Payment Policy & Coding Monthly Policy Updates

Effective September 15, 2026 (unless otherwise noted)

Note – Log-in is needed for policy update sections marked with an asterisk *. Use this link to log-in, Cigna for Health Care Professionals > Resources > Reimbursement and Payment Policies.

Medical Coverage Policy	New, Updated, or Retired?	Comments
Amplitude-Modulated Radiofrequency Electromagnetic Fields Therapy – (0581)	Updated	**Posted 6/15/2026, Effective 9/15/2026** Important change(s) in coverage criteria/policy: • Title change from "Amplitude-Modulated Radiofrequency Electromagnetic Fields Therapy" to "Electromagnetic Field and Alternating Electric Field Therapy for Cancer Treatment". • Added policy statement for the use of tumor treating fields (TTFields) therapy in supratentorial glioblastoma.
Benign Prostatic Hyperplasia (BPH) Surgical Treatments - (0159)	Updated	Important change in coverage criteria/policy: • Removed the policy statement for HIFU because the associated CPT code is not managed.
Electrical Stimulation Therapy and Devices	Updated	Important change in coverage criteria/policy:

in a Home Setting – (0160)		• Removed percutaneous electrical nerve field stimulation (PENFS) from list of devices/therapies considered experimental, investigational, or unproven. • Editorial updates and restructuring throughout for clarity and readability.
Flow Cytometry – (0538)	Updated	Important change(s) in coverage criteria/policy: • Revised policy statement to include platelet function disorders and acquired and congenital red cell disorders in the medically necessary indications.
Manipulation Under Anesthesia – (0276)	Updated	Important change(s) in coverage criteria/policy: • Revised the conservative treatment requirements for adhesive capsulitis/frozen shoulder by condensing requirements down to physical therapy and intra-articular corticosteroid injections. • Revised the conservative treatment requirements for chronic contractures and arthrofibrosis of the knee by condensing requirements down to physical therapy.
Open Neuroplasty Lumbar Plexus – (0587)	Updated	**Posted 9/15/2026, Effective 12/15/2026** Important changes in coverage criteria/policy: • Revised policy statements for medically necessary open neuroplasty of the lumbar plexus to clarify clinical findings and conservative treatments • Added policy statement for diagnostic nerve block for suspected LFCN involvement • Revised not medically necessary policy statement to clarify conditions not consistent with lumbar plexus–related neuropathy
Orthotic Devices and Shoes – (0543)	Updated	Minor changes in coverage criteria/policy: • Removed "Not Covered or Reimbursable" and "Experimental, Investigational or Unproven" sections; moved items therein to orthosis-specific sections. • Revised statements for cranial orthoses to remove benefit-related verbiage and add Note referring to the background section for information on cranial asymmetry measurements. • Revised spinal orthoses statements to add "protective body socks" as not covered or reimbursable. • Revised Therapeutic Shoes section to add "other modifications, including but not limited to flared heels (HCPCS code A5507)" as covered shoe modifications. • Editorial updates and restructuring throughout for clarity and readability.

Percutaneous Electrical Nerve Field Stimulation (PENFS) – (0589)	New	• New coverage policy.
Redundant Skin Surgery – (0470)	Updated	**Posted 6/15/2026, Effective 9/15/2026** Important changes in coverage criteria/policy: • Revised the medically necessary policy statement regarding preoperative photographs to remove requirement for sensitive anatomical areas (e.g., genital or buttock regions) • Revised the medically necessary policy statement regarding rhytidectomy to include criteria that the individual is a non-smoker or agree to abstain from all tobacco and nicotine products for at least three (3) weeks before and three (3) weeks after surgery • Revised the formatting of the medically necessary policy statement regarding persistent intertriginous dermatitis, cellulitis, or skin ulceration to improve clarity and consistency in policy statements • Revised the medically necessary policy statement regarding procedures performed following significant weight loss to be incorporated clearly as criteria rather than a note below the related policy statement • Revised the medically necessary policy statement regarding procedures performed following significant weight loss to include criteria for weight loss is associated with glucagon-like peptide-1 (GLP-1) agonist therapy • Removed policy statement regarding cosmetic procedure: surgery for glabellar frown lines • Revised policy statement regarding labiaplasty to include description as well as updated title of related Coverage Policy for Gender Dysphoria Treatment
Surgical Treatments for Obstructive Sleep Apnea - (0158)	Updated	**Posted 9/15/2026, Effective 12/15/2026** Minor changes in coverage criteria/policy: • Remove CPT codes 61886 & 64568 from policy. 90 day posting required. Coding clarification edit. No clinical changes are proposed.
Adjustable Continence Therapy – (0573)	Updated	• No change in coverage.

Ambulatory External Implantable Electrocardiographic Monitoring - (0547)	Updated	• No change in coverage.
Cardiac Omnibus Codes - (0574)	Updated	• No change in coverage.
Category III Current Procedural Terminology (CPT®) codes - (0558)	Updated	• No change in coverage.
Cervical Cancer Screening Visualization Technologies - (0127)	Updated	• No change in coverage.
Gender Dysphoria Treatment – (0266)	Updated	• No change in coverage.
Genetic Testing for Hereditary and Multifactorial Conditions – (0052)	Updated	• No change in coverage.
Infant Nutritional Formula - (0136)	Updated	• No change in coverage.
Intraocular Lens Implant – (0125)	Updated	• No change in coverage
Minimally Invasive Anti-Reflux Procedures and Peroral Endoscopic Myotomy (POEM) Procedures - (0019)	Updated	• No change in coverage
Molecular and Proteomic Diagnostic Testing for Hematology and Oncology Indications – (0520)	Updated	**Effective 9/13/2026** • No change in coverage.

Neuropsychological Testing - (EN0258)	Updated	• No change in coverage.
Plasma Brain Natriuretic Peptide in the Outpatient Setting – (0028)	Updated	• No change in coverage.
Transthoracic Echocardiography in Adults - (0510)	Updated	• No change in coverage.
Transthoracic Echocardiography in Children - (0523)	Updated	• No change in coverage.
Vitamin D Testing – (0526)	Updated	• No change in coverage.
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
Electrodiagnostic Testing (EMG/NCV) - (CPG 129)	Updated	• No change in coverage.
Spinal Ultrasound - (CPG 038)	Updated	• No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-EviCore Cerebrovascular Intervention Guidelines	Updated	**Effective 10/1/2026** • Guidelines were updated with no clinically impactful changes.

Cobranded Cigna-EviCore Spine Surgery Guidelines	Updated	**Effective 9/25/2026** One guideline was updated with clinically impactful changes: • CMM-616: Vertebral Body Tethering for Adolescent Idiopathic Scoliosis Updated initial vertebral body tethering from experimental, investigational, or unproven to medically necessary for carefully selected skeletally immature adolescents with adolescent idiopathic scoliosis who meet the listed clinical and radiographic criteria.
Administrative Policy	**New, Updated, or Retired?**	**Comments**
Preventive Care Services – (A004)	Updated	Important changes in coverage criteria/policy: • Update chlamydia & gonorrhea screening policy statement language – clarification only • Update cholesterol screening coding policy statement to add CPT code 83719 – clarification only • Update Rh incompatibility screening policy statement to add CPT code 86850 – expansion.
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Abilify Mycite (IP0534)	Retired	Effective 9/15/2026 Abilify Mycite was discontinued 9/2024.
Albendazole for Individual and Family Plans (IP0462)	Retired	**Effective 9/1/2026** Albendazole relocated to Pharmacy and Medical Prior Authorization (1407)
Antiemetic Therapy - (IP0819)	New	**Effective 9/1/2026** New Policy. Akynzeo, Sancuso, Varubi relocated from 1705 Antiemetic Therapy.

