Coverage Policy Unit (CPU) - Monthly Policy Updates

Effective May 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
Ambulatory External and Implantable Electrocardiographic Monitoring – (0547)	Update	Minor changes in coverage criteria/policy: • Minor correction of criteria to align with American College of Cardiology wording
Donor lymphocyte Infusion and Hematopoietic Progenitor Cell HPC Boost – (0261)	Update	Minor changes in coverage criteria/policy: • EIU language changed to not medically necessary in the DLI and HPC boost for any other indications statement because the technology doesn't fit our definition of EIU.

External Counterpulsation – (0058)	Update	Minor changes in coverage criteria/policy: • EIU language changed to not medically necessary in the external counterpulsation for any other indication statement because the technology doesn't fit our definition of EIU. • "Microvascular dysfunction" added as another name for "microvascular angina" for clarity.
Liver and Liver-Kidney Transplantation – (0355)	Update	Important changes in coverage criteria: • Minor clarifications to hepatocellular carcinoma criteria wording to align with UNOS/OPTN policy wording update. • Remain not covering Mechanical Preservation Machine (MPM)
Omnibus Codes – (0504)	Update	Minor changes in coverage criteria/policy: • Annual update of: Neurology (3 topics); Urology (1 topic); Endocrine (1 topic); Gastroenterology (7 topics). • No changes in coverage.

Plasma Brain Natriuretic Peptide in the Outpatient Setting – (0028)	Update	Important changes in coverage criteria:
		• Expanded coverage to include:
		  • amyloidosis
		  • multiple myeloma
		  • on immunotherapy

Remote ~~Patient~~ Physiologic Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) – (0563)	Update	Important **changes** in coverage criteria: **OR** Minor **changes** in coverage criteria/policy: • Title change to reflect verbiage change from "Remote Patient Monitoring" to "Remote Physiologic Monitoring" because this is the more widely accepted verbiage for this technology. • Changed verbiage throughout the policy from "Remote Patient Monitoring" to "Remote Physiologic Monitoring" because this is the more widely accepted verbiage for this technology. • Added "Self-Measured Blood Pressure (SMBP)" to the policy because SMBP monitoring has its own code set and is designated as a separate technology. • Expand coverage by removing the criteria statement under RPM for FDA approval because a vetted list of FDA cleared devices does not exsit. • Clarify non-coverage of RPM for any other indication by adding "isolated hypertension" as an example because we are seeing a lot of requests for this. • Change verbiage in the non-covered RTM statement from "ALL" to "ANY" indication to be consistent with standardly used language.

Seat Lift Mechanisms, Patient Lifts and Standing Devices – (0343)	Update	Minor **changes** in coverage criteria: • Listed out criteria for a standard walker and gait trainer under section for "combination transfer and mobility devices" • This criteria used to be in Coverage Policy 0050 Ambulatory Assistance Devices, which has been retired. • Removed redundant language regarding benefit plan exclusions
Serum Folate and Red Blood Cell Folate Testing – (0567)	NEW	New Coverage Policy
Site of Care: High-tech Radiology – (0550)	Update	Important changes in coverage criteria: • Added language to clarify when policy does not apply • Revised language to clarify when hospital-based imaging department or facility is considered medically necessary.
Genetic Testing for Hereditary and Multifactorial Conditions – (0052)	Update	Changes to the Genetic testing on Variants
Genetic Testing for Hereditary Cancer Susceptibility Syndromes – (0518)	Update	Minor update
Nucleic Acid Pathogen Testing – (0530)	Update	Minor update:
Molecular and Proteomic Diagnostic Testing for Hematology and	Update	Multiple Changes:

Oncology Indications - (0520)		
Allergy Testing and Non-Pharmacologic Treatment - (0070)	Update	No change in coverage.
Bone Growth Stimulators: Electrical (Invasive, Noninvasive), Ultrasound – (0084)	Update	No change in coverage.
Carotid Intima-Media Thickness Measurement - (0475)	Update	No change in coverage.
Cell-Based Therapy for Cardiac and Peripheral Arterial Disease – (0287)	Update	No change in coverage.
Helicobacter Pylori Serology Testing – (0308)	Update	No change in coverage.
Injectable Fillers – (0511)	Update	No change in coverage.

