Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective January 15, 2023 (unless otherwise noted)

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

New Medical Coverage Policies

- Oncology Imaging Amendment to Cigna-eviCore General Oncology Imaging Guideline – (DV002)
  - Originally provided advance notification on **October 15, 2022**, of new policy, effective **January 15, 2023**:
    - Clarified coverage for magnetic resonance imaging (MRI) for breast cancer staging evaluation.

Modified Medical Coverage Policies

- Ambulatory External and Implantable Electrocardiographic Monitoring – (0547)
  - Advance notification of important **changes** in coverage criteria, effective **April 15, 2023**:
    - Separated criteria to be met for insertable cardiac monitor (ICM) by the requested indication of cryptogenic stroke or syncope.
    - Limited coverage by adding that noninvasive ambulatory cardiac monitoring needs to be inconclusive or non-diagnostic before ICM placement for both cryptogenic stroke and recurrent or unexplained syncope.
    - Limited coverage by adding additional criteria to be met for recurrent or unexplained syncope.

- Breast Implant Removal – (0048)
  - Important **changes** in coverage criteria:
    - Expanded coverage by adding additional indications for removal.

- Gender Dysphoria Treatment – (0266)
  - Important **changes** in coverage criteria:
    - Updated to limit mastectomy to age 17 or over:
      - Under age 17 will be considered case by case.
    - Edited table 2 to add clarity about feminization/masculinization procedures.
    - Expanded to allow electrolysis up to 8 sessions of 30 minute timed units per day, when covered.
    - Added table 3 to represent services considered non-gender affirming/not covered, even with enhanced benefit offering:
      - No change to intent of coverage.
    - Removed criteria to have “lived in the desired gender role for at least 12 months” for genital reconstructive surgery for age over 18:
      - Consistent with World Professional Association for Transgender Health (WPATH) Version 8.
    - Removed requirement for two letters from a mental health professional:

- Only one is necessary; consistent with WPATH 8.
- We will maintain requirement of a mental health professional.

- Reduced duration of hormone therapy to 6 months rather than 12 months:
  - Consistent with WPATH 8.
- Changed from covered with benefit to noncovered:
  - Hair removal.
  - Hair transplant.
  - Removal of redundant facial skin.
  - Laser hair removal.

- Headache, Occipital and/or Trigeminal Neuralgia Treatment – (0063)
  - Advance notification of important **changes** in coverage criteria, effective **April 15, 2023**:
    - Updated title from "Headache and Occipital Neuralgia Treatment" to current title to reflect broadened scope.
    - Added not covered statements for occipital, trigeminal, sphenopalatine ganglion, and peripheral nerve blocks for the treatment of the various types of headache, migraine, trigeminal neuralgia, or occipital neuralgia.

- High Intensity Focused Ultrasound (HIFU) – (0274)
  - Important **changes** in coverage criteria:
    - Expanded coverage for magnetic resonance guided focused ultrasound for essential tremor when criteria are met.

- Intensive Behavioral Interventions – (0499)
  - Important **changes** in coverage criteria:
    - Expanded coverage of intense behavioral interventions for individuals with autism spectrum disorder (ASD):
      - Added specific criteria to be met for severe behavior program.
    - Clarified policy statements:
      - Updated DSM-5 to DSM-5-TR (text revision).
      - Defined ASD DSM-5-TR diagnostic criteria:
        - Social communication and social interaction; and restricted, repetitive patterns of behavior, interests, or activities.
      - Changed client to individual.
      - Clarified requirement of assessment instrument from "the instrument includes" to "all of the following must apply."
      - Clarified "Treatment Plan/Plan of Care":
        - Clarified that treatment plan needs to be developed and provided; not just developed.
        - Replaced assessment instrument with full and comprehensive ABA assessment.
        - Clarified that each goal identifies collection method used to report data.
        - Clarified that skills may be acquired in all settings and environments.
        - Clarified that goals and discharge criteria need to be directly related to the symptoms of ASD and their effects.
        - Clarified time requirements for direct and indirect case supervision.
        - Clarified stakeholder (caregiver) goals are individualized and all relevant stakeholder(s) will be taught the behavioral interventions.
        - Added that baseline data is obtained and provided, with dates recorded, for all stakeholder behaviors and skills identified for intervention everywhere treatment will occur.
        - Added statement for retrospective reviews indicating that all criteria from initiation of treatment section (and continued treatment section as applicable) are met, coinciding with the dates of service identified within the request as education to providers.