Antifungals – Cresemba (Oral) (IP0305)	Updated	**Effective 9/1/2026** No criteria changes.
Antifungals – Posaconazole (Oral) for Individual and Family Plans (IP0536)	Updated	**Effective 9/15/2026** **Cryptococcal Meningitis – Treatment.** **Updated** criterion **from** "Approve for 12 months to complete the course of therapy. Preferred product criteria is met for the products as listed in the below table**" to** "Approve for 12 months if the patient meets the following: Preferred product criteria is met for the products as listed in the below table." **Chronic Granulmatous Disease.** This was added as a new condition for approval under Other Uses with Supportive Evidence. **Patient is Currently Receiving Posaconazole.** **Updated** criterion **from** "Approve for 3 months to complete the course of therapy. Preferred product criteria is met for the products as listed in the below table" **to** "Approve for 3 months to complete the course of therapy." **Preferred Product Table.** **Removed** Noxafil delayed-release tablets and Noxafil oral suspension. The brand name drug has been discontinued **Noxafil PowderMix: Added** "Patient has tried ONE of the following: posaconazole tablets (Noxafil, generic) OR posaconazole oral suspension (Noxafil oral suspension, generics)."
Antifungals – Tolsura (IP0275)	Updated	**Effective 9/1/2026** No criteria changes.
Antifungals – Voriconazole (IP0306)		**Effective 9/1/2026** No criteria changes.
Antiseizure Medications – Ztalmy (IP0508)	Updated	**Effective 9/15/2026** No criteria changes.
Bone Modifiers - Denosumab Products (Prolia) Preferred Specialty Management (PSM033)	Updated	**Effective 9/1/2026** Osvyrti was added as a Preferred. The exception criteria were updated to include Osvyrti.

Bone Modifiers - Denosumab Products (Xgeva) Preferred Specialty Management (PSM034)	Updated	**Effective 9/1/2026** Jubereq was added as a Preferred. The exception criteria were updated to include Jubereq.
Bone Modifiers – Denosumab Products (Prolia) Prior Authorization (IP0331)	Updated	**Effective 9/1/2026** Osvyrti was added to the policy with the same criteria as the other denosumab (Prolia, biosimilars) products. **Coding Information** **Added** HCPCS code J5166
Bone Modifiers – Denosumab Products (Xgeva) Prior Authorization (IP0332)	Updated	**Effective 9/1/2026** Jubereq was added to the policy with the same criteria as the other denosumab (Xgeva, biosimilars) products. **Coding Information** **Added** HCPCS code Q5166
Brands with Bioequivalent Generics (IP0011)	Updated	**Effective 9/1/2026** **Removed for Employer Plans:** Taclonex Suspension
Brands with Bioequivalent Generics (IP0011)	Updated	**Effective 9/15/2026** **Removed for Employer Plans and Individual and Family Plans:** Vytorin
Cholbam (IP0289)	Updated	**Effective 9/1/2026** No criteria changes.
Complement Inhibitors – Eculizumab Products (IP0549)	Updated	**Effective 9/15/2026** No criteria changes.
Complement Inhibitors – Ultomiris (IP0550)	Updated	**Effective 9/15/2026**

		No criteria changes.
Dermatology-Anzupgo (IP0759)	Updated	**Effective 9/15/2026** No criteria changes.
Dermatology – Gene Therapy - Zevaskyn (IP0747)	Updated	**Effective 9/1/2026** The Policy Statement was updated to clarify that "All approvals are provided for one single application. The approval duration is 6 months to allow for an adequate timeframe to administer Zevaskyn."
Diabetes – Symlin for IFP (IP0698)	Updated	**Effective 9/15/2026** No criteria changes.
Drugs Requiring Medical Necessity Review for Employer Plans (1602)	Updated	**Effective 9/15/2026** ○ **Added preferred product requirement criteria for the following:** Widaplik and Evesse
Enzyme Replacement Therapy – Elfabrio (IP0570)	Updated	**Effective 9/15/2026** **Added** "Documentation: Documentation is required where noted in the criteria as [documentation required]. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, prescription receipts and/or other information. All documentation must include patient-specific identifying information." **Fabry Disease. Updated** criterion **from** "Patient has a laboratory test demonstrating deficient α-galactosidase A activity in leukocytes or fibroblasts" **to** "Patient has a laboratory test demonstrating deficient α-galactosidase A activity in leukocytes or fibroblasts [documentation required]" **Updated** criterion **from** "Patient has a molecular genetic test demonstrating a pathogenic variant in the galactosidase alpha (GLA) gene" **to** "Patient has a molecular genetic test demonstrating a pathogenic variant in the galactosidase alpha (GLA) gene [documentation required]**"** **Added** Nephrologist amongst the specialists that can prescribe Elfabrio. **Added** dosing information.
Enzyme Replacement Therapy – Fabrazyme (IP0406)	Updated	**Effective 9/15/2026** **Added "Documentation:** Documentation is required where noted in the criteria as [documentation required]. Documentation may include, but is not limited to, chart notes,

		laboratory tests, claims records, prescription receipts and/or other information. All documentation must include patient-specific identifying information." **Fabry Disease.** **Updated** criterion **from** "Patient has a laboratory test demonstrating deficient α-galactosidase A activity in leukocytes or fibroblasts" **to** "Patient has a laboratory test demonstrating deficient α-galactosidase A activity in leukocytes or fibroblasts [documentation required]" **Updated** criterion **from** "Patient has a molecular genetic test demonstrating a pathogenic in the galactosidase alpha gene (GLA)" **to** "Patient has a molecular genetic test demonstrating a pathogenic variant in the galactosidase alpha gene (GLA) [documentation required]"
Enzyme Replacement Therapy – Strensiq (IP0308)	Updated	**Effective 9/15/2026** No criteria changes.
Firdapse (IP0290)	Updated	**Effective 9/15/2026** The policy name was changed from Amifampridine Products to Firdapse. Ruzurgi was removed from the policy (obsolete > 3 years). Added "All documentation must include patient-specific identifying information." to documentation statement. Throughout the policy, references to "amifampridine" were updated to "Firdapse".
Gamifant (IP0113)	Updated	**Effective 9/1/2026** **Added** Policy Statement **Added** "All documentation must include patient-specific identifying information." to documentation statement. **Hemophagocytic Lymphohistiocytosis, Primary.** **Removed: "**(for example, confirmed bi-allelic pathogenic or likely pathogenic variants in AP3B1, LYST, PRF1, UNC13D/Munc13-4, STX11, STXBP2, RAB27a, XIAP/BIRC4 or SH2D1A)" from Molecular genetic diagnosis consistent with primary hemophagocytic lymphohistiocytosis criteria. **Updated from** "Documentation of at least FIVE of the following diagnostic criteria from the American Histiocyte Society (at baseline prior to treatment)" **to** "Prior to treatment, the patient meets at least FIVE of the following diagnostic criteria at baseline"

