Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective November 15, 2024 (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
Ambulatory External and Implantable Electrocardiographic Monitoring – (CP0547)	Update	Important **changes** in coverage criteria: • Clarification of criteria/sub-bullet for syncope
Bone Growth Stimulators: Electrical (Invasive, Noninvasive), Ultrasound – (CP0084)	Update	Posted and Effective **11/1/2024** Important **changes** in coverage criteria: • Title change from Bone Growth Stimulators: Electrical (Invasive, Noninvasive), Ultrasound to Bone Growth Stimulators: Electrical (Invasive~~,~~ ~~Noninvasive~~), Ultrasound. • Removed content related to spinal surgery procedures, which will be addressed in the cobranded spinal surgery guidelines (this is also noted in a separate entry below regarding policies impacted by EviCore management of certain spine, lab, and vascular procedures).

Cardiac Omnibus Codes – (CP0574)	Update	Important **changes** in coverage criteria **EFFECTIVE 11/01/2024**: Endovascular Repair of Iliac Artery by Deployment of an Iliac Branched Endograft (i.e., GORE® EXCLUDER® Iliac Branch Endoprosthesis [IBE] device: • 34717 will be removed from precert as of 11/01/24. So, this code/content was removed from CP 0574 as of 11/01/2024. • 34718 will be delegated to EviCore as of 11/01/24. So, this code/content was removed from CP 0574 as of 11/01/2024.
Cochlear and Auditory Brainstem Implants - (CP0190)	Update	Important **changes** in coverage criteria: • Expanded coverage by removing the word "pneumococcal" from the hearing aid trial waiver statement because cochlear ossification can occur as a result of other types of meningitis beyond pneumococcal. • Expanded coverage by adding the additional option of "MRI" to the "evidence of cochlear ossification" statement in the hearing aid trial waiver statement because CT isn't the only option. • Changed language for a traditional cochlear implant for the treatment of tinnitus from EIU to NMN because this technology doesn't meet Cigna's definition of EIU.
Genetic Testing for Reproductive Carrier Screening and Prenatal Diagnosis - (CP0514)	Update	Posted and Effective **11/1/2024.** Minor **changes** in coverage criteria/policy: • Removed policy statements for genetic counseling and preimplantation genetic testing for aneuploidy, as codes representing these services are not managed. • Fragile X testing statement: Changed "biologic female parent" to "parent whose sex assigned at birth is female", as preferred terminology. • Revised statement for testing for variants in persons of Ashkenazi Jewish descent: Removed examples of conditions/codes as redundant, and with aim to be ethnic and population neutral/more inclusive of diverse populations. • Removed statement regarding in vitro fertilization (IVF) services associated with preimplantation genetic testing (PGT), as IVF services are not managed by this policy. • Removed carrier testing/PGT condition tables to remove redundancy in criteria. • Removed content related to certain genetic tests which will be addressed in the cobranded laboratory management guidelines (this is also noted in a

		separate entry below regarding policies impacted by EviCore management of certain spine, lab, and vascular procedures).
Laboratory Testing for Transplantation Rejection - (CP0465)	Update	Posted and Effective **11/1/2024** Important **changes** in coverage criteria: • Added coverage for Allomap starting at two months post-transplant • CPT code 81479 being delegated to Evicore. Therefore, removed the examples of donor-derived cell-free DNA testing TruGraf, AlloSure®, Prospera™, and the coverage statement for combined gene expression profiling and donor-derived cell-free DNA testing (i.e. HeartCare®, OmniGraf™). These are addressed in the Cigna/EviCore cobranded guidelines, and therefore removed from this policy. • CPT 0118U will no longer be on precert eff 11/01/2024. The corresponding test is Viracor TRAC. That will be removed from the examples of donor-derived cell-free DNA testing. • New CPT codes 0508U and 0509U that represent VitaGraft™ Kidney (donor-derived cell-free DNA testing) are being added to precert. The tests will be added as examples of donor-derived cell-free DNA testing.
Lymphedema and Lipedema Surgical Treatments - (CP0531)	Update	Important **changes** in coverage criteria to the lymphedema section of the coverage statement: • Removing tissue transfer (e.g. omental or mesenteric flap) from the EIU statement. There are multiple textbooks that address the omentum as a site for obtaining lymph nodes for vascularized lymph node transfer. • Remove the word treatment from the EIU statement • Clarification of EIU statement for procedures proposed for preventive use by adding examples
Minimally Invasive Spine Surgery Procedures and Trigger Point Injections - (CP0139)	Update	Posted and Effective **11/1/2024** Important **changes** in coverage criteria: • Title changed from "Minimally Invasive Spine Surgery Procedures and Trigger Point Injections" to "Trigger Point Injections" • Removed content related to spinal surgery procedures, which will be addressed in the cobranded spinal surgery guidelines (this is also noted in a separate entry below regarding policies impacted by EviCore management of certain spine, lab, and vascular procedures).
Transcatheter Closure of Cardiovascular Defects - (CP0011)	**Update**	**Posting 11/15/2024; Effective 2/15/2025** Important **changes** in coverage criteria:

		• Removed the word "complex" from the ventricular septal defect bullet and replace with "muscular or perimembranous" for clarity. • Clarified the VSD bullet by adding "the individual is ≥5.2kg" to make it clear that this criteria applies to the pediatric population. • Changed the language for 'transcatheter closure of CVD for any other indication' and 'closure of ostium primum or sinus venosus ASDs' from EIU to NMN because this technology doesn't meet Cigna's definition of EIU.
Benign Prostatic Hyperplasia (BPH) Surgical Treatments – (CP0159) Bone Graft Substitutes – (CP0118) Bone Growth Stimulators: Electrical (Invasive, Noninvasive), Ultrasound – (CP0084) Cardiac Omnibus Codes – (CP0574) Genetic Testing for Hereditary and Multifactorial Conditions – (CP0052) Genetic Testing for Reproductive Carrier Screening and Prenatal Diagnosis – (CP0514) Headache, Occipital, and/or Trigeminal Neuralgia Treatment – (CP0063) Infertility Services – (CP0089) Inflammatory Bowel Disease - Testing for the Diagnosis and Management – (CP0121)	Update	Multiple spine, lab, and vascular CPT codes were delegated to EviCore as of **11/01/2024.** The Cigna/EviCore cobranded guidelines that are used to manage these codes are posted at https://www.evicore.com/cigna. • All the CPs listed in the left-hand column had one or more codes that aligned with the EviCore delegated codes. These codes, and related policy statements/content, have been removed from the CPs effective 11/1/24 • The updated CPs were posted on **11/01/2024.** • See Retired CP section below for the list of CPs that are being retired because codes in the policy are delegated.

Minimally Invasive Spine Surgery Procedures and Trigger Point Injections (title will change to Trigger Point Injections) – (CP0139) Molecular and Proteomic Diagnostic Testing for Hematology and Oncology Indications – (CP0520) Oral Cancer Screening Systems – (CP0372) Pharmacogenetic Testing for Non-Cancer Indications – (CP0500) Stem Cell Therapy for Orthopaedic Applications – (CP0552) Treatment of Cutaneous and/or Deep Tissue Hemangioma, Port Wine Stain and Other Vascular Lesions – (CP0313)		
Compression Devices - (CP0354)	Update	• No change in coverage.
Hospital Beds and Pressure Reducing Support Surfaces - (CP0042)	Update	• No change in coverage.
Intensive Behavioral Interventions – (EN0499)	Update	• No change in coverage.
Complementary and Alternative Medicine - (EN0086)	Update	• No change in coverage.
Staff-Assisted Home Hemodialysis - (CP0229)	Update	• No change in coverage.