Hearing Aids – (0093)	Update	No change in coverage.
Hyperbaric and Topical Oxygen Therapies – (0053)	Update	No change in coverage.
Negative Pressure Wound Therapy/Vacuum-Assisted Closure (VAC) for Non-Healing Wounds – (0064)	Update	No change in coverage.
Neuropsychological Testing - (EN0258)	Update	No change in coverage.
Treatment of Cutaneous and/or Deep Tissue Hemangioma, Port Wine Stain and Other Vascular Lesions – (0313)	Update	No changes in coverage.
Tumor In Vitro Chemosensitivity and Chemoresistance Assays – (0203)	Update	No change in coverage.
ASH Guidelines	**New, Updated,**	**Comments**

	or Retired?	
Strapping and Taping – (CPG 143)	Update	Minor changes in coverage criteria/policy: • Removed the strapping for any indication not listed statement because it was redundant with the following statement. • Changed verbiage in the strapping for the following body parts and for any other indication statement from not covered or reimbursable to not medically necessary because the technology fits the definition of not medically necessary.
Complex Lymphedema Therapy (Complete Decongestive Therapy) – (CPG 157)	Update	No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**

Cobranded Cigna-EviCore Comprehensive Musculoskeletal Management Guidelines	Update	Posting May 1, 2024. Effective August 1, 2024:
		
		Important changes in coverage criteria.
		• Three guidelines had an expansion of coverage:
		  • CMM-314: Hip Surgery-Arthroscopic and Open Procedures
		  • CMM-315: Shoulder Surgery – Arthroscopic and Open Procedures
		  • CMM-318: Shoulder Arthroplasty/Replacement/Resurfacing/Revision/Arthrodesis
		• Three guidelines had positive and adverse changes in coverage:
		  • CMM-311: Knee Replacement/Arthroplasty
		  • CMM-312: Knee Surgery: Arthroscopic and Open Procedures
		  • CMM-313: Hip Replacement/Arthroplasty

Cobranded Cigna-EviCore	Update	Posted April 1, 2024. Effective May 1, 2024:

Interventional Pain Management Guidelines		Important change in coverage criteria.
		• Guideline with positive change in coverage:
		  • CMM-211 Spinal Cord and Dorsal Root Ganglion Stimulation
		  • Removed noncoverage statement for closed loop dual-mode dorsal column stimulators.

Cobranded Cigna-EviCore Radiation Oncology Guidelines	Update	Posted January 27, 2024. Effective May 1, 2024.
		
		Important changes in coverage criteria.
		
		The updated guidelines included:
		• Three guidelines had an expansion of coverage:
		  • Kidney Cancer
		  • Oligometastases
		  • Thymoma and Thymic Cancer
		• One guideline had positive and adverse changes in coverage:
		  • Brain Metastases
		• The remaining 38 guidelines and two informational documents had no changes in coverage:
		  • ^{177}Lu-dotatate (Lutathera®)
		  • Abbreviations and Definitions for Radiation Oncology Guidelines
		  • Adrenocortical Carcinoma
		  • Anal Canal Cancer
		  • Azedra® (iobenguane I-131)
		  • Bladder Cancer
		  • Bone Metastases
		  • Brachytherapy of the Coronary Arteries
		  • Breast Cancer
		  • Cervical Cancer
		  • Endometrial Cancer
		  • Esophageal Cancer
		  • Gastric Cancer
		  • Head and Neck Cancer
		  • Hepatobiliary Cancer
		  • Hodgkin Lymphoma
		  • Hyperthermia

		• Image-Guided Radiation Therapy (IGRT)
		• Multiple Myeloma and Solitary Plasmacytomas
		• Neutron Beam Therapy
		• Non-Hodgkin Lymphoma
		• Non-Malignant Disorders
		• Non-Small Cell Lung Cancer
		• Other Cancers
		• Pancreatic Cancer
		• Pluvicto® (lutetium Lu^{177} vipivotide tetraxetan)
		• Preface to the Radiation Oncology Guidelines
		• Primary Craniospinal Tumors and Neurologic Conditions
		• Prostate Cancer
		• Rectal Cancer
		• Selective Internal Radiation Therapy (SIRT)
		• Skin Cancer - Melanoma
		• Skin Cancer - Non-Melanoma
		• Small Cell Lung Cancer
		• Soft Tissue Sarcomas
		• Testicular Cancer
		• Urethral Cancer and Cancers of the Ureter and Renal Pelvis
		• Vulvar Cancer
		• Xofigo® (Radium-223)
		• Zevalin®
		
		Posted April 1, 2024. Effective May 1, 2024.
		
