Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective January 15, 2024 (unless otherwise noted)

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

Medical Coverage Policy	New, Updated, or Retired?	Comments
Cardiac Resynchronization Therapy (CRT) and Advanced Cardiac Pacing Technologies (0174)	Update	Minor **changes** in coverage criteria/policy: • Revised statement for biventricular pacemaker for all other indications. • Expanded coverage by removing policy statement for body surface potential mapping.
Drug Testing (0513)	Update	Important **changes** in coverage criteria: • Removed annual limit for presumptive and definitive drug testing
Genetic Testing for Hereditary and Multifactorial Conditions – (0052)	Update	Important **changes** in coverage criteria: • Updated verbiage regarding credentials of individual who can perform genetic counseling • Updated verbiage for name of entities who credential individuals who can perform genetic counseling. • For clarity, added criteria for genetic testing for mitochondrial disorders • For clarity, added criteria for genetic testing for connective tissue disorders and Thoracic Aortic Aneurysm (TAA) and Dissection (TAD)

		• Expanded coverage by changing genetic testing for familial amyolateral sclerosis (FALS) from not covered and reimbursable to medically necessary • Added criteria to reflect that genetic testing is considered not medically necessary in an individual with isolated or non-syndromic generalized joint hypermobility or hypermobile Ehlers Danlos syndrome (hEDS).
Headache, Occipital, and/or Trigeminal Neuralgia Treatment 0063	Update	Important **changes** in coverage criteria: • Expanded coverage by removing "all indications" from the not covered or reimbursable statement.
Lumbar Fusion for Spinal Instability and Degenerative Disc Conditions, Including Sacroiliac Fusion 0303	Update	Important changes to criteria: • Added clarification to DDD 4criteria for psych clearance for consistency with other related spine CPs. • statement from a primary care physician, neurologist, physiatrist, psychiatrist, psychologist, or other licensed behavioral and/or medical health care provider provider not involved with the recommended plan of treatment, attesting to the absence of untreated, underlying mental health conditions/issues (e.g., depression, drug, alcohol abuse) as a major contributor to chronic back pain • Added clarification and updated SI joint fusion policy statement • Added clarification to EIu statement for C1831 personalized 3D implants
Prosthetic Devices 0536	Update	Important **changes** in coverage criteria: • Added EIU statement for Esper hand, brain computer interfaces EMG controlled upper limb prosthetic, similar to sensor controlled upper limb devices • No other changes
Stem Cell Transplantation: Solid Tumors 0534	Update	Important **changes** in coverage criteria: • Removed the policy statement for primary central nervous system lymphoma from the policy. This policy statement has been moved to CP 0533 Stem Cell Transplantation: Blood Cancers.
Whole Exome and Whole Genome Sequencing for Non-Cancer Indications 0519	Update	Minor **changes** in coverage criteria/policy: • Revised policy statement for genetic counseling, updated genetic nurse credentialing requirements.

Foot Care Services 0277	retired	No longer has business value.
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
		• No updates for January 2024
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-eviCore Gastrointestinal Endoscopic Procedure Guidelines	Update	Important **changes** in coverage criteria. Posting **January 2, 2024**. Effective **April 1, 2024**. Guideline with expansion of coverage: • Capsule Endoscopy Guideline with positive and adverse changes in coverage: • Esophagogastroduodenoscopy (EGD)
Cobranded Cigna-eviCore High-Tech Imaging Guidelines	Update	Important **changes** in coverage criteria. Posting **January 2, 2024**. Effective **April 1, 2024**. Guideline with expansion of coverage: • Pelvis Imaging Guideline with positive and adverse changes in coverage: • Pediatric Oncology Imaging
Cobranded Cigna-eviCore Radiation Oncology Guidelines	Update	Important **changes** in coverage criteria. Posting **January 27, 2024**. Effective **May 1, 2024**. **The updated guidelines included:** Four guidelines had an expansion of coverage: • Kidney Cancer

		• Oligometastases • Proton Beam Therapy • Thymoma and Thymic Cancer One guideline had positive and adverse changes in coverage: • Brain Metastases The remaining 38 guidelines and two informational documents had no changes in coverage: • ^{177}Lu-dotatate (Lutathera®) • Abbreviations and Definitions for Radiation Oncology Guidelines • Adrenocortical Carcinoma • Anal Canal Cancer • Azedra® (iobenguane I-131) • Bladder Cancer • Bone Metastases • Brachytherapy of the Coronary Arteries • Breast Cancer • Cervical Cancer • Endometrial Cancer • Esophageal Cancer • Gastric Cancer • Head and Neck Cancer • Hepatobiliary Cancer • Hodgkin Lymphoma • Hyperthermia • Image-Guided Radiation Therapy (IGRT) • Multiple Myeloma and Solitary Plasmacytomas • Neutron Beam Therapy • Non-Hodgkin Lymphoma • Non-Malignant Disorders • Non-Small Cell Lung Cancer • Other Cancers • Pancreatic Cancer • Pluvicto® (lutetium Lu^{177} vipivotide tetraxetan) • Preface to the Radiation Oncology Guidelines

