Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective June 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
Cardiac Resynchronization Therapy (CRT) - (0174)	Updated	Posted **3/15/2025;** Effective **6/15/2025:** Important **changes** in coverage criteria: • Title changed from "Cardiac Resynchronization Therapy (CRT) and Advanced Cardiac Pacing Technologies" to "Cardiac Resynchronization Therapy (CRT)". • Added criterion to specify the time frame for optimal pharmacologic regimen prior to consideration of CRT, of at least three months. • Revised criteria where applicable from New York Heart Association (NYHA) Class IV to NYHA "ambulatory" Class IV. • Expanded coverage by removing criterion for "no prior implant", where applicable. • Combined criteria for ischemic and nonischemic cardiomyopathy with left ventricular ejection fraction ≤ 35% and sinus rhythm. • Limited coverage by removing selected stand-alone indications (see below). • Added specific coverage criteria for CRT in persistent or permanent atrial fibrillation. • Changed from not covered to covered for conduction system pacing, with criteria.

		• Removed "wireless pacing CRT" from statement, as aligned codes are not managed.
Cervical Plexus Block - (0579)	Updated	**Posting 6/15/2025; Effective 9/15/2025** Changed criteria from not covered or reimbursable to not medically necessary: **Cervical plexus block is considered medically necessary for procedures involving the neck, shoulder and/or clavicle region, including ANY of the following:** • acromioclavicular dislocations • anterior cervical discectomy fusion • carotid endarterectomy • ear surgery • lymph node biopsy, dissection, located in the neck region • open reduction and internal fixation (ORIF) of the clavicle • shoulder surgery (e.g., rotator cuff repair, arthroplasty) • superficial neck surgery (e.g., thyroidectomy, parathyroidectomy) • treatment of clavicle fractures (e.g., open reduction and internal fixation (ORIF) of the clavicle)
Hearing Aids - (0093)	Updated	No changes in coverage criteria • clarification of coverage statement for FDA approved hearing aid device • clarification of coverage statement for bone conduction hearing aid devices for readability • removing statement for personal sound amplification product because there are no CPT or HCPCS codes that represent the device
Injectable Fillers for Head and Neck Conditions - (0511)	Updated	Posted **6/15/2025;** Effective **9/15/2025** Important **changes** in coverage criteria: ▪ Title change from Injectable Fillers to Injectable Fillers for Head and Neck Conditions ▪ Added a benefit coverage statement for injectable fillers ▪ Removed policy statement for laryngeal injection of hyaluronic acid with or without lidocaine (e.g. Restylane) due to CPT code Q4112 no longer being managed ▪ Expanded coverage by adding velopharyngeal insufficiency as a condition with medical necessity criteria ▪ Added a statement to refer to other policies for coverage criteria not specific to injectable fillers for head and neck conditions.
Headache, Occipital, and/or Trigeminal	Updated	Important **changes** in coverage criteria:

Neuralgia Treatment – (0063)		• Removed the policy statement for "nerve root decompression" because the associated CPT codes (63035, 63040, 63043, 63075, 63076, 64722, 64716) are either not managed or are managed via an admin or reimbursement policy. • Removed the policy statement for "occipital nerve neurolysis" because the associated CPT codes (62281, 64633, 64634) are delegated to EviCore.
Home Ventilators – (0546)	Updated	Important **changes** in coverage criteria: • Removed the policy statement for invasive interfaces because the associated CPT code isn't managed with a coverage policy.
Inhaled Nitric Oxide (INO) – (0453)	Updated	Posted **6/15/2025;** Effective **9/15/2025:** Important **changes** in coverage criteria: • Limited coverage of inhaled nitric oxide therapy to until the underlying oxygen desaturation has resolved, up to a maximum of 14 days. • Minor change to separate statement for vasoreactivity testing from therapeutic uses of inhaled nitric oxide.
Laboratory Testing for Transplantation Rejection – (0465)	Update	Posting **6/15/2025** with effective date **9/15/2025** Important **changes** in coverage criteria: • Added Prospera back to the examples of experimental, investigational or unproven donor-derived cell-free DNA testing.
Partial Rhinectomy, Rhinoplasty, Vestibular Stenosis Repair, and Septoplasty (0119)	Update	Posting **6/15/2025**; Effective **9/15/2025** Important **changes** in coverage criteria: • Updated CP Title to align with increased scope of policy: ➢ From: Rhinoplasty, Vestibular Stenosis Repair and Septoplasty ➢ To: Partial Rhinectomy, Rhinoplasty, Vestibular Stenosis Repair, and Septoplasty • Addition of codes on precert to coverage policy with corresponding criteria: ➢ 30150: Rhinectomy, partial (new coverage statement) ➢ 30620: Septal or other intranasal dermatoplasty (does not include obtaining graft) • Removal of unmanaged codes and corresponding statement
Prescription Digital Therapeutics - (0565)	New	Posting **6/15/2025**; Effective **9/15/2025** **Coverage for prescription digital therapy varies across plans. Please refer to the customer's benefit plan document for coverage details.**
Prosthetic Devices – (0536)	Updated	Important **changes** in coverage criteria:

		• Added not covered statement for intent decoding or pattern recognition add-on module for an upper limb myoelectric prosthetic device (HCPCS code L6700)
Rosacea Procedures – (0482)	Updated	Minor **changes** in coverage criteria/policy: • Removed policy statement for surgical treatment of rhinophyma, as aligned codes are not managed.
Seat Lift Mechanisms, Patient Lifts and Standing Devices – (0343)	Updated	Minor **changes** in coverage criteria/policy: • Removed "standard non-powered" from reference to standing devices in the "Replacement & Duplicate Equipment" statement.
Transvaginal Ultrasound, Non-Obstetrical – (0398)	Updated	Important **changes** in coverage criteria: • Removal of non-implemented statement and all contraceptive ICD-10 codes.