- Clarified that for continued treatment, baseline data is needed, with dates recorded across all settings/environments for new and/or proposed interventions, and are updated as necessary and have been collected within no more than 30 days before implementation of the intervention associated with identified behavior and skill.
- Clarified that for continued treatment, updated/current data needs to have the date when data was collected and that there has been ongoing and sustained progress toward mastering the stakeholder training goals.

- Lumbar Fusion for Spinal Instability and Degenerative Disc Conditions, Including Sacroiliac Fusion – (0303)
  - Minor **changes** in coverage criteria/policy:
    - Clarified coverage:
      - Added parenthetical "transfixing device" to percutaneous sacroiliac (SI) joint fusion statement as covered when criteria are met.
      - Edited criteria for imbalance for flatback syndrome:
        - Can be either neurologic compromise or neurologic symptoms with objective neurologic findings.
    - Added as not covered to policy statement only:
      - OptiMesh, a mesh graft containment device as EIU for interbody fusion.
      - No change to coverage.

- Pelvis Imaging Amendment to Cigna-eviCore General Pelvis Imaging Guideline – (DV001)
  - Originally provided advance notification on **October 15, 2022**, of minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
    - Removed "Primary Amenorrhea" and "Pelvic Pain" sections.
      - Addressed in eviCore Pelvis Imaging guideline.
      - Secondary Amenorrhea remains in this guideline.

- Pharmacogenetic Testing for Non-Cancer Indications – (0500)
  - Important **change** in coverage criteria:
    - Added new not covered policy statement for gene expression classifiers.

- Surgical Treatment for Hyperhidrosis – (0037)
  - Minor **changes** in coverage criteria/policy:
    - Updated for clarification.

Retired Medical Coverage Policies

- No retired policies for January 2023.

New Cigna-American Specialty Health (ASH) Cobranded Clinical Practice Guidelines (CPGs)

- No new Cigna-ASH CPGs for January 2023.

Modified Cigna-ASH Cobranded CPGs

- No updates for January 2023.

New Cigna-eviCore Cobranded Guidelines

- No new guidelines for January 2023.

Modified Cigna-eviCore Cobranded Guidelines

- High-Tech Radiology (HTR or Imaging) guidelines
  - Originally provided advance notification on **October 15, 2022**, of important **changes** to the following imaging guidelines, effective **January 15, 2023**:
    - Updated informational document “Preface to the Imaging Guidelines”.
    - Expanded coverage in four guidelines:
      - Cardiac.
      - Musculoskeletal.
      - Pediatric Abdomen.
      - Pediatric Musculoskeletal.
    - Adverse changes in coverage for one guideline:
      - Breast.
    - Positive and adverse changes in coverage in eight guidelines:
      - Abdomen.
      - Chest.
      - Head.
      - Oncology.
      - Pelvis.
      - Peripheral Vascular Disease.
      - Pediatric Head.
      - Pediatric Oncology.
    - No changes in coverage to the remaining ten guidelines:
      - Neck.
      - Peripheral Nerve Disorders.
      - Spine.
      - Pediatric Cardiac.
      - Pediatric Chest.
      - Pediatric Neck.
      - Pediatric Pelvis.
      - Pediatric Peripheral Nerve Disorders.
      - Pediatric Peripheral Vascular Disease.
      - Pediatric Spine.

New Administrative Policies

- No new policies for January 2023.

Modified Administrative Policies

- No updates for January 2023.

New Drug and Biologic Coverage Policies: Effective January 1, 2023 unless otherwise noted