		• Primary Craniospinal Tumors and Neurologic Conditions • Prostate Cancer • Rectal Cancer • Selective Internal Radiation Therapy (SIRT) • Skin Cancer - Melanoma • Skin Cancer - Non-Melanoma • Small Cell Lung Cancer • Soft Tissue Sarcomas • Testicular Cancer • Urethral Cancer and Cancers of the Ureter and Renal Pelvis • Vulvar Cancer • Xofigo® (Radium-223) • Zevalin®
Administrative Policy	**New, Updated, or Retired?**	**Comments**
Authorized Generics (A008)	Update	Important changes to criteria: • Standard / Performance Drug List Plan and Legacy Drug List Plan: Humalog and Symbicort removed from the policy and Flector added to the policy. • Value / Advantage Drug List Plan: Flector and Humalog added to the policy and Flovent and Symbicort removed from the policy. • Effective **1/1/2024**.
Oral Appliances for the Treatment of Obstructive Sleep Apnea (A016)	New	Important changes: New administrative policy Administrative Policy: Standard Cigna benefit plans consider an oral appliance to be a covered benefit when medical necessity criteria are met under the Medical Coverage Policy. This policy describes how medically necessary services are reported through CPT/HCPCS and ICD-10-CM coding.
Preventive Care Services (A004)	Update	Important changes • Added HIV-2 screening as a preventive service ➢ 87391 HIV-2 immunoassay ➢ 87537 HIV-2 direct probe

		➢ 87538 HIV-amplified probe • Additional new codes added: ➢ A4287 new code collection bag breast milk ➢ G0011, G0013- counseling for PReP ➢ G0012- injection PReP drug ➢ J0750, J0751- oral PReP drugs ➢ J0799- unlisted PReP drug ➢ Q0516, Q0517, Q0519- Pharmacy supply fee for Prep drugs ➢ 90623 Meningococcal pentavalent vaccine ➢ 90683 RSV vaccine ➢ G9886 behavioral counseling diabetes, in-person ➢ G9887 behavioral counseling diabetes, distance learning • G9888 maintenance weight management
Drug & Biologic Coverage Policy	**New, Updated, or Retired?**	**Comments** **All policy changes effective January 1, 2024, unless otherwise stated**
Abatacept Intravenous – (IP0232)	Update	Important **changes** in coverage criteria: • Updated the Individual and Family Plans preferred product requirements by adding Otezla, Stelara SC and Tremfya as options. • Effective date **1/1/2024**.
Abatacept Subcutaneous – (IP0231)	Update	Important **changes** in coverage criteria: • Updated the Individual and Family Plans preferred product requirements by adding Otezla, Stelara SC and Tremfya as options. • Effective date **1/1/2024**.
Alemtuzumab (IP0213)	Update	Important **changes** in coverage criteria: • Updated the Employer Group Plan preferred product requirements from a dimethyl fumarate step to a dimethyl fumarate OR fingolimod option. • Policy aligned to current language and template standards. • Effective date: **1/1/2024**
Antihyperglycemic Therapy (Non-Insulin) – (P0098)	Update	Important **changes** in coverage criteria: • Updated policy with criteria to require step through two preferred alternatives for Victoza • Removed Victoza as a preferred alternative from Adlyxin criteria • Effective date: **1/1/2024**

Antitussives (IP0586)	New	This is a **new** coverage policy. • This is a new policy supporting pharmacy prior authorization of non-covered antitussive products. • This policy replaces CP P0083 (Antitussives). • Effective date **1/15/2024**.
Apremilast – (IP0226)	Update	Important **changes** in coverage criteria: • Updated policy to move Otezla from a non-preferred brand to a preferred brand product on all Individual and Family Plan formularies. • Effective **1/1/2024**.
Attention Deficit Hyperactivity Disorder (ADHD) Stimulants for Employer Group Plans – (IP0477)	Update	
Avacincaptad Intravitreal Injection – (IP0581)	New	Important **changes** in coverage criteria: • New coverage criteria to support medical precertification for employer group plans and IFP • Effective date: **1/15/2024**
Avonex (interferon beta-1a) (IP0254)	Update	Important changes in coverage criteria: • Clarified that the Employer Group Plan preferred product requirements will only apply to multiple sclerosis treatment naïve individuals. • Updated the Employer Group Plan preferred product requirements from a dimethyl fumarate step to a dimethyl fumarate **OR** fingolimod option. • Separated the Employer and Individual and Family Plan preferred product approaches. • Policy aligned to current language and template standards. • Effective date **1/1/2024**.
Baricitinib (IP0225)	Update	Important **changes** in coverage criteria: • Modified criteria for Alopecia Areata diagnostic statement with the addition of alopecia universalis and alopecia totalis were listed as subtypes of alopecia areata. • Clarified the requirement for a trial of systemic therapy by updating to more specifically state conventional systemic therapy. Also, an exception to this requirement was added if the patient has already tried Litfulo. • The exclusion for use in androgenetic alopecia or other causes of hair loss other than alopecia areata has been removed.

