Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective June 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 Rehabilitation (Phase II Outpatient) – (0073)	Update	Important **changes** in coverage criteria: • Changed from not covered to silent (covered) for virtual/remote home-based and hybrid cardiac rehabilitation.

Compression Devices – (0354)	Update	Important **changes** in coverage criteria:
		• Changed from not covered to covered for chest and truncal pneumatic appliances.
		• Minor changes:
		  ○ Grouped criteria by “standard” devices and “calibrated gradient pressure” devices.
		  ○ Removed “limited to the lowest-cost alternative” from policy statement.
		  ○ Added device examples for nonpneumatic pumps (e.g. Koya Dayspring) and cold therapy compression devices (e.g. Game Ready).

COVID-19: In Vitro Diagnostic Testing – (0557)	Update	Minor **changes** in coverage criteria/policy: • Added an example of a test that is not diagnostic back to existing not covered or reimbursable coverage statement.
Duplex Scan to Evaluate for Carotid Artery Stenosis – (0542)	Update	Minor **changes** in coverage criteria/policy: • Added coverage for history of head and neck radiation
Home Ventilators - (0546)	Update	Important **changes** in coverage criteria: • Added coverage for the VOCSN VC and VOCSN VC Pro ventilators (E0468) because these ventilators are substantially equivalent to the multi-function ventilator that's already considered medically necessary in the policy except that these are dual function. • Added E0468 to the code range in the "additional or duplicate devices" and "not medically necessary" sections of the policy statement.
Rosacea Procedures – (0482)	Update	Minor **changes** in coverage criteria/policy: • Minor changes: ○ Removed benefit plan verbiage. ○ Bulleted out criteria for the treatment of rhinophyma, for improved readability.
Tissue-Engineered Skin Substitutes – (0068)	Update	Important **changes** in coverage criteria: • Expanded coverage by increasing the number of initial applications that are allowed for diabetic foot ulcers. • Based on each products' criteria, the following skin substitutes were changed accordingly: ○ initial treatment is limited to up to five applications (max eight in 12 weeks): ▪ AlloPatch Pliable ▪ AmnioBand ▪ Dermagraft ▪ Geistlich Derma-Gide® Advanced Wound Matrix ▪ Grafix® ○ initial treatment is limited to up to four applications (max four in 12 weeks): ▪ Apligraf ▪ EpiFix® Amniotic Membrane ▪ Integra® Dermal Regeneration Template/ Omnigraft Dermal Regeneration Matrix ▪ Oasis® Wound Matrix/Oasis® Ultra Tri-Layer Matrix ▪ TheraSkin ○ initial treatment is limited to up to three applications (max three in 12 weeks) ▪ PriMatrix

Ultrasound in Pregnancy (including 3D, 4D and 5D Ultrasound) – (0142)	Update	Minor **changes** in coverage criteria/policy: • Minor changes: ○ Updated noncoverage rationale for 3D, 4D and 5D ultrasound, from experimental, investigational or unproven, to not medically necessary. ○ Grouped noncovered indications into bulleted list, for improved readability.
Cervical Fusion – (0527)	Update	No change in coverage.
Headache Occipital and/or Trigeminal Neuralgia Treatment – (0063)	Update	No change in coverage.
Pancreatic Islet Cell Transplantation – (0107)	Update	No change in coverage.
Pelvic Denervation Procedures - (0368)	Update	No change in coverage.
Percutaneous Vertebroplasty, Kyphoplasty, and Sacroplasty – (0040)	Update	No change in coverage.
Plasmapheresis – (0153)	Update	No change in coverage.
Redundant Skin Surgery – (0470)	Update	No change in coverage.
Rhinoplasty, Vestibular Stenosis Repair and Septoplasty – (0119)	Update	No change in coverage.
Umbilical Cord Blood Banking - (0466)	Update	No change in coverage.
Venous Angioplasty and/or Stent Placement in Adults – (0541)	Update	No change in coverage.

