Monthly Policy Updates

Effective January 15, 2025 (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

Airway Clearance Devices in the Ambulatory Setting – (0069)	Update	Posting 10/15/2024; Effective 1/15/2025
		
		Important **changes** in coverage criteria:
		• Removed the following devices from the policy because they're not managed:
		  ○ acoustical percussor, positive expiratory pressure and aerosol drug delivery system combination devices (e.g., Vibralung®; E0480)
		  ○ mechanical percussors (HCPCS E0480)
		  ○ oscillatory (vibratory) positive expiratory pressure devices (HCPCS E0484; S8185)
		• Added medical necessity criteria back into the policy for positive expiratory pressure devices because the associated code, E1399, is being added back to precertification (this is also noted in a separate entry below regarding all of the policies impacted by E1399 being added to precertification).

Attention-Deficit/Hyperactivity Disorder (ADHD): Assessment and Treatment – (0231)	Update	Minor **changes** in coverage criteria/policy: • No changes in coverage. • Removed policy statements if the applicable code is not implemented and indicated as not covered, or there is no applicable code in the policy for the indication.
Autism Spectrum Disorders/Pervasive Developmental Disorders: Assessment and Treatment – (0447)	Update	Minor **changes** in coverage criteria/policy: • A Not Covered or Reimbursable policy statement for electronic devices was posted 10/15/24, effective 1/15/25. • No other changes in coverage. • Removed policy statements if the applicable code is not implemented and indicated as not covered, or there is no applicable code in the policy for the indication.
Bariatric Surgery and Procedures – (0051)	Update	Posting date 10/15/2024, effective date 1/15/2025 Minor **changes** in coverage criteria/policy: • Added the word initial to both adult and adolescent to the coverage statement to indicate what surgery is approved for a first or initial surgery. • Added CPT codes C9784 and C9785 to the EIU coverage statement for the correct procedures they represent. • Changed the EIU statement for bariatric surgery for primary treatment of any condition other than morbid obesity to NMN because it doesn't meet Cigna's definition of EIU.
Breast Implant Removal - (0048)	Update	Minor **changes** in coverage criteria/policy: • Add the word "current" to exposure of a breast implant for clarification.

Electrical Stimulation Therapy and Devices in a Home Setting - (0160)	Update	Posted **10/15/2024 and 1/15/2025**; Effective **1/15/2025**
		
		Important **changes** in coverage criteria:
		• Removed the following devices/technologies from the policy, as the corresponding codes are not managed:
		  ○ auricular electroacupuncture
		  ○ cranial electrical stimulation
		  ○ pelvic floor electrical stimulation
		  ○ transcutaneous electrical joint stimulation

		• Added not covered device: transcutaneous auricular neurostimulation (tAN) (e.g., Sparrow Ascent®) (HCPCS Code E0721)
		• Added the following devices/treatments to the policy statement as experimental, investigational or unproven; the associated HCPCS code (E1399) is being added to precertification (this is also noted in a separate entry below regarding all of the policies impacted by E1399 being added to precertification).:
		  ○ bioelectric nerve block
		  ○ combination therapy
		  ○ electrical sympathetic stimulation therapy
		  ○ electrotherapeutic point stimulation
		  ○ H-WAVE electrical stimulation
		  ○ high-voltage galvanic stimulation
		  ○ microcurrent electrical nerve stimulation
		  ○ threshold/therapeutic electrical stimulation

Gender Dysphoria Treatment - (0266)	Update	Minor **change:** • Added CPT code 19357 *(Tissue expander placement in breast reconstruction, including subsequent expansion(s))* to Table 1 as a medically necessary procedure for male to female reconstructive chest surgery.
Intensive Behavioral Interventions – (EN0499)	Update	Minor **changes** in coverage criteria/policy: • No changes to coverage criteria. • Revised policy statement for readability/clarification.
Mammary Ductoscopy, Aspiration and Lavage – (0057)	Update	Minor **changes** in coverage criteria/policy: • No changes to coverage criteria. Revised policy statement for readability.
Stem Cell Transplantation: Non-Cancer Disorders – (0535)	Update	Important **changes** in coverage criteria: • Removed the terms, "myeloablative" and "non-myeloablative" from the sickle cell disease and thalassemia major policy statements.
Stem Cell Transplantation: Solid Tumors – (0534)	Update	Minor **changes** in coverage criteria/policy: • Changed all EIU language in the policy to not medically necessary instead because technology doesn't fit Cigna's definition of EIU.

Tissue-Engineered Skin Substitutes – (0068)	Update	Posting date 10/15/2024, Effective date 1/15/2025. Important **changes** in coverage criteria: • Added not covered: code Q4205 for Membrane graft or membrane wrap. This code was previously in the policy as experimental, investigational, or unproven (EIU) and has been added back to the EIU section of the coverage statement. • Clarified the wording for the conditions of coverage that apply for the diabetic foot ulcers (DFUs). • Expanded coverage: Added increased initial applications for venous stasis ulcers (VSUs) as was approved for diabetic foot ulcers (DFUs) at May HMAC this year
Airway Clearance Devices in the Ambulatory Setting – (0069) Autism Spectrum Disorders/ Pervasive Developmental Disorders: Assessment and Treatment – (0047) Diabetes Equipment and Supplies – (0106) Electrical Stimulation Therapy and Devices in a Home Setting – (0160) Ventricular Assist Devices (VADs) and Percutaneous Cardiac Support Systems and Total Artificial Heart – (0054)	Update	Statements related to HCPCS E1399 (Durable medical equipment, miscellaneous) were added into the listed CP. All the equipment that was added had previously been in the respective CPs. Current evidence for the equipment was reviewed. The equipment was determined to be either not medically necessary or experimental, investigational, or unproven. • The updated CPs were **posted 10/15/2024. Effective 1/15/2025.**

Electroencephalograph - (0521)	Update	• No change in coverage.
Oral Cancer Screening Systems – (0372)	Update	• No change in coverage.
Speech Generating Devices - (0049)	Update	• No change in coverage.
Vagus Nerve Stimulation - (0350)	Update	• No change in coverage.
Vascularized Composite Allograft (VCA) Transplantation – (0560)	Update	• No change in coverage.
Ventricular Assist Devices (VADs), Percutaneous Cardiac Support Systems and Total Artificial Heart – (0054)	Update	• No change in coverage.
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
		• No updates for January 2025
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-EviCore Lab Management Program Guidelines	Update	Posted **10/1/2024**; Effective **1/1/2025** Important **changes** in coverage criteria.

		• Expanded coverage for testing addressed in the following guidelines/sections:
		  ○ Expanded Carrier Screening Panels
		  ○ Somatic Mutation Testing
		  ○ BRCA Analysis
		  ○ Epilepsy Genetic Testing
		  ○ Human Platelet and Red Blood Cell Antigen Genotyping
		  ○ Special Circumstances Influencing Coverage Determinations
		• New guidelines/sections:
		  ○ Laboratory Billing and Reimbursement
		  ○ Inflammatory Bowel Disease Biomarker Testing
		  ○ Non-Invasive Prenatal Screening
		• Retired sections/guidelines:
		  ○ Bloom Syndrome Genetic Testing
		  ○ Canavan Disease Genetic Testing
		  ○ Gaucher Disease Genetic Testing
		  ○ Niemann-Pick Disease Types A and B Genetic Testing
		  ○ Niemann-Pick Disease Type C Genetic Testing
		  ○ AlloMap Gene Expression Profiling for Heart Transplant Rejection
		  ○ Genetic Presymptomatic and Predictive Testing for Adult-Onset Conditions in Minors
		  ○ Laboratory Procedure Code Requirements
		• Remaining guidelines/sections had no clinically impactful changes.

