Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective May 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
Cervical Plexus Block – (0579)	Updated	Minor change(s) in coverage criteria/policy: • Revised policy statement to remove redundant 6th bullet point regarding ORIF of the clavicle
Circumcision – (0582)	Updated	Important change in coverage criteria/policy: • Expand coverage by adding HSV-2 and HPV as additional criteria for coverage when circumcision is requested for the purposes of preventing infection. • Revise wording of phimosis bullet for clarity.
COVID-19: In Vitro Diagnostic Testing - (0557)	Updated	Important change in coverage criteria/policy:

		• Expand coverage of serology testing to include immunocompromised individuals with known or clinically suspected COVID-19 infection when results will be used to inform therapy.
Gait Analysis – (0315)	Updated	Important change in coverage criteria/policy: • Revised policy statement for medically necessary gait analysis to include coverage of individuals with a diagnosis of myelomeningocele as part of preoperative assessment.

Hearing Aids - (0093)	Updated	Minor change(s) in coverage criteria/policy:
		• Removed policy statements for:
		  ○ air conduction hearing aids
		  ○ initial and replacement batteries

Hyperbaric and Topical Oxygen Therapies – (0053)	Updated	Minor change(s) in coverage criteria/policy: • Revised not medically necessary clinical policy statement for the condition Crohn's disease to inflammatory bowel disease (i.e. Crohn's disease, ulcerative colitis)

Molecular and Proteomic Diagnostic Testing for Hematology and Oncology Indications – (0520)	Updated	Minor change(s) in coverage criteria/policy:
		• Revised Not Covered or Reimbursable section to remove two tests:
		  ○ EXaCT–1 whole exome testing (CPT code 0036U)
		  ○ Solid Tumor Expanded Panel (CPT code 0379U)

Nucleic Acid Pathogen Testing - (0530)	Updated	**Posted 05/15/2026, Effective 08/15/2026** Important change(s) in coverage criteria/policy: • Add CPT code 87632 (Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus, 6-11 targets) to coding section of policy to accommodate addition of code to processing edits, effective 8/15/2026. This code changed from not covered to not managed in 2025. Due to limiting coverage of a previously unmanaged code, this policy requires advance posting.
Partial Rhinectomy, Rhinoplasty, Vestibular	Updated	Important change(s) in coverage criteria/policy:

Stenosis Repair and Septoplasty – (0119)		• Removed conservative management criteria from the rhinoplasty and vestibular stenosis and septoplasty sections of the policy because medical management that reduces mucosal inflammation is ineffective when obstruction is due to a fixed structural deformity. • Removed "ARC" from the "VivAer ARC Stylus" verbiage because FDA clearance and marketing no longer mention "ARC". • Revised the first bullet point in the septoplasty section of the policy for improved clarity.
Peripheral Nerve Destruction for Pain Conditions - 0525	Updated	**Posted 02/15/2026, Effective 05/15/2026** Important change(s) in coverage criteria/policy: • Removed policy statement for peripheral nerve destruction for trigeminal neuralgia • Revised policy statement for percutaneous cryoablation • Added policy statement for pulsed radiofrequency ablation • Revised list of not covered or reimbursable conditions
Plantar Fasciitis Treatments – (0097)	Updated	**Posted 02/15/2026, Effective 05/15/2026** Important change(s) in coverage criteria/policy: • Revision of policy statement for not medically necessary treatments for plantar fasciitis to remove pulsed radiofrequency electromagnetic field (PREF) therapy • Revision of policy statement for experimental, investigational or unproven treatments for plantar fasciitis to add coblation® (e.g., Topaz™) to the list of EIU procedures
Plasma Brain Natriuretic Peptide in the Outpatient Setting – (0028)	Updated	Important change in coverage criteria/policy: • Added a new criteria for risk stratification or monitoring of pulmonary hypertension. • Added criteria for the use of BNP testing in the initial workup of CRS related to the use of T-cell engaging bispecific agents.
Seat Lift Mechanisms, Patient Lifts and Standing Devices – (0343)	Updated	**Effective 6/14/2026** Minor change(s) in coverage criteria/policy:

		• Removed policy statements for patient lifts and multi-positional transfer systems. • Revised policy statements for combination transfer and mobility devices, replacement equipment, and not covered items. • Added policy statement for wheelchair power standing feature/standing wheelchair.
Treatment of Cutaneous and Vascular Lesions (0313)	Updated	Important change(s) in coverage criteria/policy: • Revised title to reflect policy focus and intent: Treatment of Cutaneous and Vascular Lesions • Revised policy statements to update terminology from port wine stain to capillary malformation. • Revised policy statements to remove references to non-cutaneous or superficial vascular lesions. • Revised policy statement for laser destruction of cutaneous vascular lesions for any other indications to improve clarity. • Removed policy statement for inpatient hospitalization of an infant for administration of oral propranolol for the treatment of cutaneous and/or deep tissue hemangioma
Autism Spectrum Disorders/Pervasive Developmental Disorders: Assessment and Treatment – (0447)	Updated	• No change in coverage.
Bone Growth Stimulators: Electrical (Invasive), Ultrasound - (0084)	Updated	• No change in coverage.
Cardiac Rehabilitation (Phase II Outpatient) - (0073)	Updated	• No change in coverage.
Cell-Based Therapy for Cardiac and Peripheral Arterial Disease – (0287)	Updated	• No change in coverage.
Donor Lymphocyte Infusion and Hematopoietic Progenitor Cell HPC Boost - (0261)	Updated	• No change in coverage.

External Counterpulsation - (0058)	Updated	• No change in coverage.
Genetic Testing for Reproductive Carrier Screening and Prenatal Diagnosis - (0514)	Updated	• No change in coverage.
Intensive Behavioral Interventions – (EN0499)	Updated	• No change in coverage.
Laboratory Testing Services - (0604)	Updated	• No change in coverage.
Negative Pressure Wound Therapy/Vacuum Assisted Closure (VAC) for Nonhealing Wounds - (0064)	Updated	• No change in coverage.
Neuropsychological Testing - (EN0258)	Updated	• No change in coverage.
Pharmacogenetic Testing - (0500)	Updated	**Effective 5/16/2026** • No change in coverage.
Remote Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) - (0563)	Updated	• No change in coverage
Wheelchairs/Power Operated Vehicles - (0030)	Retired	**Effective 6/14/2026** • Items will be managed via other medical, administrative, and reimbursement policies.
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
Complex Lymphedema Therapy (Complete	Updated	• No change in coverage.

Decongestive Therapy) - (CPG157)		
Strapping and Taping - (CPG143)	Updated	• No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-EviCore Gastrointestinal Endoscopic Procedure Guidelines	Updated	**Effective 5/1/2026** Important **changes** in coverage criteria. One guideline was updated with clinical changes which will expand and limit coverage: • Esophagogastroduodenoscopy (EGD)
Cobranded Cigna-EviCore Guidelines – Supplemental Information	Updated	**Effective 5/1/2026** One guideline was updated with no clinically impactful changes: Management of Unlisted Codes
Administrative Policy	**New, Updated, or Retired?**	**Comments**
		• No updates for May 2026
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Antiseizure Medications – Diacomit (IP0409)	Updated	**Effective 5/1/2026** **Treatment-Refractory Seizures/Epilepsy (Specific Rare Conditions):** The specific rare conditions which fall under this approval condition were moved to a Note. Additionally, under examples of other antiseizure medications, Banzel was

		updated to rufinamide and Fycompa was updated to perampanel to reflect generic availability of these products.
Antiseizure Medications – Epidiolex (IP0410)	Updated	**Effective 5/1/2026** **Dravet Syndrome:** Updated from "Patient has failure, contraindication or intolerance, or is concomitantly receiving at least two other antiseizure medications" to "Patient has tried or is concomitantly receiving at least two other antiseizure medications" Updated from "Patient has failure, contraindication or intolerance or is concomitantly receiving one of Fintepla, Diacomit, or clobazam" to "Patient has tried or is concomitantly receiving one of Fintepla (fenfluramine oral solution), Diacomit (stiripentol capsules, powder for oral suspension), or clobazam". **Lennox-Gastaut Syndrome:** Updated from "Patient has failure, contraindication or intolerance, or is concomitantly receiving at least two other antiseizure medications" to "Patient has tried or is concomitantly receiving at least two other antiseizure medications" Under examples of other antiseizure medications, Banzel was updated to rufinamide and Fycompa was updated to perampanel to reflect generic availability of these products. **Tuberous Sclerosis Complex:** Updated from "Patient has failure, contraindication or intolerance, or is concomitantly receiving at least two other antiseizure medications" to "Patient has tried or is concomitantly receiving at least two other antiseizure medications" Under examples of other antiseizure medications, Banzel was updated to rufinamide and Fycompa was updated to perampanel to reflect generic availability of these products. **Treatment-Refractory Seizures/Epilepsy (Specific Rare Conditions**): The specific rare conditions which fall under this approval condition were moved to a Note. Updated from "Patient has failure, contraindication or intolerance, or is concomitantly receiving at least two other antiseizure medications" to "Patient has tried or is concomitantly receiving at least two other antiseizure medications" Additionally, under examples of other antiseizure medications, Banzel was updated to rufinamide and Fycompa was updated to perampanel to reflect generic availability of these products.
Antiseizure Medications – Fintepla (IP0042)	Updated	**Effective 5/1/2026**