Unlisted Procedure Codes - (0583)	New	Posted **6/15/2025;** Effective **9/15/2025**
		
		A service, supply or item represented by an unlisted Current Procedure Terminology (CPT®) or Healthcare Common Procedure Coding System (HCPCS) code is considered medically necessary when not addressed in a separate Coverage Policy and ALL of the following criteria are met:
		• Absence of an available CPT or HCPCS procedure code that accurately describes the service
		• The code is appropriately used to describe ANY of the following:
		  ○ a procedure that is entirely new, unproven, or potentially investigational
		  ○ an established procedure performed by a different method or approach
		  ○ an established procedure using a different device than described by standard available codes
		  ○ procedure is performed at a different anatomical location than described in standard available codes
		• The medical necessity of the service is established by supporting documentation, including a specific written report describing the service, and, when applicable, an invoice for unlisted miscellaneous items or supplies

Oncology Imaging Amendment to Cigna-EviCore General Oncology Imaging Guideline - (DV002)	Retired	• No longer needed. No longer a conflict with EviCore guidelines as of 6.15.25.

Umbilical Cord Blood Banking - (0466)	Retired	• No longer utilized.
ASH Therapy Guidelines	**New, Updated, or Retired?**	**Comments**
Biofeedback – (CPG 294)	Updated	Posted **6/15/2025;** Effective **9/15/2025:** Important **changes** in coverage criteria: • Limited coverage by adding the InTandem device to the existing EIU statement because the corresponding code is managed and the technology meets Cigna's definition of EIU. • Removed the Leva Pelvic Health System from the policy since the associated code isn't managed.
Occupational Therapy – (CPG 155)	Updated	Posted **6/15/2025;** Effective **9/15/2025:** Important **changes** in coverage criteria: • Limited coverage by adding Low Frequency Non-Contact, Non-Thermal Ultrasound (MIST) to the existing EIU statement because the corresponding code is managed and the technology meets Cigna's definition of EIU.
Physical Therapy – (CPG 135)	Updated	Posted **6/15/2025;** Effective **9/15/2025:** Important **changes** in coverage criteria: • Limited coverage by adding Low Frequency Non-Contact, Non-Thermal Ultrasound (MIST) to the existing EIU statement because the corresponding code is managed and the technology meets Cigna's definition of EIU.
Range of Motion Testing – (CPG 146)	Updated	• No change in coverage.
Sensory and Auditory Integration Therapy – (CPG 149)	Updated	• No change in coverage.

EviCore Policies	New, Updated, or Retired?	Comments

Cobranded Cigna-EviCore High-Tech Imaging Guidelines	Update	Posted **5/15/2025;** Effective **6/15/2025**
		
		Important **changes** in coverage criteria:
		• Two guidelines were updated with clinical changes which will expand coverage:
		  ○ Pediatric and Special Populations Oncology Imaging
		  ○ Spine Imaging

Cobranded Cigna-EviCore Radiation Oncology Guidelines	Update	Posted **6/1/2025**; Effective **7/15/2025**
		
		Important **changes** in coverage criteria:
		• One guideline was updated with clinical changes to expand coverage:
		  ○ Pluvicto
		  ▪ Added indication for use in individuals for whom a delay in taxane-based chemotherapy has been deemed appropriate.

Cobranded Cigna-EviCore Sleep Management Guidelines	Update	Posted **3/1/2025**; Effective **6/1/2025** Important **changes** in coverage criteria. • Guidelines were updated with clinical changes that will expand and limit coverage. Posted **6/1/2025**; Effective **9/1/2025** Important **changes** in coverage criteria. • Guidelines were updated with clinical changes that will limit coverage.
Cobranded Cigna-EviCore Vascular Intervention Guidelines	Update	Posted **2/28/2025**; Effective **6/2/2025** Important **changes** in coverage criteria. • Previous guideline separated into two independent guidelines: Peripheral Vascular Intervention and Cerebrovascular Intervention • Guidelines were updated with clinical changes that will expand and limit coverage.

Administrative Policy	New, Updated, or Retired?	Comments
Preventive Care Services - (A004)	Update	Effective **6/15/2025** Minor change: • Removed notation regarding precertification for Osteoporosis screening: CPT Codes 77078 and Lung Cancer screening: 71271
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Adrenal Hyperplasia – Crenessity - (IP0726)	New	Effective **6/1/2025** • New coverage policy.
Allergen Immunotherapy – Grass Pollen Sublingual Products - (IP0515)	Updated	Effective **6/1/2025** Policy title updated to "Allergen Immunotherapy – Grass Pollen Sublingual Products" • Updated the Grastek timing of prescribing requirement. • Updated the diagnostic statement clarifying the diagnosis is grass pollen-induced allergic rhinitis. • Removed the prerequisite steps through an intranasal corticosteroid and an oral of inhaled antihistamine. • Reworded the conditions not covered statement.
Alpha1-Proteinase Inhibitor Products - (IP0387)	Updated	Effective **6/1/2025** • Added Aralast-NP and Zemaira preferred product requirements for both Employer Plans and Individual and Family Plans, effective 7/1/2025.
Amyloidosis – Amvuttra - (IP0478)	Updated	Effective: **6/1/2025**

