Coverage Policy - Monthly Policy Updates

Effective March 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 Omnibus Codes – (0574)	Updated	Important changes in coverage criteria: • Added a new policy statement / topic for 'left atrial pressure sensor' (new CPT code 0933T) • Removed codes that are not/will not be implemented; added codes that are/will be implemented.
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.
Gender Dysphoria Treatment - (0266)	Updated	Effective 1/31/2025: Minor change: • Added note that Oregon fully insured plans are not subject to utilization management for gender dysphoria treatment, effective 1/31/2025.
Hyperhidrosis: Surgical Treatments – (0037)	Updated	Minor changes in coverage criteria/policy: • Title change: ~~Surgical Treatment for~~ Hyperhidrosis: Surgical Treatments • No changes in coverage. • Removed criteria and code for sympathectomy for plantar hyperhidrosis because 64818 (Sympathectomy, lumbar) is not implemented. • Administrative correction of other policy wording to align with implementation.

Prosthetic Devices - (0536)	Updated	Minor changes in coverage criteria/policy:
		• Clarified that iris prostheses are considered experimental, investigational or unproven for any indication, including but not limited to the treatment of full or partial aniridia.
		• Revised mechanical lower limb section to remove reference to "base device" criteria.
		• Removed statements aligned with non-implemented codes, including those related to the following:
		  ○ consumable supplies
		  ○ upper limb sensor and myoelectric controlled prosthetic device with simultaneous multiple degrees of freedom
		  ○ upper limb prosthetic device using electromyography-based brain computer interface
		  ○ several lower limb additions/components
		  ○ osseointegrated/osseoanchored lower limb prosthetic device
		  ○ repair or replacement of a prosthetic device

Scar Revision - (0328)	Updated	Minor changes in coverage criteria/policy:
		• Updates made in order to align with the EviCore Radiation Oncology Clinical Guidelines; the EviCore guideline manages radiation treatment for keloid scars.
		• Cigna CP updates:
		  ○ Removal of the word "radiation" from list of treatment modalities
		  ○ Addition of a statement directing readers to the EviCore guideline with hyperlink

Total Ankle Arthroplasty/ Replacement - (0285)	Updated	Important changes in coverage criteria: • Expanded coverage by removing criterion requiring the presence of one of the following: arthritis in adjacent joints; severe arthritis of the contralateral ankle; or previous arthrodesis of the contralateral ankle. • Moved criteria for skeletal maturity and arthritis from the header statement to individual bullets.

		• Changed the last criterion header from "absence of ALL of the following" to "individual has NONE of the following contraindications to total ankle arthroplasty".
Transcranial Magnetic Stimulation – (EN0383)	Updated	Important changes in coverage criteria: • Expanded coverage for transcranial magnetic stimulation (TMS) for adolescents (age ≥15 years) for major depressive disorder. • Expanded coverage by removing the bullet in the Repeat TMS sections for both major depressive disorder and obsessive-compulsive disorder stating that all of the above criteria for initial TMS we met prior to the initial course.
Vitamin D Testing – (0526)	Updated	Minor changes in coverage criteria/policy: • Expanded list of diagnoses that the frequency edit does not apply to, to include hypoparathyroidism.
Atrial Fibrillation: Nonpharmacological Treatments – (0469)	Updated	• No change in coverage.
Diagnostic Nasal/Sinus Endoscopy, Functional Endoscopic Sinus Surgery (FESS) and Turbinectomy - (0554)	Updated	• No change in coverage.
Nutritional Support – (0136)	Updated	• No change in coverage.
Panniculectomy and Abdominoplasty - (0027)	Updated	• No change in coverage.
Site of Care: High-tech Radiology – (0550)	Updated	• No change in coverage.

Tympanostomy with iontophoresis local anesthesia – (0570)	Retired	• Only code in policy, CPT 0583T, is not implemented
ASH Guidelines	**New, Updated, or Retired?**	Comments
Low-Level Laser and High-Power Laser Therapy – (CPG030)	Updated	• No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	Comments
Cobranded Cigna-EviCore High-Tech Imaging Guidelines	Updated	Posted 12/1/2024; Effective 3/1/2025: Important changes in coverage criteria. Two guidelines were updated with clinical changes which both expand and limit coverage: • Cardiac Imaging • Peripheral Vascular Disease Imaging Two guidelines were updated with no change in coverage: • Pediatric Cardiac Imaging • Pediatric Peripheral Vascular Disease Imaging Posted and effective 2/28/2025: Minor revision, no change to coverage.