		Dravet Syndrome: In the list of other antiseizure medications tried, the generic names for Epidiolex (cannabidiol oral solution) and Diacomit (stiripentol capsules, powder for oral suspension) were added for clarity. **Lennox-Gastaut Syndrome:** Under examples of other antiseizure medications, Fycompa was updated to perampanel to reflect generic availability. The generic name for Epidiolex (cannabidiol oral solution) was added for clarity
Antiseizure Medications – Nayzilam (IP0338)	Updated	**Effective 5/1/2026** No criteria changes.
Antiseizure Medications – Rufinamide (IP0048)	Updated	**Effective 5/1/2026** **Lennox-Gastaut Syndrome:** In initial therapy criteria, where previously stated "patient has tried and/or is concomitantly receiving at least two other antiseizure medications", the "and/or" was updated to "or" (the "and" is redundant). Additionally, under examples of other antiseizure medications, Fycompa was updated to perampanel to reflect generic availability. **Treatment-Refractory Seizures/Epilepsy:** In initial therapy criteria, where previously stated "patient has tried and/or is concomitantly receiving at least two other antiseizure medications", the "and/or" was updated to "or" (the "and" is redundant). Additionally, under examples of other antiseizure medications, Fycompa was updated to perampanel to reflect generic availability.
Antiseizure Medications – Valtoco (IP0105)	Updated	**Effective 5/1/2026** **Policy Statement:** The Policy Statement was updated to include "because of the specialized skills required for evaluation and diagnosis of patients treated with Valtoco as well as the monitoring required for adverse events and efficacy, approval requires Valtoco to be prescribed by or in consultation with a physician who specializes in the condition being treated." There were no changes to the criteria.
Antiseizure Medications – Xcopri Drug Quantity Management Policy – Per Days for Employer Plans - (DQM025)	New	**Effective 5/1/2026** • New policy.
Antiseizure Medications – Vigabatrin Drug Quantity	New	**Effective 5/1/2026**

Management Policy – Per Days for Individual and Family Plans - (DQM023)		• New policy.
Attention Deficit Hyperactivity Disorder (ADHD) Stimulants for Employer Group Plans (IP0477)	Updated	**Effective 5/15/2026** **Added** a policy statement. **Removed** the documentation statement and documentation requirements. **Removed** Adhansia XR from the policy. **Updated** the preferred product requirements for Adderall, Adderall XR, Adzenys XR-ODT, amphetamine extended-release orally disintegrating tablets (generic for Adzenys XR-ODT), Aptensio XR, Azstarys, Concerta, Cotempla XR ODT, Desoxyn, Dexedrine, Dyanavel XR, Evekeo, Evekeo ODT, Focalin, Focalin XR, Jornay PM, metadate CD, Methylin, methylphenidate extended-release 45mg, 63mg, 72 mg tablets, Mydayis, Quillichew ER, Quillivant XR, Relexxii, Ritalin, Ritalin LA, Xelstrym and Zenzedi. **Conditions Not Covered:** Under Long-Term Combination Therapy (i.e., > 2 months) with atomoxetine capsules (Strattera, generic), the phrase "and Central Nervous System (CNS) Stimulants for the treatment of Attention Deficit/Hyperactivity Disorder (e.g., mixed amphetamine salts extended-release capsules [Adderall XR®, generics], methylphenidate extended-release tablets, methylphenidate immediate-release tablets)" was removed for clarity.
Attention Deficit Hyperactivity Disorder (ADHD) Stimulants for Individual and Family Plans (IP0584)	Updated	**Effective 5/15/2026** **Added** a policy statement. **Added** Adderall, Adderall XR, Aptensio XR, Azstarys, Concerta, Cotempla XR ODT, Desoxyn, Dexedrine, Dyanavel XR, Evekeo, Evekeo ODT, Focalin, Focalin XR, Jornay PM, Methylin, methylphenidate extended-release 45mg, 63mg, 72 mg tablets, Quillichew ER, Quillivant XR, Ritalin, Ritalin LA, and Xelstrym to the policy. **Updated** the preferred product requirements for Adzenys XR-ODT, amphetamine extended-release orally disintegrating tablets (generic for Adzenys XR-ODT), dextroamphetamine sulfate tablets, Metadate CD, Mydayis, Relexxii, Vyvanse capsules and chewable tablets, and Zenzedi.

		Conditions Not Covered: Under Long-Term Combination Therapy (i.e., > 2 months) with atomoxetine capsules (Strattera, generic), the phrase "and Central Nervous System (CNS) Stimulants for the treatment of Attention Deficit/Hyperactivity Disorder (e.g., mixed amphetamine salts extended-release capsules [Adderall XR®, generics], methylphenidate extended-release tablets, methylphenidate immediate-release tablets)" was removed for clarity.
Barth Syndrome – Forzinity for Individual and Family Plans - (IP0786)	Updated	**Effective 5/15/2026** Policy title updated from "Barth Syndrome – Forzinity for Individual and Family Plans" to "Barth Syndrome – Forzinity"
Botulinum Toxins – Botox (IP0637)	Updated	**Effective 5/15/2026** **Updated policy template.** **Chronic Migraine Headache Prevention:** The qualifier "chronic" was added to the condition of approval. The qualifier "migraine" was removed from "Patient has ≥ 15 headache days per month with a headache lasting 4 hours per day or longer." Also, the requirement "prior to initiation of Botox therapy" was clarified to "prior to initiating a migraine-preventative medication." **Essential Tremor:** The dosing limitation was decreased from 400 units to 100 units. **Hemifacial Spasm:** The dosing limitation was decreased from 400 units to 100 units. **Hyperhidrosis, Gustatory:** The dosing limitation was decreased from 400 to 100 units. **Hyperhidrosis, Primary Craniofacial:** The qualifier "facial" was replaced with "craniofacial.". The dosing limitation was decreased from 400 to 100 units.
Brands with Bioequivalent Generics (IP0011)	Updated	**Effective 5/15/2026:** **Removed for Employer Plans:** Lopressor
California: Weight Loss Medications - Glucagon-Like Peptide-1 Agonists Benefit Exclusion Override Policy BMI ≥ 40 (INT028)	Updated	**Effective 5/1/2026** Wegovy injection **Weight Loss in an Adult with Obesity or is Overweight.** Wegovy tablet was added to the following: Patient is Currently Receiving Wegovy injection or Wegovy tablet. The following note was updated to include Wegovy injection and Wegovy tablet: For a patient who has not completed 7 months of initial therapy with Wegovy injection and/or Wegovy tablet, refer to Initial Therapy criteria above. **Weight Loss in a Pediatric Patient with Obesity.** Wegovy tablet was added to the following: Patient is Currently Receiving Wegovy injection or Wegovy tablet. The

		following note was updated to include Wegovy injection and Wegovy tablet: For a patient who has not completed 7 months of initial therapy with Wegovy injection and/or Wegovy tablet, refer to Initial Therapy criteria above. Wegovy tablet **Weight Loss in an Adult with Overweight or Obesity.** Initial Therapy. The approval duration was changed to 7 months (previously 6 months). Wegovy injection was added to Patient is Currently Receiving Wegovy tablet or Wegovy injection. The following note was updated to include Wegovy injection and Wegovy tablet, and to reflect the 7-month initial approval duration: For a patient who has not completed 7 months of initial therapy with Wegovy injection and/or Wegovy tablet, refer to Initial Therapy criteria above.
Cardiology – Myqorzo for Individual and Family Plans - (IP0791)	New	**Effective 5/1/2026** New policy.
Chenodiol Products (IP0203)	Updated	**Effective 5/15/2026** **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. 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."
Complement Inhibitors – Zilbrysq (IP0622)	Updated	**Effective 5/1/2026** **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." **Conditions Not Covered** The condition "Concomitant Use with Another Complement Inhibitor, a Neonatal Fc Receptor Blocker, or a Rituximab Product" was revised to "Concomitant Use