ASH Guidelines	New, Updated, or Retired?	Comments
Sensory and Auditory Integration Therapy-Facilitated Communication – (CPG 149)	Update	No change in coverage.
Range of Motion Testing – (CPG 146)	Update	No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**
Cobranded Cigna-EviCore Guidelines	New	Posted **June 1, 2024**, Effective **June 1, 2024**: New informational document, no change to coverage: • Cigna-EviCore Co-branded Guideline Definitions
Cobranded Cigna-EviCore Comprehensive Musculoskeletal Management Guidelines	Update	Posting **June 27, 2024**, Effective **August 1, 2024**: Informational document updated, no change to coverage: • Preface to the Comprehensive Musculoskeletal Management (CMM) Guidelines
Cobranded Cigna-eviCore Sleep Disordered Breathing Diagnosis and Treatment Guidelines	Update	Important **changes** in coverage criteria Posted **March 1, 2024**, Effective **June 15, 2024**: Updates to the guidelines included both positive and adverse changes in coverage, including: • Added covered sleep-related signs and symptoms (e.g., presence of atrial fibrillation or systolic congestive heart failure) • Added coverage for testing in a subset of pediatric individuals with Down Syndrome
Administrative Policy	**New, Updated, or Retired?**	**Comments**
Midwife, Home Birth and Non-Clinical Maternal Services – (A002)	Update	No coverage changes

Non-Participating Laboratory Services - (A001)	Update	No coverage changes
Drug & Biologic Coverage Policy	**New, Updated, or Retired?**	**Comments** **All policy changes effective June 1, 2024, unless otherwise stated**
Abatacept Subcutaneous - (IP0231)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements.
Abatacept Intravenous - (IP0232)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements.
Adalimumab - (IP0245)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements.
Anakinra - (IP0243)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements.
Antibiotics (Inhaled) – TOBI Podhaler – (IP0499)	Update	Effective 6/15/2024 • **Policy Name Change: Updated** Policy Name from "Tobramycin Inhalation Powder" to "Antibiotics (Inhaled) – TOBI Podhaler." • **Added** preferred product requirement criteria for Individual and Family Plans. • **Continuation of TOBI Podhaler: Changed** approval duration from 12 months to 1 month. **Removed** the requirement that the medication be prescribed by or in consultation with a pulmonologist.
Anticoagulants – Savaysa – (IP0034)	Update	Effective 6/1/2024 • **FDA-Approved Indications:** Added age restriction for Savaysa usage across all indications. • **Other Uses with Supportive Evidence:** Added age restriction for Savaysa usage across all indications. • **Conditions Not Covered:** Removed criterion regarding prophylaxis of Venous Thromboembolism in Individuals with Factor V Leiden thrombophilia and Antiphospholipid Syndrome.

Antiseizure Medications – Valtoco - (IP0105)	Update	Effective 6/1/20204 **Intermittent Episodes of Frequent Seizure Activity: Removed** age-related requirement criterion. **Removed** criterion pertaining to use for acute treatment of seizure activity.
Baricitinib - (IP0225)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements.
Bone Modifiers – Xgeva – (IP0332)	Update	Effective 6/15/2024 • **Bone Metastases from Solid Tumors – Prevention of Skeletal-Related Events:** Relocated zoledronic acid requirement and the exceptions to a preferred product table and added an additional exception for "Patient has renal impairment (creatinine clearance < 30 mL/min)"; Updated statement "Is currently receiving denosumab (Xgeva) and has demonstrated a beneficial clinical response" to now be "Patient has a previous history of using Xgeva" • **Giant Cell Tumor of Bone:** Removed specialist prescriber requirement • **Hypercalcemia of Malignancy:** Updated authorization approval duration to 2 months, was previously 12 months; Removed specialist prescriber requirement • **Multiple Myeloma – Prevention of Skeletal-Related Events:** Relocated zoledronic acid requirement and the exceptions to a preferred product table and added an additional exception for "Patient has renal impairment (creatinine clearance < 30 mL/min)"; Updated statement "Is currently receiving denosumab (Xgeva) and has demonstrated a beneficial clinical response" to now be "Patient has a previous history of using Xgeva"
Brands with Bioequivalent Generics – (IP0011)	Update	Effective 6/1/2024 • **Removed** Apriso • **Added** Tasmar
Brodalumab - (IP0246)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements. • **Added** Sotyktu as a preferred product option.
Cabenuva – (IP0123)	Update	Effective: 6/1/2024 **Human Immunodeficiency Virus (HIV)-1, Treatment.** • **Added** criterion for minimum weight. • **Added** criterion for screening individual treated with a stable regimen for at least 3 months. • **Updated** criterion for continuation of treatment.
Cenegermin Ophthalmic Solution - (IP0302)	Update	Effective: 6/15/2024