		• Cardiomyopathy of Wild-Type or Hereditary Transthyretin-Mediated Amyloidosis (ATTR-CM): This condition and criteria for approval were added to the policy.
Cinacalcet for Individual and Family Plans - (IP0464)	Updated	Effective: **6/1/2025** • Preferred Product Table: • Updated from "Trial of cinacalcet tablets (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction [may require prior authorization]" **to** "The patient has tried the bioequivalent generic product cinacalcet tablets , AND cannot take due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the Brand and the bioequivalent generic product which would result, per the prescriber, in a significant allergy or serious adverse reaction [may require prior authorization]."
Drugs Requiring Medical Necessity Review for Employer Plans - (1602)	Updated	Effective: **6/15/2025** • Added preferred product step requirement for the Iluvien • Updated preferred product step requirement for the following products: Cabtreo, nitrofurantoin 50 mg/5 mL oral suspension, Dhivy, Primidone 125 mg tablets (brand), Serevent Diskus, Furoscix, Nevanac, Atropine sulfate 1% ophthalmic solution (preservative free) [brand], clobetasol propionate 0.05% ophthalmic suspension, FML Forte, Maxidex, Pred Mild, Carospir, Pokonza, and meclizine 50 mg tablets
Dronabinol Products - (IP0719)	Updated	Effective: **6/15/2025** • Preferred Product Table. • Syndros: Removed documentation from "Patient cannot swallow or has difficulty swallowing capsules." • Conditions Not Covered. • "Chronic Non-Cancer Pain" was removed from conditions considered not medically necessary.

Enzyme Replacement Therapy – Lamzede - (IP0563)	Updated	Effective: **06/01/2025** • Alpha-mannosidosis. • Updated from "Patient has biallelic pathogenic variants in Mannosidase Alpha Class 2B Member 1 (*MAN2B1)* as confirmed by mutation testing" to "Patient has biallelic pathogenic variants in Mannosidase Alpha Class 2B Member 1 (*MAN2B1)* as confirmed by genetic testing"
Familial Chylomicronemia Syndrome – Tryngolza - (IP0733)	New	Effective **6/15/2025** • New coverage policy.
Filgrastim - (IP0528)	Updated	Effective **6/1/2025** • Nypozi (filgrastim-txid) added to the policy. • Updated criteria for Granix, Neupogen and Releuko.
Diabetes – Glucagon-Like Peptide-1 Agonists for Employer Plans: Standard/ Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (IP0701)	Updated	Effective: **6/1/2025** • Added generic exenatide to the policy to follow Byetta criteria • Preferred Product Table: • Updated Adlyxin alternative from "Bydureon BCise OR Byetta" to "Bydureon BCise OR Byetta OR exenatide subcutaneous injection"
Diabetes – Glucagon-Like Peptide-1 Agonists for Employer Plans for Individual and Family Plans - (IP0702)	Updated	Effective: **6/1/2025** • Added generic exenatide to the policy to follow Byetta criteria
Hepatology – Rezdiffra - (IP0642)	Updated	Effective: **6/15/2025**

		• Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH), with Moderate to Advanced Liver Fibrosis. • Initial Therapy. The criterion that the liver biopsy shows non-alcoholic fatty liver disease activity score of ≥ 4 with a score of > 1 in ALL of the following [documentation required]: Steatosis, ballooning, and lobular inflammation; was modified such that a score of ≥ 1 is required in ALL of the following [documentation required]: Steatosis, ballooning, and lobular inflammation. The timeframe within the criterion for an imaging exam was changed from within the 3 months preceding treatment with Rezdiffra to within the 6 months preceding treatment with Rezdiffra.
Immunologicals – Adbry Prior Authorization Policy – (IP0653)	Updated	Effective **6/1/2025** • Conditions Not Covered Concurrent Use of Adbry with another Monoclonal Antibody Therapy: Added Ebglyss® (lebrikizumab-lbkz subcutaneous injection) and Nemluvio® (nemolizumab-ilto subcutaneous injection) as examples of monoclonal antibody therapies. • Conditions Not Covered Concurrent Use of Adbry with Janus Kinase (JAK) Inhibitors (oral or topical): Added Leqselvi™ (deuruxolitinib tablets) and Rinvoq® LQ (upadacitinib oral solution) as examples of JAK inhibitors.
Immunologicals – Xolair - (IP0487)	Updated	Effective **6/1/2025** • Immunoglobulin (IgE)-Mediated Food Allergy: Criteria were updated to require the patient to have either a positive skin prick test response OR a positive *in vitro* test (i.e., a blood test) for IgE to one or more foods. Previously, criteria required the patient to have both a positive skin prick test response and a positive *in vitro* test (i.e., a blood test) for IgE to one or more foods. • For Concurrent use of Xolair with another Monoclonal Antibody Therapy: Added Ebglyss and Nemluvio as additional examples of monoclonal antibody therapies to not be used concurrently.
Inflammatory Conditions – Adalimumab Products	Updated	Effective **6/1/2025**

Prior Authorization Policy – (IP0652)		• Adalimumab-aaty (unbranded Yuflyma) was added to the policy. The same criteria apply as the other adalimumab subcutaneous products.
Inflammatory Conditions – Arcalyst – (IP0437)	Updated	Effective **6/1/2025** • COVID-19 (Coronavirus Disease 2019): Removed from Conditions Not Covered.
Inflammatory Conditions – Cibinqo Prior Authorization Policy – (IP0677)	Updated	Effective **6/1/2025** • COVID-19 (Coronavirus Disease 2019): Removed from Conditions Not Covered.
Inflammatory Conditions – Entyvio Intravenous Prior Authorization Policy - (IP0674)	Updated	Effective **6/1/2025** • Crohn's Disease: Updated dosing to add option of approval for 300 mg intravenous infusion administered at Week 0 and 2. • Ulcerative Colitis: Updated dosing to add option of approval for 300 mg intravenous infusion administered at Week 0 and 2.
Inflammatory Conditions – Ilaris Prior Authorization Policy – (IP0235)	Updated	Effective **6/1/2025** • COVID-19 (Coronavirus Disease 2019): Removed from Conditions Not Covered.
Inflammatory Conditions – Kevzara Prior Authorization Policy – (IP0679)	Updated	Effective **6/1/2025** • COVID-19 (Coronavirus Disease 2019): Removed from Conditions Not Covered.
Inflammatory Conditions – Kineret Prior Authorization Policy – (IP0661)	Updated	Effective **6/1/2025** • COVID-19 (Coronavirus Disease 2019): Removed from Other Uses with Supportive Evidence.
Inflammatory Conditions – Olumiant	Updated	Effective **6/1/2025**