- **Supports pharmacy prior authorization:**
  - Acyclovir 5% Ointment for Individual and Family Plans - (IP0498)
  - Albendazole for IFP - (IP0462)
  - Aminocaproic Acid for Individual and Family Plans - (IP0463)
  - Attention Deficit Hyperactivity Disorder (ADHD) Stimulants - (IP0477)
    - Replaces Attention Deficit Hyperactivity Disorder (ADHD) Stimulants – (P0047).
  - Beta Blockers - (IP0461)
    - Supports requirements for propranolol extended-release capsule (InnoPran XL).
  - Betaine (Cystadane) for IFP - (IP0465)
  - Cinacalcet for IFP - (IP0464)
  - Ciprofloxacin-fluocinolone for IFP - (IP0468)
  - Collagenase for IFP – (IP0470)
  - Cysteamine bitartrate (Cystagon) for IFP - (IP0466)
  - Entadfi (finasteride and tadalafil) - (IP0519)
    - Effective **January 15, 2023**.
  - Erenumab - (IP0503) and
  - Fremanezumab - (IP0504) and
  - Galcanezumab - (IP0505)
    - Replaces criteria found in Calcitonin Gene-Related Peptide (CGRP) Inhibitors for Employer Group Plans – (IP0050).
  - L-glutamine Oral Powder for Individual and Family Plans - (IP0475)
  - Metyrosine - (IP0450)
  - Nitazoxanide for IFP – (IP0467)
  - Paromomycin - (IP0520)
    - Effective **January 15, 2023**.
  - Quazepam for Individual and Family Plans - (IP0469)
  - Rifaximin for Individual and Family Plans - (IP0473)
  - Roflumilast - (IP0527)
    - Effective **January 15, 2023**.
  - Tobramycin/loteprednol etabonate (Zylet) Ophthalmic Suspension for Individual and Family Plans - (IP0474)

- Tolvaptan for IFP - (IP0471)

- Topical Estrogen Products (Non-Patch) - (IP0459)
  - Supports requirements for estradiol 0.1% gel (Divigel) and estradiol 0.06% gel (Elestrin).

- Transdermal Estrogen and Estrogen-Progestin Patches - (IP0460)
  - Supports requirements for:
    - Estradiol transdermal patch (Climara, Minivelle and Vivelle-Dot).
    - Estradiol/ levonorgestrel transdermal patch (Climara Pro).

- Weight Loss - Semaglutide (Wegovy) - (IP0521)
  - Effective **January 15, 2023**.
  - Moved Wegovy criteria from Weight Loss – Liraglutide (Saxenda) - (IP0206).

- **Supports medical precertification:**
  - Elivaldogene Autotemcel - (IP0529)
    - Effective **January 6, 2023**.

  - Eptinezumab - (IP0506)
    - Replaces criteria found in Calcitonin Gene-Related Peptide (CGRP) Inhibitors for Employer Group Plans – (IP0050).

- **Supports medical necessity criteria:**
  - Apomorphine (Kynmobi) - (IP0488)
    - Content moved from Antiparkinson Agents - (IP0076).

Modified Drug and Biologic Coverage Policies: Updates in this section effective January 1, 2023 unless otherwise noted

- Abatacept Intravenous - (IP0232) and
- Abatacept Subcutaneous - (IP0231)
  - Important **changes** in coverage criteria:
    - Updated Individual and Family Plan (IFP) preferred product table noting following products will be non-formulary:
      - Otezla.
      - Stelara subcutaneous/intravenous (SC/IV).
      - Taltz.
      - Tremfya.

- Angiotensin Receptor Blockers - (IP0326)
  - Minor **changes** in coverage criteria/policy:
    - Extended current criteria approach for Value/Advantage /Total Savings formularies to Standard/Performance and Legacy formularies for Atacand, Atacand HCT and Azor.

- Antiparkinson Agents - (IP0076)
  - Minor **changes** in coverage criteria/policy:
    - Removed Kynmobi:
      - Content placed in Apomorphine (Kynmobi) - (IP0488).

- Apremilast - (IP0226)
  - Important **change** in coverage criteria:
    - Updated IFP preferred product table noting Otezla will be non-formulary.

- Attention Deficit Hyperactivity Disorder (ADHD) Stimulants - (IP0477)
  - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
    - Added new strengths of 45mg and 63mg tabs for Relexxii and its authorized generic Methylphenidate ER.
    - Updated criteria.

- Belumosudil (Rezurock) - (IP0313)
  - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
    - Updated format to current template and language standards.
      - No change to criteria content.

- Brands with Bioequivalent Generics - (IP0011)
  - Minor **change** in coverage criteria/policy, effective **January 15, 2023**:
    - Removed Humatin (paromomycin).

- Burosumab – (IP0285)
  - Minor **change** in coverage criteria/policy, effective **January 15, 2023**:
    - Added dosing.

- Brodalumab - (IP0246) and
- Secukinumab – (IP0223)
  - Important **changes** in coverage criteria:
    - Updated IFP preferred product table noting the following are non-formulary:
      - Otezla.
      - Stelara SC/IV.
      - Taltz.
      - Tremfya.

- Clotting Factors and Antithrombin – (8007)
  - Important **change** in coverage criteria, effective **January 15, 2023**:
    - Added criteria for Rebinyn for routine prophylaxis to reduce the frequency of bleeding episodes.