Cobranded Cigna-EviCore Pacemaker Guidelines	Update	Posted **1/1/2025**; Effective **3/1/2025** No change in coverage.

Cobranded Cigna-EviCore Peripheral Vascular Intervention Guidelines	Update	Posted **12/20/2024**; Effective **1/24/2025**
		
		Important **changes** in coverage criteria.
		• Expanded coverage:
		  ○ Removed nonindication for embolization before surgical excision of carotid body tumor; highly vascular tumors added to indications.
		  ○ Added indications for prostate artery embolization and varicocele embolization.

Cobranded Cigna-EviCore Spine Surgery Guidelines	Update	Posted **12/26/2024**; Effective **12/27/2024** CMM-606: Lumbar Microdiscectomy (Laminotomy, Laminectomy, or Hemilaminectomy)

		• Removed coding and statement for disc annular repair; no impact to coverage.
Administrative Policy	**New, Updated, or Retired?**	**Comments**
Authorized Generics - (A008)	Update	Effective: 1/1/2025 **Preferred Product Table:** **Individual and Family Plan.** • **Removed** preferred product criteria for fluticasone HFA Authorized Generic • **Updated** Insulin lispro (U-100 pens) Authorized Generic criteria **from** "Insulin lispro (U-100 vials and U-100 pens) Authorized Generic" **to** ""Insulin lispro (U-100 pens) Authorized Generic" • **Added** preferred product criteria for Humalog U-100 vial • **Added** preferred product criteria for Insulin degludec Authorized Generic
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Amikacin Liposome - (IP0383)	Update	Effective: 1/15/2025 ***Mycobacterium avium* Complex (MAC) Lung Disease.** **Removed** "Has refractory MAC lung disease defined as not-achieving negative sputum cultures after a minimum of 6 consecutive months of a background multidrug regimen" **Added** "Patient has completed ≥ 6 consecutive months of a background multidrug regimen; Note: A multidrug regimen typically includes a macrolide (azithromycin or clarithromycin), ethambutol, and a rifamycin (rifampin or rifabutin)." **Added** "Patient has a positive sputum culture for *Mycobacterium avium* complex; Note: Any positive sputum culture taken after the patient has completed ≥ 6 consecutive months of a background multidrug regimen fulfills this criterion."
Antibiotics – Xifaxan for Individual and	Update	Effective: 1/1/2025

Family Plans – (IP0473)		**Updated** policy title from *Rifaximin for Individual and Family Plans* to *Antibiotics – Xifaxan for Individual and Family Plans*. **Traveler's Diarrhea.** **Added** criterion screening the patient is afebrile. **Added** criterion screening the patient does not have blood in stool. **Pouchitis, Chronic Antibiotic-Dependent.** **Updated** format of recurrent pouchitis criterion **Added** "According to the prescriber, the episodes of pouchitis respond to antibiotic therapy but relapse shortly after antibiotic discontinuation". **Added** "According to the prescriber, alternative causes of recurrent pouchitis have been ruled out; AND Note: Alternative etiologies of recurrent pouchitis include but are not limited to Clostridioides difficile infection of the pouch, mechanical obstructions, pelvic floor dysfunction". **Added** "The medication is prescribed by, or in consultation with, a gastroenterologist".
Antiemetic Therapy – (1705)	Update	Effective 1/1/2025 • **Removed** Emend capsules and relocated to Brands with Bioequivalent Generics – IP0011
Antihyperglycemic Therapy (Non-Insulin) - (0098)	Update	Effective 1/1/2025 • Removed Januvia, Janumet, and Janumet XR. • Updated the Total Savings criteria for Alogliptan, Nesina, Onglyza, Alogliptan / metformin, Alogliptan/pioglitazone, Kazano, Kombiglize XR and Oseni, aligning to the other formularies.
Attention Deficit Hyperactivity Disorder Non-Stimulant Medications - (IP0217)	Update	Effective 1/15/2025 • **Added** Individual and Family Plans to the policy. • **Added** Onyda XR to the policy • **Added** a definition of documentation. • **Updated** the Employer Plans and Individual and Family Plans Qelbree preferred product criteria.

Belatacept - (IP0219)	Update	Effective: 1/15/2025 • **Updated** from "Prophylaxis of Organ Rejection" to "Kidney Transplantation – Prophylaxis of Organ Rejection." • **Added** dosing information for Kidney Transplantation – Prophylaxis of Organ Rejection. • **Added** "Solid Organ Transplantation Other Than Kidney – Prophylaxis of Solid Organ Rejection in a Patient Currently Receiving Nulojix" and **added** authorization duration of 12 months. • **Conditions Not Covered:** • **Removed** "Liver Transplantation. Nulojix has a boxed warning stating that use in liver transplant recipients is not recommended due to an increase risk of graft loss and death."
Bowel Agents – Opioid-Induced Constipation - (IP0401)	Update	Effective 1/1/2025 • **Added** preferred product requirements for Relistor tablets.
Brands with Bioequivalent Generics - (IP0011)	Update	Effective 1/1/2025 • **Removed** Moviprep and Suprep.
Contraceptives - (IP0036)	Update	Effective: 1/1/2025 • **Preferred Product Table:** • **Added** preferred product requirement criteria for Lo Loestrin FE for employer plans.
Denosumab - (IP0331)	Update	Effective: **1/15/2025** • **Treatment of Bone Loss in Patients with Prostate Cancer Receiving Androgen Deprivation Therapy:** This was added as a new condition of approval in the "Other Uses with Supportive Evidence" section. Dosing was added.

		• **Increase Bone Mineral Density in Patients with Breast Cancer:** This was added as a new condition of approval in the "Other Uses with Supportive Evidence" section. Dosing was added.
Drugs Requiring Medical Necessity Review for Employer Plans - (1602)	Update	Effective: 1/1/2025 • **Added preferred product step requirement for the following products:** MoviPrep, Plenvu, Suprep, Zituvimet (effective 2/1/2025), Zituvimet XR (effective 2/1/2025), Dolobid (effective 2/1/2025), and clobetasol propionate ophthalmic suspension 0.05% (effective 1/15/2025)
Drugs Requiring Medical Necessity Review for Employer Plans - (1602)	Update	Effective: 1/15/2025 • **Added preferred product step requirement for the following products:** • Neffy (effective 2/1/2025), Estratest H.S. (effective 2/1/2025), Zoryve 0.3% cream and Zoryve 0.3% topical foam
Gaucher Disease – Substrate Reduction Therapy – Miglustat - (IP0446)	Update	Effective: 1/15/2025 • **Gaucher Disease Type 1:** For confirmation by genetic testing, the term "documenting" was rephrased to "showing". • **Niemann-Pick disease Type C:** This was added as a new condition of approval.
Gonadotropin-Releasing Hormone Agonists – Central Precocious Puberty – Leuprolide - (IP0108)	Update	Effective 1/1/2025 • **Preferred Product Table:** • **Added** preferred product step requirement for patients with central precocious puberty for employer plans and individual and family plans.
Gonadotropin-Releasing Hormone Agonists – Implants for Non-Oncology Indications - (IP0620)	Update	**Effective 1/1/2025** • Added preferred product requirement criteria for patients with central precocious puberty for employer plans and individual and family plans.