		• Chest Imaging ○ Removed section for Subclavian Steal Syndrome (CH-27.1), as this coverage criteria has been moved to the Peripheral Vascular Disease (PVD) Imaging Guidelines, section PVD-4.1 Upper Extremity PVD – Imaging.
Cobranded Cigna-EviCore Pacemaker Guidelines	Updated	Posted 1/1/2025; Effective 3/1/2025 • No change in coverage.
Cobranded Cigna-EviCore Sleep Management Guidelines	Updated	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.

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

Administrative Policy	**New, Updated,**	**Comments**

	or Retired?	
		• No updates for March 2025
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Amyloidosis – Amvuttra - (IP0478)	Updated	**Effe**ctive: 3/1/2025 Added "Documentation: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, genetic test results, claims records, and/or other information." Polyneuropathy of Hereditary Transthyretin–Mediated Amyloidosis (hATTR) Updated criteria from "Patient has a transthyretin pathogenic variant as confirmed by genetic testing" to "Documentation provided that the patient has a transthyretin pathogenic variant as confirmed by genetic testing." Updated criteria from "Patient has symptomatic polyneuropathy" to "Documentation provided that the patient has symptomatic polyneuropathy." Conditions Not Covered Concurrent use with other medications indicated for the treatment of polyneuropathy of hereditary transthyretin-mediated amyloidosis or transthyretin-mediated amyloidosis-cardiomyopathy (e.g., Attruby (acoramidis tablets), Onpattro (patisiran intravenous infusion), Tegsedi (inotersen subcutaneous injection), Wainua (eplontersen subcutaneous injection), or a tafamidis product) was changed to as listed (previously, concomitant use with Onpattro [patisiran intravenous injection], Tegsedi [inotersen subcutaneous injection], Wainua [eplontersen subcutaneous injection, or a Tafamidis product was listed.)

Amyloidosis – Onpattro - (IP0418)	Updated	Effective: 3/1/2025 Added "Documentation: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, genetic test results, claims records, and/or other information. " Polyneuropathy of Hereditary Transthyretin–Mediated Amyloidosis (hATTR) Updated criteria from "Patient has a transthyretin pathogenic variant as confirmed by genetic testing" to "Documentation provided that the patient has a transthyretin pathogenic variant as confirmed by genetic testing." Updated criteria from "Patient has symptomatic polyneuropathy" to "Documentation provided that the patient has symptomatic polyneuropathy." Conditions Not Covered Concurrent use with other medications indicated for the treatment of polyneuropathy of hereditary transthyretin-mediated amyloidosis or transthyretin-mediated amyloidosis-cardiomyopathy (e.g., Amvuttra (vutrisiran subcutaneous injection), Attruby (acoramidis tablets), Tegsedi (inotersen subcutaneous injection), Wainua (eplontersen subcutaneous injection), or a Tafamidis Product.) was changed to as listed (previously, concomitant use with Amvuttra [vutrisiran subcutaneous injection], Tegsedi [inotersen subcutaneous injection], Wainua [eplontersen subcutaneous injection], or a Tafamidis product was listed.)
Amyloidosis - Tafamidis Products - (IP0149)	Updated	Effective: 3/1/2025 Added "Documentation: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, genetic test results, claims records, and/or other information." Cardiomyopathy of Wild-Type or Hereditary Transthyretin Amyloidosis. The criterion Amyloid deposits are identified on cardiac biopsy was changed to A tissue biopsy with confirmatory TTR amyloid typing by mass spectrometry, immunoelectron microscopy or immunohistochemistry.

		For diagnosis confirmed by genetic testing, rephrased the term "mutation" to "pathogenic variant." Conditions Not Covered Concurrent use with other medications indicated for polyneuropathy of hereditary transthyretin-mediated amyloidosis or transthyretin-mediated amyloidosis-cardiomyopathy (e.g., Amvuttra (vutrisiran subcutaneous injection), Attruby (acoramidis tablets), Onpattro (patisiran lipid complex intravenous infusion), Tegsedi (inotersen subcutaneous injection), or Wainua [eplontersen subcutaneous injection]) was changed to as listed (previously Concomitant Use With Amvuttra (vutrisiran subcutaneous injection), Onpattro (patisiran lipid complex intravenous infusion), Tegsedi (inotersen subcutaneous injection), or Wainua [eplontersen subcutaneous injection]).
Amyloidosis – Tegsedi - (IP0417)	Updated	Effective: 3/1/2025 Added "Documentation: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, genetic test results, claims records, and/or other information." Polyneuropathy of Hereditary Transthyretin–Mediated Amyloidosis (hATTR) Updated criteria from "Patient has a transthyretin pathogenic variant as confirmed by genetic testing" to "Documentation provided that the patient has a transthyretin pathogenic variant as confirmed by genetic testing." Updated criteria from "Patient has symptomatic polyneuropathy" to "Documentation provided that the patient has symptomatic polyneuropathy." Conditions Not Covered Concurrent use with other medications indicated for the treatment of polyneuropathy of hereditary transthyretin-mediated amyloidosis or transthyretin-mediated amyloidosis-cardiomyopathy (e.g., Amvuttra (vutrisiran subcutaneous injection), Attruby (acoramidis tablets), Onpattro (patisiran lipid complex intravenous infustion), Wainua (eplontersen subcutaneous injection), or a Tafamidis Product.) was changed to as listed (previously, concomitant use with Amvuttra [vutrisiran subcutaneous injection], Onpattro [patisiran lipid complex