		with Another Complement Inhibitor, a Neonatal Fc Receptor Blocker, a Rituximab Product, or Uplizna® (inebilizumab-cdon intravenous infusion)."
Cushing's – Isturisa (IP0044)	Updated	**Effective 5/1/2026** No criteria changes
Cushing's – Recorlev (IP0389)	Updated	**Effective 5/1/2026** No criteria changes
Cushing's – Signifor (IP0482)	Updated	**Effective 5/1/2026** No criteria changes
Desmopressin Nasal Spray (IP0132)	Updated	**Effective 5/15/2026** ○ No criteria changes.
Diabetes – Diabetic Supplies (IP0272)	Updated	**Effective 5/1/2026** No criteria changes. Individual and Family Plans: Added (keywords updated) Easy Comfort Lancets and Safety Lancets to policy.
Diabetes – Tzield (IP0537)	Updated	**Effective 5/1/2026** **Type 1 Diabetes (Clinical/Stage 3), Delay of Onset:** **Removed** "Patient has at least one biological relative with a diagnosis of type 1 diabetes; AND Note: Examples of relatives include first-degree relatives (e.g., parent, sibling) or other relatives (e.g., grandparent, aunt, uncle, cousin)."
Dichlorphenamide (IP0204)	Updated	**Effective 5/15/2026** **Primary Hypokalemic Periodic Paralysis (HypoPP), Primary Hyperkalemic Periodic Paralysis (HyperPP), and Related Variants** were divided into separate indications for coverage: **Hypokalemic Periodic Paralysis (HypoPP) and Related Variants and Hyperkalemic Periodic Paralysis (HyperPP) and Related Variants.** **Hypokalemic Periodic Paralysis (HypoPP) and Related Variants:** **Updated** approval duration **from** 3 months **to** 2 months.

		Added "Patient has a confirmed diagnosis of primary hypokalemic periodic paralysis by meeting at least ONE of the following: Patient has had a serum potassium concentration of less than 3.5 mEq/L during a paralytic attack, Patient has a family history of the condition, or Patient has a genetically confirmed skeletal muscle calcium or sodium channel mutation" **Added** "The prescriber has excluded other reasons for acquired hypokalemia" **Added** "Note: Examples of other reasons for acquired hypokalemia include renal, adrenal, or thyroid dysfunction; renal tubular acidosis; and diuretic or laxative abuse." **Added** "Patient has had improvements in paralysis attack symptoms with potassium intake" **Updated from** "Documented failure, contraindication, or intolerance to acetazolamide capsules or tablets" **to** "Patient has tried oral acetazolamide therapy" **Added** "The medication is prescribed by or in consultation with a neurologist or a physician who specializes in the care of patients with primary periodic paralysis (e.g., muscle disease specialist, physiatrist)" Patient is Currently Receiving Dichlorphenamide: **Added** "the patient has responded to dichlorphenamide (e.g., decrease in the frequency or severity of paralytic attacks) as determined by the prescriber" **Hyperkalemic Periodic Paralysis (HyperPP) and Related Variants:** **Updated** approval duration **from** 3 months **to** 2 months. **Added** Patient has a confirmed diagnosis of primary hyperkalemic periodic paralysis by meeting at least ONE of the following criteria: Patient has had an increase from baseline in serum potassium concentration of greater than or equal to 1.5 mEq/L during a paralytic attack, Patient has had a serum potassium concentration during a paralytic attack of greater than 5.0 mEq/L, Patient has a family history of the condition or, Patient has a genetically confirmed skeletal muscle sodium channel mutation" **Added** "The prescriber has excluded other reasons for acquired hyperkalemia" **Added** "Note: Examples of other reasons for acquired hyperkalemia include drug abuse, renal dysfunction, and adrenal dysfunction." **Updated from** "Documented failure, contraindication, or intolerance to acetazolamide capsules or tablets" **to** "Patient has tried oral acetazolamide therapy" **Added** "The medication is prescribed by or in consultation with a neurologist or a physician who specializes in the care of patients with primary periodic paralysis (e.g., muscle disease specialist, physiatrist)" Patient is Currently Receiving Dichlorphenamide: **Added** "the patient has responded to dichlorphenamide (e.g., decrease in the frequency or severity of paralytic attacks) as determined by the prescriber"

		Employer Plans Preferred Product Table: **Removed** [may require prior authorization] from Keveyis criteria.
Drugs Requiring Medical Necessity Review for Employer Plans (1602)	Updated	**Effective 5/15/2026** **Added preferred product requirement criteria for the following products (EFFECTIVE 5/15/2026):** metoprolol tartrate 12.5 mg tablets (brand), Ontralfy, tizanidine capsules, Zybic, Orudis, and Lopressor tablets (12.5 mg, 50 mg and 100 mg) **Added preferred product requirement criteria for the following products (EFFECTIVE 6/1/2026):** Ibsrela, Zelnorm, Azasan, azathioprine 75 mg and 100 mg tablets, albuterol sulfate inhalation powder (Prasco manufacturer), levalbuterol HFA inhalation aerosol, ProAir Respiclick, Ventolin HFA and Xopenex HFA **Updated preferred product requirement criteria for the following products (EFFECTIVE 6/1/2026):** Consensi, Vowst, niacin 500 mg tablets, Niacor, Asacol HD, Colazal, Delzicol, Dipentum, Pentasa 250 mg capsule, Zerviate, Ciloxan ointment, Betimol 0.25% and 0.5% ophthalmic solution, Timoptic 0.25% Ocudose, oxybutynin chloride 2.5mg tablet (brand), Drizalma Sprinkle, venlafaxine ER 112.5mg tablets (formerly Venbysi XR), and Condylox 0.5% topical gel **Removed preferred product requirement criteria for the following products (EFFECTIVE 6/1/2026):** Symjepi, Alocril, and Alomide
Enspryng (IP0078)	Updated	**Effective 5/1/2026** ○
Enzyme Replacement Therapy – Aldurazyme (IP0445)	Updated	**Effective 5/15/2026** No criteria changes
Enzyme Replacement Therapy – Fabrazyme (IP0406)	Updated	**Effective 5/15/2026** No criteria changes
Enzyme Replacement Therapy – Kanuma (IP0443)	Updated	**Effective 5/15/2026** No criteria changes
Enzyme Replacement Therapy – Lamzede (IP0563)	Updated	**Effective 5/15/2026**

		• **Alpha-mannosidosis.** Added documentation to the diagnostic and genetic testing requirements.
Enzyme Replacement Therapy – Loargys - (IP0798)	New	**Effective 5/1/2026** New Policy.
Enzyme Replacement Therapy – Mepsevii (IP0449)	Updated	**Effective 5/15/2026** No criteria changes
Gastroenterology – Eohilia (IP0630)	Updated	**Effective 5/15/2026** **No criteria changes.**
Gaucher Disease – Enzyme Replacement Therapy – Cerdelga (IP0441)	Update	**Effective 5/1/2026** **Policy Title:** **Updated** from "Eliglustat" to "Gaucher Disease – Substrate Reduction Therapy – Cerdelga". **Gaucher Disease Type 1:** **Clarified** medical necessity criteria for eliglustat (Cerdelga) in Gaucher disease type 1. **Added** an explicit **approval duration of 1 year** when all criteria are met. **Updated** diagnostic criteria to clarify that Gaucher disease must be established by **one qualifying method** (enzyme activity testing *or* molecular genetic testing), with documentation requirements specified. **Updated** CYP2D6 metabolizer requirements by simplifying and clarifying eligibility language and removing redundant subtype listings. Editorial updates made to improve clarity, consistency, and alignment with current prescribing and documentation standards; no change to overall intent of coverage.
Gaucher Disease – Enyzme Replacement Therapy – Cerezyme (IP0162)	Updated	**Effective 5/1/2026** **Gaucher Disease – Type 1 or Type 3:** Gaucher Disease Type 3 was added to this indication (previously, approved as Other Uses with Supportive Evidence). For Gaucher Disease – Type 1, a criterion was added to require the medication is not being used for the management of neurological manifestations; the requirement

		remains in place for Gaucher Disease Type 3. For 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 three times per week; previously, not to exceed 120 U/kg administered intravenously no more frequently than once every 2 weeks. For both Gaucher Disease – Type 1 and Type 3, the requirement that the patient is ≥ 2 years of age was removed. There is no longer an age criterion. **Gaucher Disease – Type 3:** This Other Use with Supportive Evidence was added to the FDA-approved indication. Refer to *Gaucher Disease – Type 1 or Type 3.*
Gaucher Disease – Enyzme Replacement Therapy – Cerezyme (IP0162)	Updated	**Effective 5/15/2026** No criteria changes.
Gaucher Disease – Enzyme Replacement Therapy – Elelyso (IP0163)	Update	**Effective 5/1/2026** **Gaucher Disease – Type 1 and – Type 3:** Updated diagnostic criteria with documentation requirements specified.
Gaucher Disease – Miglustat (IP0446)	Update	**Effective 5/1/2026** **Gaucher Disease – Type 1:** • Updated diagnostic criteria with documentation requirements specified.
Gaucher Disease – Enzyme Replacement Therapy – Vpriv (IP0164)	Update	**Effective 5/1/2026** **Gaucher Disease – Type 1 and – Type 3:** • **Updated** diagnostic criteria with documentation requirements specified.
Gonadotropin-Releasing Hormone Agonists – Lupron Depot (IP0109)	Updated	**Effective 5/15/2026** **Uterine Cancer.** Coverage of strengths 3.75 mg and 11.25 mg were added for this diagnosis.
Hematology – Pyrukynd (IP0451)	Updated	**Effective 5/1/2026** **Added documentation policy statement.**