		• Added causes of hair loss other than alopecia areata as an excluded use in the Conditions Not Covered section. • Policy effective **1/1/2024**.
Belimumab Subcutaneous – (IP0430)	Update	Important **changes** in coverage criteria: • Removed criterion requiring autoantibody-positive SLE, defined as positive for antinuclear antibodies (ANA) and/or anti-double-stranded DNA (anti-dsDNA antibody) for Lupus Nephritis in alignment with P&T guidance. • Updated policy format and language to current template standards. • Effective date: 1/15/2024
Belimumab Intravenous – (IP0429)	Update	Important **changes** in coverage criteria: • Removed criterion requiring autoantibody-positive SLE, defined as positive for antinuclear antibodies (ANA) and/or anti-double-stranded DNA (anti-dsDNA antibody) for Lupus Nephritis in alignment with P&T guidance. • Added dosing in alignment with ESI UM policy. • Updated policy format and language to current template standards. • Effective date: 1/15/2024
Betaine for IFP – (IP0465)	Update	Important **changes** in coverage criteria: • Updated policy with criteria to support IFP non-covered product for brand Cystadane • Effective date: **1/1/2024**
Brodalumab (IP0246)	Update	Important **changes** in coverage criteria: • Updated the Individual and Family Plan Plaque Psoriasis preferred product requirements, by adding Otezla, Stelara SC and Tremfya as options. • Effective: **1/1/2024**
Carglumic Acid – (IP0438)	Update	Important **changes** in coverage criteria: • Added a generic step requirement to Carbaglu brand for Individual and Family Plans • Effective: **1/1/2024**
Certolizumab – (IP0244)	Update	Important **changes** in coverage criteria: • Updated the Individual and Family Plans preferred product requirements by adding Otezla, Stelara SC and Tremfya as options. • Effective date **1/1/2024**

Cipaglucosidase alfa-atga (IP0591)	New	The policy supports medical necessity review for Employer Group benefit plans. Effective date: 1/15/2024
Cladribine (IP0261)	Update	Important changes in coverage criteria: • Updated the Employer Group Plan preferred product requirements from a dimethyl fumarate step to a dimethyl fumarate **OR** fingolimod option. • Separated the Employer and Individual and Family Plan preferred product approaches. • Policy aligned to current language and template standards. • Effective date **1/1/2024**.
Corticosteroid / Long-Acting Beta2-Agonist Combination Inhalers (IP0022)	Update	Important **changes** in coverage criteria: • Business update responsive to business decision to move Symbicort and the Authorized Generic for AirDuo Respiclick from PB to NPB. • Criteria updated for Advair Diskus, Advair HFA, AirDuo RespiClick, and fluticasone-salmeterol HFA. • Criteria added for Symbicort and the Authorized Generic for AirDuo Respiclick. • Criteria for Breo Ellipta moved from CP IP045 and reconciled to current P&T guidance. • Effective **1/1/2024**.
COVID-19 Drug and Biologic Therapeutics	Update	Important **changes** in coverage criteria: • The initial Quantity Limit (1 carton per 120 days) added to the policy. • The Quantity Limit exception criteria, for both Paxlovid and Lagevrio, will be updated to current P&T standards. • Effective **1/15/2024**.
Cyclosporine Ophthalmic Products (IP0026)	Update	Important **changes** in coverage criteria: • Restasis Multidose criteria updated by removing intolerance language as there are no differences between the ingredients in the generic and multidose formulations. • The concomitant use statements have been updated to include products FDA approved since the last review of the policy. • Policy aligned to current language and template standards.

		• Effective date **1/15/2024**.
Deucravacitinib – (IP0538)	Update	Important **changes** in coverage criteria: • Updated the Individual and Family Plans preferred product requirements by adding Otezla, Stelara SC and Tremfya as options. • Effective date **1/1/2024**.
Deucravacitinib – (IP0538)	Update	Important **changes** in coverage criteria: • Added Adalimumab - adbm (CF) as a preferred prerequisite option to the Employer Plans and Individual and Family Plans preferred product requirements. • Updated Hyrimoz to clarify only the Sandoz/Novartis brand is covered. • Updated preferred product requirements from two down to one product required for Employer Plans • Effective date of 1/15/2024.
Diroximel fumarate (IP0253)	Update	Important changes in coverage criteria: • Clarified that the Employer Group Plan preferred product requirements will only apply to multiple sclerosis treatment naïve individuals. • Updated the Employer Group Plan preferred product requirements from a dimethyl fumarate step to a dimethyl fumarate **OR** fingolimod option. • Separated the Employer and Individual and Family Plan preferred product approaches. • Policy aligned to current language and template standards. • Effective date **1/1/2024**.
DaxibotulinumtoxinA-lanm – (IP0588)	New	This is a **new** coverage policy. • The policy supports medical precertification for daxibotulinumtoxinA-lanm (Daxxify) • Effective date **1/15/2024**
Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review	Update	Important **changes** in coverage criteria: • Clarified that Trianex and its generic are NOT augmented triamcinolone 0.05% ointment preparations.