Growth Disorders – Ngenla - (IP0577)	Update	Effective 1/1/2025 • **Updated** Individual and family Plan preferred product requirements.
Growth Disorders – Skytrofa - (IP0375)	Update	Effective 1/1/2025 • **Updated** Individual and family Plan preferred product requirements.
Hemophilia – Altuviiio - (IP0564)	Update	Effective 1/15/2025 • In Hemophilia A, for Initial therapy, the threshold for a positive inhibitor test was changed to ≥ 1.0 Bethesda units/mL; previously, it was ≥ 0.6 Bethesda units/mL. It was added that a patient who has not received Factor VIII therapy in the past is not required to meet the inhibitor testing requirements. • For a Patient Currently Receiving Altuviiio or has received Altuviiio in the past, the Factor VIII inhibitor testing timeframe was changed to within the past 365 days; previously, the timeframe was within the last 30 days. The wording "prescribing physician" was replaced with "prescriber".
Hemophilia – Factor VIII Products - (IP0618)	Update	Effective 1/15/2025 • **Hemophilia A: Added** dosing for Adynovate, Eloctate, Esperoct, and Jivi for immune tolerance therapy (also known as immune tolerance induction).
HIV Products for Individual and Family Plans - (IP0090)	Update	Effective 1/1/2025 • **Removed** Descovy from the policy.
Hypoparathyroidism – Natpara - (IP0177)	Update	Effective 1/15/2025 • **Added** Hypoparathyroidism to "Natpara" as a header to the policy. ○ **Chronic Hypoparathyroidism:** A nephrologist was added as a physician type that counts toward the specialist requirement.

Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Legacy Drug List Plans - (PSM003)	Update	Effective 1/1/2025 • **Policy Title: Updated from** Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy **to** Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Legacy Drug List Plans • **Humira (NDCs starting with 83457):** Removed from the policy. Humira products with NDCs starting with 83457 are benefit excluded. • **Hyrimoz:** All requests for Hyrimoz are directed to adalimumab-adaz.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy: Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists - (PSM013)	New	Effective 1/1/2025 • Criteria has been relocated from *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy – (PSM003)* into this newly created policy for Standard/Performance, Value/Advantage, Total Savings drug list plans. The existing Non-Preferred Products were given a designation of Step 3; the requirement that a patient is taking the requested Non-Preferred Product for at least 120 days was removed. For targeted indications, a patient will also be referred to other (non-adalimumab) Preferred Products as listed in the respective *Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans*. • **Humira:** Products with NDCs starting with 00074 were moved from Preferred to a newly created Step 2 Non-Preferred. A patient is directed to a trial of one Preferred Product with documentation requirements. Documentation is also required to support the requirement that formulation difference(s) in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Patients who are currently taking Humira (NDCs starting with 00074) are allowed an exception to the preferred product requirement. • **Hyrimoz:** All requests for Hyrimoz are directed to adalimumab-adaz. • **Humira (NDCs starting with 00074):** An exception was added for a patient currently taking Humira to allow continuation of therapy.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for	New	Effective 1/1/2025 • Criteria has been relocated from *Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy – (PSM003)* into to this newly created policy for Individual and Family Plans. The existing Non-Preferred Products were given a

Individual and Family Plans - (PSM014)		designation of Step 3; the requirement that a patient is taking the requested Non-Preferred Product for at least 120 days was removed. For targeted indications, a patient will also be referred to other (non-adalimumab) Preferred Products as listed in the *Inflammatory Conditions for Individual and Family Plans*. • **Humira:** Products with NDCs starting with 00074 were moved from Preferred to a newly created Step 2 Non-Preferred. A patient is directed to a trial of one Preferred Product with documentation requirements. Documentation is also required to support the requirement that formulation difference(s) in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction. Patients who are currently taking Humira (NDCs starting with 00074) are allowed an exception to the preferred product requirement. • **Hyrimoz:** All requests for Hyrimoz are directed to adalimumab-adaz. • **Humira (NDCs starting with 00074):** An exception was added for a patient currently taking Humira to allow continuation of therapy.
Inflammatory Conditions – Bimzelx Prior Authorization Policy - (IP0658)	Update	Effective 1/1/2025 • **Ankylosing Spondylitis:** This condition and criteria for approval were added to the policy. • **Non-Radiographic Axial Spondyloarthritis:** This condition and criteria for approval were added to the policy. • **Plaque Psoriasis:** For initial approval and for a patient currently receiving Bimzelx, requirements were added that the prescriber attests the patient has been evaluated for the risks of suicidal ideation and behavior versus the benefits of therapy and that the patient does not have moderately severe to severe depression. For initial approval, a requirement was added that within the past 5 years, the patient does not have a history of suicidal ideation or suicidal behavior; for a patient currently receiving Bimzelx, a requirement was added that, according to the prescriber the patient does not have suicidal ideation or suicidal behavior. • **Psoriatic Arthritis:** This condition and criteria for approval were added to the policy.
Inflammatory Conditions – Cimzia	Update	Effective 1/1/2025

Prior Authorization Policy - (IP0672)		• **Juvenile Idiopathic Arthritis:** This newly approved condition was added to the policy.
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists Plans - (PSM009)	Update	Effective 1/1/2025 • Policy name was changed to as listed. • **Ankylosing Spondylitis and Psoriatic Arthritis:** Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products.
Inflammatory Conditions – Cosentyx Intravenous Preferred Specialty Management Policy for Legacy Prescription Drug Lists Plans - (PSM016)	New	Effective 1/1/2025 • New policy addressing Cosentyx IV preferred product requirements for the Legacy formulary.
Inflammatory Conditions – Cosentyx Intravenous Prior Authorization Policy - (IP0683)	Update	Effective 1/1/2025 • Updated the Preferred Specialty Management Policy note.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total	Update	Effective 1/1/2025 • Updated title to remove Legacy Drug Lists. Legacy Drug List Plans criteria were relocated to a new policy (PSM017). • **Humira:** Throughout the policy, NDCs starting with 00074 were removed from the Preferred Products. A previous trial of these NDCs counts towards a trial of an adalimumab product.

Savings Prescription Drug Lists - (PSM001)		• **Hyrimoz:** Throughout the policy, NDCs starting with 61314 were removed from the Preferred Products. A previous trial of these NDCs counts towards a trial of an adalimumab product. • **Tremfya Subcutaneous:** For **Ulcerative Colitis**, Tremfya subcutaneous was added as a Preferred Product. • **Cimzia:** For **Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, Plaque Psoriasis,** and **Crohn's Disease**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added to Step 3a. Documentation of a trial of two Step 1 or 2a Products is required. A trial of a tocilizumab intravenous product (Actemra intravenous, biosimilar), Kevzara, Orencia intravenous or subcutaneous, an infliximab product (e.g., Remicade, biosimilars), or Simponi Aria also counts. For **Psoriatic Arthritis** and **Plaque Psoriasis**, it was clarified that Tremfya is the subcutaneous formulation. • **Simponi Subcutaneous:** For **Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Ulcerative Colitis**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products. For **Psoriatic Arthritis**, it was clarified that Tremfya is the subcutaneous formulation. For **Ulcerative Colitis**, Tremfya subcutaneous was added as Preferred Products. • **Actemra Subcutaneous and Tyenne Subcutaneous:** For **Rheumatoid Arthritis** and **Polyarticular Juvenile Idiopathic Arthritis**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products. For **Polyarticular Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. • **Kevzara:** For **Rheumatoid Arthritis** and **Juvenile Idiopathic Arthritis**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. • **Bimzelx:** For **Ankylosing Spondylitis, Non-Radiographic Spondyloarthritis,** and **Psoriatic Arthritis**, Bimzelx was added to Step 2a and requests are directed to a trial of one Step 1 Product. For **Plaque Psoriasis**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products.