		Updated from "Persistent Fever" **to** "Fever ≥ 38.5° C" **Updated from** "Cytopenia involving at least 2 cell lines (hemoglobin less than 9 g/dL or less than 10 g/dL in infants less than 4 weeks of age, absolute neutrophil count less than 1000/µL, platelets less than 100,000/µL)" **to "**Cytopenia defined as at least TWO of the following (TWO of 1, 2, or 3): Hemoglobin < 9 g/dL (or < 10 g/dL in infants less than 4 weeks of age); OR Platelets < 100 x 10^9/L; OR Neutrophils < 1.0 x 10^9/L" **Updated from** "Hypertriglyceridemia (fasting triglycerides 265mg/dL or greater) or hypofibrinogenemia (fibrinogen less than 1.5 g/L or greater than 3 standard deviations less than normal value for age)" **to** "Patient meets ONE of the following (1 or 2):1.Fasting triglycerides ≥ 265mg/dL: OR 2.Fibrinogen ≤ 1.5 g/L" **Removed** "with no evidence of malignancy" from Hemophagocytosis in bone marrow, spleen, or lymph nodes criteria. **Removed** "Evidence of active disease (for example, fever, splenomegaly, central nervous system symptoms, cytopenia, elevated fibrinogen and/or D-dimer, elevated ferritin, and elevated soluble CD25 [also referred to as soluble interleukin-2 receptor] levels)" **Updated from** "Refractory, recurrent, or progressive disease during conventional HLH therapy OR has demonstrated an intolerance to conventional HLH therapy (examples of conventional therapy include, etoposide, corticosteroids, cyclosporine, antithymocyte globulin, methotrexate)" **to** "According to the prescriber, the patient has experienced at least one of the following (i or ii): i.Refractory, recurrent, or progressive disease during conventional therapy (e.g., etoposide, cyclosporine A, or anti-thymocyte globulin); OR ii.Intolerance to conventional therapy (e.g., etoposide, cyclosporine A, or anti-thymocyte globulin)" **Hemophagocytic Lymphohistiocytosis/Macrophage Activation Syndrome (HLH/MAS).** **Updated** authorization duration from 8 months to 8 weeks. ○ **Removed** reauthorization criteria section from policy.
Gonadotropin-Releasing Hormone Agonists – Implants for Non-Oncology Indications (IP0620)	Updated	**Effective 9/1/2026** **Zoladex** **For Endometriosis, added "**Patient has tried ONE of the following, unless contraindicated (i, ii, or iii): i. A contraceptive; OR Note: Examples of contraceptives include combination oral contraceptives, levonorgestrel-releasing intrauterine systems [e.g., Mirena®, Liletta®]); ii. An oral progesterone (e.g., norethindrone tablets); OR iii. A depo-medroxyprogesterone injection. Note: An exception to the requirement for a trial of the above therapies can be made if the patient has previously used a gonadotropin-releasing hormone (GnRH) agonist (e.g., Lupron Depot) or antagonist (e.g., Orilissa) for endometriosis.

Hematology – Fibrinogen Products (IP0357)	Updated	**Effective 9/15/2026** No criteria changes.
Hemophilia – Non-Factor Routine Prophylaxis Products – Alhemo (IP0730)	Updated	**Effective 9/1/2026** **Hemophilia A with Factor VIII Inhibitors:** For initial therapy, the requirements were removed that Factor VIII inhibitor titer testing has been performed within the past 30 days AND patient has a positive test for Factor VIII inhibitors of ≥ 0.6 Bethesda units/mL. Added "Patient has diagnosis of Hemophilia A with Factor VIII Inhibitors **[documentation required]**" **Hemophilia A without Factor VIII inhibitors:** For initial therapy, the requirement was removed that the patient has moderately severe to severe hemophilia A as evidence by a baseline (without Factor VIII replacement therapy) Factor VIII level ≤ 2%. Also, the requirements were removed that Factor VIII inhibitor titer testing has been performed within the past 30 days AND patient does not have a positive test for Factor VIII inhibitors of ≥ 1.0 Bethesda units/mL OR that the patient has not received Factor VIII therapy in the past. Added "Patient has diagnosis of Hemophilia A without Factor VIII Inhibitors **[documentation required]**" **Hemophilia B with Factor IX Inhibitors:** For initial therapy, the requirements were removed that Factor IX inhibitor titer testing has been performed within the past 30 days AND patient has a positive test for Factor VIII inhibitors of ≥ 0.6 Bethesda units/mL. Added "Patient has diagnosis of Hemophilia B with Factor IX Inhibitors **[documentation equired]**" **Hemophilia B without Factor IX inhibitors:** For initial therapy, the requirement was removed that the patient has moderately severe to severe hemophilia B as evidence by a baseline (without Factor IX replacement therapy) Factor IX level ≤ 2%. Also, the requirements were removed that Factor IX inhibitor titer testing has been performed within the past 30 days AND patient does not have a positive test for Factor VIII inhibitors of ≥ 1.0 Bethesda units/mL OR that the patient has not received Factor IX therapy in the past. Added "Patient has diagnosis of Hemophilia B without Factor IX Inhibitors **[documentation required]**"
Hemophilia – Non-Factor Routine Prophylaxis Products – Hympavzi (IP0731)	Updated	**Effective 9/1/2026** **Hemophilia A with Factor VIII Inhibitors:** This was added as a new condition of approval. **Hemophilia A without Factor VIII inhibitors:** For initial therapy, the approval age was changed to ≥ 6 years of age; previously, it was ≥ 12 years of age. Also, the requirement was removed that the patient has moderately severe to severe hemophilia A as evidence by a baseline (without Factor VIII replacement therapy) Factor VIII level ≤ 2%. Additionally,

		the requirements were removed that Factor VIII inhibitor titer testing has been performed within the past 30 days AND patient does not have a positive test for Factor VIII inhibitors of ≥ 1.0 Bethesda units/mL OR that the patient has not received Factor VIII in the past. Added "Patient has diagnosis of Hemophilia A without Factor VIII Inhibitors" **[documentation required]**" **Hemophilia B with Factor IX Inhibitors:** This was added as a new condition of approval. • **Hemophilia B without Factor IX inhibitors:** For initial therapy, the approval age was changed to ≥ 6 years; previously, it was ≥ 12 years of age. Also, the requirement was removed that the patient has moderately severe to severe hemophilia B as evidence by a baseline (without Factor IX replacement therapy) Factor IX level ≤ 2%. Additionally, the requirements were removed that Factor IX inhibitor titer testing has been performed within the past 30 days AND patient does not have a positive test for Factor IX inhibitors of ≥ 1.0 Bethesda units/mL OR patient has not received Factor IX therapy in the past. Added "Patient has diagnosis of Hemophilia B without Factor IX Inhibitors"
Hemophilia – Non-Factor Routine Prophylaxis Products – Qfitlia (IP0742)	Updated	**Effective 9/1/2026** **Hemophilia A with Factor VIII Inhibitors:** For initial therapy, the requirements were removed that Factor VIII inhibitor titer testing has been performed within the past 30 days AND patient has a positive test for Factor VIII inhibitors of ≥ 0.6 Bethesda units/mL. Added "Diagnosis of Hemophilia A with Factor VIII Inhibitors **[documentation required]**" **Hemophilia A without Factor VIII inhibitors:** For initial therapy, the requirement was removed that the patient has moderately severe to severe hemophilia A as evidence by a baseline (without Factor VIII replacement therapy) Factor VIII level ≤ 2%. Also, the requirements were removed that Factor VIII inhibitor titer testing has been performed within the past 30 days AND patient does not have a positive test for Factor VIII inhibitors of ≥ 1.0 Bethesda units/mL OR the patient has not received Factor VIII therapy in the past. Added "Diagnosis of Hemophilia A without Factor VIII Inhibitors **[documentation required]**" **Hemophilia B with Factor IX Inhibitors:** For initial therapy, the requirements were removed that Factor IX inhibitor titer testing has been performed within the past 30 days AND patient has a positive test for Factor IX inhibitors of ≥ 0.6 Bethesda units/mL. Added "Diagnosis of Hemophilia B with Factor IX Inhibitors **[documentation required]**" **Hemophilia B without Factor IX inhibitors:** For initial therapy, the requirement was removed that the patient has moderately severe to severe hemophilia B as evidence by a baseline (without Factor IX replacement therapy) Factor IX level ≤ 2%. Also, the requirements were removed that Factor VIII inhibitor titer testing has been performed within the past 30 days AND patient does not have a positive test for Factor VIII inhibitors of ≥ 1.0