Employer Group Plans: Standard, Performance, or Legacy Prescription Drug List (1601)		• Xdemvy (lotilaner 0.25% ophthalmic solution) added to the policy and will be effective 2/1/2024 • Effective date **1/15/2024**. Important **changes** in coverage criteria: • Added DRT criteria for Alocril, Alomide, Avar-E, Avar-E Green, Betimol 0.25%, Betimol 0.5%, Carospir, Clioxan, Cleocin vaginal ovules, Clindesse, desvenlafaxine, Dutoprol, fluticasone HFA, FML Forte, Hemangeol, Inderal XL, Iopidine, Kapspargo, Karbinal, Maxidex, Nevanac, Nitrofurantoin, Nuvessa, Pred G, Pred Mild, Pulmicort, Qbrelis, Solosec, Synera, Timoptic, and Tobrex. • Criteria for Alvesco, Asmanex and Striverdi removed from the policy. • Prerequisite requirements updated for ArmonAir Digihaler and Arnuity Elipta. • New criteria added for Flovent Discus, Flovent HFA, Pulmicort and Serevent. • Myrbetriq 8 mg/mL granules moved from CP IP0238. • Effective date **1/1/2024**.
Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review Employer Group Plans: Value, Advantage, or Cigna Total Savings Prescription Drug List (1602)	Update	Important **changes** in coverage criteria: • Veozah (fezolinetant tablets) added to the policy, and will be effective. • Clarified that Trianex and its generic are NOT augmented triamcinolone 0.05% ointment preparations. • Xdemvy (lotilaner 0.25% ophthalmic solution) added to the policy and will be effective 2/1/2024 • Effective date **1/15/2024**. Important **changes** in coverage criteria: • Added criteria for Avar-E, Avar-E Green, Betimol 0.25%, Betimol 0.5%, Carospir, Clioxan, Cleocin vaginal ovules, Clindesse, desvenlafaxine, Dutoprol, fluticasone HFA, FML Forte, Hemangeol, Inderal XL, Iopidine, Kapspargo, Karbinal, Maxidex, Nevanac, Nitrofurantoin, Nuvessa, Pred G, Pred Mild, Pulmicort, Qbrelis, Solosec, Synera, Timoptic, and Tobrex. • Criteria for Alvesco, Asmanex and Striverdi removed from the policy. • Prerequisite requirements updated for ArmonAir Digihaler and Arnuity Elipta. Flovent Discus, Flovent HFA. • Criteria for Pulmicort and Serevent added to the policy. • Pristiq and Paxil CR removed from the policy. • Myrbetriq 8 mg/mL granules moved from CP IP0238.

		• Effective date **1/1/2024**.
Estrogen Transdermal – (IP0590)	New	The policy supports medical necessity review for Employer Group benefit plans. • IP0459 Topical Estrogen Products (Non-Patch) and IP0460 Transdermal Estrogen and Estrogen-Progestin Patches consolidated into IP0590. • IP0459 and IP0460 both retired. • Effective date: 1/15/2024
Givosiran – (IP0118)	Update	Minor **changes** in coverage criteria: • Updated medical necessity criteria to include dosing information • Updated to current template/ language standards • Effective: **1/15/2024**
Golimumab Subcutaneous – (IP0237)	Update	Important **changes** in coverage criteria: • Updated the Individual and Family Plans preferred product requirements by adding Otezla, Stelara SC and Tremfya as options. • Effective date **1/1/2024**.
Gonadotropin-Releasing Hormone (GnRH) Antagonists for Infertility Use – (IP0333)	Update	Important **changes** in coverage criteria: • Added a generic step requirement to Cetrotide brand for Individual and Family Plans. • Effective date **1/1/2024**.
Guselkumab (IP0234)	Update	Important **changes** in coverage criteria: • Removed the Individual and Family Plan Crohn's Disease and Ulcerative Colitis preferred product requirements. • Effective date **1/1/2024**
Hereditary Angioedema – C1 Esterase Inhibitors (IV) - (IP0315)	Update	Important changes in coverage criteria: • Updated medical necessity criteria to include dosing for all indications. • Updated to current template/ language standards • Effective: **1/15/2024**

Hereditary Angioedema – C1 Esterase Inhibitors (SC) – (IP0316)	Update	Important **changes** in coverage criteria: • Updated medical necessity criteria to include dosing information for HAE prophylaxis • Updated to current template/ language standards • Effective: **1/15/2024**
HMG-CoA Reductase Inhibitors (Statins) and Combination Products (IP0064)	Update	Important **changes** in coverage criteria: • Added an MSB step to the current Value/ Advantage / Total Savings approach for Livalo and extended to the Standard / Performance / Legacy formularies. • Added an MSB step to the current Value/ Advantage / Total Savings approach for Livalo. • Pitavastatin added as a prerequisite option to Altoprev, Atorvaliq, Crestor, Ezallor, FloLipid, Lescol XL, Lipitor, Pravachol, Vytorin, Zocor and Zypitamag. • Effective date **1/1/2024**.
Ibrexafungerp – (IP0301)	Update	Important **changes** in coverage criteria: • Added expanded indication for Recurrent Vulvovaginal Candidiasis. • Updated Reauthorization Criteria and Authorization Duration sections. • Updated policy format. • Effective date **1/15/2024**.
Inclisiran – (IP0380)	Update	Important **changes** in coverage criteria: • Added new condition of coverage for primary hyperlipidemia • Effective date **1/15/2024**.
Insulins (Rapid-Acting) (IP0065)	Update	Important **changes** in coverage criteria: • Removed Humalog U-100 vials as a prerequisite requirement. • Added criteria for Humalog U-100 vials. • Added criteria for Fiasp Pump cart. • Added insulin lispro as a prerequisite option. • Responsive to P&T guidance, updated the prerequisite requirements for all targeted products (Admelog, Apidra, Fiasp, insulin aspart and Novolog),