		• **Cosentyx Subcutaneous:** For **Ankylosing Spondylitis, Psoriatic Arthritis,** and **Plaque Psoriasis**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products. For • **Psoriatic Arthritis** and **Plaque Psoriasis**, it was clarified that Tremfya is the subcutaneous formulation. • **Siliq:** For **Plaque Psoriasis**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products, and it was clarified that Tremfya is the subcutaneous formulation. • **Ilumya:** For **Plaque Psoriasis**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products, and it was clarified that Tremfya is the subcutaneous formulation. • **Entyvio Subcutaneous:** For **Crohn's Disease** and **Ulcerative Colitis**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products. For **Ulcerative Colitis**, Tremfya subcutaneous was added as a Preferred Product; a previous trial of Tremfya intravenous also counts. • **Kineret:** For **Rheumatoid Arthritis**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products. • **Orencia Subcutaneous:** For **Rheumatoid Arthritis, Juvenile Idiopathic Arthritis**, and **Psoriatic Arthritis**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. For **Psoriatic Arthritis**, it was clarified that Tremfya is the subcutaneous formulation; for a patient ≥ 18 years of age, Cosentyx and Bimzelx were added as agents that count towards a trial of a Preferred Product. • **Olumiant:** For **Rheumatoid Arthritis**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products. • **Rinvoq:** For **Rheumatoid Arthritis, Ankylosing Spondylitis, Juvenile Idiopathic Arthritis, Psoriatic Arthritis, Crohn's Disease,** and **Ulcerative Colitis**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. For **Psoriatic Arthritis**, it was clarified that Tremfya is the subcutaneous formulation. For **Ulcerative Colitis**, Tremfya subcutaneous was added as a Preferred Product. • **Rinvoq LQ:** For **Juvenile Idiopathic Arthritis** and **Psoriatic Arthritis**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed

		from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. For **Psoriatic Arthritis**, it was clarified that Tremfya is the subcutaneous formulation. • **Xeljanz/Xeljanz XR:** For **Rheumatoid Arthritis, Ankylosing Spondylitis, Juvenile Idiopathic Arthritis** (Xeljanz tablets only), **Psoriatic Arthritis,** and **Ulcerative Colitis**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. For **Psoriatic Arthritis**, it was clarified that Tremfya is the subcutaneous formulation. For **Ulcerative Colitis**, Tremfya subcutaneous was added as a Preferred Product. • **Xeljanz Oral Solution:** For **Juvenile Idiopathic Arthritis**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. • **Velsipity:** For **Ulcerative Colitis**, Humira (NDCs starting with 00074) and Hyrimoz (NDCs starting with 61314) were removed from the Preferred Products; Tremfya subcutaneous was added as a Preferred Product; a previous trial of Tremfya intravenous also counts.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Legacy Prescription Drug Lists - (PSM017)	New	• Effective 1/1/2025 • Legacy Drug List Plans criteria were relocated to a new policy. The criteria were previously located within Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans (PSM001). The following updates were made to the previous criteria. • **Hyrimoz:** Throughout the policy, NDCs starting with 61314 were removed from the Preferred Products. A previous trial of these NDCs counts towards a trial of an adalimumab product. • **Tremfya Subcutaneous:** For **Ulcerative Colitis**, Tremfya subcutaneous was added as a Preferred Product. • **Cimzia:** For **Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, Plaque Psoriasis,** and **Crohn's Disease**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia

		was added to Step 3a. Documentation of a trial of two Step 1 or 2a Products is required. A trial of a tocilizumab intravenous product (Actemra intravenous, biosimilar), Kevzara, Orencia intravenous or subcutaneous, an infliximab product (e.g., Remicade, biosimilars), or Simponi Aria also counts. For **Psoriatic Arthritis** and **Plaque Psoriasis**, it was clarified that Tremfya is the subcutaneous formulation. • **Simponi Subcutaneous:** For **Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Ulcerative Colitis**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products. For **Psoriatic Arthritis**, it was clarified that Tremfya is the subcutaneous formulation. For **Ulcerative Colitis**, Tremfya subcutaneous was added as Preferred Products. • **Actemra Subcutaneous and Tyenne Subcutaneous:** For **Rheumatoid Arthritis** and **Polyarticular Juvenile Idiopathic Arthritis**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products. For **Polyarticular Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. • **Kevzara:** For **Rheumatoid Arthritis** and **Juvenile Idiopathic Arthritis**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. • **Bimzelx:** For **Ankylosing Spondylitis, Non-Radiographic Spondyloarthritis,** and **Psoriatic Arthritis**, Bimzelx was added to Step 2a and requests are directed to a trial of one Step 1 Product. For **Plaque Psoriasis**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products. • **Cosentyx Subcutaneous:** For **Ankylosing Spondylitis, Psoriatic Arthritis,** and **Plaque Psoriasis**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products. For **Psoriatic Arthritis** and **Plaque Psoriasis**, it was clarified that Tremfya is the subcutaneous formulation. • **Siliq:** For **Plaque Psoriasis**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products, and it was clarified that Tremfya is the subcutaneous formulation. • **Ilumya:** For **Plaque Psoriasis**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products, and it was clarified that Tremfya is the subcutaneous formulation. • **Entyvio Subcutaneous:** For **Crohn's Disease** and **Ulcerative Colitis**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products. For

		Ulcerative Colitis, Tremfya subcutaneous was added as a Preferred Product; a previous trial of Tremfya intravenous also counts. • **Kineret:** For **Rheumatoid Arthritis**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products. • **Orencia Subcutaneous:** For **Rheumatoid Arthritis, Juvenile Idiopathic Arthritis**, and **Psoriatic Arthritis**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. For **Psoriatic Arthritis**, it was clarified that Tremfya is the subcutaneous formulation; for a patient ≥ 18 years of age, Cosentyx and Bimzelx were added as agents that count towards a trial of a Preferred Product. • **Olumiant:** For **Rheumatoid Arthritis**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products. • **Rinvoq:** For **Rheumatoid Arthritis, Ankylosing Spondylitis, Juvenile Idiopathic Arthritis, Psoriatic Arthritis, Crohn's Disease,** and **Ulcerative Colitis**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. For **Psoriatic Arthritis**, it was clarified that Tremfya is the subcutaneous formulation. For **Ulcerative Colitis**, Tremfya subcutaneous was added as a Preferred Product. • **Rinvoq LQ:** For **Juvenile Idiopathic Arthritis** and **Psoriatic Arthritis**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. For **Psoriatic Arthritis**, it was clarified that Tremfya is the subcutaneous formulation. • **Xeljanz/Xeljanz XR:** For **Rheumatoid Arthritis, Ankylosing Spondylitis, Juvenile Idiopathic Arthritis** (Xeljanz tablets only), **Psoriatic Arthritis,** and **Ulcerative Colitis**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. For **Psoriatic Arthritis**, it was clarified that Tremfya is the subcutaneous formulation. For **Ulcerative Colitis**, Tremfya subcutaneous was added as a Preferred Product. • **Xeljanz Oral Solution:** For **Juvenile Idiopathic Arthritis**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products. For **Juvenile Idiopathic**