		intravenous infusion], Wainua [eplontersen subcutaneous injection], or a Tafamidis product was listed).
Amyloidosis – Wainua - (IP0628)	Updated	Effective: 3/1/2025 Added "Documentation: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, genetic test results, claims records, and/or other information." Polyneuropathy of Hereditary Transthyretin–Mediated Amyloidosis (hATTR) Updated criteria from "Patient has a transthyretin pathogenic variant as confirmed by genetic testing" to "Documentation provided that the patient has a transthyretin pathogenic variant as confirmed by genetic testing." Updated criteria from "Patient has symptomatic polyneuropathy" to "Documentation provided that the patient has symptomatic polyneuropathy." Conditions Not Covered Concurrent use with other medications indicated for the treatment of polyneuropathy of hereditary transthyretin-mediated amyloidosis or transthyretin-mediated amyloidosis-cardiomyopathy (e.g., Amvuttra (vutrisiran subcutaneous injection), Attruby (acoramidis tablets), Onpattro (patisiran intravenous infusion), Tegsedi (inotersen subcutaneous injection), or a Tafamidis Product) was changed to as listed (previously Concomitant Use With Amvuttra (vutrisiran subcutaneous injection), Onpattro (patisiran intravenous infusion), Tegsedi (inotersen subcutaneous injection), or a Tafamidis Product). Updated HCPCS Coding: Added C9399
Anticoagulants – Dabigatran - (IP0033)	Update	Effective 3/1/2025 Removed prior authorization requirements for generic dabigatran capsules on all Employer plans and Individual and Family plans.

Contraceptives - (IP0036)	Updated	Effective 3/15/2025 Preferred Product Table: Added preferred product requirement criteria for Femlyv for Employer plans and Individual and Family plans.
Drugs Requiring Medical Necessity Review for Employer Plans - (1602)	Updated	Effective: 3/15/2025 Added preferred product step requirement for Cobenfy Updated preferred product step requirement for Gemtesa
Hepatology – Rezdiffra - (IP0642)	Updated	Effective: 3/15/2025 For Metabolic-Dysfunction Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH), with Moderate to Advanced Liver Fibrosis, for Initial Therapy, the timeframe requirement for a patient with a liver biopsy was changed to be within the 3 years preceding treatment with Rezdiffra, previously within the past 6 months preceding treatment with Rezdiffra. For a Patient Currently Receiving Rezdiffra, the criteria that the patient has completed ≥ 1 year and < 2 years of therapy with Rezdiffra and has derived benefit from treatment with Rezdiffra as demonstrated by one of the following, according to the prescriber: 1) MASH/NASH resolution AND no worsening of fibrosis; OR No worsening of MASH/NASH AND improvement in fibrosis by ≥ 1 stage, was removed. A patient who has completed ≥ 1 year of therapy with Rezdiffra is now reviewed under the same criterion that was previously applied for a patient who has completed ≥ 2 years of therapy. As revised, a patient who has completed ≥ 1 year of therapy with Rezdiffra AND according to the prescriber has not had worsening of fibrosis or MASH/NASH may be approved if other criteria are met.
Hyperhidrosis – Qbrexza - (IP0074)	Updated	Effective 3/1/2025 Updated the formularies addressed in the Employer Plans preferred product requirement table.
Inflammatory Conditions –	Updated	Effective: 3/15/2025

Adalimumab Products Preferred Specialty Management Policy: Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists - (PSM013)		Velsipity: This drug was added as a Preferred Non-Adalimumab Product for Ulcerative Colitis.
Inflammatory Conditions – Adalimumab Products Preferred Specialty Management Policy for Legacy Drug List Plans - (PSM003)	Updated	Effective: 3/15/2025 Velsipity: This drug was added as a Preferred Non-Adalimumab Product for Ulcerative Colitis.
Inflammatory Conditions – Omvoh Intravenous Prior Authorization Policy - (IP0662)	Updated	Effective 3/15/2025 Crohn's disease: This newly approved condition was added to the policy.
Inflammatory Conditions – Omvoh Subcutaneous Prior Authorization Policy - (IP0663)	Updated	Effective 3/15/2025 Crohn's disease: This newly approved condition was added to the policy.
Inflammatory Conditions – Omvoh Intravenous Preferred	Updated	Effective 3/15/2025 For Crohn's Disease, Omvoh intravenous was added as a Step 2 Non-Preferred Product and is

Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings; Individual and Family Plan Prescription Drug Lists - (PSM011)		directed to a trial of one Step 1 Product.
Inflammatory Conditions – Omvoh Intravenous Preferred Specialty Management Policy: Legacy Prescription Drug Lists - (PSM019)	Updated	Effective 3/15/2025 For Crohn's Disease, Omvoh intravenous was added as a Step 2 Non-Preferred Product and is directed to a trial of one Step 1 Product.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists - (PSM001)	Updated	Effective 3/15/2025 Velsipity: For Ulcerative Colitis, Velsipity was added as a Preferred Product. Simponi Subcutaneous: For Ulcerative Colitis, Velsipity was added as a Preferred Product. Rinvoq: For Ulcerative Colitis, Velsipity was added as a Preferred Product. Xeljanz/XR: For Ulcerative Colitis, Velsipity was added as a Preferred Product. Omvoh Subcutaneous: For Ulcerative Colitis, Velsipity was added as a Preferred Product. For Crohn's Disease, Omvoh subcutaneous was added as a Step 2a Non-Preferred Product and is directed to a trial of one Step 1 Product. Entyvio Subcutaneous: For Ulcerative Colitis, Velsipity was added as a Preferred Product. For Crohn's Disease, Omvoh subcutaneous was added as a Step 2a Non-Preferred Product.

Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Legacy Prescription Drug Lists - (PSM017)	Updated	Effective 3/15/2025 Velsipity: For Ulcerative Colitis, Velsipity was added as a Preferred Product. Simponi Subcutaneous: For Ulcerative Colitis, Velsipity was added as a Preferred Product. Rinvoq: For Ulcerative Colitis, Velsipity was added as a Preferred Product. Xeljanz/XR: For Ulcerative Colitis, Velsipity was added as a Preferred Product. Omvoh Subcutaneous: For Ulcerative Colitis, Velsipity was added as a Preferred Product. For Crohn's Disease, Omvoh subcutaneous was added as a Step 2a Non-Preferred Product and is directed to a trial of one Step 1 Product. Entyvio Subcutaneous: For Ulcerative Colitis, Velsipity was added as a Preferred Product. For Crohn's Disease, Omvoh subcutaneous was added as a Step 2a Non-Preferred Product.
Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)	Updated	Effective 3/15/2025 Sotyktu: For Plaque Psoriasis, Sotyktu was added as a Preferred Product. Bimzelx: For Plaque Psoriasis, Sotyktu was added as a Preferred Product. Cimzia: For Plaque Psoriasis, Sotyktu was added as a Preferred Product. Ilumya: For Plaque Psoriasis, Sotyktu was added as a Preferred Product. Siliq: For Plaque Psoriasis, Sotyktu was added as a Preferred Product. Taltz: For Plaque Psoriasis, Sotyktu was added as a Preferred Product. Omvoh Subcutaneous: For Crohn's Disease, Omvoh subcutaneous was added as a Step 2 Non-Preferred Product and is directed to a trial of one Step 1 Product. Entyvio Subcutaneous: For Ulcerative Colitis, Omvoh subcutaneous was added as a Step 2 Product. For Crohn's Disease, Omvoh subcutaneous was added as a Step 2 Product.
Metabolic Disorders – Primary Hyperoxaluria Medications – Rivfloza - (IP0629)	Updated	Effective 3/1/2025 Added and defined documentation requirements to the policy. Primary Hyperoxaluria Type 1: For Initial Therapy – Updated the statement "a genetic test confirming the diagnosis of Primary Hyperoxaluria Type 1 via identification of an