Prior Authorization Policy – (IP0681)		• COVID-19 (Coronavirus Disease 2019) – Hospitalized Patient. Removed from the policy and updated policy statement to indicate that the acute treatment of COVID-19 in hospitalized patients is not addressed in this policy. Of note, this includes requests for cytokine release syndrome associated with COVID-19. • Conditions Not Covered, Concurrent Use with a Biologic Immunomodulator: Added Ebglyss (lebrikizumab-lbkz subcutaneous injection) and Nemluvio (nemolizumab-ilto subcutaneous injection) as examples of biologic immunomodulators which are not allowed concurrently with Olumiant. • Conditions Not Covered, Treatment of COVID-19 in a Non-Hospitalized Patient: Updated to more generally state COVID-19.
Inflammatory Conditions – Rinvoq/Rinvoq LQ Prior Authorization Policy – (IP0682)	Updated	Effective **6/1/2025** • COVID-19 (Coronavirus Disease 2019): Removed from Conditions Not Covered. • Giant Cell Arteritis: This newly approved indication was added to the policy.
Inflammatory Conditions – Tocilizumab Intravenous Products Prior Authorization Policy – (IP0656)	Updated	Effective **6/1/2025** • COVID-19 (Coronavirus Disease 2019) – Hospitalized Patient: Removed from the policy and updated policy statement to indicate that the acute treatment of COVID-19 in hospitalized patients is not addressed in this policy. • Cytokine Release Syndrome Associated with Chimeric Antigen Receptor (CAR) T-Cell Therapy: Aucatzyl (obecabtagene autoleucel) and Carvykti (ciltacabtagene autoleucel) were added to the Note as examples of CAR T-cell therapy. • Still's Disease, Adult Onset: Added a Note that a previous trial of one biologic (e.g., Ilaris [canakinumab subcutaneous injection], Kineret [anakinra subcutaneous injection]) other than the requested drug also counts towards a trial of one other conventional systemic agent for Still's disease. A biosimilar of the requested biologic does not count. • Conditions Not Covered: Treatment of COVID-19 in a Non-Hospitalized Patient was changed to more generally state COVID-19.
Inflammatory Conditions – Tocilizumab	Update	Effective **6/1/2025** • Conditions Not Covered: Removed COVID-19.

Subcutaneous Products Prior Authorization Policy – (IP0657)		
Inflammatory Conditions – Ustekinumab Subcutaneous Drug Quantity Management Policy – Per Days - (DQM001)	New	Effective **6/1/2025** • New policy.
Inflammatory Conditions – Ustekinumab Subcutaneous Drug Quantity Management Policy – Per Days - (DQM001)	Updated	Effective **6/15/2025** • Ustekinumab 45 mg vials, 45 mg prefilled syringes, and 90 mg prefilled syringes (unbranded Stelara): New quantity limits were added to the policy. The same quantity limits and overrides apply to ustekinumab as have previously applied to the other ustekinumab products. • Imuldosa 45 mg prefilled syirnges and 90 mg prefilled syringes: New quantity limits were added to the policy. The same quantity limits and overrides apply to Imuldosa as have previously applied to the other ustekinumab products. • Ustekinumab-aekn 45 mg prefilled syringes and 90 mg prefilled syringes (unbranded Selarsdi): New quantity limits were added to the policy. The same quantity limits and overrides apply to ustekinumab-aekn as have previously applied to the other ustekinumab products.
Inflammatory Conditions – Xeljanz/Xeljanz XR PA – (IP0692)	Updated	Effective **6/1/2025** • COVID-19 (Coronavirus Disease 2019): Removed from Conditions Not Covered.
Metabolic Disorders – Primary Hyperoxaluria Medications – Rivfloza – (IP0629)	Updated	Effective: **6/1/2025** • Primary Hyperoxaluria Type 1: For Initial Therapy, the option of approval was changed to the patients is ≥ 2 years of age (previously ≥ 9 years of age). The requirement for urinary oxalate excretion ≥ 0.5 mmol/24 hours/1.73 m^2 with the

		absence of secondary sources of oxalate, or urinary oxalate: creatinine ratio above the age-specific upper limit of normal, or plasma oxalate level ≥ 20 µmol/L were changed to apply only to a patient who is ≥ 12 years of age (previously applied to all patients ≥ 9 years of age). For a patient between 2 and < 12 years of age, a requirement was added for urinary oxalate excretion ≥ 0.5 mmol/24 hours/1.73 m^2 with the absence of secondary sources of oxalate (with documentation provided), or patients has a urinary oxalate: creatinine ratio above 2 times the 95th percentile for age. • Added Individual and Family Plan Preferred Product Criteria • Coding Information. • Added: C9399
Muscular Dystrophy – Amondys 45 - (IP0137)	Updated	Effective: **6/1/2025** • Added "Documentation: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, and/or other information." • Duchenne Muscular Dystrophy • Updated criteria from "Documented diagnosis of Duchenne muscular dystrophy is confirmed by a pathogenic or likely pathogenic variant in the DMD gene that is amenable to exon 45 skipping" to "Documentation is provided that the patient has a diagnosis of Duchenne muscular dystrophy which is confirmed by a pathogenic or likely pathogenic variant in the DMD gene that is amenable to exon 45 skipping."
Neurology – Daybue - (IP0578)	Updated	Effective **6/15/2025** • Individual and Family plans added to the policy. • Added a note defining the diagnostic criteria and exclusion criteria for classic/typical Rett syndrome. • Updated the requirement for a patient to be "past the initial period of regression" to "past the initial period of regression and has reached the plateau phase" • Reworded the conditions not covered statement.