Neuropsychological Testing - (EN0258)	Update	• No change in coverage. • Posting/effective 11/10/2024.
Nucleic Acid Pathogen Testing - (CP0530)	Update	• No change in coverage. • Posting/effective 11/10/2024.
Transcranial Magnetic Stimulation – (EN0383)	Update	• No change in coverage.
Transplantation Donor Charges - (CP0132)	Update	• No change in coverage.
Wide-Area Transepithelial Tissue Sampling with Computer-Assisted 3D Analysis (WATS3D) – (CP0578)	Update	• No change in coverage.
Atherosclerotic Cardiovascular Disease Risk Assessment: Emerging Laboratory Evaluations - (CP0137)	Retire 11/01/24	• Retiring due to lack of business value.
Adrenal Tissue Transplant – (CP0572)	Retire 11/01/24	• Policy retiring because code S2103 coming off precert as of 11/01/2024.
Exhaled Nitric Oxide in the Management of Respiratory Disorders – (CP0439)	Retired 11/15/24	• The single code in this policy, CPT 95012, is not managed.
Omnibus Codes – (CP0504)	Retired 11/15/24	• No longer has business value. As of 11/15, it will no longer contain any implemented codes.
Percutaneous Vertebroplasty, Kyphoplasty, and Sacroplasty – (CP0040) Intervertebral Disc (IVD) Prosthesis – (CP0104)	Retired 11/01/24	Multiple spine, lab, and vascular CPT codes were delegated to EviCore as of **11/01/2024**. The Cigna/EviCore cobranded guidelines that are used to manage these codes are posted at https://www.evicore.com/cigna. The CPs listed in the left hand column had their codes delegated to EviCore as of Nov 1. Therefore, these CPs are **retired as of 11/01/2024.**

Varicose Vein Treatments – (CP0234) Lumbar Fusion for Spinal Instability and Degenerative Disc Conditions, Including Sacroiliac Fusion – (CP0303) Discography – (CP0393) Interspinous Process Spacer Devices – (CP0448) Comparative Genomic Hybridization (CGH)/ Chromosomal Microarray Analysis (CMA) for Selected Hereditary Conditions – (CP0493) Genetic Testing for Cardiomyopathies and Arrhythmias – (CP0517) Genetic Testing for Hereditary Cancer Susceptibility Syndromes – (CP0518) Whole Exome and Whole Genome Sequencing for Non-Cancer Indications – (CP0519) Cervical Fusion – (CP0527)		

Percutaneous Revascularization of the Lower Extremities in Adults (tentative) – (CP0537) Venous Angioplasty with or without Stent Placement in Adults (tentative) – (CP0541) Angioplasty (Extracranial, Intracranial) and Intracranial Aneurysm Repair – (CP0545)		
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
Biofeedback – (CPG 294)	Update	Minor **change** in coverage criteria/policy: • Changed the 'biofeedback for any other indications' from EIU to NMN because this technology doesn't meet Cigna's definition of EIU.
Physical Performance Test or Measurement - (CPG 295)	Update	• No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-EviCore Lab Management Program Guidelines	New	Posted **August 1, 2024;** Effective **November 1, 2024** **New** guidelines. • New guidelines with coverage criteria for select laboratory tests.
Cobranded Cigna-EviCore Peripheral Vascular Intervention Guidelines	New	Posted **July 1, 2024;** Effective **November 1, 2024** **New** guidelines. • New guidelines with coverage criteria for select arterial and venous interventional procedures.

Cobranded Cigna-EviCore Spine Surgery Guidelines	New	Posted **July 1, 2024;** Effective **November 1, 2024**
		
		New guidelines.
		• New guidelines with coverage criteria for select spine procedures:
		  • CMM-401 Discography
		  • CMM-600 Preface to the 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-609 Lumbar Fusion (Arthrodesis)
		  • CMM-610 Lumbar Total Disc Arthroplasty
		  • CMM-611 Sacroiliac Joint Fusion or Stabilization
		  • CMM-612 Grafts
		  • CMM-613 Thoracic Decompression/Discectomy
		  • CMM-614 Thoracic/Thoracolumbar Fusion (Arthrodesis)
		  • CMM-615 Electrical and Low Frequency Ultrasound Bone Growth Stimulation (Spine)
		  • CMM-616 Vertebral Body Tethering for Adolescent Idiopathic Scoliosis

Cobranded Cigna-EviCore High-Tech Imaging Guidelines	Update	Posted **October 29, 2024**; Effective **February 1, 2025** Important **changes** in coverage criteria. Six guidelines were updated with clinical changes that expand coverage: • Breast Imaging • Chest Imaging • Musculoskeletal Imaging • Pediatric Neck Imaging • Pediatric and Special Populations Spine Imaging • Preface to the Imaging Guidelines

		Eleven guidelines were updated with clinical changes that both expand and limit coverage: • Abdomen Imaging • Head Imaging • Neck Imaging • Oncology Imaging • Pelvis Imaging • Peripheral Nerve and Neuromuscular Disorders (PNND) Imaging • Spine Imaging • Pediatric Abdomen Imaging • Pediatric Head Imaging • Pediatric Musculoskeletal Imaging • Pediatric and Special Populations Oncology Imaging Three guidelines were updated with no change in coverage: • Pediatric Chest Imaging • Pediatric Pelvis Imaging • Pediatric Peripheral Nerve and Neuromuscular Disorders (PNND) Imaging Please see the Cigna-EviCore Cobranded Guidelines Homepage for updates.

Cobranded Cigna-EviCore Musculoskeletal Management Guidelines	Update	Posted **July 1, 2024;** Effective **November 1, 2024**
		
		Important **change** in coverage criteria.
		
		• CMM-208: Radiofrequency Joint Ablations/Denervations
		  • Title changed: CMM-208: ~~Radiofrequency Joint~~ Ablations/Denervations of Facet Joints and Peripheral Nerves
		  • Added not covered statement for radiofrequency ablation of the intraosseous basivertebral nerve for the treatment of vertebrogenic back pain.
		
		Informational document updated, no change to coverage:
		
		• Preface to the Comprehensive Musculoskeletal Management (CMM) Guidelines

Cobranded Cigna-EviCore Radiation Oncology Guidelines	Update	Posted **August 1, 2024.** Effective **November 1, 2024** **New** guideline:

		• Biology-Guided Radiation Therapy (BgRT) Important **changes** in coverage criteria. Two guidelines were updated to reflect an expansion of coverage: • Cervical Cancer ➢ Removed exceptions required for coverage of intensity-modulated radiation therapy (IMRT). • Prostate Cancer ➢ Added option of 36 Gy in six fractions for treatment of low-volume metastatic disease and removed statement requiring contraindication to National Comprehensive Cancer Network (NCCN) category 1 systemic regimens. The remaining guidelines had no clinical changes.
Administrative Policy	**New, Updated, or Retired?**	**Comments**
Authorized Generics - (A008)	Update	Effective 11/15/2024 • **Added** criteria for Oxycodone tablets (Authorized Generic for Roxybond)
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Amifampridine Products – (IP0290)	Update	Effective: 11/1/2024 **Policy Title:** **Updated from** "Amifampridine" **to** "Amifampridine Products" **Lambert-Eaton Myasthenic Syndrome (LEMS).** **Updated** criteria for confirmation of diagnosis **from** "neurophysiology studies" **to** "Electrodiagnostic study (e.g., repetitive nerve stimulation)".

Antifungals – Cresemba (Oral) - (IP0305)	Update	Effective 11/1/2024 **Policy Title:** **Updated from** "Isavuconazonium (Oral)" **to** "Antifungals – Cresemba (Oral)" **Fungal Infection (Systemic) in a Patient With Cancer and Neutropenia – Prophylaxis.** **Added** "Note: Examples of cancers predisposing neutropenic patients to risk of fungal infections include: myelodysplastic syndrome, acute myeloid leukemia, patients post-allogeneic hematopoietic cell transplant."
Antifungals – Posaconazole (Oral) for Individual and Family Plans - (IP0536)	Update	Effective: 11/1/2024 **Policy Name:** **Updated** title **from** "Posaconazole PowderMix for Delayed-Release Oral Suspension for Individual and Family Plans" **to** "Antifungals – Posaconazole (Oral) for Individual and Family Plans." **Added** Noxafil delayed release tablets and Noxafil oral suspension to the policy. **Treatment of systemic fungal Infection in a Patient with Human Immunodeficiency Virus (HIV) Infection (examples; Histoplasmosis, Coccidioidomycosis):** • **Removed** the examples, histoplasmosis and coccidioidomycosis **Fungal Infection (Systemic) in a Patient with Cancer and Neutropenia – Prophylaxis:** • **Added** "Note: Examples of cancers predisposing neutropenic patients to risk of fungal infections include: myelodysplastic syndrome, acute myeloid leukemia, patients post-allogeneic hematopoietic cell transplant." **Oropharyngeal Candidiasis – Treatment:** • **Updated from** "Treatment of Oropharyngeal and/or Esophageal Candidiasis" **to** "Oropharyngeal Candidiasis – Treatment." **Other Uses with Supportive Evidence:** • **Added** "Mouth and Esophageal Infection (Refractory to Other Azole Antifungals) – Treatment" **Added** preferred product requirement criteria table for Noxafil tablet and oral suspension and Noxafil PowderMix.
Antifungals – Voriconazole (Oral) - (IP0306)	Update	Effective: 11/1/2024