		Important changes in coverage criteria.
		• Guideline with positive change in coverage:
		  • Proton Beam Therapy
		  • Added coverage for proton beam therapy for several Group 1 indications; Group 2 indications updated accordingly.
		  • Minor change to list additional examples of noncovered (Group 3) indications

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

	or Retired?	
A0011 Long Term Care Hospitals (LTCH) – (A0011)	Retired	Retired 5/1/2024 No longer has value
Drug & Biologic Coverage Policy	**New, Updated, or Retired?**	**Comments** **All policy changes effective May 1, 2024, unless otherwise stated**
Alirocumab - (IP0250)	Update	Effective: 5/15/2024 • Added *Coronary Artery Disease* as a condition that represents use in *Atherosclerotic Cardiovascular Disease*

Anticoagulants – Dabigatran - (IP0033)	Update	Effective: 5/1/2024
		• Dabigatran capsules:
		  • Added an age restriction to all covered indications.
		• Pradaxa oral pellets:
		  • Venous Thromboembolic Events, Treatment.
		  • Removed the requirement for 5 days of parenteral anticoagulant therapy.
		• Employer Plans preferred product requirements:
		  • Extended the current Pradaxa 75 mg and 150 mg approach to Pradaxa 110 mg capsules.
		• Clarified the Pradaxa Oral pellets difficulty swallowing option allows for FCI to Xarelto tablets or suspension.
		• Individual and Family Plans preferred product requirements:
		  • Extended the current Pradaxa 110 mg approach to Pradaxa 75 mg and 150 mg capsules.
		• Conditions Not Covered: Removed Prophylaxis of Venous Thromboembolism in Individuals with Factor V Leiden thrombophilia and Antiphospholipid syndrome as a non-covered indication.

Antihyperglycemic Therapy (Non-Insulin) - (IP0098)	Update	Effective: 5/1/2024 • Removed Glyxambi – effective 7/1/2024 • Removed Qtern – effective 7/1/2024

		• Removed Steglujan – effective 7/1/2024 • Removed Trijardy XR – effective 7/1/2024
Antiseizure Medications – Epidiolex - (IP0410)	Update	Effective: 5/15/2024 • Updated coverage policy title from Cannabidiol to Antiseizure Medications – Epidiolex. • Added criterion for Dravet Syndrome allowing for treatment with Epidiolex if there is either failure, contraindication or intolerance to, or concomitantly receiving Fintepla, Diacomit or clobazam. • Removed criterion for Lennox-Gastaut Syndrome, Tuberous Sclerosis Complex and Treatment-Refractory Seizures/ Epilepsy requiring a contraindication, intolerance or not a candidate for all alternative formulary anti-epileptic medications.
Bempedoic Acid - (IP0248)	Update	Effective: 5/1/2024 • Atherosclerotic Cardiovascular Disease: Coronary artery disease was added as a condition or diagnosis that represents this indication of use in this related requirement.
Bempedoic Acid/Ezetimibe - (IP0249)	Update	Effective: 5/1/2024 • Atherosclerotic Cardiovascular Disease: Coronary artery disease was added as a condition or diagnosis that represents this indication of use in this related requirement.

Casgevy for Sickle Cell Disease – (IP0615)	Update	Effective: 5/1/2024
		• Updated the statement regarding verification in claims history for certain criteria was revised to add the qualifier "if claims history is available." The revised statement reads: If claims history is available, verification is required for certain criteria as noted by [verification in claims history required]
		• Sickle Cell Disease:
		  • Updated: the Note regarding the requirement for no previous gene therapy for sickle cell disease was revised to add the qualifier "(or if claims history is not available)" and to remove "Verify through claims history that the patient has not previously received Casgevy or Lyfgenia (lovotibeglogene autotemcel intravenous infusion)." The revised Note reads: If no claim for Casgevy or Lyfgenia (lovotibeglogene autotemcel intravenous infusion) is present (or if claims history is not available), the prescribing physician confirms that the patient has not previously received Casgevy or Lyfgenia.
		  • Updated: the criterion regarding cellular screening was revised such that cellular screening is negative for human immunodeficiency virus (HIV)-1 and -2 and negative for Human T-lymphotrophic virus-1 and -2; previously, it was HIV-1 or -2 and Human T-lymphotrophic virus-1 or -2.