Neurology – Gene Therapy – Kebilidi – (IP0725)	New	Effective **2/27/2025** • New coverage policy
Neurology – Gene Therapy – Lenmeldy - (IP0695)	Updated	Effective **6/5/2025** • Metachromatic Leukodystrophy: • Added: "according to the prescribing physician, the patient will have discontinued from anti-retrovirals (prophylactic for human immunodeficiency virus [HIV]) for at least 1 month prior to mobilization". A Note was added that examples of anti-retrovirals include abacavir, emtricitabine, lamivudine, and zidovudine. The qualifier "Prior to collection of cells for manufacturing" as well as the word "cellular" was removed from the requirement regarding screening for certain viruses and the word "Patient" was added. The criterion now reads: "Patient screening is negative for ALL of the following...." Regarding dosing, the phrase "of body weight" was added after the cited dosing which is in units of cells/kg. The phase "the past" was added before the criterion regarding body weight which now states that "Current patient body weight has been obtained within the past 30 days".
Oncology – Everolimus Products - (IP0408)	Updated	Effective: **6/15/2025** • Updated title from "Everolimus Products for Non-Oncology Uses" to "Oncology – Everolimus Products" • Added Torpenz™ (everolimus tablets – Upsher-Smith) • FDA-Approved Indications. • Added the following: Breast Cancer, Neuroendocrine Tumors of the Pancreas, Gastrointestinal Tract, Lung, and Thymus (Carcinoid Tumors), Renal Cell Carcinoma, Tuberous Sclerosis Complex-Associated Subependymal Giant Cell Astrocytoma (SEGA). • Other Uses with Supportive Evidence. • Added the following: Endometrial Carcinoma, Gastrointestinal Stromal Tumors, Histiocytic Neoplasm, Classic Hodgkin Lymphoma, Meningioma, Soft Tissue Sarcoma, Thymomas and Thymic Carcinomas, Thyroid Carcinoma, Differentiated, Uterine Sarcoma, Waldenström Macroglobulinemia/Lymphoplasmacytic Lymphoma.

Oncology (Injectable CAR-T) – Abecma - (IP0168)	Updated	Effective: **6/1/2025** **Multiple Myeloma:** Added patient has received at least three prior lines of therapy as a new option for approval. **Updated HCPCS/CPT Coding** **Added** code deleted note to CPT Codes: 0537T, 0538T, 0539T, 0540T (Codes deleted 12/31/2024) **Added** CPT Codes: 38225, 38226, 38227, 38228 **Updated** the description for HCPCS Q2055 to match the 2024 revision.
Oncology (Injectable CAR-T) – Carvykti - (IP0414)	Updated	Effective: **6/1/2025** • Multiple Myeloma: Removed patient has received four or more lines of systemic therapy, including one from each of the following as an option for approval. Added patient has received at least three prior lines of therapy as an option for approval. • Updated CPT/HCPCS Coding • Added code deleted note to CPT Codes: 0537T, 0538T, 0539T, 0540T (Codes deleted 12/31/2024) • Added CPT Codes: 38225, 38226, 38227, 38228
Oncology (Injectable CAR-T) – Kymriah - (IP0197)	Updated	Effective: **06/01/2025** • B-Cell Lymphoma: Follicular lymphoma moved to an option for approval if the medication is used for relapsed or refractory disease after two or more lines of systemic therapy. Added Note with examples of systemic therapy. Large B-cell lymphoma, diffuse large B-cell lymphoma, diffuse large B-cell lymphoma arising from indolent lymphoma, high-grade B-cell lymphoma, human immunodeficiency virus (HIV)-related B-cell lymphoma, human herpes virus 8-positive diffuse large B-cell lymphoma, primary effusion lymphoma, post-transplant lymphoproliferative disease, B-cell type moved to new options for approval; if medication is used for disease that is relapsed or refractory after two or more lines of systemic therapy, or disease relapse > 12 months after first-line therapy and partial response to second-line therapy were added as options of approval. Added Notes with examples of systemic therapy. Added HIV-related plasmablastic lymphoma as a new option for approval. • Updated CPT Coding: • Removed CPT Codes: 0537T, 0538T, 0539T, 0540T (Codes deleted 12/31/2024)