		Added [documentation required] to "Presence of at least two variant/mutant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene" and "At least one of the variant/mutant alleles was a missense variant for initial therapy and patients currently receiving therapy." • **Conditions Not Covered:** The condition of Alpha-Thalassemia or Beta-Thalassemia was added. Also, an exclusion was added regarding a patient who is currently receiving Aqvesme.
Hemophilia – Altuviiio (IP0564)	Updated	**Effective 5/1/2026** **Updated from** "0.6" **to** "1.0" Bethesda units/mL in the following criteria: Patient does not have a positive test for Factor VIII inhibitors ≥ 1.0 Bethesda units/mL; under Patient is Currently Receiving Altuviiio or Has Received Altuviiio in the Past
Hemophilia – Factor IX Products (IP0623)	Updated	**Effective 5/1/2026** No criteria changes.
Hemophilia – Factor VIII Products (IP0618)	Updated	**Effective 5/1/2026** ○ No criteria changes.
Hemophilia – Gene Therapy – Hemgenix (IP0535)	Updated	**Effective 5/1/2026** No criteria changes.
Hepatitis C – Epclusa Prior Authorization Policy – (IP0184)	Updated	**Effective 5/1/2026** No criteria changes.
Hepatitis C – Mavyret Prior Authorization for Preferred Specialty Management Policy – (IP0737)	Updated	**Effective 5/1/2026** No criteria changes.
Hepatitis C Virus Direct-Acting Antivirals Preferred Specialty Management Policy for Employer Plans -(PSM025)	Updated	**Effective 5/1/2026** • No criteria changes.

Hepatitis C Virus Direct-Acting Antivirals Preferred Specialty Management Policy for Individual and Family Plans - (PSM026)	Updated	**Effective 5/1/2026** No criteria changes.
Hepatitis C – Zepatier Prior Authorization Policy - (IP0158)	Updated	**Effective 5/1/2026** No criteria changes.
Hepatology – Metabolic Dysfunction-Associated Steatohepatitis – Wegovy Benefit Exclusion Overrides Policy for Individual and Family Plans (IP0781)	Updated	**Effective 5/1/2026** **Policy Statement:** Reference to Wegovy was clarified to apply to Wegovy injection. A note was added that Wegovy tablet is not targeted in this policy. **Documentation Statement:** Reference to Wegovy was clarified to apply to Wegovy injection. Wegovy injection: **Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH).** Initial Therapy. Reference to Wegovy was updated to specify Wegovy injection throughout. Wegovy tablet 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 tablet was added to the following: Patient is Currently Receiving Wegovy injection or Wegovy tablet. The following note was updated to include Wegovy injection and Wegovy tablet: For a patient who has received < 1 year of therapy with Wegovy injection and/or Wegovy tablet, or who is restating therapy, refer to Initial Therapy. For the following requirement (and the associated note), reference to Wegovy was updated to specify Wegovy injection and to add Wegovy tablet: Patient has completed ≥ 1 year of therapy with Wegovy injection and/or Wegovy tablet AND according to the prescriber, the patient has not had worsening of fibrosis or MASH/NASH.
Hyperlipidemia – Omega-3 Fatty Acid Products - (IP0051)	Updated	**Effective 5/1/2026** • No criteria changes.

Human Immunodeficiency Virus – Cabenuva - (IP0123)	Updated	**Effective 5/1/2026** No criteria changes.
Human Immunodeficiency Virus – Trogarzo - (IP0171)	Updated	**Effective 5/15/2026** • No criteria changes.
Hyperlipidemia – PCSK9 Inhibitors – Leqvio – (IP0380)	Updated	**Effective 5/15/2026** The policy name was changed to as listed. Previously, it was Proprotein Convertase Subtilisin Kexin Type 9 Related Products – Leqvio. **Heterzygous Familial Hypercholesterolemia:** The age of approval was changed to ≥ 12 years of age; previously, it was ≥ 18 years of age. The diagnostic requirement was updated to include a requirement that if the patient is between 12 and 17 years of age, they have to meet both of the following: have an untreated low-density lipoprotein cholesterol (LDL-C) ≥ 160 mg/dL (prior to treatment with antihyperlipidemic agents) and according to the prescriber, have a family history of early atherosclerotic cardiovascular disease (ASCVD) or elevated low-density lipoprotein cholesterol (LDL-C) or total cholesterol (TC) in a parent. **Homozygous Familial Hypercholesterolemia**: This condition of approval was added to the policy. **Hypercholesterolemia**: The name of this indication was changed to as listed (Previously "Primary Hyperlipidemia."). The Note in the asterisk at the end of the criteria was updated to reflect this modification. **Conditions Not Recommended for Approval**: Lerochol was added as an agent that cannot be taken concurrently with Leqvio.
Hyperlipidemia – PCSK9 Inhibitors – Praluent – (IP0250)	Updated	**Effective 5/15/2026** The policy name was changed to as listed. Previously, it was Proprotein Convertase Subtilisin Kexin Type 9 Inhibitors – Praluent. Documentation requirements were added throughout the policy. **Reduce Major Adverse Cardiovascular Events in Patients at Increased Risk**: The diagnosis of Established Cardiovascular Disease was changed to as listed. A Note

		was added that this includes only patients with established cardiovascular disease. A Note was also updated with this reworded indication. **Heterozygous Familial Hypercholesterolemia:** For a patient between 8 and 17 years of age, a requirement was added that untreated LDL-C is ≥ 160 mg/dL prior to treatment with antihyperlipidemic agents, and that, according to the prescriber, the patient has a family history of early atherosclerotic cardiovascular disease or elevated LDL-C or total cholesterol in a parent. Previously, these patients were required to have an LDL-C ≥ 190 mg/dL. **Hypercholesterolemia**: The diagnosis of Primary Hyperlipidemia was changed to as listed. A Note was also updated with this reworded indication. **Conditions Not Recommended for Coverage**: Lerochol was added as an agent that cannot be taken concurrently with Praluent.
Hyperparathyroidism – Parsabiv – (IP0718)	Updated	**Effective 5/15/2026** No criteria changes.
Immune Disorders – Joenja (IP0568)	Updated	**Effective 5/1/2026** ○ No criteria changes.
Immunologicals – Cinqair (IP0423)	Update	**Effective 5/1/2026** **Updated** preferred product criteria to require trial of two formulary alternatives; previously, coverage required trial of one formulary alternative.
Infectious Disease – Ivermectin Tablets (IP0300)	Updated	**Effective 5/1/2026** No criteria changes.
Inflammatory Conditions – Arcalyst - (IP0437)	Updated	**Effective 5/1/2026** No criteria changes.
Inflammatory Conditions – Ilaris Prior Authorization Policy - (IP0235)	Updated	**Effective 5/1/2026** **Cryopyrin-Associated Periodic Syndromes (CAPS).** Added The patient has a confirmed diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS) with documentation requirements. **Familial Mediterranean Fever:** The requirement that patient has tried "colchicine unless contraindicated" was separated and clarified that patient has tried colchicine at the "maximum tolerated dose".