		Policy Name: **Updated** title **from** "Voriconazole (Oral)" **to** "Antifungals – Voriconazole (Oral)" **Added** the following indications with an initial treatment duration of 3 months: Candida (Systemic) Infection – Treatment, Esophageal Candidiasis – Treatment, Candida Endophthalmitis – Treatment, and Oropharyngeal Candidiasis (Fluconazole-Refractory) – Treatment, and Fungal Infection (Systemic) that is Susceptible to Voriconazole – Treatment. **Added "Note:** Examples of cancers predisposing neutropenic patients to risk of fungal infections include: myelodysplastic syndrome, acute myeloid leukemia, patients post-allogeneic hematopoietic cell transplant" under Fungal Infection (Systemic) in a Patient With Cancer and Neutropenia – Prophylaxis. **Added** preferred product requirement criteria table for all indications for both Employer Plans and Individual and Family Plans. **Updated** initial approval duration **from** "6 months" **to** "3 months" for the following indications: Aspergillus Infection – Treatment, Fusarium Infection – Treatment, Scedosporium apiospermum Infection – Treatment, Blastomycosis – Treatment. **Updated** "Continuation of Therapy for Individual Currently Receiving Intravenous Voriconazole or Oral Voriconazole (Tablets or Oral Suspension) to Complete a Course of Therapy" **to** "Patient is Currently Receiving Voriconazole. " and updated the duration of therapy to 3 months for patients Currently Receiving Voriconazole **Removed** the following indication: Treatment of Invasive or Severe Candida Infections (for example, abdomen, bladder wall, candidemia, endophthalmitis, esophageal, kidney, oropharyngeal, or skin) when there is failure, intolerance, or contraindication to fluconazole **Removed** the following indications: Treatment of Coccidioidomycosis, Histoplasmosis, or Cryptococcosis when there is failure, intolerance, or contraindication to either fluconazole or itraconazole.
Antifungals – Tolsura - (IP0275)	Update	Effective 11/1/2024 **Policy Title: Updated from** "Itraconazole (Tolsura)" **to** "Antifungals – Tolsura" **Aspergillosis – Pulmonary or Extrapulmonary – Treatment.**

		Updated indication from "Aspergillosis" to "Aspergillosis – Pulmonary or Extrapulmonary – Treatment" **Removed** "18 years of age or older" **Removed** "Intolerant or refractory to amphotericin B therapy" **Updated** authorization duration from "12 months" to "3 months" **Blastomycosis – Pulmonary or Extrapulmonary – Treatment.** **Updated** indication from "Blastomycosis" to "Blastomycosis – Pulmonary or Extrapulmonary – Treatment" **Removed** "18 years of age or older" **Updated** authorization duration from "12 months" to "3 months" **Histoplasmosis – Including Chronic Cavitary Pulmonary Disease and Disseminated, Non-Meningeal – Treatment.** **Updated** indication from "Histoplasmosis" to "Histoplasmosis – Including Chronic Cavitary Pulmonary Disease and Disseminated, Non-Meningeal – Treatment." **Removed** "18 years of age or older" **Updated** authorization duration from "12 months" to "3 months" **Preferred Product Table.** **Updated** "There is documentation of EITHER of the following (A or B): A. Individual has had an inadequate response, contraindication, or is intolerant to Itraconazole capsule or solution (generic Sporanox), B. Individual is currently receiving Tolsura" to "**ONE** of the following: 1.Approve if the patient has tried one of itraconazole capsules (generics) or itraconazole oral solution (generics). **NOTE:** A trial of either the conventional intraconazole capsules or intraconazole solution would count toward meeting criteria regardless of the formulary status of the product. 2.Patient has been started on a current course of therapy with Tolsura (for a non-oncychomycosis diagnosis): approve to complete the current course. **Added** Individual and Family Plan Preferred Product table
Antiseizure Medications – Vigabatrin - (IP0049)	Update	Effective 11/15/2024 **Vigafyde:** Vigafyde was added to the policy. **Preferred Product Table.** **Removed** Vigadrone oral solution

		Added Vigafyde oral solution
Antiseizure Medications – Ztalmy - (IP0508)	Update	Effective: 11/1/2024 **Updated** coverage policy title from "Ganaxolone" to "Antiseizure Medications – Ztalmy."
Brands with Bioequivalent Generics – (IP0011)	Update	Effective 11/1/2024 The following were **added** to the policy to support medical necessity review: **Effective 11/1/2024** **Added for Employer Plans:** Cytomel (Individual and Family plans already utilize this policy), Synthroid, Unithroid **Effective 1/1/2025** **Added for Employer Plans and Individual and Family Plans:** Aciphex tablet, Altace, Atacand, Atacand HCT, Avalide, Avapro, AZOR, Benicar, Benicar HCT, Carafate tablets, Cardizem LA, Cellcept 200mg/ml oral suspension, Cellcept 250mg capsule, Cellcept 500mg tablet, Cozaar, Diovan, Diovan HCT, Emend 80mg capsule and Emend Trifold Pack, Estrace cream, Exforge, Exforge HCT, Flomax, Hyzaar, Lomotil, Micardis, Micardis HCT, Natroba, Noxafil tablet (added dosage form to clarify tablet and suspension), Provera, Rapamune, Soma, Tribenzor, Vagifem, Valium, Xanax, Xanax XR, Zestril **Added for Employer Plans:** Diclegis, BiDil, Carafate suspension, Epaned, Gralise 300mg and 600mg, Estrace tablet (Individual and Family Plans already utilize this policy), Aczone (5% gel and 7.5% gel pump) **Added for Individual and Family Plans:** Celontin, Prezista 600mg and 800mg tablets, Noxafil 40mg/ml oral suspension (Employer plans already utilize this policy for tablet and suspension), Welchol (Employer plans already utilize this policy)
Cholbam - (IP0289)	Update	Effective: 11/1/2024 **Updated** coverage policy title from "Cholic Acid" to "Cholbam."

		Bile Acid Synthesis Disorders Due to Single Enzyme Defects (SEDs). Initial Therapy. **Removed** "consistent with a bile acid synthesis disorder" from "an abnormal urinary bile acid as confirmed by Fast Atom Bombardment ionization – Mass Spectrometry analysis." **Removed** the example from "molecular genetic testing consistent with diagnosis" criterion. **Bile Acid Synthesis Disorders Due to Peroxisomal Disorders (PDs), Including Zellweger Spectrum Disorders.** Initial Therapy. **Removed** "analysis consistent with a peroxisomal disorder as confirmed" "an abnormal urinary bile acid by Fast Atom Bombardment ionization – Mass Spectrometry analysis." **Removed** the example from "molecular genetic testing consistent with diagnosis" criterion.
Complement Inhibitors – Fabhalta - (IP0614)	Update	Effective 11/1/2024 **Primary Immunoglobulin A Nephropathy**: **Added** this condition and criteria for approval to the policy. **Conditions Not Covered:** Concomitant Use with Another Complement Inhibitor: **Added** Piasky (crovalimab-akkz intravenous infusion or subcutaneous injection) and Voydeya (danicopan tablets) to the Note that lists examples of complement inhibitors.
Complement Inhibitors – PiaSky - (IP0694)	Update	Effective 11/15/2024 **Added** a preferred product step, through Soliris or Ultomiris, for both Employer Plans and Individual and Family Plans.
Corticosteroid / Long-Acting Beta2-Agonist Combination Inhalers - (IP0022)	Update	Effective 11/15/2024 • No criteria changes.
COVID-19 Drug and Biologic Therapeutics - (2016)	Update	Effective 11/1/2024