		• Added CPT Codes: 38225, 38226, 38227, 38228 (Codes effective 1/1/2025)
Oncology (Injectable – CAR-T) – Yescarta - (IP0198)	Updated	Effective: **06/01/2025** • B-Cell Lymphoma. • Follicular was changed to indolent in the option for approval "diffuse large B-cell lymphoma arising from indolent lymphoma." Removed diffuse large B-cell lymphoma arising from nodal marginal zone lymphoma. Removed "in a patient with intent to proceed to transplantation who has" from option for approval "disease relapse > 12 months after first-line therapy and partial response to second-line therapy." Added notes with examples for systemic therapy and first line therapy. • Removed documentation from diagnosis criteria • Added HIV-related plasmablastic lymphoma as a new option for approval. • Updated CPT Coding: • Removed CPT Codes: 0537T, 0538T, 0539T, 0540T (Codes deleted 12/31/2024) • Added CPT Codes: 38225, 38226, 38227, 38228 (Codes effective 1/1/2025)
Oncology Medications - (CP1403)	Updated	Effective: **6/15/2025** Afinitor. • Removed Afinitor criteria Bosulif. Employer Plans • Updated from "For Chronic Myeloid Leukemia (CML), Philadelphia Chromosome Positive, documentation of ONE the following:Trial of, contraindication, or significant intolerance to ONE of the following: Generic dasatinib, Generic imatinib, Scemblix [may require prior authorization], Tasigna [may require prior authorization] Note: Prior use of Gleevec (imatinib), Phyrago (dasatinib), or Sprycel (dasatinib) counts" to "For Chronic Myeloid Leukemia (CML), Philadelphia Chromosome Positive, ONE the following: Trial of, contraindication, or significant intolerance to ONE of the following: dasatinib, imatinib, Danziten [may require prior authorization], Imkeldi [may require prior authorization], Scemblix [may require prior authorization], Tasigna [may require prior authorization]Note: Prior use of brand Gleevec, Phyrago, or Sprycel counts."

		• Added "Patient has a history of a serious, chronic lung disease or has had or is at risk of pleural effusion; Note: Examples of lung disease are pulmonary arterial hypertension and interstitial pneumonitis." • Added Danziten, Imkeldi to "Patient has a resistant mutation" criteria Bosulif Individual and Family Plans • Updated from "For Chronic Myeloid Leukemia (CML), Philadelphia Chromosome Positive, documentation of ONE the following: Trial of, contraindication, or significant intolerance to ONE of the following: generic imatinib [may require prior authorization], generic dasatinib or Sprycel [may require prior authorization] Note: Prior use of Gleevec (imatinib), Imkeldi, or Phyrago (dasatinib) counts" **to** "For Chronic Myeloid Leukemia (CML), Philadelphia Chromosome Positive, ONE the following: Trial of, contraindication, or significant intolerance to ONE of the following: imatinib [may require prior authorization], dasatinib or Sprycel [may require prior authorization] Note: Prior use of brand Gleevec, Imkeldi, or Phyrago also counts" Danziten. • Added Danziten criteria. Hercessi. • Added Hercessi criteria Iclusig. Employer Plans • Updated from "For Chronic Myeloid Leukemia (CML), Philadelphia Chromosome Positive, documentation of ONE of the following:Trial of, contraindication, significant intolerance to TWO of the following: ○ Generic Dasatinib, generic imatinib, Scemblix [may require prior authorization], Tasigna [may require prior authorization] Note: Prior use of Gleevec (imatinib), Phyrago (dasatinib), or Sprycel (dasatinib) counts." To " ○ For Chronic Myeloid Leukemia (CML), Philadelphia Chromosome Positive, ONE of the following:Trial of, contraindication, significant intolerance to TWO of the following: dasatinib, imatinib, Danziten [may require prior authorization],

		Imkeldi [may require prior authorization], Scemblix [may require prior authorization], Tasigna [may require prior authorization] Note: Prior use of brand Gleevec, Phyrago, or Sprycel also counts." • Added Danziten to tyrosine kinase inhibitor examples • Added Danziten, Imkeldi to "Patient has a resistant mutation" criteria • Updated from "For Acute Lymphoblastic Leukemia (ALL), Philadelphia Chromosome-Positive, documentation of ONE of the following: Trial of, contraindication, significant intolerance to ONE of the following: generic dasatinib, generic imatinib Note: Prior use of Gleevec (Imatiib), Phyrago (dasatinib), or Sprycel (dasatinib) counts." To "Trial of, contraindication, **si**gnificant intolerance to ONE of the following: dasatinib, imatinib Note: Prior use of Gleevec , Imkeldi, Phyrago, or Sprycel also counts." • Removed examples of dasatinib products • Added "Patient is currently receiving therapy with Iclusig Iclusig Individual and Family Plans. • Updated form "For Chronic Myeloid Leukemia (CML), Philadelphia Chromosome Positive, documentation of ONE of the following: • Patient meets BOTH of the following: Patient meets ONE of the following:Trial of, contraindication, significant intolerance to generic imatinib [may require prior authorization] Note: Prior use of Gleevec (Imatinib) also counts." To "For Chronic Myeloid Leukemia (CML), Philadelphia Chromosome Positive, ONE of the following: • Patient meets BOTH of the following:Patient meets ONE of the following: • Trial of, contraindication, significant intolerance to imatinib [may require prior authorization] Note: Prior use of brand Gleevec or Imkeldi also counts. • Added Danziten to examples of tyrosine kinase inhibitors • Removed "Patient is at risk of bleeding" with note • Updated from "For Acute Lymphoblastic Leukemia (ALL), Philadelphia Chromosome-Positive, documentation of ONE of the following: According to the prescriber, patient has had a trial of, contraindication, significant intolerance to ONE of the following: generic imatinib [may require prior authorization], generic dasatinib or Sprycel [may require prior authorization] Note: Prior use of Gleevec (imatinib), or Phyrago (dasatiib) counts." **To** "For Acute Lymphoblastic Leukemia (ALL), Philadelphia Chromosome-Positive, ONE of the following: According to the prescriber, patient has