- COVID-19 Drug and Biologic Therapeutics - (2016)
  - Important **change** in coverage criteria, effective **December 6, 2022**:
    - Removed coverage criteria for bebtelovimab secondary to emergency use authorization withdrawal issued on November 30, 2022.

- Cyclosporine Ophthalmic Products - (IP0026)
  - Minor **changes** in coverage criteria/policy:
    - Updated format to current template and language standards.
    - Extended current criteria approach for Value/Advantage /Total Savings formularies to Standard/Performance and Legacy formularies for Restasis Multidose.

- Dextromethorphan/quinidine (Nuedexta) for IFP - (IP0324)
  - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
    - Updated format to current template and language standards.
    - Added documentation of beneficial response to align with standard criteria language under “Continuation of Therapy” section.

- Drug and Biologic Medical Necessity (Injectables) – medical benefits – (2027)
  - Important **changes** in coverage criteria, effective **January 15, 2023**:
    - Updated to address coverage of injectable drugs and biologics, not otherwise specified, allowed under medical plan benefits.

- Dupilumab – (IP0453)
  - Important **change** in coverage criteria, effective **January 15, 2023**:
    - Added criteria for prurigo nodularis.

- Guselkumab - (IP0234) and
- Ixekizumab - (IP0224)
  - Important **changes** in coverage criteria:
    - Updated IFP preferred product table noting:
      - Tremfya is non-formulary.
      - Skyrizi is preferred.

- Immunomodulators – Oral and Subcutaneous (Individual and Family Plans) - (1903)
  - Important **changes** in coverage criteria:
    - Updated preferred alternative requirements list for:
      - Certolizumab (Cimzia).
      - Golimumab (Simponi).

- Insulin Glargine - (P0023)
  - Important **change** in coverage criteria, effective **January 15, 2023**:
    - Added Basaglar Tempo Pen.

- Intraarticular Hyaluronic Acid Derivatives - (IP0322)
  - Minor **changes** in coverage criteria/policy:
    - Updated format to current template and language standards.
    - Updated IFP covered alternatives.
    - Updated coding table updated to reflect changes to non-covered products listing.

- Ivabradine - (IP0286)
  - Important **changes** in coverage criteria, effective **January 15, 2023**:
    - Simplified criteria for:
      - Heart failure.
      - Heart failure due to dilated cardiomyopathy in pediatric individuals.
      - Inappropriate sinus tachycardia.

- Ivermectin - (IP0300)
  - Important **changes** in coverage criteria, effective **January 15, 2023**:
    - Updated format to current template and language standards.
    - Added Demodex folliculorum infection as new condition of approval.
    - Simplified criteria for pediculosis.

- Lanreotide for Non-Oncology Uses – (IP0323)
  - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
    - Updated format to current template and language standards.
      - No content changes to criteria
    - Supports prior authorization.

- Lisocabtagene maraleucel - (IP0130)
  - Important **changes** in coverage criteria, effective **January 15, 2023**:
    - Revised criteria due to FDA expanded indication for certain B-cell lymphoma types to require only one line of systemic therapy.
    - Added human herpesvirus-8 (HHV8)-positive diffuse large B-cell lymphoma diagnosis for coverage.
    - Removed the following diagnoses from coverage:
      - Gastric mucosa-associated lymphoid tissue (MALT) lymphoma.
      - Non-gastric MALT lymphoma.

        - Splenic marginal zone lymphoma.
    - Revised Eastern Cooperative Oncology Group performance to allow from 0 to 2.
    - Added dose management guidance.

- Lonapegsomatropin - (IP0375)
    - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
        - Updated preferred product requirements to require both preferred Somatropin products, before coverage for Skytrofa for Employer formularies and IFP formularies.

- Luspatercept – (IP0115)
    - Important **changes** in coverage criteria, effective **January 15, 2023**:
        - Revised criteria for beta-thalassemia.

- Obeticholic Acid - (IP0304)
    - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
        - Updated format to current template and language standards.
        - Removed examples from criterion C-i without change to intent of criterion.
        - Supports prior authorization criteria for Ocaliva.

- Odevixibat - (IP0363)
    - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
        - Updated format to current template and language standards.
            - No changes to criteria.
        - Supports medical necessity exception criteria for Bylvay.

