pathologic Conditions of the Knee Other than Osteoarthritis** **Updated** note **from** "(e.g., chondromalacia patellae, osteochondritis dissecans, patellofemoral syndrome, post-anterior cruciate ligament [ACL] reconstruction)" **to** **"**Note: Examples of pathologic conditions of the knee other than osteoarthritis include chondromalacia patellae, osteochondritis dissecans, patellofemoral syndrome, post-anterior cruciate ligament [ACL] reconstruction." **Removed** non-covered criterion "The combination of any other product, (for example, platelet rich plasma (PRP), stem cell products, amniotic products, corticosteroids) with a viscosupplement injection."
Long-Acting Muscarinic Antagonist (LAMA)/Long-Acting Beta2-Agonist (LABA) Combination Inhalers – (IP0020)	Retired	**Effective 3/1/2026** Bevespi Aerosphere and Duaklir Pressair have been relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602)
Metabolic Disorders – Imcivree – (IP0104)		**Effective 3/15/2026** **No criteria changes.** **Updated** policy template.
Metabolic Disorders – Phenylbutyrate Products – (IP0169)	Updated	**Effective 3/1/2026** **Employer Group Plans:** **Updated** preferred product criteria for Olpruva and Ravicti.
Multiple Sclerosis (Injectable – CD20-Directed Cytolytic Antibody) – Ocrevus Zunovo – (IP0705)	Updated	**Effective 3/1/2026** The name of the policy was changed from Multiple Sclerosis – Ocrevus Zunovo to Multiple Sclerosis (Injectable – CD20-Directed Cytolytic Antibody) – Ocrevus Zunovo. **Removed** the documentation statement. **Added** a policy statement. **Multiple Sclerosis, Relapsing Forms. Initial therapy**

		Removed documentation from the diagnostic requirement. **Multiple Sclerosis, Relapsing Forms. Patient is Currently Receiving Ocrevus Zunovo for ≥ 1 Year** **Removed** documentation from the diagnostic requirement. **Updated** the conditions not covered statement. In the Appendix, it was noted that Mavenclad is available as a generic. Extavia was removed. And Tysabri and Tyruko are now cited in the Appendix as follows: Natalizumab Intravenous Products (Tysabri, biosimilar).
Multiple Sclerosis – (Oral – Other) – Mavenclad – (IP0261)	Updated	**Effective 3/1/2026** The name of the policy was changed from Multiple Sclerosis (Oral – Other) – Mavenclad to Multiple Sclerosis (Oral – Other) – Cladribine. The generic to Mavenclad was added to the policy with related changes made in criteria. ○ In the Appendix, it was noted that Mavenclad is available as a generic. Also, Tysabri and Tyruko are now cited in the Appendix as follows: Natalizumab Intravenous Products (Tysabri, biosimilar).
Muscular Dystrophy – Vyondys 53 – (IP0136)	Updated	**Effective 3/1/2026** **Added** "**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. All documentation must include patient-specific identifying information." **Duchenne Muscular Dystrophy:** **Updated from** "Documented diagnosis of Duchenne muscular dystrophy is confirmed by a pathogenic or likely pathogenic variant in the DMD gene that is amenable to exon 53 skipping" **to** "Diagnosis of Duchenne muscular dystrophy is confirmed by a pathogenic or likely pathogenic variant in the DMD gene that is amenable to exon 53 skipping **[documentation required]**"
Nasal Steroids and Nasal Steroid/Antihistamine Combinations – (IP0274)	Retired	**Effective 3/1/2026** • Baconase AQ and Nasonex has been discontinued, and the associated criteria will be retired.