		Bethesda units/mL OR the patient has not received Factor IX therapy in the past. Added "Diagnosis of Hemophilia B without Factor IX Inhibitors **[documentation required]**"
Hemophilia – Non-Factor Routine Prophylaxis Products – Hemlibra (IP0121)	Updated	**Effective 9/1/2026** **Hemophilia A with Factor VIII Inhibitors:** For initial therapy, the requirements were removed that Factor VIII inhibitor titer testing has been performed within the past 30 days AND patient has a positive test for Factor VIII inhibitors of ≥ 0.6 Bethesda units/mL. Added "Patient has diagnosis of Hemophilia A with Factor VIII Inhibitors **[documentation required]**" **Hemophilia A without Factor VIII inhibitors:** For initial therapy, the requirements were removed that Factor VIII inhibitor titer testing has been performed within the past 30 days AND patient does not have a positive test for Factor VIII inhibitors of ≥ 1.0 Bethesda units/mL OR patient has not received Factor VIII therapy in the past. Added "Patient has diagnosis of Hemophilia A without Factor VIII Inhibitors **[documentation required]**"
Hepatology – Bylvay (IP0363)	Updated	**Effective 9/15/2026** **Alagille Syndrome:** For initial therapy and in a patient currently receiving treatment, the requirement that the patient does not have cirrhosis or portal hypertension was removed. In the note listing examples of a hepatic decompensation event, gastroesophageal varices was added. **Progressive Familial Intrahepatic Cholestasis:** For initial therapy and in a patient currently receiving treatment, the requirement that the patient does not have cirrhosis or portal hypertension was removed. In the note listing examples of a hepatic decompensation event, gastroesophageal varices was added.
Hepatology – Livmarli (IP0341)	Updated	**Effective 9/15/2026** **Alagille Syndrome:** For initial therapy and in a patient currently receiving treatment, the requirement that the patient does not have cirrhosis or portal hypertension was removed. In the note listing examples of a hepatic decompensation event, gastroesophageal varices was added. **Progressive Familial Intrahepatic Cholestasis:** For initial therapy and in a patient currently receiving treatment, the requirement that the patient does not have cirrhosis or portal hypertension was removed. In the note listing examples of a hepatic decompensation event, gastroesophageal varices was added.

Hepatology – Ocaliva (IP0304)	Retired	**Effective 9/1/2026** Ocaliva (obeticholic acid) was voluntarily withdrawn from the U.S. market in 2025 at the FDA's request. The manufacturer, Intercept Pharmaceuticals, announced the withdrawal on September 11, 2025, for its indication in primary biliary cholangitis (PBC): • Ocaliva received FDA accelerated approval in 2016 for adults with PBC who had an inadequate response to or were intolerant of ursodeoxycholic acid (UDCA). [biospace.com], [webmd.com] • Safety concerns accumulated over time, including reports of serious liver injury and liver failure. FDA had already restricted use in certain patients with advanced cirrhosis in 2021. • In 2025, FDA requested market withdrawal because of concerns that Ocaliva may increase the risk of serious liver injury, leading Intercept to remove the product from the U.S. market. • The product remained available during a transition period and was no longer commercially available in the U.S. after November 14, 2025.
Hereditary Angioedema – Dawnzera (IP0761)	Updated	**Effective 9/15/2026** No criteria changes.
Hereditary Angioedema – Ekterly Drug Quantity Management Policy – Per Days (DQM010)	Updated	**Effective 9/15/2026** Policy title updated from "Hereditary Angioedema – Ekterly Drug Quantity Management Policy – Per Days for Individual and Family Plans" to "Hereditary Angioedema – Ekterly Drug Quantity Management Policy" No criteria changes.
HMG-CoA Reductase Inhibitors (Statins) and Combination Products (IP0064)	Retired	**Effective 9/1/2026** atorvastatin/ezetimibe and Pravachol has been discontinued • All others have been moved to 1602 and 1407
Hypertriglyceridemia - Redemplo (IP0773)	Updated	**Effective 9/1/2026** The name of the policy was changed to as listed. Previously, it was Familial Chylomicronemia Syndrome – Tryngolza Prior Authorization policy. **Familial Chylomicronemia Syndrome**: The duration of approval for Initial Therapy was changed to 6 months. Previously, it was 1 year. Continuation of therapy was added for

		patient who is currently receiving Tryngolza and has experienced a response to therapy. A Note of examples of a response was included. **Hypertriglyceridemia**: This was added as a new condition for approval. • **Conditions Not Recommended for Approval:** Hypertriglyceridemia (in the absence of a confirmed diagnosis of familial chylomicronemia syndrome) was removed.
Hypertriglyceridemia – Tryngolza (IP0733)	Updated	**Effective 9/1/2026** The name of the policy was changed to as listed. Previously, it was Familial Chylomicronemia Syndrome – Tryngolza Prior Authorization policy. **Familial Chylomicronemia Syndrome**: The duration of approval for Initial Therapy was changed to 6 months. Previously, it was 1 year. Continuation of therapy was added for patient who is currently receiving Tryngolza and has experienced a response to therapy. A Note of examples of a response was included. **Hypertriglyceridemia**: This was added as a new condition for approval. **Conditions Not Recommended for Approval:** Hypertriglyceridemia (in the absence of a confirmed diagnosis of familial chylomicronemia syndrome) was removed.
Immune Globulin – Intravenous (IP0776)	Updated	**Effective 9/3/2026** **Primary Immunodeficiencies:** Removed 'unspecified hypogammaglobulinemia' from the criteria. For a diagnosis of common variable immunodeficiency or other immunodeficiencies with significant hypogammaglobulinemia, both an impaired antibody response and recurrent infections are required to be met; previously only one was required. For the criterion, patient has an impaired antibody response (i.e., failure to produce antibodies to specific antigens), 'that is' (i.e.) was replaced with 'for example' (e.g.). • **Myasthenia Gravis:** Added "if preferred product criteria is met for the product(s) as listed in the below table(s)" for patient with myasthenic crisis or impending myasthenic crisis criteria. The Initial Therapy for Maintenance criteria was updated. The following criteria were removed: patient has refractory myasthenia gravis, patient has tried pyridostigmine, and patient has tried an immunosuppressive therapy with at least one of the following agents: azathioprine, cyclosporine, cyclophosphamide, mycophenolate mofetil, methotrexate, tacrolimus AND has had an inadequate response. The following criteria were added: Patient has tried at least one of the following medications for myasthenia gravis AND has had an inadequate response: a complement inhibitor, a neonatal Fc receptor blocker, or a CD19-directed monoclonal antibody OR according to the prescriber, these therapies are not clinically

		appropriate for the patient. Examples of each class of medication were also added in a note.
Immune Globulin – Subcutaneous (IP0777)	Updated	**Effective 9/3/2026** **Primary Immunodeficiencies:** Removed 'unspecified hypogammaglobulinemia' from the criteria. For a diagnosis of common variable immunodeficiency or other immunodeficiencies with significant hypogammaglobulinemia, both an impaired antibody response and recurrent infections are required to be met; previously only one was required. For the criterion, patient has an impaired antibody response (i.e., failure to produce antibodies to specific antigens), 'that is' (i.e.) was replaced with 'for example' (e.g.).
Immunologicals – Adbry Drug Quantity Management Policy – Per Days - (DQM029)	New	**Effective 9/1/2026** New policy.
Immunologicals – Dupixent Drug Quantity Management Policy – Per Days - (DQM028)	New	**Effective 9/1/2026** ○ New policy.
Immunologicals – Ebglyss Drug Quantity Management Policy – Per Days - (DQM030)	New	**Effective 9/1/2026** New policy.
Immunologicals – Fasenra Drug Quantity Management Policy – Per Days - (DQM031)	New	**Effective 9/1/2026** New policy.
Immunologicals – Nucala Drug Quantity Management Policy – Per Days - (DQM032)	New	**Effective 9/1/2026** New policy.