		from a double step to a single step through an insulin lispro preferred product. • Effective date **1/1/2024**.
Interferon beta-1b (IP0256)	Update	Important changes in coverage criteria: • Clarified that the Employer Group Plan preferred product requirements will only apply to multiple sclerosis treatment naïve individuals. • Updated the Employer Group Plan preferred product requirements from a dimethyl fumarate step to a dimethyl fumarate **OR** fingolimod option. • Policy aligned to current language and template standards. • Effective date **1/1/2024**
Intraarticular Hyaluronic Acid Derivatives (IP0322)	Update	Important **changes** in coverage criteria: • Dosing information added to the policy. • Employer Group and Individual and Family Plan preferred product requirement tables combined. • Added *Pathologic Conditions of the Knee Other than Osteoarthritis* as an excluded use. • Policy updated to current template and language standards. • Effective date **1/15/2024**.
Ixekizumab (IP0224)	Update	Important **changes** in coverage criteria: • Updated the Individual and Family Plan Plaque Psoriasis and Psoriatic Arthritis preferred product requirements, by adding Otezla, Stelara SC and Tremfya as options. • Effective date **1/1/2024**.
Lonapegsomatropin (IP0375)	Update	Important **changes** in coverage criteria: • Criteria updated responsive to current P&T guidance. • Policy aligned to current language and template standards. • Effective date **1/1/2024**.
Natalizumab (IP0215)	Update	Important **changes** in coverage criteria: • Updated the Multiple Sclerosis Employer Group Plan preferred product requirements from a dimethyl fumarate step to a dimethyl fumarate OR fingolimod option. • Policy aligned to current language and template standards. • Effective date: **1/1/2024**

Ozanimod (IP0214)	Update	Important **changes** in coverage criteria: • Clarified that the Employer Group Plan preferred product requirements will only apply to multiple sclerosis treatment naïve individuals. • Updated the Employer Group Plan preferred product requirements, for Relapsing Forms of Multiple Sclerosis, from a dimethyl fumarate step to a dimethyl fumarate OR fingolimod option. • Separated the Employer and Individual and Family Plan preferred product approaches. • Policy aligned to current language and template standards. • Effective date: **1/1/2024**
Pasireotide – (IP0482)	Update	Important **changes** in coverage criteria: • Updated formatting to current standards • Effective date: **1/15/2024.**
Tasimelteon – (IP0428)	Update	Important **changes** in coverage criteria: • Added a generic step requirement to Hetlioz brand for Individual and Family Plans. • Effective date: **1/1/2024**
Teduglutide – (IP0288)	Update	Important **changes** in coverage criteria: • Updated formatting to current standards • Effective date **1/15/2024.**
Tofacitinib (IP0230)	Update	Important **changes** in coverage criteria: • Removed the Individual and Family Plan Crohn's Disease and Ulcerative Colitis preferred product requirements. • Effective date **1/1/2024**.
Topical Acne – Non-Retinoid Products – (IP0166)	Update	Important **changes** in coverage criteria: • Removed Aktipak topical gel and Duac topical gel from policy due to market withdrawal to align with the corresponding ESI policy • Effective: **1/15/2024**
Topical Alpha Adrenergic Agonists – (IP0284)	Update	Important **changes** in coverage criteria: • Individual and Family Plan to benefit exclude Brimonidine gel 0.33% • Effective date: **1/1/2024**
Topical Vitamin D Analogs – (IP0361)	Update	Important **changes** in coverage criteria: • Added Calsodore – a new branded generic for calcipotriene 0.005% cream (Dovonex)

		• Added a generic step requirement for Calsodore to Employer Group and Individual and Family Plans. • Effective date: 1/15/2024.
Ustekinumab Intravenous (IP0240)	Update	Important **changes** in coverage criteria: • Removed the Individual and Family Plan Crohn's Disease and Ulcerative Colitis preferred product requirements. • Effective date **1/1/2024**.
Ustekinumab Subcutaneous (IP0239)	Update	Important **changes** in coverage criteria: • Removed the Individual and Family Plan Crohn's Disease, Plaque Psoriasis – Adult, Plaque Psoriasis - Pediatric/Adolescent, Psoriatic Arthritis - Adult Psoriatic Arthritis - Pediatric/Adolescent and Ulcerative Colitis preferred product requirements. • Effective date **1/1/2024**.
Varenicline Nasal Solution (IP0395)	Update	Minor **changes** in coverage criteria: • No change to criteria intent. • Policy aligned to current language and template standards. • Effective date **1/15/2024**.
Vutrisiran – (IP0478)	Update	Important **changes** in coverage criteria: • Updated formatting to current standards • Effective date **1/15/2024**.
Dabigatran – (IP0033)	Update	Important **changes** in coverage criteria: • Added new criteria for Pradaxa 110 mg • Revised criteria for Pradaxa 75mg and 150 mg for Individual and Family Plan • Effective: **1/1/2024.**
Dichlorphenamide – (IP0204)	Update	Important **change** in coverage criteria: • Added non-covered product criteria for Keveyis • Effective: 1/1/2024
Eflapegrastim (IP0526)	Update	Important **changes** in coverage criteria: • Moved Udenyca to PB and Ziextenzo to NPB, for all IFP formularies and the Standard, Performance, Value, Advantage and Legacy Drug List Plans. • Effective date **1/1/2024**.