		Removed Olumiant, Kevzara, Kineret, Tocilizumab IV, Xeljanz/Xeljanz XR from the policy and relocated medical necessity criteria to each respective individual policy as follows: Olumiant IP0681, Kevzara IP0679, Kineret IP0661, Tocilizumab IV IP0656, Xeljanz/Xeljanz XR IP0692.
Drugs Requiring Medical Necessity Review for Employer Plans - (1602)	Update	Effective: 11/1/2024 **Added preferred product step requirement for the following products:** Carac, Imiquimod 3.75% cream and cream pump, Klisyri, Zyclara 2.5% cream pump, Zyclara 3.75% cream and cream pump, valsartan oral solution (effective 1/1/2025), Edarbi (effective 1/1/2025), Edarbyclor (effective 1/1/2025), Posfrea, Focinvez, carbinoxamine maleate ER suspension, Fanapt (effective 1/1/2025), Innopran XL, Suflave (effective 1/1/2025), Clenpiq (effective 1/1/2025), Sutab (effective 1/1/2025), Katerzia, Norliqva, Estratest F.S., Tradjenta (effective 1/1/2025), Jentadueto (effective 1/1/2025), Jentadueto XR (effective 1/1/2025), insulin glargine U-300 SoloStar (effective 12/1/2024), Myhibbin, dihydroergotamine mesylate nasal spray (effective 1/1/2025), Migranal (effective 1/1/2025), Trudhesa (effective 1/1/2025), Creon (effective 1/1/2025), Pertzye (effective 1/1/2025), Ohtuvayre (effective 11/15/2024), Ermeza, levothyroxine capsules, Thyquidity, Tirosint, Tirosint-SOL, Adthyza (16.25mg, 32.5mg, 65mg, 97.5mg, and 130mg) tablets, and Armour Thyroid **Updated preferred product step requirement for the following products:** Hemangeol, Inderal XL, Kapspargo Sprinkle, Allopurinol 200 mg tablets , and Gemtesa
Eflapegrastim - (IP0526)	Update	Effective 11/15/2024 **Preferred Product Table:** Employer Group Non-Covered Products and Criteria table for Cigna Total Savings Drug List Plan: **Removed** Neulasta, **added** Fulphila
Enzyme Replacement Therapy – Strensiq - (IP0308)	Update	Effective: 11/1/2024 **Policy Title:** **Updated** from "Asfotase alfa" to "Enzyme Replacement Therapy - Strensiq" **Hypophosphatasia – Perinatal/Infantile- and Juvenile-Onset:**

		Updated the term "mutation" to "pathogenic variant" for diagnosis by genetic testing. **Added** criterion, "an elevated level of a tissue non-specific alkaline phosphatase substrate (i.e., serum pyridoxal 5'-phosphate, serum, or urinary inorganic pyrophosphate, urinary phosphoethanolamine)" for diagnosis of perinatal/infantile-onset or juvenile-onset hypophosphatasia (HPP)".
Fertility Injectables - (IP1012)	Update	Effective 11/15/2024 **Simplified** criteria for all products. **Removed** Bravelle as it has been discontinued.
Hematology – Rytelo – (IP0693)	Update	Effective 11/1/2024 **Preferred Product Table:** **Added** a prerequisite step through Reblozyl prior to coverage of Rytelo, for both Employer and Individual and Family Plans.
Hematology – Plerixafor - (IP0139)	Update	Effective: 11/1/2024 **Policy Title:** **Updated from** "Plerixafor" **to** "Hematology – Plerixafor" **Multiple Myeloma.** **Added** "The medication is prescribed by a hematologist or a stem cell transplant physician" **Added** dosing **Non-Hodgkin's Lymphoma.** **Added** "The medication is prescribed by a hematologist or a stem cell transplant physician" Added dosing **Hematopoietic Stem Cell Donors.** **Added** new condition of approval **Added** dosing **Conditions Not Covered.** **Removed** "As a mobilizing agent for an allogeneic stem cell donor"

		Removed "Following myeloablative allogeneic hematopoietic stem cell transplant to augment hematopoietic recovery" Added "WHIM syndrome (Warts, Hypogammaglobulinemia, Infections, and Myelokathexis)"
Hepatology – Bylvay - (IP0363)	Update	Effective: 11/1/2024 **Updated** policy name from "Odevixibat" from "Hepatology – Bylvay" **Progressive Familial Intrahepatic Cholestasis.** **Added** "Patient is Currently Receiving Bylvay" criteria **Updated** "Has moderate-to-severe pruritus" to "Patient has moderate-to-severe pruritus, according to the prescriber" **Updated** "Documentation of failure, contraindication, or intolerance to TWO systemic medications for progressive familial intrahepatic cholestasis (for example, cholestyramine, naltrexone, rifampicin, sertraline, or ursodeoxycholic acid [ursodiol])" to "Patient has tried at least two systemic medications for progressive familial intrahepatic cholestasis, unless contraindicated; Note: Systemic medications for progressive familial intrahepatic cholestasis include cholestyramine, naltrexone, rifampicin, sertraline, and ursodeoxycholic acid (ursodiol)." **Alagille Syndrome.** **Added** "Patient is Currently Receiving Bylvay" criteria **Updated** "Has moderate-to-severe pruritus" to "Patient has moderate-to-severe pruritus, according to the prescriber" **Updated** "Failure, contraindication, or intolerance to at least TWO systemic medications for Alagille syndrome, unless contraindicated (for example, cholestyramine, naltrexone, rifampicin, sertraline, or ursodeoxycholic acid [ursodiol])" to "Patient has tried at least two systemic medications for Alagille syndrome, unless contraindicated; Note: Systemic medications for Alagille syndrome include cholestyramine, naltrexone, rifampicin, sertraline, and ursodeoxycholic acid (ursodiol)"
Hepatology – Ocaliva - (IP0304)	Update	Effective: 11/1/2024 • **Updated** policy name from "Obeticholic Acid" to "Hepatology – Ocaliva" **Primary Biliary Cholangitis.** **Updated** "Documented intolerance or contraindication with ursodiol (ursodeoxycholic acid)" to "According to the prescriber the patient is unable

		to tolerate ursodiol therapy; Note: Examples of ursodiol therapy include ursodiol generic tablets and capsules, Urso 250, Urso Forte, and Actigall." **Added** a note to: "Has compensated cirrhosis without evidence of portal hypertension" **Added** "Patient is Currently Receiving Therapy" criteria
Human Immunodeficiency Virus – Rukobia - (IP0083)	Update	Effective: 11/1/2024 **Policy Title:** **Updated from** "Fostemsavir" **to** "Human Immunodeficiency Virus – Rukobia." **Human Immunodeficiency Virus-1 Infection.** **Updated from** "Human Immunodeficiency Virus Infection" **to** "Human Immunodeficiency Virus-1 Infection". Initial Therapy **Updated** approval duration **from** "12 months" **to** "6 months". **Updated from** "History of multi-drug resistant Human Immunodeficiency Virus" **to** "According to the prescriber, the patient is failing a current antiretroviral regimen for HIV". **Added** criterion, "According to the prescriber, the patient has exhausted at least FOUR of the following antiretroviral classes defined as elimination of all antiretrovirals within a given class due to demonstrated or projected resistance to the agent(s) in that class OR due to significant intolerance (FOUR of a, b, c, d, e, or f): a) Nucleoside reverse transcriptase inhibitor; OR Note: Examples of nucleoside reverse transcriptase inhibitors include abacavir, didanosine, emtricitabine, lamivudine, stavudine, tenofovir disoproxil fumarate, tenofovir alafenamide, zidovudine. b) Non-nucleoside reverse transcriptase inhibitor; OR Note: Examples of non-nucleoside reverse transcriptase inhibitor include delavirdine, efavirenz, etravirine, nevirapine, nevirapine XR, rilpivirine. c) Protease inhibitor; OR Note: Examples of protease inhibitors include atazanavir, darunavir, fosamprenavir, indinavir, nelfinavir, ritonavir, saquinavir, tipranavir. d) Fusion inhibitor; OR Note: Examples of fusion inhibitors include Fuzeon (enfuvirtide subcutaneous injection). e) Integrase strand transfer inhibitor; OR

		Note: Examples of integrase strand-transfer inhibitors include raltegravir, dolutegravir, elvitegravir. f) CCR5 antagonist; AND Note: Examples of CCR5 antagonists include Selzentry (maraviroc tablets)". Patient is Currently Receiving Rukobia. **Updated from** "Reauthorization Criteria. Fostemsavir extended-release (Rukobia) tablets are considered medically necessary for continued use when initial criteria are met AND there is documentation of beneficial response" **to** Patient is Currently Receiving Rukobia. Approve for 1 year if the patient meets BOTH of the following (i and ii): i. The medication will continue to be taken in combination with an optimized antiviral background regimen including one or more other antiretroviral agents; AND ii. Patient has responded to a Rukobia-containing regimen, as determined by the prescriber. Note: Examples of a response are HIV RNA < 40 cells/mm3, HIV-1 RNA ≥ 0.5 log10 reduction from baseline in viral load, improvement, or stabilization of CD4 T-cell count."
Hyperhidrosis – Sofdra - (IP0703)	New	Effective 11/15/2024 • New policy
Immunologicals – Ebglyss - (IP0708)	New	Effective 11/15/2024 • New policy
Inflammatory Conditions – Ilaris Prior Authorization Policy – (IP0235)	Update	Effective 11/1/2024 **Updated** policy title from "Inflammatory Conditions – Ilaris" to "Inflammatory Conditions – Ilaris Prior Authorization Policy" **Added** "Policy Statement"
Inflammatory Conditions - Spesolimab Intravenous Prior Authorization Policy – (IP0501)	Update	Effective 11/1/2024