		Arthritis, Cimzia was added as an agent that counts towards a trial of a Preferred Product. • **Velsipity:** For **Ulcerative Colitis**, Hyrimoz (NDCs starting with 61314) was removed from the Preferred Products; Tremfya subcutaneous was added as a Preferred Product; a previous trial of Tremfya intravenous also counts.
Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)	Update	• Effective 1/1/2025 • **Humira:** Throughout the policy, NDCs starting with 00074 were removed from the Preferred Products. A previous trial of these NDCs counts towards a trial of an adalimumab product. • **Hyrimoz:** Throughout the policy, NDCs starting with 61314 were removed from the Preferred Products. A previous trial of these NDCs counts towards a trial of an adalimumab product. • **Tremfya Subcutaneous:** For **Ulcerative Colitis**, Tremfya subcutaneous was added as a Preferred Product. • **Cimzia:** For **Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, Plaque Psoriasis,** and **Crohn's Disease**, Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added to Step 3a. Documentation of a trial of two Step 1 or 2a Products is required. A trial of a tocilizumab intravenous product (Actemra intravenous, biosimilar), Kevzara, Orencia intravenous or subcutaneous, an infliximab product (e.g., Remicade, biosimilars), or Simponi Aria also counts towards a trial of a Preferred Product. For **Psoriatic Arthritis** and **Plaque Psoriasis**, it was clarified that Tremfya is the subcutaneous formulation. • **Simponi Subcutaneous:** For **Rheumatoid Arthritis, Ankylosing Spondylitis, Psoriatic Arthritis, and Ulcerative Colitis**, Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products. For **Psoriatic Arthritis**, it was clarified that Tremfya is the subcutaneous formulation. For **Ulcerative Colitis**, Tremfya subcutaneous was added as a Preferred Product. • **Actemra Subcutaneous and Tyenne Subcutaneous:** For **Rheumatoid Arthritis** and **Polyarticular Juvenile Idiopathic Arthritis**, Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred

		Products. For **Polyarticular Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. • **Kevzara:** For **Rheumatoid Arthritis** and **Juvenile Idiopathic Arthritis**, Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. • **Bimzelx:** For **Ankylosing Spondylitis, Non-Radiographic Spondyloarthritis,** and **Psoriatic Arthritis**, Bimzelx was added to Step 3a and requests are directed to a trial of two Step 1 or 2 Products. For **Plaque Psoriasis**, Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products. • **Siliq:** For **Plaque Psoriasis**, Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products, and it was clarified that Tremfya is the subcutaneous formulation. • **Taltz:** For **Ankylosing Spondylitis** and **Non-Radiographic Spondyloarthritis,** Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) removed from the Preferred Products. For **Plaque Psoriasis** and **Psoriatic Arthritis,** Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products, and it was clarified that Tremfya is the subcutaneous formulation. • **Ilumya:** For **Plaque Psoriasis**, Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products, and it was clarified that Tremfya is the subcutaneous formulation. • **Omvoh SC**: For **Ulcerative Colitis**, Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products, and it was clarified that Tremfya is the subcutaneous formulation. • **Tremfya:** It was clarified that Tremfya is the subcutaneous formulation. • **Entyvio Subcutaneous:** For **Crohn's Disease** and **Ulcerative Colitis**, Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products. For **Ulcerative Colitis**, Tremfya subcutaneous was added as a Preferred Product; a previous trial of Tremfya intravenous also counts. • **Kineret:** For **Rheumatoid Arthritis**, Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products. • **Orencia Subcutaneous:** For **Rheumatoid Arthritis, Juvenile Idiopathic Arthritis**, and **Psoriatic Arthritis**, Humira (NDCs starting with 00074) and Hyrimoz

		(NDC's starting with 61314) were removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. For **Psoriatic Arthritis**, it was clarified that Tremfya is the subcutaneous formulation; for a patient ≥ 18 years of age, Bimzelx was added as an agent that count towards a trial of a Preferred Product. • **Olumiant:** For **Rheumatoid Arthritis**, Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products. • **Rinvoq:** For **Rheumatoid Arthritis, Ankylosing Spondylitis, Juvenile Idiopathic Arthritis, Psoriatic Arthritis, Crohn's Disease,** and **Ulcerative Colitis**, Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. For **Psoriatic Arthritis**, it was clarified that Tremfya is the subcutaneous formulation. For **Ulcerative Colitis**, Tremfya subcutaneous was added as a Preferred Product. • **Rinvoq LQ:** For **Juvenile Idiopathic Arthritis** and **Psoriatic Arthritis**, Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. For **Psoriatic Arthritis**, it was clarified that Tremfya is the subcutaneous formulation. • **Xeljanz/Xeljanz XR:** For **Rheumatoid Arthritis, Ankylosing Spondylitis, Juvenile Idiopathic Arthritis** (Xeljanz tablets only), **Psoriatic Arthritis,** and **Ulcerative Colitis**, Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. For **Psoriatic Arthritis**, it was clarified that Tremfya is the subcutaneous formulation. For **Ulcerative Colitis**, Tremfya subcutaneous was added as a Preferred Product. • **Xeljanz Oral Solution:** For **Juvenile Idiopathic Arthritis**, Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products. For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. • **Velsipity:** For **Ulcerative Colitis**, Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products; Tremfya subcutaneous was added as a Preferred Product; a previous trial of Tremfya intravenous also counts.

		• **Sotyktu:** For **Plaque Psoriasis,** Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products and it was clarified that Tremfya is the subcutaneous formulation.
Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings; Individual and Family Plan Prescription Drug Lists - (PSM011)	Update	Effective 1/1/2025 • **Updated** policy title **from** Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy **to** Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings; Individual and Family Plan Prescription Drug Lists. • **Humira:** Throughout the policy, NDCs starting with 00074 were removed from the Preferred Products. A previous trial of these NDCs counts towards a trial of an adalimumab product. • **Hyrimoz:** Throughout the policy, NDCs starting with 61314 were removed from the Preferred Products. A previous trial of these NDCs counts towards a trial of an adalimumab product. • For **Ulcerative Colitis – Induction Therapy**, Tremfya was added as an agent that counts towards a trial of a Preferred Product.
Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy: Legacy Prescription Drug Lists - (PSM019)	New	Effective 1/1/2025 • Criteria for Legacy Drug List Plans was previously located within Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy (PSM011). The following changes were made to update the criteria upon relocation to this new policy: • **Hyrimoz:** Throughout the policy, NDCs starting with 61314 were removed from the Preferred Products. A previous trial of these NDCs counts towards a trial of an adalimumab product. • For **Ulcerative Colitis – Induction Therapy**, Tremfya was added as an agent that counts towards a trial of a Preferred Product.
Inflammatory Conditions – Orencia Intravenous Preferred	Update	Effective 1/1/2025 • **Updated** the policy title **from** Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Employer Plans **to** Inflammatory

Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists - (PSM006)		Conditions – Orencia Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists. • **Humira:** Throughout the policy, NDCs starting with 00074 were removed from the Preferred Products. A previous trial of these NDCs counts towards a trial of an adalimumab product. • **Hyrimoz:** Throughout the policy, NDCs starting with 61314 were removed from the Preferred Products. A previous trial of these NDCs counts towards a trial of an adalimumab product. • For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. • For **Polyarticular Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Individual and Family Plans - (PSM010)	Update	Effective 1/1/2025 • **Humira:** Throughout the policy, NDCs starting with 00074 were removed from the Preferred Products. A previous trial of these NDCs counts towards a trial of an adalimumab product. • **Hyrimoz:** Throughout the policy, NDCs starting with 61314 were removed from the Preferred Products. A previous trial of these NDCs counts towards a trial of an adalimumab product. • For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. • For **Polyarticular Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product.
Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Legacy Prescription Drug Lists - (PSM018)	New	Effective 1/1/2025 • Criteria for Legacy Drug List Plans was previously located within Inflammatory Conditions – Orencia Intravenous Preferred Specialty Management Policy for Employer Plans (PSM006). The following changes were made to update the criteria upon relocation to this new policy:

		• **Hyrimoz:** Throughout the policy, NDCs starting with 61314 were removed from the Preferred Products. A previous trial of these NDCs counts towards a trial of an adalimumab product. • For **Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product. • For **Polyarticular Juvenile Idiopathic Arthritis**, Cimzia was added as an agent that counts towards a trial of a Preferred Product.
Inflammatory Conditions – Tremfya Subcutaneous Prior Authorization Policy - (IP0689)	Update	Effective 1/1/2025 • Policy name was changed to as listed (previously was Inflammatory Conditions – Tremfya). • **Ulcerative Colitis:** This new condition of approval was added to the policy.
Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings; Individual and Family Plan Prescription Drug Lists - (PSM011)	Update	Effective 1/15/2025 • **Added** Tremfya IV as a Step 1 Preferred product. • **Updated** the Note to clarify that a trial of the "subcutaneous" Tremfya formulation also counts towards a trial of a Preferred Product.
Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy: Legacy Prescription Drug Lists - (PSM019)	Update	Effective 1/15/2025 • **Added** Tremfya IV as a Step 1 Preferred product. • **Updated** the Note to clarify that a trial of the "subcutaneous" Tremfya formulation also counts towards a trial of a Preferred Product.

Inpefa - (IP0582)	Update	Effective 1/1/2025 • **Updated** Individual and family Plan preferred product requirements.
Migraine – Elyxyb - (IP0640)	New	Effective: 1/1/2025 • New standalone coverage policy
Migraine Treatment - (IP0029)	Update	Effective: 1/1/2025 • **Preferred Product Table:** ○ **Removed** Dihydroergotamine 4 mg/mL nasal spray, Elyxyb, Migranal, and Trudhesa from coverage policy.*Dihydroergotamine 4 mg/mL nasal spray, Migranal & Trudhesa relocated to coverage policy: Drugs Requiring Medical Necessity Review for Employer Plans (1602).Elyxb relocated to new standalone coverage policy: Migraine – Elyxyb (IP0640).*
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy for Individual and Family Plans - (PSM008)	Update	Effective 1/1/2025 • **Ulcerative Colitis:** Humira (NDCs starting with 00074) and Hyrimoz (NDC's starting with 61314) were removed from the Preferred Products. Tremfya subcutaneous was added as Preferred Product. In the Note, it was added that previous trial of Tremfya intravenous also counts; since it is now Preferred.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy for Legacy Prescription Drug List Plans - (PSM004)	Update	Effective 1/1/2025 • Policy name was changed to as listed. • **Ulcerative Colitis:** Hyrimoz [NDCs starting with 61314] was removed from the Preferred Products. Tremfya subcutaneous was added as Preferred Product. In the Note, it was added that previous trial of Tremfya intravenous also counts; since it is now Preferred.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred	New	Effective 1/1/2025

Specialty Management Policy: Standard/Performance, Value/Advantage, Total Savings Prescription Drug List Plans - (PSM015)		• New policy addressing Zeposia preferred product requirements for the Standard/Performance, Value/Advantage, and Total Savings formularies.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Prior Authorization Policy - (IP0655)	Update	Effective 1/1/2025 • **Updated** the Preferred Specialty Management Policy note.
Multiple Sclerosis – Briumvi - (IP0545)	Update	Effective 1/1/2025 • **Removed** Individual and Family Plans preferred product requirements.
Multiple Sclerosis – Kesimpta - (IP0260)	Update	Effective 1/1/2025 • **Removed** Individual and Family Plans preferred product requirements.
Multiple Sclerosis – Ocrevus - (IP0212)	Update	Effective 1/1/2025 • **Removed** Individual and Family Plans preferred product requirements.
Nasal Steroids and Nasal Steroid/Antihistamine Combinations - (IP0274)	Update	Effective: 1/15/2025 • **Preferred Product Table:** • **Updated** preferred product criteria for Xhance **from** "Xhance is medically necessary for the treatment of nasal polyps when there is documentation of ALL of the following: (1) 18 years of age or older; (2) Medication is prescribed by, or in consultation with, an allergist, immunologist, or otolaryngologist (ear, nose, and throat [ENT]); (3) Failure, contraindication, or intolerance to Patient has tried ALL of the following: flunisolide 25mcg/spray nasal solution, fluticasone 50mcg/spray nasal suspension, and mometasone furoate 50mcg/spray nasal suspension" **to** "Xhance is considered medically necessary when there is documentation of the following: (1)

		Patient has tried ALL of the following: flunisolide 25mcg/spray nasal solution, fluticasone 50mcg/spray nasal suspension, and mometasone furoate 50mcg/spray nasal suspension" • **Added** "Note: Over-the-counter (OTC) nasal steroids would count as a trial of an alternative."
Oncology (Injectable) – Cosela - (IP0150)	Update	Effective: 1/15/2025 **Small Cell Lung Cancer: Added** criterion that during the first cycle of chemotherapy, Cosela will not be co-administered with a colony stimulating factor or an erythropoiesis-stimulating agent, per the prescriber.
Oncology Medications - (1403)	Update	Effective: 1/1/2025 **Bosulif** **Employer Plans:** • **Updated from** 'Sprycel [may require prior authorization]' **to '**generic dasatinib' • **Updated from** 'Note: Prior use of Gleevec or Phyrago (dasatinib) counts.' **to** 'Note: Prior use of Gleevec (imatinib), Phyrago (dasatinib), or Sprycel (dasatinib) counts.' • **Individual and Family Plans:** • **Added** 'generic dasatinib or' **to** 'Sprycel [may require prior authorization]' **Keytruda** • **Updated** preferred product criteria **from** "Cigna Pathwell Specialty Drug List Plans" **to** "Employer Plans and Individual and Family Plans" • **Updated from** "Tumor is tumor mutational burden-high (TMB-H) [≥ 10 mutations/megabase]" **to** "Tumor is tumor mutational burden-high (TMB-H) [≥ 10 mutations/megabase]" • **Added** patient has recurrent or metastatic disease, tumor is programmed death-ligand 1 positive (combined positive score [CPS] ≥ 1), and medication is used as subsequent therapy as new option for approval. **Iclusig** **Employer Plans:** • **Updated from** 'Sprycel [may require prior authorization]' **to '**generic dasatinib'

		• **Updated from** 'Note: Prior use of Gleevec or Phyrago (dasatinib) counts.' **to** 'Note: Prior use of Gleevec (imatinib), Phyrago (dasatinib), or Sprycel (dasatinib) counts.' • **Individual and Family Plans: Added** 'generic dasatinib' or' **to** 'Sprycel [may require prior authorization]' **Lanreotide acetate (by Cipla)** • **Added** "Effective 1/1/2025 through 2/15/2025" to criteria; criteria after 2/15/2025 will be placed into IP0323 – Somatostatin Analogs – Lanreotide Products **Opdivo** • **Updated** preferred product criteria **from** "Cigna Pathwell Specialty Drug List Plans" **to** "Employer Plans and Individual and Family Plans" • **Added** patient has recurrent or metastatic non-keratinizing disease and medication is used for subsequent therapy as new option for approval **Scemblix** • **Individual and Family Plans: Updated from** Trial of, contraindication, significant intolerance to **Sprycel' to '**Trial of, contraindication, significant intolerance to **generic dasatinib or Sprycel'** **Sprycel** • **Added** preferred product preferencing criteria for Employer Plans **Tasigna** **Employer Plans:** • **Updated from** 'Sprycel [may require prior authorization]' **to '**generic dasatinib' • **Updated from** 'Note: Prior use of Gleevec or Phyrago (dasatinib) counts.' **to** 'Note: Prior use of Gleevec (imatinib), Phyrago (dasatinib), or Sprycel (dasatinib) counts.' **Individual and Family Plans:** • **Added** 'generic dasatinib or' **to** 'Sprycel [may require prior authorization]' **Vectibix**