Glatiramer (IP0257)	Update	Important changes in coverage criteria: • Updated the preferred product requirements, for both Employer Group Plans and Individual and Family Plans, from a double step through glatiramer and dimethyl fumarate, to a single step through glatiramer. • Policy aligned to current language and template standards. • Effective date **1/1/2024**
Glecaprevir/Pibrentasvir – (IP0187)	Update	Important **changes** in coverage criteria: • Glecaprevir/pibrentasvir was removed as a preferred product for Employer Group Plans and non-covered product criteria was added to support medical necessity review. • Effective date **1/1/2024**.
Grazoprevir/Elbasvir – (IP0158)	Update	Important **changes** in coverage criteria: • Removed sofosbuvir/velpatasvir, ledipasvir/sofosbuvir, and Mavyret as preferred products for Employer Group Plans. • Effective date **1/1/2024**.
HMG-CoA Reductase Inhibitors (Statins) and Combination Products (IP0064)	Update	Important **changes** in coverage criteria: • Extended the current Value/ Advantage / Total Savings approach for Lescol XL to the Standard / Performance / Legacy formularies. • Extended the current Value/ Advantage / Total Savings approach for Pravachol to the Standard / Performance / Legacy formularies. • Extended the current Value/ Advantage / Total Savings approach for Zocor to the Standard / Performance / Legacy formularies. • Effective date **1/1/2024**.
Insulin Glargine – (P0023)	Update	Important **changes** in coverage criteria: • Updated coverage policy to reflect insulin glargine-yfgn (SEMGLEE-YFGN) as a preferred brand on Employer Standard and Performance prescription drug list plans. • Updated coverage policy to reflect Levemir as non-preferred brand, non-covered medication on all Employer prescription drug list plans. • Effective date: **1/1/2024**
Ledipasvir/Sofosbuvir – (IP0186)	Update	Important **changes** in coverage criteria:

		• Ledipasvir/sofosbuvir tablets were removed as a preferred product for Employer Group Plans and non-covered product criteria was added to support medical necessity review. • Effective date **1/1/2024**.
Long-Acting Muscarinic Antagonist (LAMA)/Long-Acting Beta$_2$-Agonist (LABA) Combination Inhalers (IP0020)	Update	Important **change** in coverage criteria: • Extended the current V/A/TS Bevespi approach to S/P/LEG formularies. • Removed Bevespi from the Duaklir Pressair S/P/LEG approach. • Effective **1/1/2024**.
Miglustat – (IP0446)	Update	Important **change** in coverage criteria: • Added Yargesa (miglustat) to coverage policy • Effective date **1/15/2024**.
Monomethyl fumarate (IP0255)	Update	Important changes in coverage criteria: • Clarified that the Employer Group Plan preferred product requirements will only apply to multiple sclerosis treatment naïve individuals. • Updated the Employer Group Plan preferred product requirements from a dimethyl fumarate step to a dimethyl fumarate **OR** fingolimod option. • Separated the Employer and Individual and Family Plan preferred product approaches. • Policy aligned to current language and template standards. • Effective date **1/1/2024**.
Nafarelin Acetate – (IP0415)	Update	Important **change** in coverage criteria: • Added non-covered product criteria for Synarel • Effective: 1/1/2024 •
Ocrelizumab (IP0212)	Update	Important **changes** in coverage criteria: • Clarified that the Employer Group Plan preferred product requirements will only apply to multiple sclerosis treatment naïve individuals.

		• Updated the Employer Group Plan preferred product requirements, for Relapsing Forms of Multiple Sclerosis, from a dimethyl fumarate step to a dimethyl fumarate **OR** fingolimod option. • Separated the Employer and Individual and Family Plan preferred product approaches. • Policy aligned to current language and template standards. • Effective date **1/1/2024**.
Ofatumumab (IP0260)	Update	Important changes in coverage criteria: • Clarified that the Employer Group Plan preferred product requirements will only apply to multiple sclerosis treatment naïve individuals. • Updated the Employer Group Plan preferred product requirements from a dimethyl fumarate step to a dimethyl fumarate **OR** fingolimod option. • Separated the Employer and Individual and Family Plan preferred product approaches. • Policy aligned to current language and template standards. • Effective date **1/1/2024**.
Ombitasvir/Paritaprevir/Ritonavir and Dasabuvir – (IP0189)	Update	Important **changes** in coverage criteria: • Removed sofosbuvir/velpatasvir, ledipasvir/sofosbuvir, and Mavyret as preferred products for Employer Group Plans. • Effective date **1/1/2024**.
Omega-3 Fatty Acid Products – (IP0051)	Update	Minor **changes** in coverage criteria/policy: • Clarified intent of IFP non-covered products criteria; no change to intent of non-covered products criteria • Effective date: **1/1/2024**