		alanine:glyoxylate aminotransferase gene (AGXT) mutation" to "a genetic test confirming the diagnosis of Primary Hyperoxaluria Type 1 via identification of biallelic pathogenic variants in the alanine: glyoxylate aminotransferase gene (AGXT)"; the option of approval that "the patient has a urinary oxalate excretion ≥ 0.7 mmol/24 hours/1.73 m2 was updated to the patient has a urinary oxalate excretion ≥ 0.5 mmol/24 hours/1.73 m2 with the absence of secondary sources of oxalate". For Patient is Currently Receiving Rivfloza - the requirement that the patient is continuing to derive benefit from Rivfloza was updated to remove the qualifier that this was "as determined by the most recent (i.e., within the past 6 months) objective measurement". Also, the requirement that the patient has not previously received a liver transplant was added to the Patient is Currently Receiving Rivfloza criteria set (previously, was only in the Initial Therapy criteria set).
Metabolic Disorders – Primary Hyperoxaluria – Oxlumo - (IP0095)	Updated	Effective 3/1/2025 Added and defined documentation requirements to the policy. Primary Hyperoxaluria Type 1: For Initial Therapy, removed "Liver biopsy demonstrating absent, or significantly reduced AGT Activity" as a means of confirming diagnosis. The option of approval that the patient has a urinary oxalate excretion ≥ 0.7 mmol/24 hours/1.73 m2 was updated to the patient has a urinary oxalate excretion ≥ 0.5 mmol/24 hours/1.73 m2 with the absence of secondary sources of oxalate. Added the requirement that the patient has not previously received a liver transplant (previously, was in the "Conditions Not Covered" section as "Status Post Liver Transplant"). Removed "medical geneticist" from the list of specialist prescribers. For Patient is Currently Receiving Oxlumo, added the requirement that the patient has not previously received a liver transplant (previously, was in the "Conditions Not Covered" section as "Status Post Liver Transplant"). Relocated the examples of beneficial response to a "Note".

Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy for Individual and Family Plans - (PSM008)	Updated	Effective 3/15/2025 Updated the Multiple Sclerosis requirements by moving Zeposia from Step 2 to Step 1.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy for Legacy Prescription Drug List Plans - (PSM004)	Updated	Effective 3/15/2025 Ulcerative Colitis: Velsipity was added as a Preferred Product.
Multiple Sclerosis and Ulcerative Colitis – Zeposia Preferred Specialty Management Policy: Standard/ Performance, Value/Advantage, Total Savings Prescription Drug List Plans- (PSM015)	Updated	Effective 3/15/2025 Ulcerative Colitis: Velsipity was added as a Preferred Product.
Neurology – Oxybate Products (IP0103)	Updated	Effective: 03/01/2025 Added "Documentation: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, claims records, and/or other information."

		Cataplexy Treatment in a Patient with Narcolepsy Changed the age requirement for Lumryz from ≥ 18 years of age to ≥ 7 years of age. Updated criteria from "Patient has been evaluated using polysomnography and a multiple sleep latency test" to "Documentation that the patient has been evaluated using polysomnography and a multiple sleep latency test." Updated criteria from "Diagnosis of narcolepsy has been confirmed, according to the prescriber" to "Documented diagnosis of narcolepsy has been confirmed." Updated criteria from "Patient meets ONE of the following (i or ii):" to "Documentation that the patient meets ONE of the following (i or ii)." Excessive Daytime Sleepiness in a Patient with Narcolepsy Changed the age requirement for Lumryz from ≥ 18 years of age to ≥ 7 years of age. Updated criteria from "Patient has been evaluated using polysomnography and a multiple sleep latency test" to "Documentation that the patient has been evaluated using polysomnography and a multiple sleep latency test." Updated criteria from "Diagnosis of narcolepsy has been confirmed, according to the prescriber" to "Documented diagnosis of narcolepsy has been confirmed." Updated criteria from "Patient has tried at least one of the following treatments: a central nervous system (CNS) stimulant, modafinil, or armodafinil" to "Documentation that the patient has tried at least one of the following treatments: a central nervous system (CNS) stimulant, modafinil, or armodafinil." Idiopathic Hypersomnia Updated criteria from "Patient has been evaluated using polysomnography and a multiple sleep latency test" to "Documentation that the patient has been evaluated using polysomnography and a multiple sleep latency test." Updated criteria from "Results of the polysomnography and a multiple sleep latency test are congruent with a diagnosis of idiopathic hypersomnia, according to the prescriber" to "Documentation that the results of the polysomnography and a multiple sleep latency test are congruent with a diagnosis of idiopathic hypersomnia."

		Updated criteria from "Patient has tried at least one of modafinil, armodafinil, or methylphenidate" to "Documentation that the patient has tried at least one of modafinil, armodafinil, or methylphenidate." Preferred Product Table Individual and Family Plans: <u>Cataplexy Treatment in Patients with Narcolepsy</u> Lumryz: Updated criteria from "Patient ≥ 18 years of age: Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with Wakix [may require prior authorization]" to "Patient is ≥ 18 years of age. Documentation that the patient has tried and has experienced inadequate efficacy OR a significant intolerance with Wakix [may require prior authorization]." Xyrem: Updated criteria from "ONE of the following: 1. Less than 18 years of age OR 2. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with Wakix [may require prior authorization]" to "Patient is ≥ 18 years of age. Documentation that the patient has tried and has experienced inadequate efficacy OR a significant intolerance with Wakix [may require prior authorization]." Xywav: Updated criteria from "ONE of the following: 1. Less than 18 years of age OR 2. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with Wakix [may require prior authorization" to "Patient is ≥ 18 years of age. Documentation that the patient has tried and has experienced inadequate efficacy OR a significant intolerance with Wakix [may require prior authorization]." <u>Excessive Daytime Sleepiness in Patients with Narcolepsy</u> Lumryz: Updated criteria from "Patients ≥ 18 years of age: Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with Wakix [may require prior authorization" to "Documentation that the patient has tried and has experienced inadequate efficacy OR a significant intolerance with Wakix [may require prior authorization]." Xyrem: Updated criteria from "ONE of the following: 1. Less than 18 years of age OR 2. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with Wakix [may require prior