		Throughout the policy, the following Note was updated from "For a patient who has not received 6 months of therapy or who is restarting therapy with this medication, refer to Initial Therapy criteria above." to "A patient who has received < 6 months of therapy or who is restarting therapy with this medication is reviewed under criterion A (Initial Therapy)."
Inflammatory Conditions – Kineret Prior Authorization Policy - (IP0661)	Updated	**Effective 5/1/2026** **Cryopyrin-Associated Periodic Syndromes (CAPS).** Removed "The medication is being used for treatment of familial cold autoinflammatory syndrome (FCAS), Muckle-Wells Syndrome (MWS), and/or neonatal onset multisystem inflammatory disease (NOMID) formerly known as chronic infantile neurological cutaneous and articular (CINCA) syndrome" and relocated examples of CAPS to a Note. Added The patient has a confirmed diagnosis of Cryopyrin-Associated Periodic Syndromes (CAPS) with documentation requirements. **Castleman Disease:** Approval condition was updated to include progressive disease. **Deficiency of Interleukin-1 Receptor Antagonist (DIRA):** Added documentation requirements to the criterion "Genetic testing has confirmed biallelic pathogenic variants in the *IL1RN* gene" **Immunotherapy-Related Toxicities Associated with Chimeric Antigen Receptor (CAR) T-Cell Therapy**: The Note providing examples of CAR T-cell therapy was removed. **Pericarditis**: For a patient currently receiving Kineret, the Note was updated from "For a patient who has received < 3 months of therapy or who is restarting therapy with this medication, refer to Initial Therapy criteria above." to "A patient who has received < 3 months of therapy or who is restarting therapy with this medication is reviewed under criterion A (Initial Therapy)." Added documentation requirements to the criterion "Prior to starting treatment with Kineret, the patient had a history of at least three episodes of pericarditis".
Inflammatory Conditions – Sotyktu Prior Authorization Policy - (IP0671)	Updated	**Effective 5/1/2026** **Psoriatic Arthritis:** This new condition for approval was added to the policy. **Conditions Not Covered:** Concurrent use with other potent immunosuppressants, including methotrexate, was removed and relocated to apply to Plaque Psoriasis indication only. **Plaque Psoriasis:** For initial therapy and for patients currently receiving Sotyktu, the requirement that the patient will not be taking Sotyktu concurrently with other potent immunosuppressants, including methotrexate, was relocated from Conditions Not Covered section.

		Appendix: Sotyktu was updated to include psoriatic arthritis indication.
Inflammatory Conditions - Tocilizumab Subcutaneous Products Prior Authorization Policy - (IP0657)	Updated	**Effective 5/1/2026** **Avtozma subcutaneous** was added to the policy with the same criteria as the other tocilizumab subcutaneous products. **Appendix:** **For Sotyktu:** Added Psoriatic Arthritis to the list of indications
Inflammatory Conditions – Cosentyx Subcutaneous Prior Authorization Policy - (IP0678)	Updated	**Effective 5/1/2026** **Hidradenitis Suppurativa:** For initial therapy, the requirement that the patient is ≥ 18 years of age was changed to the patient is ≥ 12 years of age. **Appendix:** Sotyktu was updated to include psoriatic arthritis indication.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Individual and Family Plans (PSM014)	Updated	**Effective 5/1/2026** ○ **Appendix: Non-Adalimumab Preferred Products:** Sotyktu (deucravacitinib tablets) was added as a Preferred product for psoriatic arthritis
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Legacy Drug List Plans - (PSM003)	Updated	**Effective 5/1/2026** **Appendix: Non-Adalimumab Preferred Products:** Sotyktu (deucravacitinib tablets) was added as a Preferred product for psoriatic arthritis
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy: Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists - (PSM013)	Updated	**Effective 5/1/2026** **Appendix: Non-Adalimumab Preferred Products:** Sotyktu (deucravacitinib tablets) was added as a Preferred product for psoriatic arthritis

Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Individual and Family Plans - (PSM023)	Updated	**Effective 5/1/2026** • **Appendix: Non-Ustekinumab Preferred Products:** Sotyktu (deucravacitinib tablets) was added as a Preferred product for psoriatic arthritis.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Legacy Prescription Drug List Plans - (PSM022)	Updated	**Effective 5/1/2026** • **Appendix: Non-Ustekinumab Preferred Products:** Sotyktu (deucravacitinib tablets) was added as a Preferred product for psoriatic arthritis.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists - (PSM021)	Updated	**Effective 5/1/2026** • **Appendix: Non-Ustekinumab Preferred Products:** Sotyktu (deucravacitinib tablets) was added as a Preferred product for psoriatic arthritis.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists - (PSM001)	Updated	**Effective 5/1/2026** **Sotyktu:** For **Psoriatic Arthritis**, Sotyktu was added as a Step 1 Preferred agent. Criteria for Bimzelx, Cimzia, Cosentyx, Orencia, Rinvoq/LQ, Simponi, and Xeljanz/XR were updated to include Sotyktu as a Preferred Product. **Simponi SC:** For **Ulcerative Colitis**, an exception was added for a patient < 18 years of age. • **Avtozma SC:** For **Rheumatoid Arthritis** and **Juvenile Idiopathic Arthritis** Avtozma was added as a Step 2a product.
Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)	Updated	**Effective 5/1/2026** **Sotyktu:** For **Psoriatic Arthritis**, Sotyktu was added as a Step 1 Preferred agent. Criteria for Bimzelx, Cimzia, Orencia, Rinvoq/LQ, Simponi, Taltz, and Xeljanz/XR were updated to include Sotyktu as a Preferred Product. **Simponi SC:** For **Ulcerative Colitis**, an exception was added for a patient < 18 years of age.

		Avtozma SC: For **Rheumatoid Arthritis** and **Juvenile Idiopathic Arthritis** Avtozma was added as a Step 2 product.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Legacy Prescription Drug Lists - (PSM017)	Updated	**Effective 5/1/2026** **Sotyktu:** For **Psoriatic Arthritis**, Sotyktu was added as a Step 1 Preferred agent. Criteria for Bimzelx, Cimzia, Cosentyx, Orencia, Rinvoq/LQ, Simponi, and Xeljanz/XR were updated to include Sotyktu as a Preferred Product. **Simponi SC:** For **Ulcerative Colitis**, an exception was added for a patient < 18 years of age. ○ **Avtozma SC:** For **Rheumatoid Arthritis** and **Juvenile Idiopathic Arthritis** Avtozma was added as a Step 2a product.
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists Plans - (PSM009)	Updated	**Effective 5/1/2026** ○ **For Psoriatic Arthritis:** Sotyktu was added as a Step 1 Preferred Product.
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Legacy Prescription Drug Lists Plans - (PSM016)	Updated	**Effective 5/1/2026** **For Psoriatic Arthritis:** Sotyktu was added as a Step 1 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 5/1/2026** **For Psoriatic Arthritis:** Sotyktu was added as a Step 1 Preferred Product. **Avtozma SC:** For **Rheumatoid Arthritis** and **Juvenile Idiopathic Arthritis,** Avtozma was added as a Step 2a product.

Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Individual and Family Plans - (PSM010)	Updated	**Effective 5/1/2026** **For Psoriatic Arthritis:** Sotyktu was added as a Step 1 Preferred Product. **Avtozma SC:** For **Rheumatoid Arthritis and Juvenile Idiopathic Arthritis** Avtozma was added as a Step 2 product.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Legacy Prescription Drug Lists - (PSM018)	Updated	**Effective 5/1/2026** **For Psoriatic Arthritis:** Sotyktu was added as a Step 1 Preferred Product. **Avtozma SC:** For **Rheumatoid Arthritis** and **Juvenile Idiopathic Arthritis,** Avtozma was added as a Step 2a product.
Inflammatory Conditions – Adalimumab Products Prior Authorization Policy - (IP0652)	Updated	**Effective 5/1/2026** **Behcet's Disease:** Otezla/Otezla XR (apremilast tablets/extended-release tablets) added as an example of conventional therapy. **Sarcoidosis**: Cylosporine, Leukeran (chlorambucil tablets), cyclophosphamide, and Thalomid (thalidomide capsules) were removed, and hydroxychloroquine was added as examples of immunosuppressive medications. Cardiologist and neurologist were added as accepted specialists to the specialist requirement. **Appendix:** Sotyktu was updated to include psoriatic arthritis indication.
Inflammatory Conditions – Orencia Intravenous Prior Authorization Policy - (IP0664)	Updated	**Effective 5/1/2026** **Graft-Versus-Host Disease – Prevention:** Requirements removed that the patient will also receive a calcineurin inhibitor and methotrexate for the prevention of acute graft-versus-host disease, and that the patient will undergo hematopoietic stem cell transplantation from a matched unrelated donor or 1-allele mismatched unrelated donor. The approval duration was increased to 60 days. **Chronic Graft-Versus-Host Disease – Treatment:** This new condition for approval was added to the policy. **Appendix:** Otezla XR (apremilast extended-release tablets) was added under the Oral Therapies/Targeted Synthetic Oral Small Molecular Drugs. Sotyktu was updated to include psoriatic arthritis indication.
Inflammatory Conditions – Kevzara Prior Authorization Policy - (IP0679)	Updated	**Effective 5/1/2026** No criteria changes.