Oncology Medication – (1403)	Update	Important **changes** in coverage criteria:
		• For Employer Group Drug list plans:
		  ○ Added criteria to require step through Lynparza for Talzenna
		  ○ Ogivgri moved to Preferred and added as Preferred option for Herceptin, Herceptin Hylecta, Herzuma and Ontruzant
		  ○ Removed step requirement for Orgovy
		• For Cigna Pathwell Specialty Drug list plans:

		○ Added step through paclitaxel for Abraxane (brand) and generic Abraxane ○ Added preferred product step requirements for Provenge (sipuleucel-T) • Effective date: **1/1/2024**
Opioid Therapy for Employer Group Benefit Plans (IP0561)	New	Important **changes** in coverage criteria: **OR** • New policy incorporating the current Employer Group Plans approach found in the Opioid Therapy policy (1704). • The criteria approach has been reconciled to the current P&T approach and updated to current template/ language standards. • Effective date: **1/1/2024**
Opioid Therapy for Individual and Family Plans (IP0561)	New	Important **changes** in coverage criteria: **OR** • New policy incorporating the current Individual and Family Plans approach found in the Opioid Therapy policy (1704). • The criteria approach has been reconciled to the current P&T approach and updated to current template/ language standards. • Effective date: **1/1/2024**
Palivizumab – (IP0321)	Update	Important **changes** in coverage criteria: • Revised conditions not covered section • Effective date: 1/15/2024
Pegfilgrastim (IP0070)	Update	Important **changes** in coverage criteria: • Udenyca moved to preferred brand and Ziextenzo moved to non-preferred brand on Standard, Performance, Value, Advantage, Legacy and Individual and Family Plan formularies. ○ Preferred product requirement criteria updated accordingly. • Updated to current template/language format. • Effective date **1/1/2024**
Peginterferon (IP0263)	Update	Important changes in coverage criteria: • Clarified that the Employer Group Plan preferred product requirements will only apply to multiple sclerosis treatment naïve individuals.

		• Updated the Employer Group Plan preferred product requirements from a dimethyl fumarate step to a dimethyl fumarate **OR** fingolimod option. • Policy aligned to current language and template standards. • Effective date **1/1/2024**.
Pen Needles – (IP0569)	New	This is a **new** coverage policy. • The policy supports medical necessity review for formulary exceptions to non-covered pen needle products. • Effective date **1/1/2024**.
Pharmacy Prior Authorization – (1407)	Update	Important **changes** in coverage criter • Added Individual and Family Plan non-formulary formulary exception criteria for the following products: Suflave, Opvee, Veozah • Effective 1/15/2024
Pirfenidone – (IP0311)	Update	Important **changes** in coverage criteria: • Updated IFP non-covered product criteria to support brand Esbriet tablets and capsules • Effective date: **1/1/2024**
Ponesimod (IP0264)	Update	Important **changes** in coverage criteria: • Clarified that the Employer Group Plan preferred product requirements will only apply to multiple sclerosis treatment naïve individuals. • Updated the Employer Group Plan preferred product requirements from a dimethyl fumarate step to a dimethyl fumarate **OR** fingolimod option. • Separated the Employer and Individual and Family Plan preferred product approaches. • Policy aligned to current language and template standards. • Effective date **1/1/2024**.
Pulmonary Hypertension (PH) Therapy – (6121)	Update	Important **changes** in coverage criteria: • Updated experimental, investigational, or unproven section to reflect that currently Adempas is the only product indicated and covered for chronic thromboembolic pulmonary hypertension (CTEPH). • Updated criteria language for brand name products, Adcirca, Letairis, Revatio, and Tracleer related to the requirement of the generic product.

		• Effective date **1/1/2024**.
Rebif (interferon beta-1a) (IP0265)	Update	Important changes in coverage criteria: • Clarified that the Employer Group Plan preferred product requirements will only apply to multiple sclerosis treatment naïve individuals. • Updated the Employer Group Plan preferred product requirements, for Relapsing Forms of Multiple Sclerosis, from a dimethyl fumarate step to a dimethyl fumarate **OR** fingolimod option. • Policy aligned to current language and template standards. • Effective date **1/1/2024**.
Reslizumab – (IP0423)	Update	Important **change** in coverage criteria: • Added a required step through of one preferred alternative unless the individual has already started Cinqair therapy • Effective: 1/1/2024
Ritlecitinib (IP0589)	New	This is a new policy supporting pharmacy prior authorization of ritlecitinib capsules [Litfulo]. • Effective date **1/1/2024**.
Rituximab for Non-Oncology Indications – (IP0319)	Update	Important **changes** in coverage criteria: • Added criteria for an expanded indication, Immunotherapy-Related Toxicities Associated with Checkpoint Inhibitors. • Added dosing information to the policy. • Updated policy format. • Effective date 1/15/2024.
Siponimod (IP0262)	Update	Important changes in coverage criteria: • Clarified that the Employer Group Plan preferred product requirements will only apply to multiple sclerosis treatment naïve individuals. • Updated the Employer Group Plan preferred product requirements from a dimethyl fumarate step to a dimethyl fumarate **OR** fingolimod option. • Separated the Employer and Individual and Family Plan preferred product approaches. • Policy aligned to current language and template standards.