		Updated policy title from "Inflammatory Conditions – Spevigo Intravenous" to "Inflammatory Conditions – Spevigo Intravenous Prior Authorization Policy". **Added** "Policy Statement".
Inflammatory Conditions – Spevigo Subcutaneous Prior Authorization Policy - (IP0649)	Update	Effective 11/1/2024 **Updated** policy title from "Inflammatory Conditions – Spevigo Subcutaneous" to "Inflammatory Conditions – Spevigo Subcutaneous Prior Authorization Policy"
Inflammatory Conditions – Tremfya Intravenous Prior Authorization Policy - (IP0704)	New	Effective 11/1/2024 • New policy.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy - (PSM003)	New	Effective 11/1/2024 New policy replacing preferred product requirements within retired policy, Adalimumab (IP0245) • Use with New Policy, Inflammatory Conditions – Adalimumab Products Prior Authorization Policy - IP0652
Inflammatory Conditions – Adalimumab Products Prior Authorization Policy - (IP0652)	New	Effective 11/1/2024 New policy replacing prior authorization criteria within retired policy, Adalimumab (IP0245) Use with New Policy, Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy - (PSM003)
Inflammatory Conditions – Bimzelx Prior Authorization Policy - (IP0658)	New	Effective 11/1/2024 New policy replacing prior authorization criteria within retired policy, Inflammatory Conditions – Bimzelx (IP0603)

		Use with New Policy, Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001) OR Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)
Inflammatory Conditions – Cibinqo Prior Authorization Policy - (IP0677)	New	Effective 11/1/24 New policy replacing retired policy, Inflammatory Conditions – Cibinqo (IP0404)
Inflammatory Conditions – Cimzia Prior Authorization Policy - (IP0672)	New	Effective 11/1/2024 New policy replacing prior authorization criteria within retired policy, Certolizumab (IP0244) Use with New Policy, Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001) • OR Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM009)	New	Effective 11/1/24 New policy that applies only when Cosentyx Intravenous is covered under the Prescription Drug Benefit. Replaces retired policy, Secukinumab Intravenous for Employer Plans (IP0594) • Use with Inflammatory Conditions – Cosentyx Intravenous Prior Authorization Policy - (IP0683)
Inflammatory Conditions – Cosentyx Intravenous Prior Authorization Policy - (IP0683)	New	Effective 11/1/24 New policy replacing retired policy, Inflammatory Conditions – Cosentyx

		Intravenous (IP0643) • Use with Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM009)
Inflammatory Conditions – Cosentyx Subcutaneous Prior Authorization Policy - (IP0678)	New	Effective 11/1/2024 New policy replacing prior authorization criteria within retired policy Secukinumab Subcutaneous (IP0223) For employer group plans ONLY, Use with New Policy, Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001)
Inflammatory Conditions – Entyvio Intravenous Prior Authorization Policy - (IP0674)	New	Effective 11/1/24 • New policy replacing retired policy, Vedolizumab (IP0326)
Inflammatory Conditions – Entyvio Subcutaneous Prior Authorization Policy - (IP0675)	New	Effective 11/1/24 New policy replacing preferred product requirements in retired policies, Inflammatory Conditions – Entyvio Subcutaneous (IP0599) and Inflammatory Conditions – Entyvio Subcutaneous for Total Savings and Individual and Family Plans (IP0613) Use with New Policy, Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001) OR Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)

Inflammatory Conditions – Etanercept Products Prior Authorization Policy - (IP0673)	New	Effective 11/1/24 • New policy replacing retired policy, Etanercept (IP0241)
Inflammatory Conditions – Ilumya Prior Authorization Policy - (IP0659)	New	Effective 11/1/24 New policy replacing preferred product requirements in retired policy, Tildrakizumab (IP0236) Use with New Policy, Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001) OR Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002
Inflammatory Conditions – Infliximab Intravenous Products Preferred Specialty Management Policy - (PSM005)	New	Effective 11/1/24 New policy for preferred product requirements of Infliximab. • Use with Inflammatory Conditions – Infliximab Intravenous Products Prior Authorization Policy - (IP0660)
Inflammatory Conditions – Infliximab Intravenous Products Prior Authorization Policy - (IP0660)	New	Effective 11/1/24 New policy for prior auth criteria replacing retired policy Infliximab (IP0242) Use with Inflammatory Conditions – Infliximab Intravenous Products Preferred Specialty Management Policy - (PSM005
Inflammatory Conditions – Kevzara Prior Authorization Policy - (IP0679)	New	Effective 11/1/24 New policy replacing preferred product requirements in retired policy, Sarilumab (IP0233)

		Use with New Policy, Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001) OR Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)
Inflammatory Conditions – Kineret Prior Authorization Policy - (IP0661)	New	Effective 11/1/24 New policy replacing preferred product requirements in retired policy, Anakinra (IP0243) Use with New Policy, Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001) OR Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)
Inflammatory Conditions – Cosentyx Subcutaneous Prior Authorization Policy - (IP0678)	New	Effective 11/1/24 New policy replacing retired policies, Secukinumab Intravenous for Employer Plans (IP0594) and Secukinumab Subcutaneous (IP0223) Use with New Policy, Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001)
Inflammatory Conditions – Litfulo Prior Authorization Policy - (IP0680)	New	Effective 11/1/24 • New policy replacing retired policy, Ritlecitinib (IP0589)
Inflammatory Conditions – Olumiant Prior Authorization Policy - (IP0681)	New	Effective 11/1/24 New policy replacing preferred product requirements in retired policy, Baricitinib (IP0225)

		Use with New Policy, Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001) OR Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)
Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy - (PSM011)	New	Effective 11/1/24 New policy for preferred product requirements with Omvoh. Use with Inflammatory Conditions – Omvoh Intravenous Prior Authorization Policy - (IP0662)
Inflammatory Conditions – Omvoh Intravenous Prior Authorization Policy - (IP0662)	New	Effective 11/1/24 New policy replacing retired policy, Inflammatory Conditions – Omvoh Intravenous (IP0601) Use with Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy - (PSM011)
Inflammatory Conditions – Omvoh Subcutaneous Prior Authorization Policy - (IP0663)	New	Effective 11/1/24 New policy replacing retired policy, Inflammatory Conditions – Omvoh Subcutaneous (IP0602) Use with Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001) OR Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance,	New	Effective 11/1/24 New policy replacing preferred product requirements within retired policy, Abatacept Intravenous (IP0232), for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists

Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM006)		• Use with Inflammatory Conditions – Orencia Intravenous Prior Authorization Policy - (IP0664)
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Individual and Family Plans - (PSM010)	New	Effective 11/1/24 New policy replacing preferred product requirements within retired policy, Abatacept Intravenous (IP0232), for Individual and Family Plans • Use with Inflammatory Conditions – Orencia Intravenous Prior Authorization Policy - (IP0664)
Inflammatory Conditions – Orencia Intravenous Prior Authorization Policy - (IP0664)	New	Effective 11/1/24 New policy replacing retired policy, Abatacept Intravenous (IP0232). Use with Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM006) OR Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Individual and Family Plans - (PSM010)
Inflammatory Conditions – Orencia Subcutaneous Prior Authorization Policy - (IP0665)	New	Effective 11/1/24 New policy replacing retired policy, Abatacept Subcutaneous (IP0231) Use with Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001) • OR Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002

Inflammatory Conditions – Otezla Prior Authorization Policy - (IP0666)	New	Effective 11/1/24 New policy replacing retired policy, Apremilast (IP0226)
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001)	New	Effective 11/1/24 New policy replacing preferred product requirements for all inflammatory condition Oral and Subcutaneous products for Employer group plans. • Use with respective Inflammatory Conditions prior authorization policy as applies.
Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)	New	Effective 11/1/24 New policy replacing preferred product requirements for all inflammatory condition Oral and Subcutaneous products for Individual and Family Plans plans. • Use with respective Inflammatory Conditions prior authorization policy as applies.
Inflammatory Conditions – Rinvoq/Rinvoq LQ Prior Authorization Policy - (IP0682)	New	Effective 11/1/24 New policy replacing retired policy, Upadacitinib (IP0229 Use with Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001) • OR Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002
Inflammatory Conditions – Siliq Prior Authorization Policy - (IP0685)	New	Effective 11/1/24 New policy replacing retired policy, Brodalumab (IP0246)