		• Updated: In the criterion regarding a male* of reproductive potential, the additional phrase in parenthesis, "(i.e., capable of fathering a child)" was removed (not needed). • Updated: The criterion regarding current patient weight was revised to remove the qualifier "before intended receipt of Casgevy." The revised criterion reads: Current patient body weight has been obtained within 30 days [documentation required].
Hematology – Gene Therapy – Lyfgenia – (IP0617)	Update	Effective: 5/1/2024 • Updated the statement regarding verification in claims history for certain criteria was revised to add the qualifier "if claims history is available." The revised statement reads: If claims history is available, verification is required for certain criteria as noted by [verification in claims history required] • Sickle Cell Disease: • Updated the Note regarding the requirement for no previous gene therapy for sickle cell disease was revised to add the qualifier "(or if claims history is not available)" and to remove "Verify through claims history that the patient has not previously received Lyfgenia or Casgevy (exagamglogene autotemcel intravenous infusion)." The revised Note reads: If no claim for Lyfgenia or Casgevy (exagamglogene autotemcel intravenous infusion) is present (or if claims history is not available), the prescribing physician confirms that the patient has not previously received Lyfgenia or Casgevy. • Updated the criterion regarding cellular screening was revised such that cellular screening is negative for human immunodeficiency virus (HIV)-1 and -2 and negative for Human T-lymphotrophic virus-1 and -2; previously, it was HIV-1 or -2 and human T-lymphotrophic virus-1 or -2. • Updated in the criterion regarding a male* of reproductive potential, the additional phrase in parenthesis, "(i.e., capable of fathering a child)" was removed (not needed). • Updated the criterion regarding current patient weight was revised to remove the qualifier "before intended receipt of Lyfgenia." The revised criterion reads: Current patient body weight has been obtained within 30 days [documentation required].
Chelating Agents – Iron Chelators (Oral) – (IP0271)	Update	Effective 5/15/2024 • Iron Overload, Chronic – Transfusion-Related (Deferasirox): Removed age • Iron Overload, Chronic – Non-Transfusion-Dependent Thalassemia Syndromes (Deferasirox): Removed age

		• Iron Overload, Chronic – Non-Transfusion-Dependent Thalassemia Syndromes: Removed prior to starting chelating therapy, Liver iron (Fe) concentration (LIC) level greater than or equal to 5 mg Fe per gram of dry weight • Updated coverage policy title
Complement Inhibitors – Empaveli - (IP0194)	Update	Effective 5/1/2024 • Paroxysmal Nocturnal Hemoglobinuria: Removed criterion related to vaccination requirements. Initial approval duration was changed from 4 months to 6 months. Criterion regarding patient transitioning to Empaveli from Soliris or Ultomiris was revised to remove Ultomiris. • Conditions Not Covered: Criterion regarding concomitant use with Soliris or Ultomiris for > 4 weeks was revised to remove Ultomiris. Criterion regarding concomitant use of Empaveli with Fabhalta or Ultomiris was added.
COVID-19 Drug and Biologic Therapeutics - (2016)	Update	Effective 5/1/2024 • Paxlovid removed from the policy.
Erectile Dysfunction – Alprostadil Products for Individual and Family Plans - (IP0425)	Update	Effective: 5/1/2024 • Updated coverage policy title
Erectile Dysfunction – Stendra - (IP0100)	Update	Effective: 5/1/2024 • Updated coverage policy title
Esketamine – (IP0220)	Update	Effective: 5/15/2024 • Added coding to support Medicare line of business • Added post-administration monitoring is medically necessary supporting statement if approved for use secondary to Medicare coding addition
Evolocumab – (IP0195)	Update	Effective: 5/15/2024 • Added *Coronary Artery Disease* as a condition that represents use in *Atherosclerotic Cardiovascular Disease*