		• **Added** "or optometrist" to the "medication is prescribed by, or in consultation with" criterion to now read "Medication is being prescribed by, or in consultation with, an ophthalmologist or optometrist"
Certolizumab – (IP0244)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements. • **Added** Sotyktu as a preferred product for Plaque Psoriasis for Employer plans
Clotting Factors and Antithrombin – (8007)	Update	Effective 6/15/2024 • Removed Factor IX products from the policy and relocated to a new stand-alone policy, Hemophilia – Factor IX Products – (IP0623). The products removed include: AlphaNine SD, Mononine [discontinued by manufacturer], Profilnine, BeneFIX, Ixinity, Rixubis, Idelvion, Rebinyn, and Alprolix.
Complement Inhibitors – Fabhalta – (IP0614)	Update	Effective 6/1/2024 • **Paroxysmal Nocturnal Hemoglobinuria:** Initial approval duration was changed from 4 months to 6 months.
COVID-19 Drug and Biologic Therapeutics – (2016)	Update	Effective 6/15/2024 • **Removed Kineret (anakinra)**: criteria has been relocated to Inflammatory Conditions – Kineret – (IP0243). • **Removed Veklury (remdesivir)**: there is currently no utilization management on the medication.
Cushing's – Recorlev – (IP0389)	Update	Effective: 6/1/2024 • Updated title of policy; previously was Levoketoconazole. • **Endogenous Cushing's Syndrome**: Removed "Endogenous Cushing's Disease (pituitary origin only)", removed the preferred product box, relocated the requirement for a step through ketoconazole, and updated approval duration for Endogenous Cushing's Syndrome from 6 months to now be 12 months.
Desmopressin Products – Nocdurna - (IP0127)	Update	Effective 6/15/2024 • No clinical content changes
Deucravacitinib - (IP0538)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements. • **Updated** Sotyktu to be a preferred product for Plaque Psoriasis for Employer plans

Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review Employer Group Plans: Standard, Performance, or Legacy Prescription Drug List - (1601)	Update	Effective 6/1/2024 • Removed Multaq from the policy.
Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review Employer Group Plans: Value, Advantage, or Cigna Total Savings Prescription Drug List - (1602)	Update	Effective 6/1/2024 • Removed Multaq from the policy.
Glecaprevir/Pibrentasvir – (IP0187)	Update	Effective 6/1/2024 • Removed Life Expectancy Less Than 12 Months Due to Non-Liver Related Comorbidities from Conditions Not Covered
Golimumab Subcutaneous - (IP0237)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements.
Gonadotropin-Releasing Hormone Agonists – Implants for Non-Oncology Uses – (IP0620)	Update	Effective: 6/1/2024 • **Removed** histrelin acetate medical necessity criteria which defines for use relating to *Central Precocious Puberty* (onset of secondary sexual characteristics).

Gonadotropin-Releasing Hormone Agonists – Injectable Long-Acting Products for Non-Oncology and Non-infertility Indications – (IP0109)	Update	Effective 6/15/2024
		• **Policy Name Change: Updated** Policy Name from "Leuprolide – Long Acting" to "Gonadotropin-Releasing Hormone Agonists – Injectable Long-Acting Products for Non-Oncology and Non-infertility Indications."
		• **Premenstrual Disorders, including Premenstrual Syndrome and Premenstrual Dysphoric Disorder: Added** as a new coverage condition for Lupron Depot 3.75 mg and 11.25 mg.
		• **Medical Necessity Criteria:**
		  ○ **Removed** Stimulation Test to Confirm a Diagnosis of Central Precocious Puberty Prior to Initiation of Treatment - (leuprolide acetate only).
		  ○ **Added** dosing information for all FDA approved indications.