		• **Added** "According to the prescriber, patient lives in high endemic rates of alpha-gal" or "patient has known alpha-gal positivity"
Ophthalmic – Glaucoma – Prostaglandins - (IP0027)	Update	Effective 1/1/2025 **Lumigan** **For Employer Plans:** • **Updated** preferred product criteria to now require four preferred products, it was previously two. • **Added** bimatoprost 0.03% ophthalmic solution as another preferred product alternative. **For Individual and Family Plans:** • **Updated** preferred product criteria to now require four preferred products, it was previously two. • **Added** bimatoprost 0.03% and tafluprost 0.0015% as additional preferred product alternatives. **Travatan Z** **For Employer Plans and Individual and Family Plans:** • **Updated** preferred product criteria from requiring two preferred products, the generic plus one other preferred product, to now be a requirement of the bioequivalent generic product. **Vyzulta** **For Employer Plans:** • **Updated** preferred product criteria to now require four preferred products, it was previously two. **For Individual and Family Plans:** • **Updated** preferred product criteria to now require four preferred products, it was previously two, and added tafluprost 0.0015% as an additional preferred product alternative. **tafluprost 0.0015%**

		Individual and Family Plans: • **Removed** preferred product requirements. **Zioptan** **For Employer Plans and Individual and Family Plans:** • **Updated** preferred product criteria from requiring two preferred products, the generic plus one other preferred product, to now be a requirement of the bioequivalent generic product.
Opioid Therapy for Employer Group Benefit Plans - (IP0561)	Update	Effective: 1/1/2025 • **Preferred Product Requirement Table.** **Added** MSB criteria for: (1) Dilaudid 2 mg tablet, (2) Dilaudid 4 mg tablet, (3) Dilaudid 8 mg tablet, (4) Dilaudid 5mg/5mg oral liquid
Pharmacy Prior Authorization - (1407)	Update	Effective: 1/1/2025 • **Added** Individual and Family Plan product-specific medical necessity criteria: Clenpiq, Moviprep, Plenvu, Suprep, Sutab, Xhance. • **Updated** Individual and Family Plan product-specific medical necessity criteria: Suflave.
Pharmacy Prior Authorization - (1407)	Update	Effective: 1/15/2025 • **Added** Individual and Family Plan product-specific medical necessity criteria: potassium chloride ER tablet, clobetasol propionate 0.05% ophthalmic suspension, Dolobid, estradiol gel 0.06%, Estratest HS.
Pulmonary Arterial Hypertension – Adempas - (IP0600)	Update	Effective: 1/15/2025 • **Pulmonary Arterial Hypertension (PAH) [World Health Organization {WHO} Group 1]:** For a patient currently receiving Adempas, added a *note* to indicate that requirement of a right heart catheterization (RHC) refers to a RHC prior to starting therapy with a medication for WHO Group 1 PAH.

Pulmonary Arterial Hypertension – Orenitram - (IP0616)	Update	Effective: 1/15/2025 • **Pulmonary Arterial Hypertension (PAH) [World Health Organization {WHO} Group 1]:** For a patient currently receiving Orenitram, added a *note* to indicate that requirement of a right heart catheterization (RHC) refers to a RHC prior to starting therapy with a medication for WHO Group 1 PAH.
Pulmonary Arterial Hypertension – Phosphodiesterase Type 5 Inhibitors - (IP0626)	Update	Effective: 1/15/2025 • **Pulmonary Arterial Hypertension (PAH) [World Health Organization {WHO} Group 1]:** For a patient currently receiving the requested PDE5 inhibitor, added a *note* to indicate that requirement of a right heart catheterization (RHC) refers to a RHC prior to starting therapy with a medication for WHO Group 1 PAH.
Quantity Limitations - (1201)	Update	Effective 1/1/2025 • **Added** doxepin 5% cream, Ingrezza, Krintafel, Prudoxin and Zonalon to the policy. **Updated** the Vtama quantity limitation. **Removed** Oxbryta from the policy. The product has been withdrawn from the market. **Updated** the Zoryve quantity limitation.
Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors and SGLT-2 / Metformin Combinations - (IP0592)	Update	Effective 1/1/2025 • **Updated** Employer Plans metformin requirements. • **Updated** Individual and Family Plans preferred product requirements.
Somapacitan - (IP0576)	Update	Effective 1/1/2025 • **Updated** Individual and family Plan preferred product requirements.
Somatropin - (IP0452)	Update	Effective 1/1/2025 • **Updated** Individual and family Plan preferred product requirements.

Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) – (1803)	Update	Effective 1/15/2025 • **Clarified** the current Anti-Parkinsonism Drugs step therapy requirements apply to Monoamine Oxidase Type B (MAO-B) Inhibitors. • **Added** new step therapy requirements for the following Carbidopa and Levodopa Products, Crexont and Rytary.
Step Therapy – Standard and Performance Prescription Drug Lists (Employer Group Plans) – (1801)	Update	Effective 1/15/2025 • **Clarified** the current Anti-Parkinsonism Drugs step therapy requirements apply to Monoamine Oxidase Type B (MAO-B) Inhibitors. • **Added** new step therapy requirements for the following Carbidopa and Levodopa Products, Crexont and Rytary.
Step Therapy – Value and Advantage Prescription Drug Lists (Employer Group Plans) - (1802)	Update	Effective 1/15/2025 • **Clarified** the current Anti-Parkinsonism Drugs step therapy requirements apply to Monoamine Oxidase Type B (MAO-B) Inhibitors. • **Added** new step therapy requirements for the following Carbidopa and Levodopa Products, Crexont and Rytary.
Topical Acne – Non-Retinoid Products – (IP0166)	Update	Effective 1/1/2025 **Removed** Dapsone products (Aczone) and relocated to Brands with Bioequivalent Generics – IP0011
Vaginal Estrogen Products and Ospemifine - (IP0216)	Update	Effective 1/1/2025 • **Removed** Estrace vaginal cream and Vagifem and relocated to Brands with Bioequivalent Generics – IP0011
Vecamyl for Individual and Family Plans - (IP0650)	Update	Effective: 1/1/2025 **Essential Hypertension, Moderately Severe to Severe.** • **Added** 'Patient has tried four antihypertensive therapies, each from different pharmacologic classes (e.g., diuretics, calcium channel blockers, angiotensin-