Glucose Test Strips – (IP0272)	Update	Effective: 5/1/2024 • Added Blue Link glucose test strips to policy
Gonadotropin-Releasing Hormone Agonists – Central Precocious Puberty – Leuprolide - (IP0108)	Update	Effective: 5/1/2024 • No criteria change • Updated title of coverage policy • Added dosing for diagnosis, *Gender-Dysphoric/Gender-Incongruent Persons; Person Undergoing Gender Reassignment*
Gonadotropin-Releasing Hormone Agonists – Central Precocious Puberty – Triptodur - (IP0134)	Update	Effective: 5/1/2024 • No criteria change • Updated title of coverage policy • Added dosing for diagnosis, *Gender-Dysphoric/Gender-Incongruent Persons; Person Undergoing Gender Reassignment*
Hematology – Adzynma - (IP0606)	New	Effective 5/1/2024 • New Policy
Hematology – Ceprotin - (IP0342)	Update	Effective: 5/1/2024 • No criteria change • Updated coverage policy title • Added dosing information
Hematology – Coagadex - (IP0554)	Update	Effective: 5/1/2024 • Updated coverage policy title.
Hematology – Fibrinogen Products - (IP0357)	Update	Effective: 5/1/2024 • Updated coverage policy title.
Hematology – Gene Therapy – Zynteglo - (IP0486)	Update	Effective 5/1/2024 • Revised Beta Thalassemia: The word "recent" was replaced with the phrase "within 30 days before intended receipt of Zynteglo" regarding meeting thresholds for white blood cell count and platelet counts.
Hemophilia – Eptacog Products – Sevenfact - (IP0355)	Update	Effective: 5/1/2024 • Updated coverage policy title.

Hemophilia – FEIBA - (IP0354)	Update	Effective 5/15/2024 • Changed title from FEIBA
HIV Products - (P0050)	Update	Effective 5/1/2024 • Added preferred product requirement criteria for darunavir propylene glycolate to step through covered generic propylene ethanolate.
HIV Products for Individual and Family Plans - (IP0090)	Update	Effective 5/1/2024 • Added preferred product requirement criteria for darunavir propylene glycolate tablets • Organized existing criteria for Descovy and Truvada in a table to clean up policy
Ibalizumab-uiyk - (IP0171)	Update	Effective 5/15/2024 • Added dosing
Inflammatory Conditions – Simponi Aria - (IP0238)	Update	Effective: 5/1/2024 • Updated policy title • No criteria changes
Chelating Agents - Iron Chelators - (IP0271)	Update	Effective 5/15/2024 • Iron Overload, Chronic – Transfusion-Related (Deferasirox): Removed age • Iron Overload, Chronic – Non-Transfusion-Dependent Thalassemia Syndromes (Deferasirox): Removed age • Iron Overload, Chronic – Non-Transfusion-Dependent Thalassemia Syndromes: Removed prior to starting chelating therapy, Liver iron (Fe) concentration (LIC) level greater than or equal to 5 mg Fe per gram of dry weight • Ferriprox Solution for Emp and IFP: Added as a requirement option: Dose prescribed cannot be attained with deferiprone tablet and patient who cannot swallow or have difficulty swallowing tablets
Mepolizumab - (IP0422)	Update	Effective: 5/15/2024 • Added dosing • Nasal Polyps: Revised to Chronic Rhinosinusititis with Nasal Polyps; Revised requirement of intranasal steroid to 4 weeks • Added dosing to all covered conditions

Metabolic Products – Nitisinone Products - (IP0146)	Update	Effective 5/15/2024 • Changed title from Nitisinone
Muscular Dystrophy – Emflaza - (IP0131)	Update	Effective: 5/1/2024 • Deleted "…or likely pathogenic variant" for genetic testing criteria in regard to dystrophin gene • Replaced "time to run or walk 30 feet" with " time to run or walk 10 meters" for Emflaza improvements • Added 6-minute walk test to motor function tests for Emflaza improvements
Nephrology – Xphozah - (IP0608)	New	Effective 5/1/2024 • New coverage policy supporting pharmacy prior authorization of Xphozah [tenapanor] tablets.
Oncology Medications - (1403)	Update	Effective 5/15/2024 • Added preferred product requirement criteria for Fruzaqla (fruquinitinib) for Employer Plans • Added *has brain metastases* exception for Krazati (adagrasib) to the sotorasib (Lumakras) preferred product requirement
Ophthalmology – Tepezza - (IP0129)	Update	Effective: 5/15/2024 • Removed if the individual is a smoker, smoking cessation has been discussed for Thyroid Eye Disease • Updated the criterion for Thyroid Eye Disease as follows: that the patient has active disease of at least moderate severity based on signs and symptoms, according to the prescriber was changed to remove the word "active". The new criterion requires that the patient has at least moderate severity level of disease based on signs and symptoms, according to the prescriber. The Note was also revised to read: Examples of signs and symptoms of disease of at least moderate severity include the following: lid retraction ≥ 2 mm, moderate or severe soft tissue involvement, proptosis ≥ 3 mm above normal for race and sex, and diplopia (Gorman score 2 to 3).
Ophthalmology – Vascular Endothelial Growth Factor	Update	Effective 5/15/2024 • Changed title from Ranibizumab Ocular Implant