		authorization]" to "Documentation that the patient has tried and has experienced inadequate efficacy OR a significant intolerance with Wakix [may require prior authorization]." Xywav: Updated criteria from "ONE of the following: 1. Less than 18 years of age OR 2. Patient has tried and, according to the prescriber, has experienced inadequate efficacy OR a significant intolerance with Wakix [may require prior authorization" to "Documentation that the patient has tried and has experienced inadequate efficacy OR a significant intolerance with Wakix [may require prior authorization]."
Niemann-Pick disease type C – Aqneursa (IP0715)	New	Effective 3/15/2025 • New coverage policy.
Niemann-Pick disease type C – Miplyffa (IP0716)	New	Effective 3/15/2025 • New coverage policy.
Ophthalmology – Upneeq (IP0088)	Updated	Effective: 3/15/2025 Conditions Not Covered Added "Oxymetazoline hydrochloride 0.1% ophthalmic solution (Upneeq) is considered to be experimental, investigational, or unproven for blepharoptosis or conjunctivitis due to insufficient data establishing safety, efficacy, and improved health outcomes for any condition, regardless of U.S. Food and Drug Administration (FDA) approval status. Criteria will be updated as new published data are available." Removed "Any other use is considered experimental, investigational, or unproven, including the following (this list may not be all inclusive):" Updated from "Cosmetic uses. Coverage of oxymetazoline 0.1% ophthalmic solution (Upneeq) for cosmetic uses (i.e., blepharoptosis when functional limitation is absent) are excluded from coverage as not medically necessary" to "Oxymetazoline hydrochloride 0.1% ophthalmic solution (Upneeq)for cosmetic uses (i.e., blepharoptosis when functional limitation is absent) is considered to be not medically necessary."

Pharmacy & Medical Prior Authorization - (1407)	Updated	Effective: 3/1/2025 Added Individual and Family Plan product-specific medical necessity criteria: Twyneo, Opipza, Vtama, Emrosi, insulin aspart protamine-insulin aspart (Novolog 70/30 mix generic) Updated Individual and Family Plan product-specific medical necessity criteria: Differin lotion, Epiduo Forte, Ergomar
Step Therapy Individual and Family Plan - (1603)	Updated	Effective 3/1/2025 • Added Insulin Aspart as an Insulin, short-acting Step 2 product.
Testosterone (Injectable) Products - (IP0351)	Updated	Effective: 3/1/2025 • Updated policy title. • Added Azmiro to the policy; with the same criteria apply as for other testosterone products.
Testosterone (Undecatrex) – (IP0724)	New	Effective 3/15/2025 • New policy.
Wakefulness-Promoting Agents – Armodafinil, Modafinil - (IP0075)	Updated	Effective: 03/01/2025 Added "Documentation: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, claims records, and/or other information." Excessive Daytime Sleepiness Associated with Narcolepsy. Updated criteria from "Patient has been evaluated using polysomnography and a multiple sleep latency test" to "Documentation that the patient has been evaluated using polysomnography and a multiple sleep latency test." Updated criteria from "Diagnosis of narcolepsy has been confirmed, according to the prescriber" to "Documented diagnosis of narcolepsy has been confirmed."

		Excessive Daytime Sleepiness Associated with Obstructive Sleep Apnea/Hypoapnea Syndrome. Updated criteria from "Patient is unable to initiate or tolerate continuous positive airway pressure therapy" to "Documentation that the patient is unable to initiate or tolerate continuous positive airway pressure therapy." Excessive Sleepiness Associated with Shift Work Sleep Disorder. Updated criteria from "Patient works at least five overnight shifts per month" to "Documentation that the patient works at least five overnight shifts per month." Adjunctive/Augmentation Treatment for Depression in Adults. Updated criteria from "Patient is concurrently receiving other medication therapy for depression" to "Documentation that the patient is concurrently receiving other medication therapy for depression." Idiopathic Hypersomnia. Updated criteria from "The diagnosis is confirmed by a sleep specialist physician or at an institution that specializes in sleep disorders (i.e., sleep center)" to "Documented diagnosis is confirmed by a sleep specialist physician or at an institution that specializes in sleep disorders (i.e., sleep center)."
Wakefulness-Promoting Agents – Sunosi - (IP0102)	Updated	Effective: 03/01/2025 Added "Documentation: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, claims records, and/or other information." Excessive Daytime Sleepiness Associated with Narcolepsy. Updated criteria from "Patient has been evaluated using polysomnography and a multiple sleep latency test" to "Documentation that the patient has been evaluated using polysomnography and a multiple sleep latency test." Updated criteria from " Diagnosis of narcolepsy has been confirmed, according to the prescriber" to "Documented diagnosis of narcolepsy has been confirmed." Updated criteria from "Patient has tried at least ONE of the following treatments: a central nervous system (CNS) stimulant, generic modafinil or generic armodafinil" to "Documentation that the patient has tried at least ONE of the