		converting enzyme inhibitors, and angiotensin receptor blockers [as single-entity or as combination products])' • **Added** 'For each of these agents, patient meets ONE of the following (i or ii): (i) Patient has had inadequate efficacy; OR (ii) Patient has experienced adverse event(s) severe enough to warrant discontinuation of this agent, according to the prescriber.' **Uncomplicated Malignant Hypertension.** • **Added** 'Patient has tried four antihypertensive therapies, each from different pharmacologic classes (e.g., diuretics, calcium channel blockers, angiotensin-converting enzyme inhibitors, and angiotensin receptor blockers [as single-entity or as combination products])' • **Added** 'For each of these agents, patient meets ONE of the following (i or ii): (i) Patient has had inadequate efficacy; OR (ii) Patient has experienced adverse event(s) severe enough to warrant discontinuation of this agent, according to the prescriber. **Conditions Not Covered.** • **Added** 'Tourette Syndrome'
Weight Loss – Glucagon-Like Peptide-1 Agonists Benefit Exclusion Overrides Policy - (IP0621)	Update	Effective 1/1/2025 • Policy number updated from an internal policy (INT0621) to an externally posted policy (IP0621)
ZTlido for Individual and Family Plans - (IP0709)	NEW	Effective: 1/1/2025 New coverage policy.
Neurology – Gene Therapy – Skysona (IP0529)	Update	**Effective: 1/16/2025** **Added** "Policy Statement" to the policy **Added** "**Documentation:** Documentation is required for use of Skysona as noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to,

		chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information." **Cerebral Adrenoleukodystrophy:** • **Updated** criteria **from** "age 4 years to 17 years" **to** "Patient is ≥ 4 and < 18 years of age." • **Added** criteria "Patient has not received Skysona in the past [verification in claims history required] and **added** "Note: If no claim for Skysona is present (or if claims history is not available), the prescribing physician confirms that the patient has not previously received Skysona." • **Updated** criteria **from** "Documentation of adrenoleukodystrophy as demonstrated by meeting genetic confirmation of a pathogenic variant, or likely pathogenic variant, in the adenosine triphosphate binding cassette, sub family D member 1 (*ABCD1*) gene" **to** "Patient has a pathogenic variant in the adenosine triphosphate binding cassette, sub family D member 1 (ABCD1) gene [documentation required]." • **Updated** criteria **from** "According to the prescriber, is unable to receive stem cell transplant due to no matching, or unwilling, Human Leukocyte Antigen (HLA)-Matched family donor" **to** "Patient meets ONE of the following (i or ii): i. Patient does not have a Human Leukocyte Antigen (HLA)-matched donor; OR ii. Patient has an HLA-matched donor, but the individual is not able or is not willing to donate." • **Updated** criteria **from** "Prescriber attestation of the following: No active bacterial, viral, fungal or parasitic infection" **to** "Patient does not currently have an active bacterial, viral, fungal, or parasitic infection." • **Updated** criteria **from** "Prescriber attestation of the following: No prior or current malignancy or myeloproliferative disorder; No familial cancer syndrome or a history of such in their immediate family" **to** "Patient does not have any of the following (i and ii): i. Prior or current hematologic malignancy or myeloproliferative disorder; AND ii. Familial cancer syndrome or a history of such in his immediate family." • **Updated** criteria **from** "According to the prescriber, hematopoietic stem cell transplantation procedure is appropriate for the individual as required to receive Skysona gene therapy" **to** "According to the prescribing physician, hematopoietic stem cell transplantation is appropriate for the patient." • Regarding the requirement that the patient has "adequate hepatic function" this wording was changed to state that the patient has "undergone liver function testing." Also, the requirement that this information be obtained "within the past 30 days" was added. For the laboratory requirements, the phrase "values are normal or" was changed to "level is." • Regarding the requirement that the patient has "adequate renal function," this phrase was removed before the cited estimated creatinine clearance and estimated glomerular filtration rate. Also, the requirement that this information be obtained "within the past 30 days" was added.

		• **Updated** criteria **from** "Documentation of Adequate cardiac function as evidenced by a left ventricular ejection fraction greater than 40%" **to** "According to the prescribing physician, patient does not have evidence of cardiac compromise." • The phrase "Adequate hematological function as evidenced by ALL the following:" was removed before the cited hematologic laboratory requirements. Also, the requirement that this information be obtained "within the past 30 days" was added. The requirement that the patient does not have an uncorrected bleeding disorder was removed. • **Added** the criteria "Patient meets ALL of the following (i, ii, iii, and iv): i. Patient will undergo mobilization, apheresis, myeloablative conditioning, and lymphodepletion; AND ii. A granulocyte-colony stimulating factor product will be used for mobilization; AND iii. Busulfan will be used for myeloablative conditioning; AND iv. Cyclophosphamide or fludarabine will be used for lymphodepletion." • A specific individual criterion was added that current patient body weight has been obtained within the past 30 days with documentation required. • **Added** the criteria "If criteria A through R are met, approve one dose of Skysona by intravenous infusion to provide a one-time (per lifetime) single dose which contains a minimum of 5.0×10^6 CD34+ cells/kg of body weight." • Dosing criteria were rephrased to emphasize that Skysona is provided as a "one-time (per lifetime)" single dose. The requirement that the body weight be obtained based on patient weight prior to the first apheresis was removed. It was added that verification is required. **Authorization Duration:** **Updated** criteria **from** "Authorization is for a one-time treatment for 6 months" **to** "Approve for a one-time (per lifetime) single dose."
Abaloparatide - (IP0329)	Update	Effective: 1/15/2025 • No criteria changes.
Diabetes – Tzield - (IP0537)	Update	Effective: 1/15/2025 No criteria changes
Gonadotropin-Releasing Hormone Agonists – Central Precocious Puberty – Triptodur - (IP0134)	Update	• No criteria changes

Grass Pollen Sublingual Products (IP0515)	Update	• No criteria changes
Hereditary Angioedema – Berotralstat - (IP0096)	Update	• No criteria changes
Hereditary Angioedema – C1 Esterase Inhibitors (IV) - (IP0315)	Update	Effective: 1/15/2025 • No criteria changes.
Hereditary Angioedema – C1 Esterase Inhibitors (SC) - (IP0316)	Update	Effective: 1/15/2025 • No criteria changes.
Hereditary Angioedema – Ecallantide - (IP0336)	Update	• No criteria changes
Hereditary Angioedema – Icatibant - (IP0335)	Update	Effective: 1/15/2025 • No criteria changes.
Hereditary Angioedema – Lanadelumab-flyo - (IP0334)	Update	• No criteria changes
Maralixibat - (IP0341)	Update	• No criteria changes
Odactra - (IP0516)	Update	• No criteria changes
Ragwitek - (IP0518)	Update	• No criteria changes
Romosozumab - (IP0179)	Update	Effective: 1/15/2025 • No criteria changes.

Tiopronin - (IP0202)	Update	Effective 1/15/2025
Human Immunodeficiency Virus – Descovy for Employer Plans - (IP0636)	Retired	Effective: 1/1/2025
Pancrelipase - (IP0002)	Retired	Effective 1/1/2025 • Relocated into Drugs Requiring Medical Necessity Review for Employer Plans (1602) for EMP and Pharmacy Prior Authorization (1407) for IFP
Angiotensin Receptor Blockers – (IP0362)	Retired	Effective 1/1/2025
Roflumilast - (IP0527)	Retired	Effective 1/15/2025 • Relocated into Drugs Requiring Medical Necessity Review for Employer Plans (1602) for EMP and Pharmacy Prior Authorization (1407) for IFP
CareAllies Medical Necessity Guideline	**New, Updated, or Retired?**	**Comments**
		• All above updates apply
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
Precertification Policies	Updates	Effective 1/1/25 • 58 New Codes released by CMS/AMA were added to precertification.

Reimbursement Policy*	New, Updated, or Retired?	Comments
		• No updates for January 2025
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		• No updates for January 2025
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**
Code Editing Policy and Guidelines	Update	