		• Effective date **1/1/2024**.
Sofosbuvir/Velpatasvir – (IP0184)	Update	Important **changes** in coverage criteria: • Sofosbuvir/velpatasvir tablets were removed as a preferred product for Employer Group Plans and non-covered product criteria was added to support medical necessity review. • Effective date **1/1/2024**.
Somapacitan (IP0576)	New	Important points for **new policy**: • This is a new policy supporting pharmacy prior authorization of somapacitan-beco subcutaneous injection [Sogroya]. • Effective date **1/1/2024**.
Somatrogon (IP0577)	New	Important points for **new policy**: • This is a new policy supporting pharmacy prior authorization of somatrogon-ghla subcutaneous injection [Ngenla]. • Effective date **1/1/2024**.
Somatropin (IP0452)	New	Important points for **new policy**: • This is a new policy supporting pharmacy prior authorization of somatropin products [Genotropin, Humatrope, Norditropin, Nutropin AQ, Omnitrope, Saizen, Serostim, Zomacton, Zorbtive]. • The criteria approach has been aligned to current P&T guidance. • This policy replaces CP 4012 (Somatropin). • Effective date **1/1/2024**.
Step Therapy Individual and Family Plan (1603)	Update	Important **changes** in coverage criteria: • Decreasedthe number of prerequisite steps from [3] to [1] prior to coverage for Trintellix. Latuda and Toviaz removed from the policy. Aligned the Dulera step requirements current P&T guidance. • Effective date **1/1/2024**.
Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) (1803)	Update	Important **changes** in coverage criteria: • Removed brand name Livalo from the policy. • Added pitavastatin (generic for Livalo) to step one of the Statins section. Effective date: **1/1/2024**

Step Therapy – Standard and Performance Prescription Drug Lists (Employer Group Plans) (1801)	Update	Important **changes** in coverage criteria: • Removed brand name Livalo from the policy. • Added pitavastatin (generic for Livalo) to step one of the Statins section. Effective date: **1/1/2024**
Teriparatide – (IP0330)	Update	Important **changes** in coverage criteria: • Added teriparatide 620 mcg/2.48 mL to coverage policy • Added a required step through one preferred alternative before teriparatide 620 mcg/2.48 mL for Employer Group Benefit plans • Effective date: **1/1/2024**
Tildrakizumab – (IP0236)	Update	Important **changes** in coverage criteria: • Updated the Individual and Family Plans preferred product requirements by adding Otezla, Stelara SC and Tremfya as options. • Effective date **1/1/2024**.
Topical Non-Steroidal Anti-Inflammatory Drugs (NSAIDs) (IP0021)	Update	Important **changes** in coverage criteria: • Diclofenac epolamine 1.3% topical patch removed from the policy. • Effective date **1/1/2024**.
Ublituximab (IP0545)	Update	Important changes in coverage criteria: • Clarified that the Employer Group Plan preferred product requirements will only apply to multiple sclerosis treatment naïve individuals. • Updated the Employer Group Plan preferred product requirements from a dimethyl fumarate step to a dimethyl fumarate **OR** fingolimod option. • Separated the Employer and Individual and Family Plan preferred product approaches. • Policy aligned to current language and template standards. • Effective date **1/1/2024**.
Vericiguat (IP0125)	Update	Important **changes** in coverage criteria: • Responsive to a business decision (HVAC 8/1/2023), removed the concomitant use requirement. • Effective date 1/1/2024

Voclosporin – (IP0122)	Update	Important **changes** in coverage criteria: • Removed criterion requiring autoantibody-positive SLE, defined as positive for antinuclear antibodies (ANA) and/or anti-double-stranded DNA (anti-dsDNA antibody) for Lupus Nephritis in alignment with P&T guidance. • Updated policy format and language to current template standards • Effective date 1/1/2024
Somatropin - (4012)	Retired	• Policy to be retired and replaced by CP IP0452 (Somatropin). • Effective 1/1/2024
Overactive Bladder Medications - (IP0238)	Retired	• Policy to be retired. • Product moved to CPs 1601 and 1602 • Effective 1/1/2024
Opioid Therapy (1704)	Retired	• Policy to be retired and replaced by CPs IP0561 and IP0562. • Effective 1/1/2024
Fluticasone Furoate-Vilanterol (IP0454)	Retired	• Policy to be retired. • Product moved to CP IP0022 • Effective 1/1/2024
Topical Estrogen Products (Non-Patch) – (IP0459)	Retired	• Policy to be retired and replaced by IP0590 Estrogen Transdermal. • Effective date: 1/15/2024
Transdermal Estrogen and Estrogen-Progestin Products - (IP0460)	Retired	• Policy to be retired and replaced by IP0590 Estrogen Transdermal. • Effective date: 1/15/2024
Antitussives – (P0083)		• Policy to be retired and replaced by CP IP0586 (Antitussives). • Effective 1/15/2024
CareAllies Medical Necessity Guideline	**New, Updated, or Retired?**	**Comments**

		• No updates in January 2024
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
		• No updates in January 2024
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
		• No updates in January 2024
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**
Code Editing Policy and Guidelines	Update	• Updates made in January 2024