		• Dymista has been relocated to Brands with Bioequivalent Generics (IP0011) All remaining products have been relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602)
Nephrology – Tarpeyo – (IP0413)	Updated	**Effective 3/1/2026** **Employer Plans and Individual and Family Plans Preferred Product Table:** **Updated from** "Failure, contraindication or intolerance to ONE systemic corticosteroid" **to** "Patient has tried and cannot take ONE systemic corticosteroid (other than Tarpeyo) for the diagnosis." ○ **Added** Note: Examples of systemic corticosteroids include methylprednisolone, prednisone.
Oncology (Injectable – CAR-T) – Breyanzi – (IP0130)	Updated	**Effective 3/1/2026** **B-Cell Lymphoma:** Added "Marginal zone lymphoma" as one of the conditions for approval after at least two lines of prior systemic therapy.
Oncology Medications – (CP1403)	Updated	**Effective 3/1/2026** **Alymsys, Avastin, Vegzelma** **Added** examples of formulation difference in the inactive ingredient(s) "[e.g., differences in stabilizing agent, buffering agent, and/or surfactant]" **Jobevne.** **Added** criteria for Jobevne **Effective 3/15/2026** **Abraxane intravenous infusion.** **Added** "Patient has tried paclitaxel intravenous infusion" for Breast Cancer, Cervical Cancer, Endometrial Cancer, Melanoma, Non-Small Cell Lung Cancer, and Ovarian Cancer. **Akeega.** **Added** "Patient has BRCA2-mutated metastatic castration-sensitive prostate cancer **Augtyro.** **Updated from** "If Augtyro has not been tried previously, approve if the patient has symptomatic systemic progression (multiple lesions) on Rozlytrek (entrectinib capsules and pellet packet), Xalkori (crizotinib capsules), Zykadia" **to** "If Augtyro has not been

		tried previously, approve if the patient has symptomatic systemic progression (multiple lesions) on Rozlytrek (entrectinib capsules and pellet packet), Xalkori (crizotinib capsules), or Ibtrozi (taletrectinib capsules)" **Paclitaxel albumin-bound intravenous infusion.** **Added** "Patient has tried paclitaxel intravenous infusion" for Breast Cancer, Cervical Cancer, Endometrial Cancer, Melanoma, Non-Small Cell Lung Cancer, and Ovarian Cancer. **Phyrago.** **Added** "Employer Group Plans" criteria **Added** "According to the prescriber, the patient requires co-administration with a histamine-2 (H2) antagonist or proton pump inhibitor (PPI). Note: Examples of H2 antagonists include famotidine, cimetidine, nizatidine. Examples of PPIs include omeprazole, esomeprazole, pantoprazole, rabeprazole" **Ziihera.** **Removed** criteria for Ziihera.
Ophthalmology – Dry Eye Disease – Eysuvis for Individual and Family Plans – (IP0720)	Updated	**Effective 3/1/2026** **Dry Eye Disease (Short-Term Treatment):** A Note that dry eye disease includes dry eye syndrome and keratoconjunctivitis sicca was added. **Individual and Family Plans Preferred Product Table:** **Removed** artificial tear substitute.
Ophthalmology – Dry Eye Disease – Lacrisert for Individual and Family Plans – (IP0721)	Updated	**Effective 3/1/2026** **Added** a policy statement. **Updated** the Conditions Not Covered statement.
Ophthalmic – Glaucoma – Prostaglandins PA – (IP0027)	Updated	**Effective 3/1/2026** **Individual and Family Plans:** **Updated** preferred product criteria to split Zioptan and generic tafluprost into separate line items. Zioptan remains with the same multisource brand step through generic, with a note that the generic product may require a prior authorization, and generic tafluprost now requires a step through either latanoprost or bimatoprost, a step through travoprost as an alternative for patients with a benzalkonium chloride [BAK] allergy, or patients with a known sensitivity to a preservative other than BAK (e.g., sofZia).