		• **Conditions Not Covered: Removed** the conditions “Hirsutism” and “Premenstrual Syndrome (PMS).”
Hematology – Gene Therapy - (IP0486)	Update	Effective 6/15/2024 **Transfusion-Dependent Beta-Thalassemia** (previously listed as “Beta Thalassemia”): • The required patient upper age threshold was clarified to be < 51 years (previously listed as ≤ 50 years). • Regarding use of Zynteglo in the past, the criterion was changed due to the recent approval of Casgevy for this indication. It now states that the patient has not received “a gene therapy for beta-thalassemia” in the past instead of requiring that the patient has not received Zynteglo in the past. • The reference to matched family donor was changed to remove “family”. • Regarding the confirmation that the patient has a specific genotype, the phrase “by DNA analysis” was changed to “by genetic testing”. • In the requirements that define a patient as transfusion-dependent, the phrases “preceding enrollment” and “before enrollment” were removed. • The requirement was removed that the patient has received or is planning to receive prophylaxis for hepatic veno-occlusive disease/hepatic sinusoidal obstruction syndrome before myeloablative conditioning with busulfan. • The requirement was removed that the patient who is ≥ 16 years of age has a Karnofsky performance status score of ≥ 80, as well as the requirement that a patient < 16 years of age has a Lansky performance status score of ≥ 80. • The requirements were removed that within 30 days before intended receipt of Zynteglo that the patient has a white blood cell count ≥ 3 x 10^9/L and has a platelet count ≥ 100 x 10^9/L. • A requirement was added that the patient does not have significant immunodeficiency disorder. • The requirements were removed that the patient does not have the presence of any the following: familial cancer syndrome or a history of such in their immediate family; an estimated glomerular filtration rate < 70 mL/min/1.73 m^2; an uncorrected bleeding disorder; and a diffusion capacity of carbon monoxide < 50% of predicted. • Regarding iron chelation therapy, the phrase “according to the prescribing physician” was added in reference to the requirement that the patient has been discontinued from this therapy for at least 7 days prior to myeloablative conditioning. Also, the requirement was removed that use of iron chelators will be avoided for 6 months after infusion of Zynteglo. • The phrase “according to the prescribing physician” was added regarding the following: that the patient will undergo mobilization, apheresis, and myeloablative conditioning; that for mobilization, a granulocyte-colony stimulating factor product and a hematopoietic stem cell mobilizer will be utilized; and that busulfan will be used for myeloablative conditioning.

		• The word “total” was added in reference to the requirement that the hemoglobin level is ≥ 11.0 g/dL. The wording “prescribing physician confirms” was changed to “according to the prescribing physician. • A requirement was added that the patient is negative for both hepatitis B virus and hepatitis C virus. • The requirement was removed that a negative serum pregnancy test be confirmed before Zynteglo administration. • Dosing was clarified with emphasis that Zynteglo is given as a “one-time (per lifetime) single dose”. • Added in red font documentation instructions
Hematology – Pyrukynd – (IP0451)	Update	Effective 6/15/2024 • **Hemolytic Anemia due to Pyruvate Kinase Deficiency:** For a patient currently receiving therapy, the requirement that the patient has a current hemoglobin level ≤ 12 g/dL was removed.
Hemophilia – Factor IX Products – (IP0623)	New	Effective 6/15/2024 • New coverage policy
Hemophilia – Gene Therapy – Hemgenix - (IP0535)	Update	Effective 6/1/2024 **Hemophilia B:** • The following criteria were removed which stated that after the Hemgenix infusion, the physician attests that the following will be performed: 1) liver enzyme testing to monitor for liver enzyme elevations will be done at least weekly for the first 3 months and periodically thereafter; AND implementing a course of corticosteroids will be considered if the patient experiences clinically relevant increases in alanine aminotransferase levels; 2) the patient will undergo monitoring for Factor IX activity at least weekly for the first 3 months and periodically thereafter; and 3) the patient with preexisting risk factors for hepatocellular carcinoma will receive abdominal ultrasound screenings and be monitored at least annually for alpha fetoprotein elevations in the 5 years following receipt of Hemgenix. • The requirement for the specialist physician was changed to “hemophilia specialist physician”. • The criterion regarding a current patient body weight be obtained within 30 days was moved to a separate criterion. • Dosing was clarified with emphasis that Hemgenix is given as a “single dose”. • Regarding use of Hemgenix in the past, the phrase was changed to “verification in claims history required”. Wording changed to “prescribing physician confirms” regarding the verification that the patient has not previously received Hemgenix. • In the requirement that Factor IX inhibitor titer testing has been performed “within 30 days”, the phrase “before receipt of Hemgenix” was removed.