Inhibitors – Susvimo - (IP0349)		
Opioid Therapy for Employer Group Benefit Plans – (IP0561)	Update	Effective: 5/15/2024 • Added tramadol 25 mg tablet to Immediate-Release Opioid Analgesic Non-Covered Products and Criteria. • Removed requirement of generic tramadol extended-release (ER) tablets prior to approval for branded tramadol ER capsules (Conzip) for use relating to pain severe enough requiring daily, ATC long-term opioid treatment.
Opioid Therapy for Individual and Family Plans – (IP0562)	Update	Effective: 5/15/2024 • Added tramadol 25 mg tablet to Immediate-Release Opioid Analgesic Non-Covered Products and Criteria. • Removed requirement of generic tramadol extended-release (ER) tablets prior to approval for branded tramadol ER capsules (Conzip) for use relating to pain severe enough requiring daily, ATC long-term opioid treatment.
Ophthalmology – Tepezza - (IP0129)	Update	Effective: 5/15/2024 • Thyroid Eye Disease: Removed if the individual is a smoker, smoking cessation has been discussed • Thyroid Eye Disease: The criterion that the patient has active disease of at least moderate severity based on signs and symptoms, according to the prescriber was changed to remove the word "active". The new criterion requires that the patient has at least moderate severity level of disease based on signs and symptoms, according to the prescriber. The Note was also revised to read: Examples of signs and symptoms of disease of at least moderate severity include the following: lid retraction ≥ 2 mm, moderate or severe soft tissue involvement, proptosis ≥ 3 mm above normal for race and sex, and diplopia (Gorman score 2 to 3).
Pen Needles – (IP0569)	Update	Effective 5/15/2024 • Added 4 products to Noncovered Product table

Pharmacy Prior Authorization - (1407)	Update	Effective 5/1/2024
		• Added IFP product specific criteria as follows;
		  • Airsupra
		  • Bijuva

		• bromfenac • Cabtreo • Condylox • Jylamvo • Likmez • podofilox 0.5% • Pokonza • Trexall • Xatmep • Zituvio
Psychiatry – Zurzuvae - (IP0607)	New	Effective 5/15/2024 • New coverage policy supporting pharmacy prior authorization of Xphozah [zuranolone] capsules.
Proton Pump Inhibitors - (IP0061)	Update	Effective 5/1/2024 • Voquezna tablet was added to the policy, for both Employer and IFP.
Pulmonary – Roflumilast for Individual and Family Plans - (IP0609)	New	Effective 5/1/2024 • New Policy
Quantity Limitations - (1201)	Update	Effective 5/1/2024 • Paxlovid added to the policy
Ranibizumab Products - (IP0543)	Update	Effective 5/1/2024 • Revised dosing for ranibizumab products • Updated preferred product requirement criteria for Byooviz, Cimerli, and Lucentis
Sodium Glucose Co-Transporter-2 (SGLT-2) Inhibitors and SGLT-2 / Metformin Combinations - (IP0592)	Update	Effective 5/1/2024 (updated to effective 4/1/2024) • Updated to include dapagliflozin (AG for Farxiga) and dapagliflozin/metformin ER (AG for Xigduo XR) for Employer Plans and Individual and Family Plans • Removed Employer Plan approaches for Farxiga, Jardiance, Synjardy, Synjardy XR and Xigduo XR