Inflammatory Conditions – Cimzia Prior Authorization Policy - (IP0672)	Updated	**Effective 5/1/2026** No criteria changes.
Inflammatory Conditions – Entyvio Intravenous Prior Authorization Policy - (IP0674)	Updated	**Effective 5/15/2026** No criteria changes.
Inflammatory Conditions – Entyvio Subcutaneous Prior Authorization Policy - (IP0675)	Updated	**Effective 5/15/2026** No criteria changes. **Coding Information** ○ **Added** HCPCS Code J3490
Inflammatory Conditions – Olumiant Prior Authorization Policy – (IP0681)	Updated	**Effective 5/15/2026** ○ No criteria changes.
Inflammatory Conditions – Ustekinumab Intravenous Products Preferred Specialty Management Policy - (PSM024)	Updated	**Effective 5/15/2026** No criteria changes.
Inflammatory Conditions – Ustekinumab Intravenous Products Prior Authorization Policy - (IP0686)	Updated	**Effective 5/15/2026** **Crohn's Disease:** The age requirement was modified from ≥ 18 years to ≥ 2 years of age. Dosing was updated to add an option for a patient weighing ≥ 10 kg but ≤ 25 kg. In a patient weighing ≤ 55 kg, specified the lower limit of weight as > 25 kg. **Coding Information** • **Updated** the description for HCPCS code Q9998 to align with the current HCPCS coding book. • **Added** HCPCS code Q5138 • **Added** the following dagger note to HCPCS codes C9399, J3490, and J3590:

		○ Considered Medically Necessary when used to report Starjemza™ (ustekinumab-hmny intravenous infusion), provided the medical necessity criteria outlined in this Coverage Policy are met.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Prior Authorization Policy - (IP0687)		**Effective 5/15/2026** **Crohn's Disease:** The age requirement was modified from ≥ 18 years to ≥ 2 years of age
Metabolic Disorders – Carglumic Acid (IP0438)	Updated	**Policy Title**: The policy name was changed from "Carglumic Acid" to as listed. **Updated** terminology was standardized throughout the policy to align references from "Carbaglu" to "carglumic acid". **N-Acetylglutamate Synthase Deficiency with Hyperammonemia**. "N-acetylglutamate synthase (NAGS) deficiency" language was clarified, with emphasis on consistent clinical terminology.**Updated** criterion 1A: • **Clarified** approval pathways to distinguish genetic confirmation versus biochemical evidence of hyperammonemia. • **Added** documentation required for: ○ Genetic testing confirming a pathogenic variant leading to NAGS deficiency. ○ Laboratory confirmation of hyperammonemia (ammonia level above the upper limit of normal). **Clarified** duration language: • 1-year approval tied to genetic confirmation. • 3-month approval tied to hyperammonemia diagnosis. **Added** a "Note" indicating that normal ammonia reference ranges are age-dependent. **Clarified** criterion 2 approval duration: acute treatment is now explicitly limited to 7 days when criteria are met; criteria continue to require that all listed criteria (A, B, C, and D) are met, with less redundant diagnostic phrasing. **Preferred Product Criteria:** **Added** examples of formulation differences. Minor formatting and wording clarifications were made within the Coverage Policy Criteria and Preferred Product Criteria language.

Metabolic Disorders – Cysteamine Ophthalmic Solution (IP0082)	Updated	**Effective 5/15/2026** No criteria changes.
Metabolic Disorders – Nulibry – (IP0142)	Updated	**Effective 5/1/2026** No criteria changes. **Coding Information** **Removed** the note "Code effective 10/1/2025" from HCPCS code J1809 **Removed** HCPCS codes C9399 & J3490
Metabolic Disorders – Primary Hyperoxaluria – Rivfloza – (IP0629)	Updated	**Effective 5/1/2026** No criteria changes.
Metabolic Disorders - Tiopronin Products (IP0202)	Updated	**Effective 5/1/2026** No criteria changes.
Migraine – Calcitonin Gene-Related Peptide Inhibitors – Vyepti (IP0506)	Updated	**Effective 5/1/2026** **Updated** Employer Plans and Individual and Family Plans preferred product requirements.
Migraine – Zavzpret (IP0573)	Updated	**Effective 5/1/2026** **Employer Plans, Standard / Performance preferred product requirements**: **Removed** the double step through Nurtec ODT and Ubrelvy. **Updated** the triptan requirement to a single step through one triptan.
Nephrology – Filspari (IP0565)	Updated	**Effective 5/1/2026** • No criteria changes.
Neurology – Imaavy (IP0743)	Updated	**Effective 5/1/2026** **Updated** documentation statement **from** "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 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." **Conditions Not Covered** • The condition "Concomitant Use with Another Complement Inhibitor, a Neonatal Fc Receptor Blocker, or a Rituximab Product" was revised to "Concomitant Use with Another Complement Inhibitor, a Neonatal Fc Receptor Blocker, a Rituximab Product, or Uplizna® (inebilizumab-cdon intravenous infusion)."
Neurology - Lyrica CR (IP0183)	Updated	**Effective 5/15/2026** No criteria changes.
Neurology – Riluzole Products (IP0258)	Updated	**Effective 5/15/2026** **Employer Plans and Individual and Family Plans Preferred Product Table:** ○ Removed Exservan as product is obsolete.
Neurology – Rystiggo (IP0575)	Updated	**Effective 5/1/2026** **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." **Conditions Not Covered** ○ The condition "Concomitant Use with Another Complement Inhibitor, a Neonatal Fc Receptor Blocker, or a Rituximab Product" was revised to "Concomitant Use with Another Complement Inhibitor, a Neonatal Fc Receptor Blocker, a Rituximab Product, or Uplizna® (inebilizumab-cdon intravenous infusion)."

Neurology – Vyvgart Hytrulo (IP0574)	Updated	**Effective 5/1/2026** **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. All documentation must include patient-specific identifying 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." **Conditions Not Covered** The condition "Concomitant Use with Another Complement Inhibitor, a Neonatal Fc Receptor Blocker, or a Rituximab Product" was revised to "Concomitant Use with Another Complement Inhibitor, a Neonatal Fc Receptor Blocker, a Rituximab Product, or Uplizna® (inebilizumab-cdon intravenous infusion)."
Neurology – Vyvgart Intravenous (IP0376)	Updated	**Effective 5/1/2026** **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. All documentation must include patient-specific identifying 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." **Conditions Not Covered** The condition "Concomitant Use with Another Complement Inhibitor, a Neonatal Fc Receptor Blocker, or a Rituximab Product" was revised to "Concomitant Use with Another Complement Inhibitor, a Neonatal Fc Receptor Blocker, a Rituximab Product, or Uplizna® (inebilizumab-cdon intravenous infusion)."
Omadacycline – (IP0379)	Retired	**Effective 5/1/2026** Policy to be retired.
Oncology (Injectable) – Amtagvi IP0625)	Updated	**Effective 5/1/2026** No criteria changes.

Oncology (Injectable) – Cosela (IP0150)	Updated	**Effective 5/1/2026** No criteria changes.
Oncology (Injectable) – Proleukin (IP0407)	Updated	**Effective 5/1/2026** **Cutaneous Melanoma:** The requirement that Proleukin will be used as a single agent was removed. The requirement that "Proleukin will be directly injected into metastatic, recurrent, or unresectable cutaneous, subcutaneous, or nodal lesions" was changed to "The medication will be directly injected into unresectable or borderline resectable lesions."
Oncology – Jakafi (IP0318)	Updated	**Effective 5/1/2026** **Acute Lymphoblastic Leukemia:** An option of approval was added when the disease has a *EPOR* rearrangement, *SH2B3* alterations, or *IL7R* insertion/deletion.
Oncology Medications (1403)	Updated	**Effective 5/1/2026** **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), or Ibtrozi (taletrectinib capsules)" **to** "Patient has progression on Rozlytrek (entrectinib capsules and pellet packet), Xalkori (crizotinib capsules), or Ibtrozi (taletrectinib capsules)" **Bosulif, Danziten, Iclusig, Nilotinib hcl, Scemblix, Tasigna.** **Removed** "may require prior authorization" for imatinib and dasatinib for Individual and Family Plans **Danziten.** **Removed** "may require prior authorization" for nilotinib hcl for Employer Plans **Gleevec.** **Removed** "may require prior authorization" for imatinib **Imkeldi.** **Removed** "may require prior authorization" for imatinib for Individual and Family Plans **Nexavar.** **Removed** "may require prior authorization" for sorafenib.