Immunologicals – Xolair Drug Quantity Management Policy – Per Days - (DQM033)	New	**Effective 9/1/2026** • New policy.
Immunologicals – Dupixent Drug Quantity Management Policy – Per Days - (DQM028)	Updated	**Effective 9/15/2026** No criteria changes. Updated Overview and Dosing section.
Infectious Disease – Sirturo (IP0494)	Updated	**Effective 9/15/2026** No criteria changes.
Inflammatory Conditions – Etanercept Products Drug Quantity Management Policy – Per Days - (DQM034)	New	**Effective 9/15/2026** New policy. Criteria relocated from *Quantity Limitations – (1201)*
Inflammatory Conditions – Siliq Drug Quantity Management Policy – Per Days - (DQM035)	New	**Effective 9/15/2026** New policy. • Criteria relocated from *Quantity Limitations – (1201)*
Inflammatory Conditions – Inflammatory Conditions – Simponi Subcutaneous Drug Quantity Management Policy – Per Days - (DQM036)	New	**Effective 9/15/2026** New policy.

Inflammatory Conditions – Siliq Drug Quantity Management Policy – Per Days - (DQM037)	New	**Effective 9/15/2026** New policy. • Criteria relocated from *Quantity Limitations – (1201)*
Inflammatory Conditions – Inflammatory Conditions – Simponi Subcutaneous Drug Quantity Management Policy – Per Days - (DQM038)	New	**Effective 9/15/2026** New policy. Criteria relocated from *Quantity Limitations – (1201)*
Inflammatory Conditions – Skyrizi Subcutaneous Drug Quantity Management Policy – Per Days - (DQM039)	New	**Effective 9/15/2026** New policy. Criteria relocated from *Quantity Limitations – (1201)*
Inflammatory Conditions – Taltz Drug Quantity Management Policy – Per Days - (DQM040)	New	**Effective 9/15/2026** New policy. Criteria relocated from *Quantity Limitations – (1201)*
Lipodystrophy – Myalept (IP0340)	Updated	**Effective 9/15/2026** ○ **Generalized Lipodystrophy:** Approval indication was updated to "Generalized Lipodystrophy," previously it was "Generalized Lipodystrophy (Congenital or Acquired)" Throughout criteria, "gene mutation" was changed to "pathogenic variant." The approval option that the patient has had a genetic test that did not demonstrate an AGPAT2, BSCL2, CAV1, or PTRF gene mutation was removed. Hepatomegaly, elevated transaminases, amenorrhea, and hypogonadism were added to the Note listing examples of manifestation of leptin deficiency.

Lofexidine for Individual and Family Plans (IP0696)	Updated	**Effective 9/15/2026** No criteria changes.
Metabolic Disorders – Dojolvi (IP0084)	Updated	**Effective 9/1/2026** No criteria changes.
Metabolic Disorders – Nitisinone Products (IP0146)	Updated	**Effective 9/15/2026** **Updated** documentation statement to include prescription receipts. **Employer Plans Preferred Product Table.** **Harliku** **Updated from "**Patient has tried ONE of nitisinone 2 mg capsules OR Nityr 2 mg tablets [documentation required]" **to** "Patient has tried and cannot take ONE of the following: nitisinone 2 mg capsules OR Nityr 2 mg tablets [documentation required]." **Orfadin oral suspension:** **Updated from** "Patient has tried and, according to the prescriber, the patient has had inadequate efficacy or significant intolerance to nitisinone oral suspension [requires prior authorization]" **to** "Patient has tried and cannot take ONE of the following: nitisinone capsules OR Nityr tablets."
Multiple Sclerosis and Crohn's Disease (Injectable – Other) – Natalizumab Products Prior Authorization Policy - (IP0690)	Updated	**Effective 9/15/2026** **Multiple Sclerosis:** In Initial Therapy, under the criterion that the patient has highly active or aggressive multiple sclerosis, the specific criteria were removed to now state "According to the prescriber, the patient has highly-active or aggressive multiple sclerosis.". **Appendix A:** It was noted that a generic for Mavenclad (cladribine tablets) is now available. **Appendix B:** Icotyde (icotrokinra tablets) and Otezla XR (apremilast extended-release tablets) were added. It was noted that generics for Xeljanz (tofacitinib tablets and oral solution) and Xeljanz XR (tofacitinib extended-release tablets) are available. **Coding Information** **Added** HCPCS code Q5134
Multiple Sclerosis and Ulcerative Colitis (Oral – Sphingosine 1-Phosphate Receptor Modulator) – Zeposia	Updated	**Effective 9/1/2026** **Multiple Sclerosis:** Removed documentation requirements. A requirement that the patient is ≥ 18 years of age was added to initial and continuation criteria. Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a

Prior Authorization Policy – (IP0655)		patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway. **Appendix A:** Icotyde (icotrokinra tablets) was added to oral therapies along with updates to oral therapies
Multiple Sclerosis – Dalfampridine (IP0024)	Updated	**Effective 9/15/2026** **Employer Plans and Individual and Family Plans Preferred Product Table:** **Ampyra: Added** "per the prescriber" to criteria.
Multiple Sclerosis (Injectable – Beta Interferon) – Avonex (IP0254)	Updated	**Effective 9/15/2026** **Multiple Sclerosis:** Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway. **Appendix:** It was noted that a generic for Mavenclad (cladribine tablets) is now available.
Multiple Sclerosis (Injectable – Beta Interferon) – Betaseron (IP0256)	Updated	**Effective 9/15/2026** **Multiple Sclerosis:** Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway. **Appendix:** It was noted that a generic for Mavenclad (cladribine tablets) is now available.
Multiple Sclerosis (Injectable – Beta Interferon) – Plegridy (IP0263)	Updated	**Effective 9/15/2026** **Multiple Sclerosis:** Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway. ○ **Appendix:** It was noted that a generic for Mavenclad (cladribine tablets) is now available.
Multiple Sclerosis (Injectable – Beta Interferon) – Rebif (IP0265)	Updated	**Effective 9/15/2026** **Multiple Sclerosis:** Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway. **Appendix:** It was noted that a generic for Mavenclad (cladribine tablets) is now available.