		following treatments: a central nervous system (CNS) stimulant, generic modafinil or generic armodafinil." Excessive Daytime Sleepiness Associated with Obstructive Sleep Apnea. Updated criteria from "Patient is unable to initiate or tolerate CPAP therapy" to "Documentation that the patient is unable to initiate or tolerate CPAP therapy." Updated criteria from "Patient has tried generic modafinil or generic armodafinil" to "Documentation that the patient has tried generic modafinil or generic armodafinil."
Wakefulness-Promoting Agents – Wakix - (IP0292)	Updated	Effective: 03/01/2025 Added "Documentation: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, claims records, and/or other information." Cataplexy Treatment in a Patient with Narcolepsy. Updated criteria from "Patient has been evaluated using polysomnography and a multiple sleep latency test" to "Documentation that the patient has been evaluated using polysomnography and a multiple sleep latency test." Updated criteria from "Diagnosis of narcolepsy has been confirmed, according to the prescriber" to "Documented diagnosis of narcolepsy has been confirmed." Updated criteria from "Patient meets ONE of the following (i or ii): i. Patient has tried dextroamphetamine; OR ii. Patient has a contraindication or intolerance to dextroamphetamine, according to the prescriber." to "Documentation that the patient meets ONE of the following (i or ii): i. Patient has tried dextroamphetamine; OR ii. Patient has a contraindication or intolerance to dextroamphetamine." Excessive Daytime Sleepiness Associated with Narcolepsy Updated criteria from "Patient has been evaluated using polysomnography and a multiple sleep latency test" to "Documentation that the patient has been evaluated using polysomnography and a multiple sleep latency test." Updated criteria from "Diagnosis of narcolepsy has been confirmed, according to the prescriber" to "Documented diagnosis of narcolepsy has been confirmed."

		The criteria were updated to remove the restriction to patients who are ≥ 18 years of age when requiring a patient to have tried a central nervous system (CNS) stimulant, generic modafinil, or generic armodafinil OR have a history of substance use disorder prior to approval of Wakix. Updated criteria from "If the patient is ≥ 18 years of age, then the patient meets ONE of the following (i or ii): i. Patient has tried at least ONE of the following treatments: a central nervous system (CNS) stimulant, generic modafinil or generic armodafinil; OR ii. Patient has a history of substance use disorder and a wakefulness-promoting agent that is not a controlled substance is necessary, per the prescriber" to "Documentation that the patient meets ONE of the following (i or ii): "i. Patient has tried at least ONE of the following treatments: a central nervous system (CNS) stimulant, generic modafinil or generic armodafinil; OR ii. Patient has a history of substance use disorder and a wakefulness-promoting agent that is not a controlled substance is necessary."
Weight Loss – Glucagon-Like Peptide-1 Agonists - (IP0206)	Updated	Effective: 3/15/2025 Saxenda Weight Loss, Adult. Patient Continuing on Saxenda: Dosing criteria were removed. Saxenda and Wegovy Weight Loss, Pediatric. Patient Continuing on Saxenda: Dosing criteria were removed. Wegovy Weight Loss, Adult. Patient Continuing on Wegovy: Dosing criteria were removed. The approval duration was changed to 1 year. Weight Loss, Pediatric. Patient Continuing on Wegovy: Dosing criteria were removed. The approval duration was changed to 1 year. Cardiovascular Disease who is Either Obese or Overweight. Initial Therapy. The criterion requiring that the patient has a BMI ≥ 27 kg/m^2 was clarified to state that the patient has a current BMI ≥ 27 kg/m^2. Patient Continuing on Wegovy: Dosing criteria were removed. Zepbound Weight Loss, Adult. Patient Continuing on Zepbound: Dosing criteria were removed. The approval duration was changed to 1 year.