		Pazopanib 400 mg. **Added** criteria for Pazopanib 400 mg **Sprycel** **Removed** "may require prior authorization" for dasatinib **Sutent.** **Removed** "may require prior authorization" for sunitinib **Temodar.** **Removed** "may require prior authorization" for temozolomide **Tykerb.** **Removed** "may require prior authorization" for lapatinib. **Xeloda.** **Removed** "may require prior authorization" for capecitabine **Zytiga.** **Removed** "may require prior authorization" for abiraterone
Ophthalmology – Durysta (IP0218)	Updated	**Effective 5/1/2026** **Policy Statement:** Approval duration was changed from 1 month (30 days) to 3 months (90 days) for Durysta to align with implant-based administration and allow adequate time for treatment scheduling. Language was also clarified that approvals are limited to one implant per treated eye (maximum of two implants per patient).
Ophthalmic – Glaucoma – Prostaglandins (IP0027)	Updated	**Effective 5/15/2026** **Added** Omlonti to the policy for both Employer Plans and Individual and Family Plans.
Ophthalmology – Gene Therapy – Encelto (IP0744)	Updated	**Effective 5/21/2026** **Policy Statement:** The statement that "approval requires Encelto to be prescribed by or in consultation with a physician who specializes in the condition being treated" was changed to "approval requires Encelto to be administered by or in consultation with a physician who specializes in the condition being treated". Approval duration was changed from 1 month (30 days) to "90 days".

		Macular Telangiectasia Type 2, Idiopathic: Approved dosing for Encelto was added as an approval requirement, to align with the template for UM Medical policies with corresponding Embarc policies. In addition, the Dosing section was revised to align with the standard Dosing statement language. **Coding Information:** **Removed** HCPCS codes C9399 J3490 & J3590 **Removed** "code effective date 10/1/2025" from J3403
Ophthalmology – Izervay (IP0581)	Updated	**Effective 5/1/2026** **Conditions Not Recommended For Approval:** A new condition, Concomitant Use With Syfovre (pegcetacoplan intravitreal injection) was added.
Ophthalmology – Syfovre (IP0559)	Updated	**Effective 5/1/2026** **Conditions Not Recommended For Approval:** A new condition, Concomitant Use With Izervay (avacincaptad intravitreal injection) was added.
Ophthalmology – Tepezza - (IP0129)	Updated	**Effective 5/15/2026** No criteria changes.
Opioid Therapy for Employer Group Benefit Plans (IP0561)	Updated	**Effective 5/1/2026** **Removed** "in an opioid naïve individual" from the immediate-release criteria statement.
Opioid Therapy – Individual and Family Plans (IP0562)	Updated	**Effective 5/1/2026** **Removed** "in an opioid naïve individual" from the immediate-release criteria statement.
Overactive Bladder Medications Step Therapy Policy for Employer Plans: Value/Advantage/Legacy Drug Lists - (ST002)	New	**Effective 5/1/2026** New policy.
Parkinson's Disease – Nuplazid (IP0145)	Updated	**Effective 5/1/2026** No criteria changes.

Parkinson's Disease – Ongentys (IP0532)	Updated	**Effective 5/1/2026** No criteria changes.
Phenylketonuria – Palynziq (IP0294)	Update	**Effective 5/1/2026** **Phenylketonuria:** For Initial Therapy and Patient is Currently Receiving Palynziq, the age requirement was changed to ≥ 12 years of age.
Prader-Willi Syndrome – Vykat XR (IP0741)	Update	**Effective 5/1/2026** No criteria changes.
Prenatal Vitamins (IP0035)	Update	**Effective 5/1/2026** No criteria changes. Employer Plans and Individual and Family Plans: Added (keywords updated) Gestyra tablets to policy.
Sickle Cell Disease – L-Glutamine for Individual and Family Plans (IP0475)	Updated	**Effective 5/1/2026** No criteria changes.
Somatostatin Analogs – Lanreotide Products (IP0323)	Updated	**Effective 5/1/2026** No criteria changes.
Somatostatin Analogs – Mycapssa (IP0491)	Updated	**Effective 5/1/2026** No criteria changes.
Somatostatin Analogs – Octreotide Immediate-Release Products (IP0490)	Updated	**Effective 5/1/2026** **Added** Documentation Instructions. **Preferred Product Table.** **Added** Preferred Product Table for Employer Plans for Bynfezia **Added [documentation required]** for Bynfezia
Somatostatin Analogs – Signifor LAR (IP0165)	Updated	**Effective 5/1/2026** No criteria changes.

Spinal Muscular Atrophy – Spinraza PA (IP0182)	Updated	**Effective 5/1/2026** **Spinal Muscular Atrophy – Treatment**: The requirement that 4 months has elapsed since the last dose was changed to each Spinraza dose is to be administered once every 4 months as maintenance therapy.
Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) [1803]	Updated	**Effective 5/1/2026** **Updated** the Jornay PM requirement, decreasing from a quadruple step to a single step.
Step Therapy – Standard and Performance Prescription Drug Lists (Employer Group Plans) [1801]	Updated	**Effective 5/1/2026** **Added** Jornay PM as a Step 3 medication to the Attention Deficit Hyperactive Disorder (ADHD) therapeutic category.
Tasimelteon Products (IP0428)	Updated	**Effective 5/1/2026** **Sedative Hypnotic Medications or Other Medications for Insomnia or Other Sleep-Related Disorders, Concomitant Therapy:** In this Condition Not Recommended for Approval, examples of applicable medications were moved to a Note. **Sleep-Related Disorders, Other Types:** In this Condition Not Recommended for Approval, examples of applicable disorders were moved to a Note.
Tetracyclines (Oral) Step Therapy Policy for Employer Plans: Standard/Performance/Legacy Drug Lists - (ST003)	New	**Effective 5/1/2026** New policy.
Thrombocytopenia – Mulpleta (IP0156)	Updated	**Effective 5/15/2026** No criteria changes.
Tizanidine (IP0392)	Retire	**Effective 5/15/2026** Relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602)
Transplantation – Grafapex (IP0727)	Updated	**Effective 5/1/2026** No criteria changes.

Veregen - (IP0393)	Updated	**Effective 5/1/2026** No criteria changes.
Vesicular Monoamine Transporter Type 2 Inhibitors – Austedo (IP0079)	Updated	**Effective 5/15/2026** No criteria changes.
Vesicular Monoamine Transporter Type 2 Inhibitors – Ingrezza Products (IP0080)	Updated	**Effective 5/15/2026** No criteria changes.
Weight Loss Medications - Glucagon-Like Peptide-1 Agonists Benefit Exclusion Override Policy BMI ≥ 35 (INT030)	Updated	**Effective 5/1/2026** Wegovy injection **Weight Loss in an Adult with Obesity or is Overweight.** Wegovy tablet was added to the following: Patient is Currently Receiving Wegovy injection or Wegovy tablet. The following note was updated to include Wegovy injection and Wegovy tablet: For a patient who has not completed 7 months of initial therapy with Wegovy injection and/or Wegovy tablet, refer to Initial Therapy criteria above. **Weight Loss in a Pediatric Patient with Obesity.** Wegovy tablet was added to the following: Patient is Currently Receiving Wegovy injection or Wegovy tablet. The following note was updated to include Wegovy injection and Wegovy tablet: For a patient who has not completed 7 months of initial therapy with Wegovy injection and/or Wegovy tablet, refer to Initial Therapy criteria above. Wegovy tablet **Weight Loss in an Adult with Overweight or Obesity.** Initial Therapy. The approval duration was changed to 7 months (previously 6 months). Wegovy injection was added to Patient is Currently Receiving Wegovy tablet or Wegovy injection. The following note was updated to include Wegovy injection and Wegovy tablet, and to reflect the 7-month initial approval duration: For a patient who has not completed 7 months of initial therapy with Wegovy injection and/or Wegovy tablet, refer to Initial Therapy criteria above.
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 30 (IP0206)	Updated	**Effective 5/1/2026** Wegovy injection **Weight Loss in an Adult with Obesity or is Overweight.** Wegovy tablet was added to the following: Patient is Currently Receiving Wegovy injection or Wegovy tablet. The following note was updated to include Wegovy injection and Wegovy