		Use with Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001) OR Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002
Inflammatory Conditions – Simponi Aria Prior Authorization Policy - (IP0668)	New	Effective 11/1/24 New policy replacing retired policy, Golimumab Intravenous (IP0238)
Inflammatory Conditions – Simponi Subcutaneous Prior Authorization Policy - (IP0667)	New	Effective 11/1/24 New policy replacing retired policy, Golimumab Subcutaneous (IP0237) Use with Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001) OR Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)
Inflammatory Conditions – Skyrizi Intravenous Prior Authorization Policy - (IP0669)	New	Effective 11/1/24 New policy replacing retired policy, Risankizumab Intravenous (IP0476)
Inflammatory Conditions – Skyrizi Subcutaneous Prior Authorization Policy - (IP0670)	New	Effective 11/1/24 New policy replacing retired policy, Risankizumab Subcutaneous (IP0247)
Inflammatory Conditions – Sotyktu Prior Authorization Policy - (IP0671)	New	Effective 11/1/24 New policy replacing retired policy, Deucravacitinib (IP0538) For Individual and family plans ONLY, use with Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)

		•
Inflammatory Conditions - Spesolimab Intravenous Prior Authorization Policy - (IP0501)	New	Effective 11/1/24 • New Policy
Inflammatory Conditions – Stelara Intravenous Prior Authorization Policy - (IP0686)	New	Effective 11/1/24 • New policy replacing retired policy, Ustekinumab Intravenous (IP0240)
Inflammatory Conditions – Stelara Subcutaneous Prior Authorization Policy - (IP0687)	New	Effective 11/1/24 New policy replacing retired policy, Ustekinumab Subcutaneous (IP0239) •
Inflammatory Conditions – Taltz Prior Authorization Policy - (IP0688)	New	Effective 11/1/24 New policy replacing retired policy, Ixekizumab (IP0224) For Individual and family plans ONLY, use with Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)
Inflammatory Conditions – Tocilizumab Intravenous Products Preferred Specialty Management Policy - (PSM012)	New	Effective 11/1/24 New policy replacing preferred product requirements in retired policy, Tocilizumab Intravenous (IP0228) • Use with Inflammatory Conditions – Tocilizumab Intravenous Products Prior Authorization Policy - (IP0656)
Inflammatory Conditions – Tocilizumab Intravenous Products Prior Authorization Policy - (IP0656)	New	Effective 11/1/24 New policy replacing retired policy, Tocilizumab Intravenous (IP0228)

		• Use with Inflammatory Conditions – Tocilizumab Intravenous Products Preferred Specialty Management Policy - (PSM012)
Inflammatory Conditions – Tocilizumab Subcutaneous Products Prior Authorization Policy - (IP0657)	New	Effective 11/1/24 New policy replacing retired policy, Tocilizumab Subcutaneous (IP0227) Use with Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001) OR Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)
Inflammatory Conditions – Tremfya Prior Authorization Policy - (IP0689)	New	Effective 11/1/24 • New policy replacing retired policy, Guselkumab (IP0234)
Inflammatory Conditions – Velsipity Prior Authorization Policy - (IP0691)	New	Effective 11/1/24 New policy replacing retired policy, Inflammatory Conditions – Velsipity (IP0605) Use with Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001) OR Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002
Inflammatory Conditions – Xeljanz/Xeljanz XR Prior Authorization Policy - (IP0692)	New	Effective 11/1/24 New policy replacing retired policy Tofacitinib (IP0230) Use with Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (PSM001)

		OR Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)
Inflammatory Conditions - Zymfentra Prior Authorization Policy - (IP0646)	New	Effective 11/1/24 **Updated** policy title from Inflammatory Conditions – Zymfentra to Inflammatory Conditions – Zymfentra Prior Authorization Policy **Added** "Policy Statement" **Conditions Not Covered:** Concurrent use with a Biologic or with a Targeted Synthetic Oral Small Molecule Drug was updated to as listed (previously oral small molecule drug was listed as Disease-Modifying Antirheumatic Drug).
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists – (PSM001)	Update	Effective: 11/15/2024 **Added** a newly created Step 2b to the policy, which directs to a trial of one Step 1 Product. For existing Step 3a Products, it was clarified that these Products are directed a trial of two Step 1 or Step 2a Products (previously these were listed as Step 1 or Step 2 Products) with no changes to the criteria. For Plaque Psoriasis, Tremfya was clarified to be the subcutaneous formulation. **Tremfya:** For plaque psoriasis, it was clarified that the subcutaneous formulation is in Step 1. **Bimzelx:** Bimzelx was moved into Step 2a and requests are directed to a trial of one Step 1 Product (previously was in Step 2 and was directed to two Step 1 Products with documentation requirements). A previous trial of Tremfya was clarified to be the subcutaneous formulation.
Inflammatory Conditions – Siliq Prior Authorization Policy – (IP0685)	Update	Effective: 11/15/2024 **Plaque Psoriasis:** For initial approval and for a patient currently receiving Siliq, requirements were added that the prescriber attests the patient has been evaluated for the risks of suicidal ideation and behavior versus the benefits of

		therapy and that the patient does not have moderately severe to severe depression. For initial approval, a requirement was added that within the past 5 years, the patient does not have a history of suicidal ideation or suicidal behavior; for a patient currently receiving Siliq, a requirement was added that, according to the prescriber the patient does not have suicidal ideation or suicidal behavior.
Inpefa - (IP0582)	Update	Effective: 11/1/2024 **Updated** coverage policy title from "Sotagliflozin" to "Inpefa." **FDA-Approved Indication(s):** **Type 2 Diabetes, To Reduce The Risk of Cardiovascular Death, Hospitalization for Heart Failure, and Urgent Heart Failure Visit.** **Added**, "Note: Patients with heart failure should be reviewed under criteria for *Heart Failure"* for a patient that has one or more cardiovascular risk factors. **Conditions Not Covered:** **Type 1 Diabetes.** **Added**, "Note: Patients with heart failure should be reviewed under criteria for *Heart Failure"*
Interferon – Actimmune – (IP0201)	Update	Effective 11/15/2024 **Chronic Granulomatous Disease: Added** a hematologist or an infectious disease specialist to the specialist requirement; previously only an immunologist was listed.
Lofexidine for Individual and Family Plans - (IP0696)	New	Effective: 11/1/2024 • New policy
Muscular Dystrophy – Duvyzat - (IP0651)	New	Effective 11/1/2024 New coverage policy.
Neurology – Brineura - (IP0175)	Update	Effective: 11/1/2024 **Neuronal Ceroid Lipofuscinosis Type 2 (CLN2):**

		The condition name was changed to as listed; previously, the approval condition was titled Late Infantile Neuronal Ceroid Lipofuscinosis Type 2 (CLN2). The requirement that the patient is ≥ 3 years of age was removed from the criteria. **Conditions Not Covered:** **Updated from** "mutation" **to** "pathogenic variant".
Nephrology – Jesduvroq - (IP0604)	Update	Effective: 11/1/2024 **Conditions Not Covered**: **Added** "Concurrent Use with Vafseo (vadadustat tablets). The safety and efficacy of concurrent use of Jesduvroq and Vafseo have not been established."
Maralixibat - (IP0341)	Update	Effective: 11/1/2024 **Alagille Syndrome:** For diagnosis by genetic testing, the term "mutation" was rephrased to "pathogenic variant". • **Progressive Familial Intrahepatic Cholestasis:** For diagnosis by genetic testing, the term "mutation" was rephrased to "pathogenic variant". Additionally, the criterion for age was changed from > 5 years to > 12 months of age to align with FDA indication expansion for age.
Metabolic Disorders – Dojolvi - (IP0084)	Update	Effective: 11/1/2024 **Policy Title:** **Updated** title from "Triheptanoin" to "Metabolic Disorders – Dojolvi," **Long-Chain Fatty Acid Oxidation Disorders:** • For diagnosis by genetic testing, rephrased the term "mutation" to "variant". • **Added** "according to the prescriber" in the criteria stating that the patient must have inadequate efficacy or significant intolerance to an over-the-counter medium-chain triglyceride product or has a history of at least one severe or recurrent manifestation of long-chain fatty acid oxidation.
Muscular Dystrophy – Gene Therapy – Elevidys - (IP0571)	Update	Effective: 11/1/2024 **Policy Title:**

		Updated from "Muscular Dystrophy – Gene Therapy – Elevidys (delandistrogene moxeparvovec-rokl intravenous infusion)" **to** "Muscular Dystrophy – Gene Therapy – Elevidys" **Conditions Not Covered.** **Added** "The current Elevidys efficacy information is insufficient to determine if the medication demonstrates any clinically meaningful benefits. In the absence of additional clinical trials, there is not enough information to support approval."
Natalizumab - (IP0215)	Update	Effective 11/1/2024 Updated the Crohn's Disease medical necessity criteria.
Neurology – Rystiggo - (IP0575)	Update	Effective: 11/1/2024 **Updated** coverage policy title from "Rozanolixizumab" to "Neurology – Rystiggo."
Oncology (Injectable) – Tecelra - (IP0699)	New	Effective 11/1/2024 • New coverage policy.
Ophthalmology – Oxervate - (IP0302)	Update	Effective: 11/1/2024 **Updated** coverage policy title from "Cenegermin Ophthalmic Solution" to "Ophthalmology – Oxervate." **Neurotrophic Keratitis.** **Initial treatment:** **Removed** criterion screening for "stage 2 (moderate) or stage 3 (severe) neurotrophic keratitis". **Recurrence treatment:** **Removed** criterion screening for "Attestation of need for additional course of therapy based upon partial response or recurrence". **Added** criterion screening for "The medication is prescribed by an ophthalmologist or optometrist".