		Obstructive Sleep Apnea Moderate to Severe in a Patient with Obesity. A new FDA-approved condition was added to the Policy.
Weight Loss – Glucagon-Like Peptide-1 Agonists Benefit Exclusion Overrides Policy - (IP0621)	Updated	Effective 3/15/2025 Saxenda Weight Loss, Adult. Patient Continuing on Therapy with Saxenda: Dosing criteria were removed. Saxenda and Wegovy Weight Loss, Pediatric. Patient Continuing on Therapy with Saxenda: Dosing criteria were removed. Wegovy Weight Loss, Adult. Patient Continuing on Therapy with Wegovy: Dosing criteria were removed. The approval duration was changed to 1 year. Weight Loss, Pediatric. Patient Continuing on Therapy with Wegovy: Dosing criteria were removed. The approval duration was changed to 1 year. Cardiovascular Disease who is Either Obese or Overweight. Initial Therapy. The criterion requiring that the patient has a BMI ≥ 27 kg/m^2 was clarified to state that the patient has a "current" BMI ≥ 27 kg/m^2. Patient Continuing on Wegovy: Dosing criteria were removed. Zepbound Weight Loss, Adult. Patient Continuing on Therapy with Wegovy: Dosing criteria were removed. The approval duration was changed to 1 year.
Alpha1-Proteinase Inhibitors - (IP0397)	Updated	Effective: 3/15/2025 • No change in criteria.
Brolucizumab - (IP0541)	Updated	Effective: 3/1/2025 • No change in criteria.

Complement Inhibitors – Zilbrysq - (IP0622)	Updated	Effective: 3/1/2025 • No change in criteria.
Desmopressin Products – Nocdurna - (IP0127)	Updated	Effective: 3/15/2025 • No change in criteria.
Desmopressin Nasal Spray – (IP0132)	Updated	Effective: 3/15/2025 • No change in criteria.
Entadfi (finasteride and tadalafil) - (IP0519)	Updated	Effective: 3/15/2025 • No change in criteria
Enzyme Replacement Therapy – Revcovi - (IP0399)	Updated	Effective: 3/15/2025 • No change in criteria.
Hematology – Adzynma - (IP0606)	Updated	Effective: 3/1/2025 • No change in criteria.
Hematology – Ceprotin - (IP0342)	Updated	Effective: 3/15/2025 • No change in criteria

Hematology – Coagadex - (IP0554)	Updated	Effective: 3/1/2025 • No change in criteria.
Hematology – Corifact - (IP0552)	Updated	Effective: 3/1/2025 • No change in criteria.
Hematology – Tretten - (IP055	Updated	Effective: 3/1/2025 • No change in criteria
Hematology – Vonvendi - (IP0555)	Updated	Effective: 3/15/2025 • No change in criteria
Hemophilia – Eptacog - (IP0355)	Update	Effective: 3/15/2025 • No change in criteria
Hemophilia – FEIBA – (IP0354)	Update	Effective: 3/15/2025 • No change in criteria
Infectious Disease – Livtencity - (IP0394)	Updated	Effective: 3/15/2025 • No change in criteria

Infectious Disease – Pyremethamine - (IP0348)	Updated	Effective: 3/15/2025 • No change in criteria
Inflammatory Conditions – Simponi Aria Prior Authorization Policy – (IP0668)	Updated	Effective 3/1/2025 • No change in criteria
NovoSeven RT – (IP0356)	Updated	Effective: 3/15/2025 • No change in criteria
Ophthalmology – Vascular Endothelial Growth Factor Inhibitors – Ranibizumab Products - (IP0543)	Updated	Effective 3/1/2025 • No change in criteria
Penicillamine - (IP0277)	Updated	Effective: 3/15/2025 • No change in criteria
Pretomanid - (IP0384)	Updated	Effective: 3/15/2025 • No change in criteria
Trientene Products - (IP0278)	Updated	Effective: 3/15/2025 • No change in criteria

Vosoritide - (IP0402)	Updated	Effective: 3/1/2025 • No change in criteria
Anticoagulants – Eliquis - (IP0030)	Retired	Policy retired effective 3/1/2025
Anticoagulants – Xarelto - (IP0032)	Retired	Policy retired effective 3/1/2025
CareAllies Medical Necessity Guideline	**New, Updated, or Retired?**	**Comments**
	Updated	• All above updates apply
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
March 2025 Prior Authorization Requirements Commercial	Update	• Updated prior authorization requirements are available on our website, CignaforHCP.Cigna.com. • Effective March 28, 2025, Cigna removed 2 CPT and 2 HCPCS from prior authorization.
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**

Modifier 50 – Bilateral Procedures - (M50)	Updated	
Evaluation and Management Services - (R30)	Updated	
Care Integration Services - (R32)	Updated	
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		• No updates for March 2025
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**
		• No updates for March 2025