		tablet: For a patient who has not completed 7 months of initial therapy with Wegovy injection and/or Wegovy tablet, refer to Initial Therapy criteria above. **Weight Loss in a Pediatric Patient with Obesity.** Wegovy tablet was added to the following: Patient is Currently Receiving Wegovy injection or Wegovy tablet. The following note was updated to include Wegovy injection and Wegovy tablet: For a patient who has not completed 7 months of initial therapy with Wegovy injection and/or Wegovy tablet, refer to Initial Therapy criteria above. **Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease with Overweight or Obesity.** Initial Therapy and Patient is Currently Receiving Wegovy injection criteria were combined (previously each a 1 year approval); the approval duration is 1 year The requirement that the patient has a current body mass index (BMI) of ≥ 27 kg/m^2 (previously for Initial Therapy, only) was revised that at baseline, the patient had a BMI ≥ 27 kg/m^2. The note for baseline BMI was revised to state that baseline refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound) [previously Wegovy injection or Wegovy tablet, Patient is Currently Receiving Wegovy injection or Wegovy tablet]. **Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH).** Initial Therapy. Reference to Wegovy throughout criteria was updated to specify Wegovy injection. Wegovy tablet for 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 tablet was added to the following: Patient is Currently Receiving Wegovy injection or Wegovy tablet. The following note was updated to include Wegovy injection and Wegovy tablet: For a patient who has received < 1 year of therapy with Wegovy injection and/or Wegovy tablet, or who is restating therapy, refer to Initial Therapy. For the following requirement (and associated Note), reference to Wegovy was updated to specify Wegovy injection and to add Wegovy tablet: Patient has completed ≥ 1 year of therapy with Wegovy injection and/or Wegovy tablet AND according to the prescriber, the patient has not had worsening of fibrosis or MASH/NASH. Wegovy tablet **Weight Loss in an Adult with Obesity or is Overweight.** Initial Therapy. The approval duration was changed to 7 months (previously 6 months). Wegovy injection was added to Patient is Currently Receiving Wegovy tablet or Wegovy injection. The following note was updated to include Wegovy injection and Wegovy tablet, and to reflect the 7-month initial approval duration: For a patient who has not completed 7

		months of initial therapy with Wegovy injection and/or Wegovy tablet, refer to Initial Therapy criteria above. **Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease with Overweight or Obesity.** The same changes were made as Wegovy injection; refer to Wegovy injection *Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease with Overweight or Obesity,* above. Zepbound **Obstructive Sleep Apnea, Moderate to Severe, in a Patient with Obesity.** Initial Therapy. The requirement that the patient has a current BMI ≥ 30 kg/m^2 was revised that at baseline, patient had a BMI ≥ 30 kg/m^2 . A note was added that baseline refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound). Patient is Currently Receiving Zepbound. The notes that define baseline were updated that baseline refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound); previously, prior to Zepbound.
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 32 (IP0621)	Updated	Wegovy injection **Weight Loss in an Adult with Obesity or is Overweight.** Wegovy tablet was added to the following: Patient is Currently Receiving Wegovy injection or Wegovy tablet. The following note was updated to include Wegovy injection and Wegovy tablet: For a patient who has not completed 7 months of initial therapy with Wegovy injection and/or Wegovy tablet, refer to Initial Therapy criteria above. **Weight Loss in a Pediatric Patient with Obesity.** Wegovy tablet was added to the following: Patient is Currently Receiving Wegovy injection or Wegovy tablet. The following note was updated to include Wegovy injection and Wegovy tablet: For a patient who has not completed 7 months of initial therapy with Wegovy injection and/or Wegovy tablet, refer to Initial Therapy criteria above. **Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease with Overweight or Obesity.** Initial Therapy and Patient is Currently Receiving Wegovy injection criteria were combined (previously each a 1 year approval); the approval duration is 1 year The requirement that the patient has a current body mass index (BMI) of ≥ 27 kg/m^2 (previously for Initial Therapy, only) was revised that at baseline, the patient had a BMI ≥ 27 kg/m^2. The note for baseline BMI was revised to state that baseline refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor

		agonist (e.g., Zepbound) [previously Wegovy injection or Wegovy tablet, Patient is Currently Receiving Wegovy injection or Wegovy tablet]. **Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH).** Initial Therapy. Reference to Wegovy throughout criteria was updated to specify Wegovy injection. Wegovy tablet for 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 tablet was added to the following: Patient is Currently Receiving Wegovy injection or Wegovy tablet. The following note was updated to include Wegovy injection and Wegovy tablet: For a patient who has received < 1 year of therapy with Wegovy injection and/or Wegovy tablet, or who is restating therapy, refer to Initial Therapy. For the following requirement (and associated Note), reference to Wegovy was updated to specify Wegovy injection and to add Wegovy tablet: Patient has completed ≥ 1 year of therapy with Wegovy injection and/or Wegovy tablet AND according to the prescriber, the patient has not had worsening of fibrosis or MASH/NASH. Wegovy tablet **Weight Loss in an Adult with Overweight or Obesity.** Initial Therapy. The approval duration was changed to 7 months (previously 6 months). Wegovy injection was added to Patient is Currently Receiving Wegovy tablet or Wegovy injection. The following note was updated to include Wegovy injection and Wegovy tablet, and to reflect the 7-month initial approval duration: For a patient who has not completed 7 months of initial therapy with Wegovy injection and/or Wegovy tablet, refer to Initial Therapy criteria above. **Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease with Overweight or Obesity.** The same changes were made as Wegovy injection; refer to Wegovy injection *Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease with Overweight or Obesity,* above. Zepbound **Obstructive Sleep Apnea, Moderate to Severe, in a Patient with Obesity.** Initial Therapy. The requirement that the patient has a current BMI ≥ 30 kg/m^2 was revised that at baseline, patient had a BMI ≥ 30 kg/m^2 . A note was added that baseline refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound). Patient is Currently Receiving Zepbound. The notes that define baseline were updated that baseline refers to baseline prior to any glucagon-like peptide-1

		(GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound); previously, prior to Zepbound.
Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 35 (IP0739)	Updated	**Effective 5/1/2026** Wegovy injection **Weight Loss in an Adult with Obesity or is Overweight.** Wegovy tablet was added to the following: Patient is Currently Receiving Wegovy injection or Wegovy tablet. The following note was updated to include Wegovy injection and Wegovy tablet: For a patient who has not completed 7 months of initial therapy with Wegovy injection and/or Wegovy tablet, refer to Initial Therapy criteria above. **Weight Loss in a Pediatric Patient with Obesity.** Wegovy tablet was added to the following: Patient is Currently Receiving Wegovy injection or Wegovy tablet. The following note was updated to include Wegovy injection and Wegovy tablet: For a patient who has not completed 7 months of initial therapy with Wegovy injection and/or Wegovy tablet, refer to Initial Therapy criteria above. **Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease with Overweight or Obesity.** Initial Therapy and Patient is Currently Receiving Wegovy injection criteria were combined (previously each a 1 year approval); the approval duration is 1 year The requirement that the patient has a current body mass index (BMI) of ≥ 27 kg/m^2 (previously for Initial Therapy, only) was revised that at baseline, the patient had a BMI ≥ 27 kg/m^2. The note for baseline BMI was revised to state that baseline refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound) [previously Wegovy injection or Wegovy tablet, Patient is Currently Receiving Wegovy injection or Wegovy tablet]. **Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH).** Initial Therapy. Reference to Wegovy throughout criteria was updated to specify Wegovy injection. Wegovy tablet for 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 tablet was added to the following: Patient is Currently Receiving Wegovy injection or Wegovy tablet. The following note was updated to include Wegovy injection and Wegovy tablet: For a patient who has received < 1 year of therapy with Wegovy injection and/or Wegovy tablet, or who is restating therapy, refer to Initial Therapy. For the following requirement (and associated Note), reference to Wegovy was updated to specify Wegovy injection and to add Wegovy tablet: Patient has completed ≥ 1 year of therapy with Wegovy injection and/or Wegovy tablet AND

		according to the prescriber, the patient has not had worsening of fibrosis or MASH/NASH. Wegovy tablet **Weight Loss in an Adult with Overweight or Obesity.** Initial Therapy. The approval duration was changed to 7 months (previously 6 months). Wegovy injection was added to Patient is Currently Receiving Wegovy tablet or Wegovy injection. The following note was updated to include Wegovy injection and Wegovy tablet, and to reflect the 7-month initial approval duration: For a patient who has not completed 7 months of initial therapy with Wegovy injection and/or Wegovy tablet, refer to Initial Therapy criteria above. **Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease with Overweight or Obesity.** The same changes were made as Wegovy injection; refer to Wegovy injection *Major Adverse Cardiovascular Event(s) Risk Reduction in a Patient with Established Cardiovascular Disease with Overweight or Obesity,* above. Zepbound **Obstructive Sleep Apnea, Moderate to Severe, in a Patient with Obesity.** Initial Therapy. The requirement that the patient has a current BMI ≥ 30 kg/m^2 was revised that at baseline, patient had a BMI ≥ 30 kg/m^2 . A note was added that baseline refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound). Patient is Currently Receiving Zepbound. The notes that define baseline were updated that baseline refers to baseline prior to any glucagon-like peptide-1 (GLP-1) agonist (e.g., liraglutide [Saxenda, generic], Wegovy) or GLP-1/glucose-dependent insulinotropic polypeptide (GIP) receptor agonist (e.g., Zepbound); previously, prior to Zepbound.
Zycubo for Individual and Family Plans - (IP0794)	New	**Effective 5/15/2026** New policy
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
Precertification Policies	Updates	• No updates for May 2026

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