		• The phrase regarding liver "health assessment" was changed to liver "function testing". • For the requirement that the patient does not have uncontrolled human immunodeficiency virus, the word "infection" was added after this phrase. • **Conditions Not Recommended for Approval:** The condition of "Prior Receipt of Gene Therapy" was added.
Hemophilia – Gene Therapy – Hemgenix - (IP0535)	Update	Effective: 6/15/2024 **Hemophilia B:** • Regarding use of Hemgenix in the past, the criterion was changed due to the recent approval of Beqvez (fidanacogene elaparvovec intravenous infusion) for this indication. It now states that the patient has not received "a gene therapy for hemophilia B" in the past. It was added that there should not be claims present for Beqvez and that if claims history is not available, the prescribing physician confirms that the patient has not previously received Beqvez (previously, this only addressed Hemgenix). • The option of approval was removed that the patient has been receiving routine prophylaxis with Factor IX therapy continuously for ≥ 2 months. • The requirement that the patient does not currently have an inhibitor to Factor IX was reworded to state that the patient is negative for Factor IX inhibitors. • The caveat of "According to the prescribing physician" was added to the requirement that the patient does not have uncontrolled human immunodeficiency virus infection; the documentation requirement was removed from this requirement; and the Note that addressed specific laboratory factors was removed. • The requirement that within 30 days the patient has an estimated creatinine clearance ≥ 30 mL/min AND that the creatinine level is ≤ two times the upper limit of normal was changed to having to meet one of /these elements (not both). • The requirement that the patient does not have another coagulation disorder, besides hemophilia B, was removed.
Hepatitis C – Sovaldi – (IP0157)	Update	Effective 6/1/2024 • **Chronic hepatitis C virus (HCV) Genotype 2 and 3.** Removed criterion related to intolerance or contraindication to both Epclusa and Mavyret. **Conditions Not Recommended for Approval: Life Expectancy Less Than 12 Months Due to Non-Liver Related Comorbidities.** This condition was removed
Hepatitis C –Zepatier – (IP0158)	Update	Effective 6/1/2024 • **Conditions Not Recommended for Approval: Life Expectancy Less Than 12 Months Due to Non-Liver Related Comorbidities.** This condition was removed.

		• **Medical Necessity Criteria: Does not have decompensated cirrhosis (Child-Pugh B or C).** This criterion was removed.
Immune Globulin – (5026)	Update	Effective 6/1/2024 • Added new product, Alyglo, to the list of products addressed in the policy.
Infectious Disease – Ivermectin Tablets - (IP0300)	Update	Effective 6/1/2024 • **For all covered conditions**: (1) Removed requirement of 'documented diagnosis of…' respective of each covered condition (2) The number of approvable doses was removed. All approval durations are listed for one month. • **For Pediculosis**: Added (1) Patient has infection caused by pediculus humanus capitis (head lice); (2) Patient has infection caused by pediculus humanus corporis (body lice); OR (3) Patient has pediculosis pubis caused by Phthirus pubis (pubic lice). • **For Preferred Product Table**: Added business decision to step through a generic step for Stromectol • **Updated** title from Ivermectin
Inflammatory Conditions – Bimzelx - (IP0603)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements. • **Added** Sotyktu as a preferred product option.
Inflammatory Conditions – Entyvio Subcutaneous for Total Savings and Individual and Family Plans - (IP0613)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements.
Inflammatory Conditions – Omvoh Subcutaneous - (IP0602)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements.
Inflammatory Conditions – Omvoh Intravenous - (IP0601)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements.
Inflammatory Conditions – Rinvoq - (IP0229)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements.
Inflammatory Conditions – Velsipity - (IP0605)	Update	Effective 6/1/2024

		• **Updated** adalimumab preferred product requirements.
Ixekizumab - (IP0224)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements.
Ledipasvir/Sofosbuvir – (IP0186)	Update	Effective 6/1/2024 • Removed Life Expectancy Less Than 12 Months Due to Non-Liver Related Comorbidities from Conditions Not Covered
Lupus – Lupkynis – (IP0122)	Update	Effective 6/15/2024 • **Updated** coverage policy title from *Voclosporin* to *Lupus - Lupkynis* • **No** criteria changes
Maralixibat – (IP0341)	Update	Effective 6/15/2024 • **Added** Progressive Familial Intrahepatic Cholestasis as a new condition for approval.
Metabolic Disorders – Primary Hyperoxaluria Medications – Rivfloza - (IP0629)	New	Effective 6/1/2024 • New coverage policy addressing utilization management of Rivfloza (nedosiran) subcutaneous injection for Employer Plans and Individual and family Plans.
Migraine – Nurtec ODT – (IP0147)	Update	Effective: 6/1/2024 • **Updated** coverage policy title from *Rimegepant* to *Migraine – Nurtec ODT.* • **Migraine, Acute Treatment:** • **Added** requirement for trial of two triptans for Individual and Family Plans. • **Preventive Treatment of Episodic Migraine:** • **Removed** requirement for a *minimum 8-week trial* as it relates to migraine prevention therapies. • **Added** preferred product criterion for Individual and Family Plans requiring failure, contraindication, or intolerance to Emgality.
Migraine – Ubrelvy - (IP0148)	Update	Effective 6/1/2024 • **Conditions Not Covered**: Removed 'Concurrent use (for example, during the same time period) of two CGRP inhibitors indicated for the acute treatment of migraine (for example Nurtec ODT and Ubrelvy)'