Step Therapy – Standard and Performance Prescription Drug Lists (Employer Group Plans) - (1801)	Update	Effective 5/1/2024 • ADHD: Removed Vyvanse & Mydayis from Step 2 and added the generics of each to the Step 1 list of alternatives. Updated step requirement from ONE to now be FOUR Step 1 agents prior to a Step 3 agent. • Diabetes Care: Updated metformin step therapy exception criteria
Step Therapy – Value and Advantage Prescription Drug Lists (Employer Group Plans) - (1802)	Update	Effective 5/1/2024 • ADHD: Updated step requirement from ONE to now be FOUR Step 1 agents prior to a Step 3 agent. Added the generics of Vyanse and Mydayis to the Step 1 list of alternatives • Diabetes Care: Updated metformin step therapy exception criteria. Jentadueto, Jentadueto XR and Trijardy added responsive to Step 3.
Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) – (1803)	Update	Effective 5/1/2024 • ADHD: Removed Vyvanse & Mydayis from Step 2 and added the generics of each to the Step 1 list of alternatives. Updated step requirement from ONE to now be FOUR Step 1 agents prior to a Step 3 agent. • Diabetes Care: Updated metformin step therapy exception criteria
Tasimelteon - (IP0428)	Update	Effective 5/15/2024 • Added missing product Hetlioz LQ to criteria
Topical Acne – Non-Retinoid Products - (IP0166)	Update	Effective 5/1/2024 • Added new EMP criteria for Clindamycin phosphate / benzoyl peroxide 1.2% / 3.75% topical gel – effective 7/1/2024. • Updated the EMP Onexton approach. • Incorporated and updated the IFP Clindamycin phosphate / benzoyl peroxide 1.2% / 3.75% topical gel approach. • Incorporated and updated the IFP Onexton approach.
Vigabatrin - (IP0049)	Update	Effective: 5/15/2024 • Added Vigpoder 500 mg powder for oral solution
Gamifant - (IP0113)	Update	No change in coverage

Lumasiran - (IP0095)	Update	No change in coverage
Vardenafil - (IP0099)	Update	No change in coverage
Hematology – Corifact - (IP0552)	Update	No change in coverage
Hematology – Enjaymo - (IP0405)	Update	No change in coverage
Hematology – Ryplazim - (IP0382)	Update	No change in coverage
Hematology – Tretten - (IP0555)	Update	No change in coverage
Hematology – Vonvendi - (IP0555)	Update	No change in coverage
Neurology – Gene Therapy – Skysona - (IP0529)	Update	No change in coverage
Opioid-Induced Constipation - (IP0401)	Update	No change in coverage
Topical Azelaic Acid Products – (IP0172)	Update	No change in coverage
Sodium Phenylbutyrate and Taurursodiol Powder – (IP0539)	Retired	Effective 5/1/2024 Policy to be retired
CareAllies Medical Necessity Guideline	**New, Updated, or Retired?**	**Comments**
		No updates in May 2024

Precertification Policy*	New, Updated, or Retired?	Comments
		No updates in May 2024
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
Diagnosis Coding Guidelines - (R47)	Update	Notification: 04/12/2024; effective 07/14/2024 Cigna will deny when an Evaluation and Management services (excluding newborn care) is reported with a preventative Medicine service and an ICD-10-CM Z code diagnosis code as the only diagnosis on the claim. Modifiers will not override this edit denial.
Diagnosis Coding Guidelines - (R47)	New	Notification: 03/15/2024; effective 06/16/2024 Cigna will deny when an unspecified laterality diagnosis code is reported when there is a diagnosis code right, left, or bilateral.
Modifier 50 Bilateral Procedures	Update	Notification: 04/12/2024; Effective 07/14/2024, Cigna will deny claims when procedure codes are reported inappropriately with modifier 50.
Omnibus Reimbursement Policy - (R24)	Update	Effective 04/12/2024; Cigna does not reimburse for CPT code 76377 as it is considered incidental to the overall radiological service for both CMS-1500 and UB-04.
Unacceptable Primary/Principal Diagnosis Policy - (R38)	Update	Notification 03/15/2024; Effective 06/16/2024 Cigna updated the ICD-10 CM code lists for CMS-1500 and UB-04 outpatient claims.
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		No updates in May 2024
ClaimsXten Documents*	**New, Updated,**	**Comments**

	or Retired?	
		No updates in May 2024