		Updated preferred product criteria for Lumigan and Vyzulta to clarify that the generic step through product tafluprost may require a prior authorization.
Ophthalmology – Vascular Endothelial Growth Factor Inhibitors – Susvimo – (IP0349)	Updated	**Effective 3/1/2026** **No criteria changes.**
Opioid Therapy for Employer Group Benefit Plans – (IP0561)	Updated	**Effective 3/1/2026** **Removed** Opium Tincture from Appendix 1
Opioid Therapy – Individual and Family Plans – (IP0562)	Updated	**Effective 3/1/2026** **Removed** Opium Tincture from Appendix 1
Pulmonary – Antifibrotics – Ofev – (IP0312)	Updated	**Effective 3/15/2026** **Policy Title.** The policy name was changed to as listed. Previously, it was Idiopathic Pulmonary Fibrosis and Related Lung Disease – Ofev PA policy. The condition of approval **Interstitial Lung Diseases, Chronic Fibrosing with a Progressive Phenotype** was changed to **Progressive Pulmonary Fibrosis**. A Note was added to clarify that these indications are used interchangeably. • **Progressive Pulmonary Fibrosis**. The specialist requirement was updated to include a rheumatologist. Previously, only a pulmonologist was listed.
Thrombocytopenia – Wayrilz – (IP0774)	New	**Effective 3/1/2026** • New Policy.
Papillomatosis – Gene Therapy Papzimeos – (IP0765)	Updated	**Effective 3/15/26** **Coding Information** **Added** HCPCS code: J3404 (Code effective 4/1/2026) **Updated** the description for C9399, J3490 & J3590 to include the note "Code effective until 3/31/2026"

Pharmacy and Medical Prior Authorization - (1407)	Updated	**Effective 3/15/2026** **Added Added Individual and Family Plan product-specific medical necessity criteria for the following products:** ○ Javadin, desloratadine 0.5 mg/mL oral solution, carbidopa and levodopa extended-release capsules (authorized generic to Rytary), Subvenite oral suspension, Lasix Onyu, Inveltys, Lotemax SM, Lotemax (gel, ointment, and suspension), loteprednol etabonate ophthalmic gel, 0.5% (authorized generic of Lotemax 0.5% ophthalmic gel), and loteprednol etabonate ophthalmic suspension, 0.5% (authorized generic of Lotemax 0.5% ophthalmic suspension)
Quantity Limitations – (1201)	Updated	**Effective 3/1/2026** **Removed** Cimzia and relocated to a new policy, *Inflammatory Conditions – Cimzia Drug Quantity Management Policy – Per Days – (DQM018).* ○ **Removed** Rinvoq/Rinvoq LQ and relocated to new policy, *Inflammatory Conditions – Rinvoq Drug Quantity Management Policy – Per Days – (DQM021)*
Scenesse – (IP0159)	Updated	**Effective 3/1/2026** **Erythropoietic Protoporphyria (Including X-Linked Protoporphyria).** **Removed** "of erythropoietic protoporphyria (including X-linked protoporphyria)" **from** diagnosis criteria." **Removed** "medical geneticist" **from** list of prescribers. **Conditions Not Covered** **Updated** statement **from** "Any other use is considered experimental, investigational, or unproven (criteria will be updated as new published data are available)" **to** "Scenesse for any other use is considered not medically necessary. Criteria will be updated as new published data are available."
Spinal Muscular Atrophy – Evrysdi – (IP0063)	Updated	**Effective 3/15/2026** **Spinal Muscular Atrophy – Treatment**: For initial therapy, Itvisma was added as a gene therapy that the patient should not have received in the past. The Note now includes that if no claim for Itvisma is present (or if claims history is not available), the prescribing physician confirms that the patient has not previously received Itvisma.