Multiple Sclerosis (Injectable – CD20-Directed Cytolytic Antibody) – Briumvi - (IP0545)	Updated	**Effective 9/15/2026** **Multiple Sclerosis, Relapsing Forms: Added** Dosing. **Appendix:** It was noted that a generic for Mavenclad (cladribine tablets) is now available.
Multiple Sclerosis (Injectable – CD20-Directed Cytolytic Antibody) – Kesimpta - (IP0260)	Updated	**Effective 9/15/2026** **Multiple Sclerosis:** Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway. • **Appendix:** It was noted that a generic for Mavenclad (cladribine tablets) is now available.
Multiple Sclerosis (Injectable – CD20-Directed Cytolytic Antibody) – Ocrevus Intravenous (IP0212)	Updated	**Effective 9/15/2026** • **Appendix:** It was noted that a generic for Mavenclad (cladribine tablets) is now available.
Multiple Sclerosis (Injectable – CD20-Directed Cytolytic Antibody) – Ocrevus Zunovo (IP0705)	Updated	**Effective 9/15/2026** • **Multiple Sclerosis, Relapsing Forms:** Under the note regarding a patient who has received < 1 year of therapy or is restarting therapy, the word "Zunovo" was added to Ocrevus Zunovo.
Multiple Sclerosis (Injectable) – Glatiramer Products (IP0257)	Updated	**Effective 9/15/2026** **Policy Statement**: Statements regarding "Copaxone/Glatopa" were updated to "glatiramer". **Multiple Sclerosis:** Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway. **Employer Plans and Individual and Family Plans Preferred Product Tables: Added** "[e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber" to Copaxone criteria.

		• **Appendix:** It was noted that a generic for Mavenclad (cladribine tablets) is now available.
Multiple Sclerosis (Injectable) – Glatiramer Products (IP0257)	Updated	**Effective 9/15/2026** **Removed** manufacturer specific formulations of glatiramer acetate as policy will apply to all generic glatiramer acetate for Individual and Family Plans
Multiple Sclerosis (Injectable – Other) Lemtrada - (IP0213)	Updated	**Effective 9/15/2026** **Multiple Sclerosis:** In Initial Therapy, under the criterion that the patient has highly active or aggressive multiple sclerosis, the specific criteria requirements were removed to now state "According to the prescriber, the patient has highly-active or aggressive multiple sclerosis." ○ **Appendix:** It was noted that a generic for Mavenclad (cladribine tablets) is now available.
Multiple Sclerosis (Oral – Fumarate) – Bafiertam (IP0255)	Updated	**Effective 9/15/2026** **Multiple Sclerosis:** Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway. ○ **Appendix:** It was noted that a generic for Mavenclad (cladribine tablets) is now available.
Multiple Sclerosis (Oral – Fumarate) – Dimethyl Fumarate (IP0266)	Updated	**Effective 9/15/2026** **Multiple Sclerosis:** Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway. **Employer Plans and Individual and Family Plans Preferred Product Tables: Added** "[e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber" to Tecfidera criteria. **Appendix:** It was noted that a generic for Mavenclad (cladribine tablets) is now available.

Multiple Sclerosis (Oral – Fumarate) – Vumerity (IP0253)	Updated	**Effective 9/15/2026** **Multiple Sclerosis:** Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway. **Appendix:** It was noted that a generic for Mavenclad (cladribine tablets) is now available.
Multiple Sclerosis (Oral – Other) – Cladribine IP0261	Updated	**Multiple Sclerosis:** A requirement that the patient is ≥ 18 years of age was added to initial and continuation criteria. In Initial Therapy, under the criterion that the patient has highly active or aggressive multiple sclerosis, the specific criteria were removed. Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway. **Conditions Not Covered:** The condition previously listed as "Current Use with other Disease-Modifying Agents Used for Multiple Sclerosis" was updated to "Concurrent Use with other Disease-Modifying Agents Used for Multiple Sclerosis".
Multiple Sclerosis (Oral - Other)– Teriflunomide for Employer Plans: Standard/Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists (IP0252)	Updated	**Effective 9/15/2026** **Multiple Sclerosis:** A requirement that the patient is ≥ 18 years of age was added to initial and continuation criteria. Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway.
Multiple Sclerosis (Oral – Other) – Teriflunomide for Individual and Family Plans (IP0560)	Updated	**Effective 9/15/2026** **Multiple Sclerosis:** A requirement that the patient is ≥ 18 years of age was added to initial and continuation criteria. Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway.
Multiple Sclerosis (Oral – Sphingosine 1-Phosphate Receptor	Updated	**Effective 9/15/2026**

Modulator) – Fingolimod (IP0259)		**Multiple Sclerosis:** Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway. **Employer Plans and Individual and Family Plans Preferred Product Tables: Added** "[e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which, per the prescriber" to Gilenya criteria. **Appendix:** It was noted that a generic for Mavenclad (cladribine tablets) is now available.
Multiple Sclerosis (Oral – Sphingosine 1-Phosphate Receptor Modulator) – Mayzent (IP0262)	Updated	**Effective 9/15/2026** **Multiple Sclerosis:** A requirement that the patient is ≥ 18 years of age was added to initial and continuation criteria. Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway. **Conditions Not Covered:** The condition previously listed as "Current Use with other Disease-Modifying Agents Used for Multiple Sclerosis" was updated to "Concurrent Use with other Disease-Modifying Agents Used for Multiple Sclerosis".
Multiple Sclerosis (Oral – Sphingosine 1-Phosphate Receptor Modulator) – Ponvory (IP0264)	Updated	**Effective 9/15/2026** **Multiple Sclerosis**: A requirement that the patient is ≥ 18 years of age was added to initial and continuation criteria. Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway. **Appendix:** It was noted that a generic for Mavenclad (cladribine tablets) is now available.
Multiple Sclerosis (Oral – Sphingosine 1-Phosphate Receptor Modulator) – Tascenso ODT (IP0514)	Updated	**Effective 9/15/2026** **Multiple Sclerosis:** Under the requirements for a patient who has received therapy for ≥ 1 year, a Note was added clarifying that a patient who has received < 1 year of therapy or who is restarting therapy should be reviewed under the Initial Therapy pathway. **Appendix**: It was noted that a generic for Mavenclad (cladribine tablets) is now available.

Muscular Dystrophy – Gene Therapy – Elevidys (IP0571)	Updated	**Effective 9/3/2026** ○ **Duchenne Muscular Dystrophy – Treatment**: In reference to anti-adeno-associated virus antibody titers, spelled out "less than" 1:400. Previously is was "<" 1:400. In reference to left ventricular ejection fraction, spelled out "that is greater than or equal to" 40%. Previously it was "≥" 40%. Under liver function testing, removed requirements for alanine aminotransferase levels, aspartate aminotransferase levels, and glutamate dehydrogenase level. For gamma glutamyl transferase level spelled out "less than or equal to" 2 times the upper limit of normal; previously "≤" was used. For total bilirubin level, spelled out "less" than the upper limit of normal; previously it was "<" than the upper limit of normal. Under complete blood cell count, for white blood cell count spelled out "less than" 18.5 x 109/L. For platelet count spelled out "greater than" 150 x 109/L.
Nephrology – Xphozah (IP0608)	Updated	**Effective 9/15/2026** ○ No criteria changes.
Neurology – Imaavy (IP0743)	Updated	**Effective 9/1/2026** **Generalized Myasthenia Gravis**. Updated wording from "Patient previously received or is currently receiving pyridostigmine" to "Patient has received or is currently receiving pyridostigmine." Updated wording from "Patient has had inadequate efficacy, a contraindication, or significant intolerance to pyridostigmine" to "Patient has a contraindication to pyridostigmine." Added a criterion to bypass the trial of pyridostigmine if the patient has anti-muscle-specific tyrosine kinase (MuSK) antibody-positive generalized myasthenia gravis.
Neurology – Rystiggo (IP0575)	Updated	**Effective 9/1/2026** **Generalized Myasthenia Gravis**. ○ Updated wording from "Patient received or is currently receiving pyridostigmine" to "Patient has received or is currently receiving pyridostigmine." Updated wording from "Patient has had inadequate efficacy, a contraindication, or significant intolerance to pyridostigmine" to "Patient has a contraindication to pyridostigmine." Added a criterion to bypass the trial of pyridostigmine if the patient has anti-muscle-specific tyrosine kinase (MuSK) antibody-positive generalized myasthenia gravis.