		had a trial of, contraindication, significant intolerance to ONE of the following: imatinib [may require prior authorization], dasatinib or Sprycel [may require prior authorization] Note: Prior use of Gleevec, Imkeldo, or Phyrago also counts." Imkeldi. • Added Imkeldi criteria Scemblix. Individual and Family Plan. • Updated from "For Chronic Myeloid Leukemia (CML), Philadelphia Chromosome Positive, documentation of ONE of the following: Patient meets BOTH of the following: Patient meets ONE of the following:Trial of, contraindication, significant intolerance to generic imatinib Note: Prior use of Gleevec (imatinib) counts." To "For Chronic Myeloid Leukemia (CML), Philadelphia Chromosome Positive, ONE of the following: Patient meets BOTH of the following:Patient meets ONE of the following: Trial of, contraindication, significant intolerance to imatinib Note: Prior use of brand Gleevec and Imkeldi also counts." • Added Danziten to tyrosine kinase examples Tasigna Employer Group Plans • Updated from "For Chronic Myeloid Leukemia (CML), Philadelphia Chromosome Positive, documentation of ONE of the following:Trial of, contraindication, significant intolerance to ONE of the following: generic dasatinib, generic imatinib Note: Prior use of Gleevec (imatinib), Phyrago (dasatinib), or Sprycel (dasatinib) counts." To "For Chronic Myeloid Leukemia (CML), Philadelphia Chromosome Positive, ONE of the following: Trial of, contraindication, significant intolerance to ONE of the following: dasatinib, imatinib Note: Prior use of brand Gleevec, Phyrago, or Sprycel also counts." Tasigna Individual and Family Plans • Updated from "For Chronic Myeloid Leukemia (CML), Philadelphia Chromosome Positive, documentation of ONE of the following:

		• Trial of, contraindication, significant intolerance to ONE of the following: generic imatinib [may require prior authorization], generic dasatinib or Sprycel [may require prior authorization] Note: Prior use of Gleevec (imatinib), or Phyrago (dasatinib) counts." To "For Chronic Myeloid Leukemia (CML), Philadelphia Chromosome Positive, ONE of the following: Trial of, contraindication, significant intolerance to ONE of the following: imatinib [may require prior authorization], dasatinib or Sprycel [may require prior authorization] Note: Prior use of brand Gleevec, Imkeldi or Phyrago counts." Ziihera. • Added Ziihera criteria
Ophthalmology - Vascular Endothelial Growth Factor Inhibitors – Susvimo - (IP0349)	Updated	Effective: **6/15/2025** • Diabetic Macular Edema: This condition was added to the Conditions Not Recommended for Approval section.
Opioid Therapy for Individual and Family Plans - (IP0562)	Updated	Effective: **06/01/2025** • Appendix 2 • Removed Kadian from the appendix.
Parkinson's Disease – Apomorphine Subcutaneous - (IP0530)	Updated	**Effective: 6/15/2025** • Parkinson's Disease: Examples of evidence of "off" episodes were moved to a Note.
Parkinson's Disease – Carbidopa - (IP0523)	Updated	Effective: **06/01/2025** • Preferred Product Table – Employer Plans and Individual and Family Plans: • Updated from "Trial of carbidopa tablet (the bioequivalent generic product) AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction" to "The patient has tried the bioequivalent generic product carbidopa tablet, AND cannot take due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives]

		between the Brand and the bioequivalent generic product which would result, per the prescriber, in a significant allergy or serious adverse reaction."
Parkinson's Disease – Duopa - (IP0303)	Updated	Effective: **6/15/2025** • Parkinson's Disease: Examples of evidence of "off" episodes were moved to a Note.
Parkinson's Disease – Inbrija - (IP0522)	Updated	Effective: **6/15/2025** • Parkinson's Disease: Examples of evidence of "off" episodes were moved to a Note. • Preferencing Table. • Removed the preferencing table.
Parkinson's Disease – Nourianz - (IP0524)	Updated	Effective: **6/15/2025** • Parkinson's Disease: Examples of evidence of "off" episodes were moved to a Note. • Preferencing Table. • Updated from "Currently receiving Nourianz" to "Patients already started on Nourianz" • Updated from "Failure, contraindication, or intolerance" to "Tried" • Updated from "Kynmobi" to "apomorphine"
Parkinson's Disease – Nuplazid - (IP0145)	Updated	Effective **6/15/2025** • No criteria changes.
Parkinson's Disease – Ongentys - (IP0532)	Updated	Effective **6/15/2025** • No criteria changes.
Parkinson's Disease – Zelapar - (IP0525)	Updated	Effective **6/15/2025** • Updated title from "Selegiline" to "Parkinson's Disease – Zelapar" • Parkinson's Disease: Examples of evidence of "off" episodes were moved to a Note. • Updated from "Experiencing "off" episodes" to "Patient is experiencing "off" episodes" • Updated from "Currently receiving levodopa-based treatment" to "Patient is currently receiving carbidopa/levodopa therapy"

		• Updated from "Documentation of ONE of the following: i. Documentation of failure, contraindication, or intolerance, to ONE of the following: rasagiline tablets or selegiline tablets; ii. Inability to swallow tablets" to "Patient has tried one of oral selegiline tablets, selegiline capsules, or rasagiline tablets and meets ONE of the following (i or ii): i.Patient had significant intolerance, according to the prescriber; OR ii Patient has difficulty swallowing tablets or capsules"
Pharmacy & Medical Prior Authorization - (1407)	Updated	Effective: **6/1/2025** • Updated Individual and Family Plan product-specific • medical necessity criteria: Myrbetriq, Gemtesa • Removed Individual and Family Plan product-specific • medical necessity criteria: mirabegron, Posfrea, Focinvez
Qlosi - (IP0738)	New	Effective **6/1/2025** New policy.
Quantity Limitations - (1201)	Updated	Effective **6/1/2025** • Stelara removed from the policy. • Stelara moved to DQM001.
Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors and SGLT-2 / Metformin Combinations - (IP0592)	Updated	Effective: **6/15/2025** Invokana. Employer Plans. • Removed "Diabetic kidney disease AND documented contraindication or intolerance to Farxiga"
Unassigned Drug Code Outpatient Medical Precertification - (1701)	Updated	Effective: **6/1/2025** Policy Title. Error • Added "outpatient" and removed "biologic" to state "Unassigned Drug Code Outpatient Medical Precertification" Non-specified Product. • Added J3590