Muscular Dystrophy – Deflazacort - (IP0131)	Update	Effective 6/1/2024 • Emflaza tablets are available as generic deflazacort tablets. Within the policy changed Emflaza to deflazacort wherever applicable.
Nephrology - Filspari - (IP0565)	Update	Effective 6/1/2024 • **Primary Immunoglobulin A Nephropathy.** (1) Added 'Patient is currently receiving Filspari' criteria. (2) Updated high risk of disease progression criteria.
Nephrology – Tarpeyo – (IP0413)	Update	Effective 6/1/2024 • **Primary Immunoglobulin A Nephropathy:** The criterion requiring that the patient is at high risk of disease progression, defined by ONE of the following: urine-to-protein-creatinine ratio ≥ 1.5 g/g OR proteinuria ≥ 0.75 g/day was revised to require that the patient is at high risk of disease progression, defined by urine-to-protein-creatinine ratio ≥ 0.8 g/g OR proteinuria ≥ 0.75 g/day. • **Conditions Not Covered:** Removed criterion regarding the use of Tarpeyo beyond a 10-month course of therapy.
Neurology – Riluzole Products - (IP0258)	Update	Effective 6/1/2024 • **Amyotrophic lateral sclerosis (ALS). Removed** 'documented diagnosis of Amyotrophic Lateral Sclerosis (ALS)' • **Preferred product table.** (1) **Added** Teglutik (riluzole oral suspension) for IFP and Emp, (2) **Updated** criteria for Exservan, Tiglutik (added additional 'tried' criteria for required alternatives, including generic riluzole tablets and Teglutik/Tiglutik), (3) **Added** Exservan, Tiglutik for IFP to policy
Nonsteroidal Anti-inflammatory Drugs – (IP0457)	Update	Effective 6/15/2024 • Added preferred product requirement criteria for Kiprofen (ketoprofen) 25mg capsule for Employer Plans
Oncology Medications - (CP1403)	Update	Effective 6/1/2024 • **Added** preferred product requirement criteria for Augtyro (repotrectinib) for Employer Plans • **Updated** Abraxane and Paclitaxel albumin-bound preferred product requirement criteria for Cigna Pathwell Specialty Drug List Plans

Oncology (Injectable) – Amtagvi - (IP0625)	New	Effective 6/1/2024 • New coverage policy
Oncology (Injectable – CAR-T) – Carvykti - (IP0414)	Update	Effective 6/15/2024 • **Multiple Myeloma.** • **Removed** (1) 'Documentation of an Eastern Cooperative Oncology Group (ECOG) performance status of 0 to 1', (2) 'Does not have central nervous system involvement with myeloma', (3) 'Does not have presence or history of plasma cell leukemia' for alignment • **Conditions Not Covered.** • **Removed** 'Repeat administration of ciltacabtagene autoleucel (Carvykti)' and moved to medical necessity criteria to state approve for single dose for alignment
Ophthalmology – Durysta - (IP0216)	Update	Effective 6/1/2024 • **Updated policy title**: from Bimatoprost Ophthalmic Implant • **All covered uses (Ocular Hypertension, Open-Angle Glaucoma):** Added is not receiving re-treatment of eye(s) previously treated with Durysta • **Conditions Not Covered:** Added Concurrent use of Durysta with iDose TR (travoprost intracameral implant)
Ophthalmology – Syfovre - (IP0559)	New	Effective 6/1/2024 • **Geographic Atrophy**. **Updated** the criterion regarding best-corrected visual acuity (BCVA) from "Best corrected visual acuity (BCVA) of 24 letters using Early Treatment Diabetic Retinopathy Study (ETDRS) charts (approximately 20/320 Snellen equivalent), or better vision (for example, 20/70, 20/80, 20/200)", the criterion was revised such that the required BCVA can be the patient has "24 letters or better using Early Treatment Diabetic Retinopathy Study (ETDRS) charts OR 20/320 or better using the Snellen chart".
Ophthalmology – iDose TR – (IP0619)	New	Effective: 6/1/2024 • New coverage policy.
Ozanimod - (IP0214)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements.