		The note providing examples of pathogenic variants was updated from homozygous mutation to heterozygous mutation. For Patients Currently Receiving Evrysdi, Approval duration was updated to 1 year, previously it was four months.
Spinal Muscular Atrophy – Spinraza – (IP0182)	Updated	**Effective 3/15/2026** **Spinal Muscular Atrophy – Treatment:** For initial therapy, Itvisma was added as a gene therapy that the patient should not have received in the past. The Note now includes that if no claim for Itvisma is present (or if claims history is not available), the prescribing physician confirms that the patient has not previously received Itvisma. Missed maintenance doses for at least 8 months but less than 16 months was corrected to say, followed by one additional dose 14 days later, previously it stated two doses. For Patients Currently Receiving Spinraza Therapy, Approval duration was updated to 1 year, previously it was one dose to be used once within the next 4 months as maintenance therapy. **Coding Information** Removed CPT code 96450
Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) – (1803)	Updated	**Effective 3/1/2026** **Updated** the Auvelity requirement. **Removed** Prozac Weekly and Sarafem.
Step Therapy – Standard and Performance Prescription Drug Lists (Employer Group Plans) – (1801)	Updated	**Effective 3/1/2026** **Updated** the Auvelity requirement. **Removed** Prozac Weekly and Sarafem.
Step Therapy – Value and Advantage Prescription Drug Lists (Employer Group Plans) – (1802)	Updated	**Effective 3/1/2026** **Removed** the Antidepressants section.
Topical Alpha Adrenergic Agonists for Rosacea – Brimonidine – (IP0284)	Updated	**Effective 3/15/2026** **Updated** coverage policy title from "Topical Alpha Adrenergic Agonists" to "Topical Alpha Adrenergic Agonists for Rosacea - Brimonidine." **Removed** Rhofade from policy.

Topical Alpha Adrenergic Agonists for Rosacea – Rhofade – (IP0785)	New	**Effective 3/15/2026** New policy.
Topical Antifungals – (IP0273)	Retired	**Effective 3/1/2026** **For Employer Plans** • Kerydin and Loprox shampoo have been discontinued, and the associated criteria will be retired. • Extina and Loprox cream have been relocated to Brands with Bioequivalent Generics (IP0011). • All remaining products have been relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602) **For Individual and Family Plans** Jublia has been relocated to Pharmacy Prior Authorization (1407)
Uplizna - (IP0062)	Updated	**Effective 3/15/2026** **Generalized Myasthenia Gravis:** This new condition of approval was added to the policy. **Conditions Not Recommended for Approval:** The condition "Concomitant Use with a Rituximab Product, Enspryng (satralizumab-mwge subcutaneous injection), Eculizumab Intravenous Infusion (Soliris, biosimilars), or Ultomiris (ravulizumab-cwvz intravenous infusion" was revised to: "Concomitant Use with a Rituximab Product, a Complement Inhibitor, a Neonatal Fc Receptor Blocker, and Enspryng (satralizumab-mwge subcutaneous injection)". A Note of examples of complement inhibitors and a note of neonatal Fc receptor blockers were added.
Weight Loss –Appetite Suppressants and Orlistat – (IP0420)	Updated	**Effective 3/1/2026** Conditions Not Covered: **Concomitant Use with Other Medications FDA-Approved for Weight Loss.** This condition not recommended for approval was removed.
Weight Loss Medications - Glucagon-Like Peptide-1 Agonists Benefit	Updated	**Effective 3/1/2026** Wegovy tablet was added to the policy; new criteria were created.

Exclusion Override Policy BMI ≥ 35 – (INT030)		
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 30 – (IP0206)	Updated	**Effective 3/1/2026** Wegovy tablet was added to the policy; new criteria were created. Wegovy injection **Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease who is Either Obese or Overweight.** Patient is Currently Receiving Wegovy injection. The note that baseline body mass index refers to baseline prior to Wegovy injection was updated to also include Wegovy tablet.
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 32 – (IP0621)	Updated	**Effective 3/1/2026** Wegovy tablet was added to the policy; new criteria were created. Wegovy injection **Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease who is Either Obese or Overweight.** Patient is Currently Receiving Wegovy injection. The note that baseline body mass index refers to baseline prior to Wegovy injection was updated to also include Wegovy tablet.
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 35 – (IP0739)	Updated	**Effective 3/1/2026** Wegovy tablet was added to the policy; new criteria were created. Wegovy injection **Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease who is Either Obese or Overweight.** Patient is Currently Receiving Wegovy injection. The note that baseline body mass index refers to baseline prior to Wegovy injection was updated to also include Wegovy tablet.
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
Precertification Policies	Updates	• No updates in March 2026

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