Opioid Therapy – Individual and Family Plans - (IP0562)	Update	Effective 11/15/2024 **Added** preferred product criteria for Oxycodone tables (generic for RoxyBond, manufactured by Ohemo Life Sciences) **Updated** the preferred product criteria for Roxybond, aligning it to current standards.
Ozanimod - (IP0214)	Update	Effective 11/1/2024 Updated the Ulcerative Colitis medical necessity and preferred product criteria.
Neurology – Rystiggo - (IP0575)	Update	Effective: 11/1/2024 **Updated** coverage policy title from "Rozanolixizumab" to "Neurology – Rystiggo." **Updated Coding:** **Removed** C9399, J3490, J3590 **Added** J9333
Neurology – Vyvgart Intravenous - (IP0376)	Update	Effective: 11/1/2024 **Policy Name:** **Updated from** "Efgartigimod Intravenous" **to** "Neurology – Vyvgart Intravenous." **Generalized Myasthenia Gravis:** **Added** criterion to Initial therapy and Patient is currently receiving section: "Treatment cycles are no more frequent than every 50 days from the start of the previous treatment cycle." **Removed** "prior to starting therapy with Vyvgart or Vyvgart Hytrulo" **from** requirement that patient has MGFA clinical classification of II-IV and MG-ADL score of 5 or higher.
Ophthalmology – Izervay – (IP0581)	Update	Effective: 11/15/2024 **Updated** policy title **from** "Avacincaptad Intravitreal Injection **to** "Ophthalmology – Izervay." No criteria changes. **Updated Coding:**

		Removed C9399, J3490, J3590 **Added** J2782 (effective 4/1/2024)
Pegvaliase-pqpz - (IP0294)	Update	Effective 11/15/2024 **Phenylketonuria (PKU):** **Removed** the requirement for Palynziq to be prescribed in in conjunction with a phenylalanine restricted diet. **Removed** the no concomitant use with sapropterin (Kuvan), once stabilized on Palynziq. This requirement has been moved to the reauthorization criteria. **Reauthorization Criteria:** **Added** a statement limiting the treatment duration, at a dose of 60 mg, to 16 weeks. **Added** a statement prohibiting concomitant therapy with sapropterin (Kuvan).
Pharmacy Prior Authorization - (IP1407)	Update	Effective: 11/1/2024 **Added** Individual and Family Plan product-specific medical necessity criteria for: Focinvez, Myhibbin, allopurinol 200 mg oral tablet, Posfrea IV injection
Pozelimab-bbf - (IP0587)	Update	Effective 11/15/2024 **CD55-Deficient Protein-Losing Enteropathy (CHAPLE Disease [Complement Hyperactivation, Angiopathic thrombosis, and Protein-Losing Enteropathy]): Removed** the statement "Does not have active meningococcal infection". **Updated Coding:** **Added** J9376 **Removed** C9399, J3490, J3590
Rituximab for Non-Oncology Indications - (IP0319)	Update	Effective 11/1/2024 Updated the Rheumatoid Arthritis medical necessity criteria.
Spinal Muscular Atrophy – Gene Therapy – Zolgensma (IP0185)	Update	Effective: 11/21/2024 **Added** "Policy Statement" to the policy. **Added** "**Documentation:** Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to

		chart notes, laboratory results, medical test results, claims records, prescription receipts, and/or other information." **Spinal Muscular Atrophy – Treatment:** • **Updated** criterion **from "**If premature neonate, full-term gestational age has been met" to "If the patient is a premature neonate, full-term gestation age of 39 weeks and 0 days has been met" and **added** "Note: Full-term gestational age can be defined as the postmenstrual age (gestational age plus chronological age) being equal to ≥ 39 weeks and 0 days." • **Added** "Note: Pathogenic variants may include homozygous deletion, compound heterozygous mutation, or a variety of other rare mutations" to the criteria "Patient has had a genetic test confirming the diagnosis of spinal muscular atrophy with bi-allelic pathogenic variants in the survival motor neuron 1 (SMN1) gene." • **Updated** criterion **from** "No previous use of onasemnogene abeparvovec-xioi (Zolgensma)" **to "**Patient has not received Zolgensma in the past **[verification in claims history required]"** and **added "**Note: If no claim for Zolgensma is present (or if claims history is not available), the prescribing physician confirms that the patient has not previously received Zolgensma." • **Updated** criterion **from** "Prescriber attests that prophylactic systemic corticosteroids, equivalent to oral prednisolone at a dose of 1 mg/kg per day, will commence 1 day prior to Zolgensma infusion and will continue daily for a total of 30 days" **to** "According to the prescribing physician, patient has started or will receive systemic corticosteroids equivalent to oral prednisolone at a dose of 1 mg/kg per day commencing 1 day prior to Zolgensma infusion and for a total of 30 days." • The phrase "liver function assessment" was replaced with "liver function testing." • In phrases in which a requirement is "within the last 30 days", the word "last" was replaced with "past". • **Added** criterion "Current patient body weight has been obtained within the past 14 days [documentation required]." • **Added** criterion "If criteria A through N are met, approve one dose of Zolgensma to provide for a one-time (per lifetime) single dose of 1.1 x 1014 vector genomes per kg (vg/kg) of body weight by intravenous infusion [verification required]. Zolgensma is provided as a customized kit to meet dosing requirements for each patient per their weight (in kilograms). Zolgensma kit sizes (per the cited NDC) are in Table 2." **Authorization Duration:**

		Updated from "Authorization is for a one-time treatment for a one month duration or until 2 years of age, whichever comes first" to "Approve for a one-time (per lifetime) single dose if the patient meets ALL of the following;" **Conditions Not Recommended for Approval:** The conditions of "Prior Receipt of Gene Therapy" and "Administration in Individuals in Utero" were added.
Step Therapy Individual and Family Plan - (IP1603)	Update	Effective 11/15/2024 **Removed** Humalog vial, Fanapt, Flovent Discus and Flovent HFA from the policy, effective 1/1/2025. **Added** Insulin Lispro Vial and mirabegron ER (generic for Myrbetriq), as step 1 options, effective 1/1/2025 **Removed** long-acting Insulin from the policy, effective 1/1/2025. **Updated** Striverdi from step 2 to step 1 and Serevent from step 1 to step 2, effective 1/1/2025
Step Therapy – Standard and Performance Prescription Drug Lists (Employer Group Plans) – (IP1801)	Update	Effective 11/15/2024 **Removed** Aciphex, Altace, Avapro, Cozaar, Fanapt, and Zestril from the policy, effective 1/1/2025.
Step Therapy – Value and Advantage Prescription Drug Lists (Employer Group Plans) – (IP1802)	Update	Effective 11/15/2024 **Removed** Fanapt, Jentadueto, Jentadueto XR, and Tradjenta, from the policy, effective 1/1/2025.
Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) – (IP1803)	Update	Effective 11/15/2024 **Removed** Aciphex, Altace, Avapro, Cozaar, Fanapt, and Zestril from the policy, effective 1/1/2025. **Added** mirabegron ER (generic for Myrbetriq) as a step 1 medication, effective 1/1/2025.
Topical Ruxolitinib - (IP0369)	Update	Effective 11/15/2024 Individual and Family Plans added to the policy. **Mild to Moderate Atopic Dermatitis:** **Updated** the minimum topical corticosteroid trial duration from 14 to 28 days.