Parkinson's Disease – Apomorphine Subcutaneous - (IP0530)	Update	Effective 6/15/2024 **Parkinson's Disease.** • **Added** that the 'Patient has previously tried one other treatment for "off" episodes and meets ONE of the following (i)Patient had significant intolerance, according to the prescriber (ii) Patient had inadequate efficacy, according to the prescriber' and the corresponding note: 'Examples of treatments for "off" episodes include entacapone, rasagiline, pramipexole, ropinirole, tolcapone, cabergoline, selegiline, Ongentys (opicapone capsules), or Xadago (safinamide tablets)' • **Revised** 'Currently receiving levodopa-based treatment' to 'Patient is currently receiving carbidopa/levodopa therapy' • **Added** Individual and Family Plan to follow criteria in policy
Perfluorohexyloctane Ophthalmic Solution - (IP0583)	Update	Effective 6/1/2024 • **Removed** Employer Group Plans preferred product box. • **Remove** the Concomitant use with an ophthalmic cyclosporine product or Xiidra use from the Conditions not covered section. • Policy to apply to IFP only.
Pharmacy Prior Authorization – (1407)	Update	Effective: 6/1/2024 • **Added** product-specific medical necessity exception criteria for: tetracycline, gabapentin, Gralise (brand), Blue Link GTS, Indocin (brand), indomethacin, bromfenac, BromSite (brand), Adthyza, halobetasol, Lexette (brand)
Pulmonary Arterial Hypertension– Adempas – (IP0600)	New	Effective: 6/1/2024 • New coverage policy
Pulmonary Arterial Hypertension – Orenitram – (IP0616)	New	Effective: 6/1/2024 • New coverage policy
Pulmonary Arterial Hypertension – Phosphodiesterase Type 5 Inhibitors – (IP0626)	New	Effective: 6/1/2024 • New coverage policy
Pulmonary Arterial Hypertension – Uptravi – (IP0627)	New	Effective: 6/1/2024 • New coverage policy

Pulmonary Hypertension (PH) Therapy – (6121)	Update	Effective 6/1/2024 • **Removed** Adcirca, Alyq, Revatio, Tadliq, Liqrev and generics and relocated to new stand-alone policy, Pulmonary Arterial Hypertension – Phosphodiesterase Type 5 Inhibitors - IP0626 • **Removed** Adempas and relocated to new stand-alone policy, Pulmonary Arterial Hypertension–Adempas - IP0600 • **Removed** Orenitram and relocated to new stand-alone policy, Pulmonary Arterial Hypertension – Orenitram - IP0616 • **Removed** Uptravi and relocated to new stand-alone policy, Pulmonary Arterial Hypertension - Uptravi - IP0627
Infectious Disease – Pyrimethamine - (IP0348)	Update	Effective 6/15/2024 Updated the title of the policy • **For All Indications:** Added "medication is prescribed in combination with leucovorin" and relocated requirement for step through generic pyrimethamine. • **Cystoisosporiasis (formerly known as isosporiasis) – Secondary Prophylaxis (Chronic Maintenance Treatment):** "Failure, contraindication, or intolerance to ONE of the following: trimethoprim-sulfamethoxazole or systemic ciprofloxacin" was changed to "patient has tried at least one other therapy for this condition" with examples moved to a "Note". • **Cystoisosporiasis (formerly known as isosporiasis) – Treatment:** "Failure, contraindication or intolerance to ONE of the following: trimethoprim-sulfamethoxazole or systemic ciprofloxacin" was changed to "patient has tried at least one other therapy for this condition" with examples moved to a "Note". • **Pneumocystis Pneumonia – Primary Prophylaxis:** "Failure, contraindication or intolerance to ONE of the following: trimethoprim-sulfamethoxazole, systemic dapsone, aerosolized pentamidine (via Respigard II™ nebulizer) or atovaquone" was changed to "patient has tried at least one other therapy for this condition" with examples moved to a "Note". Added a requirement the medication is prescribed in combination with systemic dapsone OR atovaquone. • **Pneumocystis Pneumonia – Secondary Prophylaxis (Chronic Maintenance Therapy)**: "Failure, contraindication or intolerance to ONE of the following: trimethoprim-sulfamethoxazole, systemic dapsone, aerosolized pentamidine (via Respigard II™ nebulizer) or atovaquone" was changed to "patient has tried at least one other therapy for this condition" with examples moved to a "Note". Added a requirement the medication is prescribed in combination with systemic dapsone OR atovaquone.