		• Added "and the dosage, frequency, site of administration, and duration of therapy is not contraindicated or otherwise not recommended in the Label" to "Use is approved and listed in the FDA product information (Label)..." • Added "Clinical Pharmacology, MicroMedex, Wolters Kluwer Facts and Comparisons)" as compendia examples and removed "American Hospital Formulary Service-Drug Information [AHFS-DI]" as a compendia example Defitelio, Dsuvia, Macrilen. • Removed as drugs are primarily for inpatient use. DefenCath. • Removed DefenCath as product received unique Healthcare Common Procedure Coding System (HCPCS) code. Isuprel, Ketalar. • Updated to address outpatient use only. Regiocit. • Removed as Emergency Use Authorization was revoked on 1/16/2025.
Vesicular Monoamine Transporter Type 2 Inhibitors – Austedo - (IP0079)	Updated	Effective:**6/15/2025** • The Conditions Not Covered statement was reworded.
Vesicular Monoamine Transporter Type 2 Inhibitors – Ingrezza Products - (IP0080)	Updated	Effective:**6/15/2025** • The Conditions Not Covered statement was reworded.
Vesicular Monoamine Transporter Type 2 Inhibitors –	Updated	Effective:**6/15/2025** • The Conditions Not Covered statement was reworded.

Tetrabenazine - (IP0208)		
Amantadine Extended-Release – (IP0403)	Updated	Effective: **6/15/2025** • No change in coverage.
Antibiotics (Inhaled) – Cayston - (IP0485)	Updated	Effective: **6/15/2025** • No change in coverage.
Antibiotics (Inhaled) – TOBI Podhaler - (IP0499)	Updated	Effective: **6/15/2025** • No change in coverage.
Antibiotics (Inhaled) – Tobramycin Inhalation Solution – (IP0094)	Updated	Effective: **6/15/2025** • No change in coverage.
Antifungals – Voriconazole (Oral) - (IP0306)	Updated	Effective: **6/1/2025** • No change in coverage.
Bone Modifiers – Xgeva - (IP0332)	Updated	Effective: **6/15/2025** • No change in coverage
COVID-19 Drug and Biologic Therapeutics - (2016)	Updated	Effective **6/1/2025** • No change in coverage. • Coding Information: Updated the description for HCPCS M0248 to include the note "effective until 6/30/2025"
Gastroenterology – Eohilia– (IP0630)	Updated	Effective: **6/1/2025**

		• No change in coverage
Gaucher Disease – Enzyme Replacement Therapy – Cerezyme - (IP0162)	Updated	Effective: **6/15/2025** • No change in coverage
Gaucher Disease – Enzyme Replacement Therapy – Elelyso - (IP0163)	Updated	Effective: **6/15/2025** • No change in coverage
Gaucher Disease – Enzyme Replacement Therapy – Vpriv - (IP0164)	Updated	Effective: 6**/15/2025** • No change in coverage
Human Immunodeficiency Virus – Trogarzo (IP0171)	Updated	Effective: **6/1/2025** • No change in coverage
Hypoparathyroidism – Natpara - (IP0177)	Updated	Effective: **6/15/2025** • No change in coverage
Immune Disorder - Joenja – (IP0568)	Updated	Effective: **6/1/2025** • No change in coverage
Infectious Disease – Impavido - (IP0210)	Updated	Effective **6/15/2025** • No change in coverage

Lupus – Benlysta Intravenous - (IP0429)	Updated	Effective: **6/15/2025** • No change in coverage
Lupus – Benlysta Subcutaneous - (IP0430)	Updated	Effective: **6/15/2025** • No change in coverage
Lupus – Lupkynis - (IP0122)	Updated	Effective: **6/15/2025** • No change in coverage
Lupus – Saphnelo - (IP0280)	Updated	Effective: **6/15/2025** • No change in coverage
Metabolic Disorders – Cysteamine Ophthalmic Solution - (IP0082)	Updated	Effective: **6/15/2025** • No change in coverage
Metabolic Disorders – Phenylbutyrate Products - (IP0169)	Updated	Effective: **6/15/2025** • No change in coverage
Oncology (Injectable) – Cosela - (IP0150)	Updated	Effective **6/15/2025** • No change in coverage
Ophthalmology – Izervay – (IP0581)	Updated	Effective: **6/1/2025** • No change in coverage

Ophthalmology – Syfovre – (IP0559)	Updated	Effective: **6/1/2025** • No change in coverage
Pompe Disease – Enzyme Stabilization Therapy – Opfolda - (IP0598)	Updated	Effective **6/15/2025** • No change in coverage
CareAllies Medical Necessity Guideline	**New, Updated, or Retired?**	**Comments**
		• All above updates apply
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
Precertification Policies	Updated	Updated prior authorization requirements are available on our website, CignaforHCP.Cigna.com. • For June 27, 2025, Cigna removed 1 CPT and 1 HCPCS code from prior authorization.
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
Evaluation and Management Services - (R30)	Updated	
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**

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