Neurology – Vyvgart Hyrtulo (IP0574)	Updated	**Effective 9/1/2026** **Generalized Myasthenia Gravis**. Updated wording from "Patient received or is currently receiving pyridostigmine" to "Patient has received or is currently receiving pyridostigmine." Updated wording from "Patient has had inadequate efficacy, a contraindication, or significant intolerance to pyridostigmine" to "Patient has a contraindication to pyridostigmine." Added a criterion to bypass the trial of pyridostigmine if the patient has anti-muscle-specific tyrosine kinase (MuSK) antibody-positive generalized myasthenia gravis.
Neurology – Vyvgart Intravenous (IP0376)	Updated	**Effective 9/1/2026** **Generalized Myasthenia Gravis**. Updated wording from "Patient received or is currently receiving pyridostigmine" to "Patient has received or is currently receiving pyridostigmine." Updated wording from "Patient has had inadequate efficacy, a contraindication, or significant intolerance to pyridostigmine" to "Patient has a contraindication to pyridostigmine." Added a criterion to bypass the trial of pyridostigmine if the patient has anti-muscle-specific tyrosine kinase (MuSK) antibody-positive generalized myasthenia gravis.
Non-Steroidal Mineralocorticoid Receptor Antagonist (IP0314)	Updated	**Effective 9/1/2026** No criteria changes.
Oncology (Injectable – T-Cell Immunotherapy – MAGE A4) – Tecelra (IP0699)	Updated	**Effective 9/15/2026** **Synovial Sarcoma:** In the requirement that the patient ≥ 18 years of age was modified to the patient is ≥ 12 years of age. The requirement that the patient has received prior chemotherapy was modified to the medication is used as subsequent therapy. Dosing was modified to approve up to 10 x 10^9 MAGE-A4 T-cell receptor positive T-cells administered intravenously as a single dose. Previously stated, "the dose is 2.68 x 109 to 10 x 109 MAGE-A4 T-cell receptor positive T-cells as a single intravenous infusion."
Opioid Therapy for Employer Group Benefit Plans - (IP0561)	Updated	**Effective 9/1/2026** **Appendix 2: Added** morphine sulfate ER tablets. **Appendix 4: Updated** Morphine Milligram Equivalent (MME) Dose Calculation Table. **Nucynta IR:** Moved from a preferred product to a non-preferred product and criteria were updated to now require a trial of the bioequivalent generic product, tapentadol immediate-release tablets, prior to approval of the brand product.

Opioid Therapy – Individual and Family Plans (IP0562)	Updated	**Effective 9/1/2026** **Appendix 2: Added** morphine sulfate ER tablets. **Appendix 4: Updated** Morphine Milligram Equivalent (MME) Dose Calculation Table.
Ophthalmology – Vascular Endothelial Growth Factor Inhibitors – Afiblercept (IP0540)	Updated	**Effective 9/1/2026** **Eylea HD – Diabetic Macular Edema, Diabetic Retinopathy, Macular Edema Following Retin Vein Occlusion, and Neovascular (Wet) Age-Related Macular Degeneration):** The Note was removed from the Dosing section.
Opthalmology – Xipere (IP0371)	Updated	**Effective 9/15/2026** No criteria changes.
Overactive Bladder Medications Step Therapy Policy for Employer Plans: Legacy Drug List (ST002)	Updated	**Effective 9/15/2026** **Mirabegron granules for extended-release oral suspension:** Generic mirabegron granules for extended-release oral suspension were added to Step 1. • **Exception Criteria:** The exception criterion that approved brand Myrbetriq Granules if the patient cannot swallow or has difficulty swallowing tablets or capsules was removed.
Overactive Bladder Medications Step Therapy Policy for Employer Plans: Value/Advantage Drug List (ST007)	Updated	**Effective 9/15/2026** • **Mirabegron granules for extended-release oral suspension:** Generic mirabegron granules for extended-release oral suspension were added to Step 1.
Phenylketonuria – Sephience (IP0764)	Uodated	**Effective 9/15/2026** No criteria changes.
Pharmacy and Medical Prior Authorization (1407)	Updated	**Effective 9/15/2026**

		○ **Added preferred product requirement criteria for the following:** Altoprev, Atorvaliq, Crestor, Ezallor Sprinkle, FloLipid, Lescol XL, Lipitor, Livalo, Roszet, rosuvastatin and ezetimibe tablets, Vytorin, Zocor, and Zypitamag
Phenylketonuria – Palynziq (IP0294)	Updated	**Effective 9/15/2026** ○ No criteria changes.
Phenylketonuria – Sapropterin (IP0295)	Updated	**Effective 9/15/2026** ○ No criteria changes.
Pulmonary – Antifibrotics – Nintedanib (IP0312)	Updated	**Effective 9/15/2026** ○ No criteria changes.
Pulmonary – Antifibrotics – Pirfenidone (IP0311)	Updated	**Effective 9/15/2026** The policy name was changed to as listed. Previously, it was Idiopathic Pulmonary Fibrosis and Related Lung Disease – Pirfenidone Prior Authorization policy. ○ Generic nintedanib was added throughout the policy as an alternative to Ofev.
Pulmonary Arterial Hypertension – Treprostinil Injection (IP0757)	Updated	**Effective 9/15/2026** ○ No criteria changes.
Pulmonary – Brinsupri for Employer Plans (IP0775)	Updated	**Effective 9/15/2026** ○ No criteria changes.
Quantity Limitations – (1201)	Updated	**Effective 9/15/2026** **Removed** Enbrel and relocated to a new policy, *Inflammatory Conditions – Etanercept Products Drug Quantity Management Policy – Per Days - (DQM034).*

		Removed Ilumya and relocated to a new policy, *Inflammatory Conditions – Ilumya Drug Quantity Management Policy – Per Days - (DQM035).* **Removed** Siliq and relocated to a new policy, *Inflammatory Conditions – Siliq Drug Quantity Management Policy – Per Days - (DQM037)* **Removed** Simponi subcutaneous and relocated to a new policy, *Inflammatory Conditions – Simponi Subcutaneous Drug Quantity Management Policy – Per Days - (DQM038).* **Removed** Skyrizi subcutaneous and relocated to a new policy, *Inflammatory Conditions – Skyrizi Subcutaneous Drug Quantity Management Policy – Per Days - (DQM039).* ○ **Removed** Taltz and relocated to a new policy, *Inflammatory Conditions – Taltz Drug Quantity Management Policy – Per Days - (DQM040).*
Somatostatin Analogs – Octreotide Immediate Release Products (IP0490)	Updated	**Effective 9/1/2026** **Acromegaly:** "There are signs of tumor growth on imaging" was added as an option for approval. In addition, oncologist was added as an option to the specialist requirement. **Stellar Tumor**, specifically thyroid-stimulating hormone (TSH)-secreting tumor: This new condition of approval was added to the policy. ○ **Sellar Tumor: Added** preferred product requirement criteria.
Somatostatin Receptor Agonist – Palsonify (IP0769)	Updated	**Effective 9/15/2026** ○ No criteria changes.
Somavert (IP0291)	Updated	**Effective 9/1/2026** ○ **Acromegaly:** "There are signs of tumor growth on imaging" was added as an option for approval. In addition, oncologist was added as an option to the specialist requirement.
Spinal Muscular Atrophy – Evrysdi (IP0063)	Updated	**Effective 9/1/2026** ○ No criteria changes.
Spinal Muscular Atrophy – Spinraza (IP0182)	Updated	**Effective 9/1/2026** ○ No criteria changes.