Wakefulness-Promoting Agents – Sunosi - (IP0102)	Update	Effective 11/1/2024 **Excessive Daytime Sleepiness Associated with Narcolepsy.** The criteria were updated to include central nervous system (CNS) stimulants as an option for patients to have tried prior to approval of Sunosi. Now a patient needs to have tried a central nervous system (CNS) stimulant, generic modafinil, or generic armodafinil prior to approval of Sunosi. Previously, a patient had to have tried one of generic modafinil or generic armodafinil. Additionally, examples CNS stimulants were added to the Note.
Wakefulness-Promoting Agents – Wakix - (IP0292)	Update	Effective 11/1/2024 **Excessive Daytime Sleepiness Associated with Narcolepsy.** The criteria were updated to include central nervous system (CNS) stimulants as an option for patients who are ≥ 18 years of age to have tried prior to approval of Wakix. Now a patient who is ≥ 18 years of age needs to have tried a central nervous system (CNS) stimulant, generic modafinil, or generic armodafinil OR have a history of substance use disorder prior to approval of Wakix. Previously, a patient who is ≥ 18 years of age had to have tried one of generic modafinil or generic armodafinil. Additionally, examples CNS stimulants were added to the Note.
Vasculitis – Tavneos - (IP0398)	UPDATE	Effective date: 11/1/2024 No criteria changes.
Furosemide On-Body Infuser - (IP0551)	Retired	Effective 11/1/2024 Relocated to Pharmacy Prior Authorization (1407) and Drugs Requiring Medical Necessity Review for Employer Plans (1602)
Thyroid Hormone Supplements - (IP0060)	Retired	Effective: 11/1/2024 Relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602) for EMP, Pharmacy Prior Authorization (1407) for IFP & Brands with Bioequivalent Generics (IP0011) for both EMP and IFP
Topical Medications for Actinic Keratosis - (IP0367)	Retired	Effective: 11/1/2024 Relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602) for EMP and Pharmacy Prior Authorization (1407) for IFP
Beta Blockers - (IP0461)	Retired	Effective: 11/1/2024

		Relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602) for EMP and Pharmacy Prior Authorization (1407) for IFP
Amlodipine Oral Solution - (IP0484)	Retired	Effective: 11/1/2024 Relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602) for EMP and Pharmacy Prior Authorization (1407) for IFP
Ombitasvir/Paritaprevir/Ritonavir and Dasabuvir – (IP0189)	Retired	**Effective 11/1/2024** Policy to be retired. Product has been discontinued by the manufacturer.
Inflammatory Conditions – Bimzelx - (IP0603)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0658 (Inflammatory Conditions – Bimzelx Prior Authorization Policy)
Inflammatory Conditions – Cibinqo - (IP0404)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0677 (Inflammatory Conditions – Cibinqo Prior Authorization Policy)
Inflammatory Conditions – Cosentyx Intravenous - (IP0643)	Retired	**Effective 11/1/2024** Policy to be retired.
Secukinumab Intravenous for Employer Plans - (IP0594)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0683 (Inflammatory Conditions – Cosentyx Intravenous Prior Authorization Policy)
Secukinumab Subcutaneous - (IP0223)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0678 (Inflammatory Conditions – Cosentyx Subcutaneous Prior Authorization Policy)
Sarilumab - (IP0233)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0679 (Inflammatory Conditions – Kevzara Prior Authorization Policy)
Ritlecitinib - (IP0589)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0680 (Inflammatory Conditions – Litfulo Prior Authorization Policy)

Baricitinib - (IP0225)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0681 (Inflammatory Conditions – Olumiant Prior Authorization Policy)
Upadacitinib - (IP0229)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0682 (Inflammatory Conditions – Rinvoq/Rinvoq LQ Prior Authorization Policy)
Brodalumab - (IP0246)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0685 (Inflammatory Conditions – Siliq Prior Authorization Policy)
Ustekinumab Intravenous - (IP0240)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0686 (Inflammatory Conditions – Stelara Intravenous Prior Authorization Policy)
Ustekinumab Subcutaneous - (IP0239)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0687 (Inflammatory Conditions – Stelara Subcutaneous Prior Authorization Policy)
Ixekizumab - (IP0224)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0688 (Inflammatory Conditions – Taltz Prior Authorization Policy)
Guselkumab - (IP0234)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0689 (Inflammatory Conditions – Tremfya Prior Authorization Policy)
Tocilizumab Intravenous - (IP0228)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0656 (Inflammatory Conditions – Tocilizumab Intravenous Products Prior Authorization Policy)
Tocilizumab Subcutaneous - (IP0227)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0657 (Inflammatory Conditions – Tocilizumab Subcutaneous Products Prior Authorization Policy)

Inflammatory Conditions – Velsipity (IP0605)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0691 (Inflammatory Conditions – Velsipity Prior Authorization Policy)
Tofacitinib - (IP0230)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by CP IP0692 (Inflammatory Conditions – Xeljanz/Xeljanz XR Prior Authorization Policy)
Adalimumab - (IP0245)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Adalimumab Products Prior Authorization Policy - IP0652
Tralokinumab - (IP0386)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Immunologicals – Adbry Prior Authorization Policy - IP0653
Certolizumab - (IP0244)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Cimzia Prior Authorization Policy - IP0672
Etanercept - (IP0241)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Etanercept Products Prior Authorization Policy - IP0673
Inflammatory Conditions – Entyvio Subcutaneous - (IP0599)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Entyvio Subcutaneous Prior Authorization Policy - IP0675
Inflammatory Conditions – Entyvio Subcutaneous for Total Savings and Individual and Family Plans - (IP0613)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Entyvio Subcutaneous Prior Authorization Policy - IP0675
Tildrakizumab - (IP0236)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Ilumya Prior Authorization Policy - IP0659

Infliximab - (IP0242)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Infliximab Intravenous Products Prior Authorization Policy - IP0660
Anakinra - (IP0243)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Kineret Prior Authorization Policy – IP0661
Inflammatory Conditions – Omvoh Intravenous - (IP0601)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Omvoh Intravenous Prior Authorization Policy – IP0662
Inflammatory Conditions – Omvoh Subcutaneous - (IP0602)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Omvoh Subcutaneous Prior Authorization Policy – IP0663
Abatacept Intravenous - (IP0232)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Orencia Intravenous Prior Authorization Policy – IP0664
Abatacept Subcutaneous - (IP0231)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Orencia Subcutaneous Prior Authorization Policy – IP0665
Apremilast - (IP0226)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Otezla Prior Authorization Policy – IP0666
Golimumab Subcutaneous - (IP0237)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Simponi Subcutaneous Prior Authorization Policy – IP0667
Golimumab Intravenous - (IP0238)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Simponi Aria Prior Authorization Policy – IP0668

Risankizumab Intravenous - (IP0476)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Skyrizi Intravenous Prior Authorization Policy – IP0669
Risankizumab Subcutaneous - (IP0247)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Skyrizi Subcutaneous Prior Authorization Policy – IP0670
Deucravacitinib - (IP0538)	Retired	**Effective 11/1/2024** Policy to be retired and replaced by Inflammatory Conditions – Sotyktu Prior Authorization Policy – IP0671
Vedolizumab - (IP0326)	Retired	**Effective 11/1/24** Policy to be retired and replaced by Inflammatory Conditions – Entyvio Intravenous Prior Authorization Policy - (IP0674)
CareAllies Medical Necessity Guideline	**New, Updated, or Retired?**	**Comments**
		• All above updates apply
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
Precertification Policy	Update	• 63 codes removed from precert • 7 codes added to precert and delegated to new eviCore programs • 287 codes delegated to new eviCore programs (already on precert)
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**

Coding and Billing Accuracy - (R46)	New	Effective 01/13/2025 Cigna has developed a new policy for coding and billing accuracy.
Modifier 50 Bilateral Procedures - (M50)	Update	Effective 02/17/2025 Cigna will reimburse modifier 50 bilateral eligible procedures at 150% when billed with 1 unit on a single claim line.
Assistant Surgeon – Modifiers 80, 81, 82 Assistant-At-Surgery – Modifier AS Co-Surgeon (Two Surgeons) – Modifier 62 Surgical Team – Modifier 66 (M66)	Update	Effective 11/10/2024 CPT codes 55970 and 55980 were updated from an indicator of 9 to indicator of 2 allowing the assistant surgeon, co-surgeon or assistant-at-surgery. Policy received an annual review to added clarifying language, table of the modifiers, and the code tables by modifier were converted to links.
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		No updates for November 2024
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**
Code Editing Policy and Guidelines	Update	On November 10, 2024, ClaimsXten will be updated to Fourth Quarter Knowledge Base content and NCCI Version 30.3 for all medical and behavioral claims we process.