- Oxybate - (IP0103)
    - Minor **changes** in coverage criteria/policy:
        - Update IFP covered alternatives.
        - Added indication-specific IFP preferred product box.

- Palivizumab - (IP0321)
    - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
        - Updated format to current template and language standards.
        - Added dosing information to criteria approach.
        - Updated background and references responsive to new information.

- Pasireotide Long-Acting - (IP0165)
    - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
        - Updated format to current template and language standards.
            - No changes to criteria.
        - Supports prior authorization criteria for Signifor LAR.

- Pegvisomant - (IP0291)
    - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
        - Updated format to current template and language standards.
            - No content changes to criteria.
        - Supports prior authorization criteria for Somavert SC injection.

- Phenylbutyrate - (IP0169)
    - Important **changes** in coverage criteria, effective **January 15, 2023**:
        - Updated title from “Glycerol Phenylbutyrate” to current title.
        - Added pheburane.
        - Reworded initial approval criteria for requirement excluding concomitant therapy with Buphenyl and Ravicti to more generally not allow concurrent use with another phenylbutyrate product.

        - Updated conditions not recommended for approval for concomitant use with Buphenyl and Ravicti to read “concomitant use with another phenylbutyrate product”.

- Opioid Therapy - (1704) and
- Penicillamine - (IP0277) and
- Trientine hydrochloride - (IP0278)
    - Minor **changes** in coverage criteria/policy:
        - Updated format to current template and language standards.
        - Updated IFP covered alternatives.

- Quantity Limitations – (1201)
    - Important **change** in coverage criteria, effective **January 15, 2023**:
        - Added exception criteria for Zoryve (roflumilast cream).

- Risankizumab Intravenous - (IP0476)
    - Important **change** in coverage criteria:
        - Updated IFP preferred product table noting Skyrizi IV is a preferred product.

- Risankizumab Subcutaneous - (IP0247)
    - Important **change** in coverage criteria:
        - Updated IFP preferred product table noting Skyrizi SC is a preferred product.

- Selumetinib (Koselugo) – (IP0038)
    - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
        - Updated format to current template and language standards.
        - Revised overview section to clarify coverage policy is intended for non-oncology uses:
            - Oncology uses addressed in Oncology Medications – (1403).
        - Removed “for example” statements under requirement #2 that defined symptomatic and inoperable neurofibromas to simplify criteria.
            - No content changes to criteria.

- Somatropin - (4012)
    - Minor **changes** in coverage criteria/policy:
        - Updated IFP preferred product table to align with Employer group.

- Step Therapy for Individual and Family Plan - (1603)
    - Important **changes** in coverage criteria:
        - Removed angiotensin receptor blocker (ARB) section due to step removal for Edarbi and Edarbyclor.
        - Removed long acting narcotics – abuse deterrent formulations section due to step removal for Embeda, Hydrocodone bitartrate ER (generic for Hysingla ER) and Hysingla ER.
        - Removed long acting narcotics – non-abuse deterrent formulations section due to step removal for Nucynta ER.
        - Removed proton pump inhibitors (PPI) section due to step removal for Dexilant.
        - Removed Pexeva and Viibryd from SSRI/SNRI section due to step removal.
        - Added Vilazodone as Step 1 to SSRI/SNRI section.

- Teduglutide (Gattex) - (IP-0288)
    - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
        - Updated format to current template and language standards.
        - Reworded criteria 1Bi and removed 1Bii to clarify intent.

- Tildrakizumab - (IP0236)
    - Important **changes** in coverage criteria:
        - Updated IFP preferred product table noting the following are non-formulary:

- Otezla.
- Stelara SC/IV.
- Taltz.

- Tolvaptan (Jynarque) – (IP0287)
  - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
    - Added end-stage kidney disease to Stage 5 descriptor

- Topical Diclofenac (Solaraze) - (IP0282)
  - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
    - Updated format to current template and language standards.
      - No change to criteria.
    - Supports medical necessity review for topical diclofenac 3% gel.

- Topical Tazarotene Products - (IP0174)
  - Important **changes** in coverage criteria, effective **January 15, 2023**:
    - Updated criteria to clarify preferred alternatives for each indication.
    - Added tazarotene 0.1% foam (non-covered authorized generic for Fabior).
    - Added criteria for coverage of "Other Non-Cosmetic Conditions".
    - Removed strengths of medications where not needed.

- Topical Tretinoin Products - (IP0167)
  - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
    - Removed strengths of medications where not needed.