Topical Products – Vtama Step Therapy Policy for Employer Plans: Standard / Performance / Legacy Drug Lists (ST004)	Updated	**Effective 9/15/2026** ○ **Vtama:** Brand Dovonex was removed from the Note listing topical vitamin D analogs (obsolete). Pellix was added to the Note listing topical vitamin D analogs.
Topical Retinoids – Aklief (IP0180)	Updated	**Effective 9/15/2026** ○ No criteria changes
Vecamyl for Individual and Family Plans (IP0650)	Updated	**Effective 9/15/2026** ○ No criteria changes
Vitamin D Analogs (IP0361)	Updated	**Effective 9/1/2026** Calsodore and Dovonex has been discontinued ○ All other products relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602)
Weight Loss – Glucagon-Like Peptide-1 Agonists - Foundayo BMI ≥ 30 (IP0206)	Updated	**Effective 9/1/2026** ○ **Removed** Saxenda, liraglutide, Wegovy Tablet, Wegovy Injection and Zepbound. The products were moved to new individual policies.
Weight Loss – Glucagon-Like Peptide-1 Agonists – Liraglutide - (IP0813)	New	**Effective 9/1/2026** ○ New policy.
Weight Loss – Glucagon-Like Peptide-1 Agonists – Wegovy Injection - (IP0814)	New	**Effective 9/1/2026** ○ New policy.

Weight Loss – Glucagon-Like Peptide-1 Agonists – Wegovy Tablet - (IP0815)	New	**Effective 9/1/2026** ○ New policy.
Weight Loss – Glucagon-Like Peptide-1 Agonists – Zepbound - (IP0816)	New	**Effective 9/1/2026** ○ New policy.
Weight Loss – Glucagon-Like Peptide-1 Agonists – Foundayo - Benefit Exclusion Overrides Policy BMI ≥ 32 (BEO005)	Updated	**Effective 9/1/2026** ○ **Removed** Saxenda, liraglutide, Wegovy Tablet, Wegovy Injection and Zepbound. The products were moved to new individual policies.
Weight Loss – Glucagon-Like Peptide-1 Agonists – Liraglutide - Benefit Exclusion Overrides Policy BMI ≥ 32 - (BEO007)	New	**Effective 9/1/2026** ○ New policy.
Weight Loss – Glucagon-Like Peptide-1 Agonists – Wegovy Injection - Benefit Exclusion Overrides Policy BMI ≥ 32 - (BEO008)	New	**Effective 9/1/2026** ○ New policy.
Weight Loss – Glucagon-Like Peptide-1 Agonists – Wegovy Tablet- Benefit Exclusion Overrides	New	**Effective 9/1/2026** ○ New policy.

Policy BMI ≥ 32 - (BEO009)		
Weight Loss – Glucagon-Like Peptide-1 Agonists – Zepbound - Benefit Exclusion Overrides Policy BMI ≥ 32 (BEO010)	New	**Effective 9/1/2026** ○ New policy.
Weight Loss – Glucagon-Like Peptide-1 Agonists – Foundayo - Benefit Exclusion Overrides Policy BMI ≥ 35 (BEO006)	Updated	**Effective 9/1/2026** ○ **Removed** Saxenda, liraglutide, Wegovy Tablet, Wegovy Injection and Zepbound. The products were moved to new individual policies.
Weight Loss – Glucagon-Like Peptide-1 Agonists – Liraglutide - Benefit Exclusion Overrides Policy BMI ≥ 35 - (BEO011)	New	**Effective 9/1/2026** ○ New policy.
Weight Loss – Glucagon-Like Peptide-1 Agonists - Wegovy Injection - Benefit Exclusion Overrides Policy BMI ≥ 35 - (BEO012)	New	**Effective 9/1/2026** ○ New policy.
Weight Loss – Glucagon-Like Peptide-1 Agonists - Wegovy Tablet- Benefit Exclusion Overrides	New	**Effective 9/1/2026** ○ New policy.

Policy BMI ≥ 35 (BEO013)		
Weight Loss – Glucagon-Like Peptide-1 Agonists – Zepbound - Benefit Exclusion Overrides Policy BMI ≥ 35 (BEO014)	New	**Effective 9/1/2026** ○ New policy.
Xiaflex (IP0143)	Update	**Effective 9/15/2026** ○ No criteria changes.
Uplizna (IP0062)	Updated	**Effective 9/1/2026** **Generalized Myasthenia Gravis**. ○ Updated wording from "Patient received or is currently receiving pyridostigmine" to "Patient has received or is currently receiving pyridostigmine." Updated wording from "Patient has had inadequate efficacy, a contraindication, or significant intolerance to pyridostigmine" to "Patient has a contraindication to pyridostigmine." Added a criterion to bypass the trial of pyridostigmine if the patient has anti-muscle-specific tyrosine kinase (MuSK) antibody-positive generalized myasthenia gravis.
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
Master Precertification List	Updated	Updated prior authorization requirements are available on our websites, CignaforHCP.com and Cigna.com. Updates include existing codes that have been removed from prior authorization or terminated by AMA and CMS. **New Codes:** • No new codes added for September 2026. **Updates:**

		• For September 25, 2026, Cigna removed 1 HCPCS from prior authorization. • For September 30, 2026, CMS/AMA deleted/terminated 5 codes, 1 CPT and 4 HCPCS.
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
Mulitple Births - (R03)	Updated	• Added Maternity Banner: Earlier this year, the American Medical Association (AMA) published a new maternity coding framework and guidelines that represent a significant shift in how maternity care services are to be reported and billed beginning, January 1, 2027. During this transition period, Cigna Healthcare® believes maintaining the current billing guidance and this policy is the best way to promote access to care, minimize administrative burden, and avoid unnecessary disruption for providers and patients. **Therefore, Cigna Healthcare is not changing its current maternity billing guidance at this time.** For more information, please visit our Provider Newsroom article, which will remain up-to-date and include information on the latest Cigna Healthcare billing guidance. For now, this policy remains in effect for the remainder of 2026.
Global Maternity/Obstetric Package - (R11)	Updated	• Added Maternity Banner: Earlier this year, the American Medical Association (AMA) published a new maternity coding framework and guidelines that represent a significant shift in how maternity care services are to be reported and billed beginning, January 1, 2027. During this transition period, Cigna Healthcare® believes maintaining the current billing guidance and this policy is the best way to promote access to care, minimize administrative burden, and avoid unnecessary disruption for providers and patients. **Therefore, Cigna Healthcare is not changing its current maternity billing guidance at this time.** For more information, please visit our Provider Newsroom article, which will remain

		up-to-date and include information on the latest Cigna Healthcare billing guidance. For now, this policy remains in effect for the remainder of 2026.
Genetic Testing Panels – (R28)	Updated	• Effective 09/15/2026 CPT code 87632 to the respiratory pathogen detection panel sections. Updated the reference section.
Technology-Assisted Surgery - (R04)	Updated	**Effective 09/15/2026** • Cigna will not reimburse computer-assisted surgical navigation codes 20985, 0054T, and 0055T when reported on a UB-04 claim form. • Policy title updated from "Robotic Assisted Surgery" to "Technology-Assisted Surgery" to encompass all technology-assisted surgical techniques.
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		• No updates for September 2026
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**
		• No updates for September 2026