		• ***Toxoplasma gondii* Encephalitis – Primary Prophylaxis.** "Failure, contraindication or intolerance to ONE of the following: trimethoprim-sulfamethoxazole or atovaquone was changed to "patient has tried at least one other therapy for this condition" with examples moved to a "Note". Added a requirement the medication is prescribed in combination with systemic dapsone OR atovaquone. • ***Toxoplasma gondii* Encephalitis – Secondary Prophylaxis (Chronic Maintenance Therapy).** Added a requirement the medication is prescribed in combination with systemic clindamycin OR atovaquone, if unable to take sulfadiazine.
Quantity Limitations - (1201)	Update	Effective 6/1/2024 • Added QLs, aligned to the other adalimumab products in the policy for adalimumab-aaty, adalimumab-ryvk and Simlandi.
Ravulizumab-cwvz Intravenous - (IP0550)	Update	Effective 6/15/2024 • **Neuromyelitis Optica Spectrum Disorder:** This condition and criteria for approval were added to the policy - including examples of clinical benefit and authorization duration. • **Conditions Not Recommended for Approval:** Enspryng (satralizumab-mwge subcutaneous injection) and Uplizna (inebilizumab-cdon intravenous infusion) were added to the criterion "Concomitant Use with a Rituximab Product, Enspryng (satralizumab-mwge subcutaneous injection), or Soliris (eculizumab intravenous infusion)"; new criterion reads: "Concomitant Use with Another Complement Inhibitor, a Rituximab Product, or a Neonatal Fc Receptor Blocker, Enspryng (satralizumab-mwge subcutaneous injection), or Uplizna (inebilizumab-cdon intravenous infusion)"
Sarilumab - (IP0233)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements.
Secukinumab Intravenous - (IP0594)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements.
Secukinumab Subcutaneous - (IP0223)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements. • **Added** Sotyktu as a preferred product option.
Sofosbuvir/Velpatasvir – (IP0184)	Update	Effective 6/1/2024

		• Removed Life Expectancy Less Than 12 Months Due to Non-Liver Related Comorbidities from Conditions Not Covered
Sofosbuvir/Velpatasvir/Voxilaprevir – (IP0188)	Update	Effective 6/1/2024 • **Conditions Not Recommended for Approval: Life Expectancy Less Than 12 Months Due to Non-Liver Related Comorbidities.** This condition was removed.
Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) – (1803)	Update	Effective 6/1/2024 • Removed Apriso ER 0.375 mg and Pentasa 500 mg.
Tetracycline Antibiotics – (IP0396)	Update	Effective 6/1/2024 • **Added** preferred product requirement criteria for tetracycline 250 and 500 mg tablets
Tildrakizumab – (IP0236)		Effective 6/1/2024 • **Updated** adalimumab preferred product requirements. • **Added** Sotyktu as a preferred product for Plaque Psoriasis for Employer plans
Tocilizumab Subcutaneous - (IP0227)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements.
Tofacitinib - (IP0230)	Update	Effective 6/1/2024 • **Updated** adalimumab preferred product requirements.
Topical Acne – Winlevi – (IP0173)	Update	Effective: 6/1/2024 • For Acne Vulgaris. Criterion that "Documentation of failure, contraindication, or intolerance to at least three other prescription topical therapies" was clarified that these are non-retinoid therapies; the new criterion reads: "Documentation patient has tried at least three other prescription non-retinoid topical therapies".
Topical Rosacea Products - (IP0003)	Update	Effective 6/1/2024 • Removed Soolantra.
Vascultitis – Tavneos – (IP0398)	Update	Effective 6/15/2024 • No clinical content changes
Veregen – (IP0393)	Update	Effective: 6/1/2024

		• **Updated** coverage policy title from Sinecatechins to Veregen.
Antiseizure Medications – Diacomit (IP0409)	Update	Effective 6/15/2024 • No change in coverage
Cinacalcet for Individual and Family Plans – (IP0464)	Update	Effective 6/15/2024 • No change in coverage
Cystic Fibrosis – Bronchitol – (IP0126)	Update	No change in coverage
Hematology – Cablivi – (IP0161)	Update	Effective 6/15/2024 • No change in coverage
Ophthalmology – Verkazia – (IP0439)	Update	• No change in coverage
Zokinvy – (IP0107)	Update	• No change in coverage
Histrelin Acetate – (IP0133)	Retired	Effective: 6/1/2024 • Replaced by CP IP0620 Gonadotropin-Releasing Hormone Agonists – Implants for Non-Oncology Uses
Goserelin Acetate – (IP0353)	Retired	Effective: 6/1/2024 • Replaced by CP IP0620 Gonadotropin-Releasing Hormone Agonists – Implants for Non-Oncology Uses
CareAllies Medical Necessity Guideline	**New, Updated, or Retired?**	**Comments**
		• No updates in June 2024

Precertification Policy*	New, Updated, or Retired?	Comments
		• No updates in June 2024

Reimbursement Policy*	New, Updated, or Retired?	Comments
		• No updates in June 2024
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		• No updates in June 2024
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**
		• No updates in June 2024