- Upadacitinib - (IP0229)
  - Important **change** in coverage criteria, effective **January 15, 2023**:
    - Added criteria for non-radiographic axial spondyloarthritis (nr-axSpA).

- Uridine Triacetate - (IP0307)
  - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
    - Updated format to current template and language standards.
      - No changes to criteria.
    - Supports prior authorization criteria for Xuriden oral granules.

- Ustekinumab Intravenous – (IP0240)
  - Important **change** in coverage criteria:
    - Updated IFP preferred product table noting:
      - Stelara Intravenous is non-formulary.
      - Skyrizi is preferred.
    - Added dose management criteria for Crohn's disease and ulcerative colitis.

- Ustekinumab Subcutaneous – (IP0239)
  - Important **change** in coverage criteria:
    - Updated IFP preferred product table noting:
      - Stelara SC is non-formulary.
      - Skyrizi is preferred.

- Vaginal Estrogen Products and Ospemifene - (IP0216)
  - Important **changes** in coverage criteria:
    - Updated format to current template and language standards.
    - Removed Estring and Premarin.
    - Added Femring and Imvexxy.
    - Updated Estrace and Vagifem criteria to new multi-source brand language.
    - Updated Osphena approach as Imvexxy will now be targeted.

- Viltolarsen – (IP0066)
  - Minor **changes** in coverage criteria/policy, effective **January 15, 2023**:
    - Updated format to current template and language standards.
      - No changes to criteria.

- Voriconazole (oral) - (IP0306)
  - Minor **changes** in coverage criteria/policy:
    - Updated format to current template and language standards.
      - No changes to criteria.

- Weight Loss – Liraglutide (Saxenda) - (IP0206)
  - Important **changes** in coverage criteria, effective **January 15, 2023**:
    - Updated title from "Weight Loss – Glucagon-Like Peptide-1 Agonists" to current title.
    - Removed and relocated semaglutide (Wegovy) to Weight Loss - Semaglutide (Wegovy) - (IP0521).
    - Added impaired glucose tolerance as additional example of comorbidity.
    - Removed previous max maintenance dosing requirement from "Continuation of Therapy" criteria.
    - Removed symbols and updated format to current template and language standards.

Retired Drug and Biologic Coverage Policies: Effective January 1, 2023 unless otherwise noted

- Attention Deficit Hyperactivity Disorder (ADHD) Stimulants - (P0047)
  - Replaced with Attention Deficit Hyperactivity Disorder (ADHD) Stimulants - (IP0477).

- Calcitonin Gene-Related Peptide (CGRP) Inhibitors for Employer Group Plans – (IP0050)
  - Replaced with:
    - Eptinezumab - (IP0506) and
    - Erenumab - (IP0503) and
    - Fremanezumab - (IP0504) and
    - Galcanezumab - (IP0505)

- Calcitonin Gene-Related Peptide (CGRP) Inhibitors – Preventative Migraine Treatment for Individual and Family Plans – (2020)
  - No longer needed; therefore, is being retired.

Cigna National Formulary (CNF) Coverage Policies

- Cigna National Formulary (CNF) policies are located on the CNF Policies A-Z Index.
  - Policies are listed alphabetically by document title
    - Document titles include the policy type and may include the drug name, class, and/or condition
  - Policies can also be searched by a product identification (ID) number, which is a unique identifier to a specific product/policy.
    - When applicable, searching by product ID helps locate the corresponding CNF policy.
  - Details of updates to each CNF policy are located under the "Revision History" section.
- More information about Cigna's drug lists can be found at Prescription Drug Lists and Coverage | Cigna
- More information about Cigna's drug lists **changes** can be found at CHCP - Resources - Cigna's Prescription Drug Lists.
  - CNF formulary changes can be found in the Prescription Drug List Changes document under **Cigna National Prescription Drug List**, located at the bottom of the page.

CareAllies Medical Necessity Guidelines

- No updates for January 2023.

* Modified Precertification List – Commercial (Non-Medicare) Business

- No updates for January 2023.

* Modified Precertification List – Medicare Business

- No updates for January 2023.

* New Reimbursement Policies

- No new policies for January 2023.

* Modified Reimbursement Policies

- No updates for January 2023.

* Other Modified Coding and Reimbursement Documents

- No updates for January 2023

* ClaimsXten Documents (return to top)

- Code Edit and Policy Guidelines
  - Effective **February 18, 2023**: