Monthly Policy Updates

Effective October 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
Ablative Treatments for Malignant Breast Tumors – (0540)	Updated	Important **changes** in coverage criteria: • Added percutaneous laser ablation (0971T) to the list of ablative procedures considered to be not medically necessary
Airway Clearance Devices in the Ambulatory Setting – (0069)	Updated	**Posting/Effective 11/9/2025** Minor **changes** in coverage criteria/policy: • Header added for Positive Expiratory Pressure Device for consistency throughout the policy statements and improved readability. • Changed EIU verbiage for intrapulmonary percussive ventilation device to not medically necessary because the technology doesn't meet Cigna's definition of EIU.

Ambulance Services – (0555)	Updated	**Posting 10/15/2025, Effective 1/15/2026** Minor **changes** in coverage criteria/policy: • Title change from Ambulance Services to Fixed Wing Air Ambulance Transport • Removal of unmanaged codes and the policy statements associated with those codes • Updated and revise the medical necessity policy statement for fixed wing air transport by removing water transport as it is no longer included in this policy and added an additional medical necessity criteria statement. • Revision of the medical necessity statement for fixed wing air ambulance transport • Revision of the not medically necessary statement for fixed wing air ambulance transport.
Cardiac Electrophysiological (EP) Studies – (0532)	Updated	Important **changes** in coverage criteria: • Revised policy statement for the asymptomatic pre-excitation bullet by removing the redundant occurrence of the word "asymptomatic". • Revised policy statement for the asymptomatic pre-excitation bullet by adding the word "life-threatening" to the criteria to allow for consistency between policy statements.
Cardiac Omnibus Codes – (0574)	Updated	**Posting 10/15/25, Effective 1/15/2026** Minor **changes** in coverage criteria/policy • No change in coverage • Adding codes to policy statement •
Electrical Stimulation Therapy and Devices in a Home Setting – (0160)	Updated	Minor **changes** in coverage criteria/policy: • Revised policy statements for transcutaneous electrical nerve stimulator (TENS) to remove references to level of supervision.
Kidney Transplantation, Pancreas-Kidney Transplantation, and Pancreas Transplantation Alone - (0146)	Updated	Important **changes** in coverage criteria: • Expanding coverage to include when a transplant candidate has a history of malignancy

Liver and Liver-Kidney Transplantation -- (0355)	Updated	Important **changes** in coverage criteria: • Expanding coverage to include when a transplant candidate has a history of malignancy
Molecular and Proteomic Diagnostic Testing for Hematology and Oncology Indications – (0520)	Updated	**Posting/Effective 11/9/2025** Important **changes** in coverage criteria: • Revised and expanded coverage criteria for tissue-based broad molecular profile panel testing. • Added ClarityDx Prostate to list of tests considered Not Covered or Reimbursable. • Removed MyProstateScore 2.0 (MPS2) and Stockholm3 tests from list of Not Covered or Reimbursable tests. • Revised criteria in Primary Myelofibrosis section. • Other revisions throughout for improved clarity and readability.
Nucleic Acid Pathogen Testing – (0530)	Updated	**Posted 7/15/25, Effective 10/15/25** Minor **changes** in coverage criteria/policy • Added CPT© code 0531U • Added four new CPT codes effective 7/1/2025: 0556U, 0557U, 0563U, & 0564U • Added ICD-10 codes: R10.20-R10.24, S30.82AA-S30.82AS, Z80.44, Z85.4A, & Z86.00A • Removed ICD-10 Codes: B37.3 • Updated ICD-10 Codes description for Z83.718 • No changes to policy statement wording
Orthognathic Surgery – (0209)	Updated	Minor **changes** in coverage criteria/policy: • Revised policy statement for services considered integral to orthognathic surgery.
Partial Rhinectomy, Rhinoplasty, Vestibular Stenosis Repair and Septoplasty – (0119))	Updated	Minor **changes** in coverage criteria/policy: • Removed requirement for recent trial of conservative treatment prior to Septoplasty • Changed from not covered or reimbursable to medically necessary for any other indication not listed for Septoplasty • Removed ICD-10 codes from coding information – codes not used for management
Radiofrequency Ablation (RFA) for Thyroid Nodules – (0575)	Updated	Important **changes** in coverage criteria: • Added policy statement for the use of radiofrequency ablation (RFA) on autonomously functioning nodules as treatment for hyperthyroidism

Sacral Nerve and Tibial Nerve Stimulation for Urinary Voiding Dysfunction, Fecal Incontinence and Constipation - (0404)	Updated	Minor **changes** in coverage criteria/policy: • Title change due to removal of policy statement for Implantable Tibial Nerve Stimulation. • Removed policy statement for Implantable Tibial Nerve Stimulation as the CPT® codes specific to the FDA-approved Implantable Tibial Nerve Stimulation devices are not implemented.
Site of Care: Outpatient Hospital Setting for Physical and Occupational Therapy – (0600)	New	**Posted 7/1/2025; Effective 10/1/2025** Important **changes** in coverage criteria: • New policy to address the medical necessity for outpatient hospital site of care for PT and OT services to direct patients to the most appropriate setting for PT and OT services.
Tissue-Engineered Skin Substitutes – (0068)	Updated	Important **changes** in coverage criteria: • Added policy statement to cover Marigen™ Pacto for diabetic foot ulcers (DFU) (it is equivalent to Kerecis Omega3 Marigen Shield which is considered medically necessary for DFU) • Added policy statement to cover GRAFIX DUO for diabetic foot ulcers (DFU) and venous stasis ulcers (VSU) (Grafix is considered medically necessary for both DFU and VSU) • Added definition of large hiatal hernia to coverage statement for clarification • Added the following to EIU policy statement: Acelagraft, Acesso TrifACA, Apollo FT, Axolotl Graft™ Ultra, InnovaMatrix® FD, Natalin®, NeoThelium FT, NeoThelium 4L, and NeoThelium 4L+, Summit AAA, SurGraft AC, SurGraft ACA
Anesthesia Services for Interventional Pain Management Procedures in an Adult – (CP0551)	Updated	• No change in coverage.
Autologous Platelet-Derived Growth Factors (Platelet-Rich Plasma [PRP]) – (0507)	Updated	• No change in coverage.
Category III Current Procedural Terminology (CPT®) Codes – (0558)	Updated	• No change in coverage.

Duplex Scan of Extracranial Arteries – (0542)	Updated	• No change in coverage.
Flow cytometry – (0538)	Updated	• No change in coverage.
Head and Neck Ultrasound – (0549)	Updated	• No change in coverage.
Infant Nutritional Formula – (0136)	Updated	• No change in coverage.
Intraocular Lens Implant – (0125)	Updated	• No change in coverage.
Mucosal Integrity Testing - (CP0577	Updated	• No change in coverage.
Neuropsychological Testing – (EN0258)	Updated	• No change in coverage.
Orthotic Devices and Shoes – (0543)	Updated	• No change in coverage.
Peripheral Nerve Destruction for Pain Conditions – (0525)	Updated	• No change in coverage.
Pharmacogenetic Testing – (0500)	Updated	• No change in coverage.
Plasma Brain Natriuretic Peptide in the Outpatient Setting – (0028)	Updated	• No change in coverage.
Radiofrequency Therapy for Fecal Incontinence – (0576)	Updated	• No change in coverage.
Serum Folate and Red Blood Cell Folate Testing - (0567)	Updated	• No change in coverage.
Subtalar Joint Implantation	Updated	• No change in coverage.

(Subtalar Arthroereisis) – (0486)		
Transthoracic Echocardiography in Adults - (0510)	Updated	• No change in coverage.
Transthoracic Echocardiography in Children - (0523)	Updated	• No change in coverage.
Vitamin D Testing – (0526)	Updated	• No change in coverage.
Hospital Beds and Pressure Reducing Support Surfaces – (0042)	Retired	• Policy retired 10/11/2025—no further business need.
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
Electrodiagnostic Testing (EMG/NCV) – (CPG129)	Updated	• No change in coverage.
Low-Level Laser and High-Power Laser Therapy – (CPG030)	Updated	• No change in coverage.
Strapping and Taping – (CPG143)	Updated	• No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**

Cobranded Cigna-EviCore High-Tech Imaging Guidelines	Updated	Posted/Effective **10/1/2025**
		
		Important **changes** in coverage criteria.
		• One guideline was Updated with numerous clinical changes to expand coverage:
		  ○ Cardiac Imaging
		
		Posted **9/2/2025**; Effective **12/1/2025**
		
		Important **changes** in coverage criteria.
		• Numerous clinical changes throughout will expand and limit coverage:
		  ○ Oncology Imaging
		
		Posted **9/19/2025**; Effective **12/1/2025**
		
		Important **changes** in coverage criteria.
		• One guideline was updated with clinical changes which will expand coverage:
		  ○ Breast Imaging
		
		Posted **9/19/2025**; Effective **2/3/2026**
		
		Important **changes** in coverage criteria.
		• Four guidelines were updated with clinical changes which will expand coverage:
		  ○ Preface to the Imaging Guidelines
		  ○ Neck Imaging
		  ○ Pediatric Neck Imaging
		  ○ Pediatric Chest Imaging
		• Two guidelines were updated with clinical changes which will expand and limit coverage:
		  ○ Pediatric Abdomen Imaging
		  ○ Spine Imaging
		• One guideline was Updated with no clinically impactful changes:
		  ○ Pediatric and Special Populations Spine Imaging

Cobranded Cigna-EviCore Lab Management Guidelines	Updated	**Posted 10/1/2025; Effective 1/1/2026** Important **changes** in coverage criteria.

		Five new guidelines: • Expanded Carrier Screening Panels • Genomic Prostate Score • Prolaris • Hereditary Ataxia Genetic Testing • Hereditary Connective Tissue and Thoracic Aortic Disease Genetic Testing Eleven guidelines had clinically substantive changes: • Genetic Testing by Multigene Panels • Experimental, Investigational, or Unproven Laboratory Testing • Preimplantation Genetic Testing (Formerly Preimplantation Genetic Screening and Diagnosis) • Chromosomal Microarray Testing For Developmental Disorders (Prenatal and Postnatal) • Lynch Syndrome Genetic Testing • Somatic Mutation Testing • Facioscapulohumeral Muscular Dystrophy Genetic Testing • Exome Sequencing • Decipher Prostate Cancer Classifier • Genome Sequencing • Human Platelet and Red Blood Cell Antigen Genotyping Nine guidelines were retired: • Carrier Screening Panels, Including Targeted, Pan-Ethnic, Universal, and Expanded • Ataxia-Telangiectasia Genetic Testing • Friedreich Ataxia Genetic Testing • Hereditary Ataxia Multigene Panel Testing • Spinocerebellar Ataxia Genetic Testing • Marfan Syndrome Genetic Testing • Thoracic Aortic Aneurysms and Dissections (TAAD) Panel Genetic Testing • Ehlers-Danlos Syndrome Genetic Testing • Hereditary Connective Tissue Disorder Genetic Testing
Cobranded Cigna-EviCore Musculoskeletal Management Guidelines	Updated	Posted **9/19/2025**; Effective **12/18/2025** The following guidelines were Updated with no clinically impactful changes: • CMM-208: Ablations/Denervations of Facet Joints and Peripheral Nerves • CMM-308: Intradiscal Procedures • CMM-612: Grafts • CMM-615: Electrical and Low Frequency Ultrasound Bone Growth Stimulation (Spine)

		• Preface to the Comprehensive Musculoskeletal Management (CMM) Guidelines

Cobranded Cigna-EviCore Vascular Intervention Guidelines	Updated	Posted **7/1/2025**; Effective **10/1/2025**:
		
		Important **changes** in coverage criteria.
		• Cerebrovascular Intervention
		  ○ Added indications for venous sinus stenting in treatment of idiopathic, intracranial hypertension (IIH) for specific conditions.
		• Peripheral Vascular Intervention
		  ○ Guideline was Updated with several clinical changes which will expand and limit coverage.

Administrative Policy	**New, Updated, or Retired?**	**Comments**
Authorized Generics - (A008)	Updated	Effective: 10/1/2025 • **Added** Umeclidinium and vilanterol inhalation powder authorized generic for Anoro Ellipta as a not covered product for all Employer Plans.
Preventive Care Services – (A004)	Updated	Effective 10/15/2025 • No change in coverage. ICD10 code Updated only.
Cigna Healthcare Drug Coverage Policy	**New, Updated, or Retired?**	**Comments**
Allergen Immunotherapy – Palforzia - (IP0141)	Updated	Effective 10/15/2025 • **Peanut allergy:** Throughout the criteria, references to "epinephrine auto-injectors" were Updated to "epinephrine self-administered injectable or nasal products." Neffy was added as an example of an epinephrine self-administered injectable or nasal product.

		• **Updated** "Per the prescriber" to "According to the prescriber" throughout the policy.
Amifampridine Products - (IP0290)	Updated	Effective 10/15/2025 • **Lambert-Eaton Myasthenic Syndrome (LEMS). Added "[Documentation Required]"** to criteria.
Antifungals – Cresemba (Oral) - (IP0305)	Updated	Effective 10/15/2025 • **Esophageal Candidiasis in a Patient with Human Immunodeficiency Virus**: Previously this condition of approval was titled "Esophageal Candidiasis (Systemic) in a Patient with Human Immunodeficiency Virus." • **Fungal Infection (Systemic) in a Patient with Human Immunodeficiency Virus:** New condition of approval was added to the Other Uses with Supportive Evidence.
Bone Modifiers – Denosumab Products (Prolia) - (IP0331)	Updated	• Coding Information Updated: **Added HCPCS** Q5157 with a code effective date of 10/1/2025 **Updated** the description for C9399, J3490 & J3590 to include the note "Code effective until 09/30/2025"

Brands with Bioequivalent Generics - (IP0011)	Updated	Effective 10/01/2025
		• **Added for Employer Plans:**
		  ○ Entresto, MetroCream, MetroGel, MetroLotion, Veltin and Ziana
		• **Added for Individual and Family Plans:**
		  ○ MetroCream, MetroGel, MetroLotion, Ziana
		• **Removed for Individual and Family Plans:**
		  ○ Atralin

Chemoprotective Agent – Pedmark - (IP0512)	Updated	Effective 10/1/2025 **Policy Title:** • **Updated from** "Sodium thiosulfate" **to** "Chemoprotective Agent – Pedmark"

		• **Ototoxicity Risk Reduction.** • **Removed** the requirement that patient must be <18 years of age. • **Updated from** "Has localized, non-metastatic solid tumor" **to** "Patient has a solid tumor; Note: Examples of solid tumors include medulloblastoma, osteosarcoma, germ cell tumor, neuroblastoma, hepatoblastoma, anaplastic astrocytoma; Patient has localized, non-metastatic disease"
Complement Inhibitors – Eculizumab Products - (IP0549)	Updated	Effective 10/1/2025 • **Atypical hemolytic uremic syndrome:** Dosing recommendations were further clarified to align with the prescribing information. • **Generalized myasthenia gravis, Neuromyelitis optica spectrum disorder, Paroxysmal nocturnal hemoglobinuria, Dosing section:** Dosing recommendations were split for Initial Therapy and Patient is Currently Receiving Eculizumab. All dosing recommendations align with the prescribing information. • **Conditions Not Covered, Concomitant Use with a Rituximab Product, a Neonatal Fc Receptor Blocker, or Zilbrysq (zilucoplan subcutaneous injection):** Imaavy was added to the Note of examples of neonatal Fc receptor blockers.
Complement Inhibitors – Ultomiris - (IP0550)	Updated	Effective 10/1/2025 • **Atypical hemolytic uremic syndrome, Generalized myasthenia gravis, Neuromyelitis optica spectrum disorder, Paroxysmal nocturnal hemoglobinuria, Dosing section:** Dosing recommendations were further clarified to align with the prescribing information. • **Generalized myasthenia gravis, Neuromyelitis optica spectrum disorder, Paroxysmal nocturnal hemoglobinuria, Dosing section:** Dosing recommendations were split for Initial Therapy and Patient is Currently Receiving Eculizumab. All dosing recommendations align with the prescribing information. • **Conditions Not Covered, Concomitant Use with a Rituximab Product, a Neonatal Fc Receptor Blocker, or Zilbrysq (zilucoplan subcutaneous injection):** Imaavy was added to the Note of examples of neonatal Fc receptor blockers.

Complement Inhibitors – Zilbrysq - (IP0622)	Updated	Effective 10/1/2025 • **Conditions Not Covered, Concomitant Use with Another Complement Inhibitor, a Neonatal Fc Receptor Blocker, or a Rituximab Product:** Imaavy was added to the Note of examples of neonatal Fc receptor blockers.
COVID-19 Drug and Biologic Therapeutics - (2016)	Updated	Effective 10/15/2025 Coding Information: • **Added** HCPCS codes M0235 M0236 Q0235 (all effective 10/1/2025)
Cushing's – Isturisa - (IP0044)	Updated	Effective 10/1/2025 • **Updated** the diagnostic requirement by removing "According to the prescriber".
Dermatology-Gene Therapy-Zevaskyn - (IP0747)	Updated	Effective: 10/15/2025 • **Dystrophic Epidermolysis Bullosa; Recessive:** The requirement the prescriber attests that the medication has not been previously applied to the target wound(s) was added. The requirement "squamous cell carcinoma has been considered for the target wound(s)" was modified to "the prescriber attests that there is no evidence or clinical suspicion of squamous cell carcinoma at the target wound(s)". Coding Information: **Added HCPCS: C9399 & J3490**
Diabetes – Diabetic Supplies - (IP0272)	Updated	Effective 10/1/2025 **Employer Plans:** • **Added** FreeStyle and TRUE METRIX test strips to preferred alternatives and **removed** OneTouch test strips. • **Removed** criterion for FreeStyle Precision strips used with Freestyle Libre reader. **Individual and Family Plans:** • **Added** Glucose Meters to the policy. • **Added** FreeStyle and TRUE METRIX test strips to preferred alternatives and **removed** OneTouch test strips

		• **Removed** criterion for FreeStyle Precision strips used with Freestyle Libre reader • **Added** FreeStyle and TRUEplus lancets to preferred alternatives and **removed** OneTouch lancets • **Added** TRUEdraw lancing device to preferred alternative and **removed** OneTouch lancing device.
Drugs Requiring Medical Necessity Review for Employer Plans - (1602)	Updated	Effective 10/1/2025 • **Added preferred product step requirement for the following products:** adapalene 0.1% cream, adapalene 0.3% gel, adapalene 0.3% gel pump, adapalene 0.1% lotion, adapalene 0.1% solution, Altreno, Atralin, Retin-A Cream (0.025%, 0.05%, and 0.1%), Retin-A Gel (0.025% and 0.01%), Retin-A Micro Gel (0.04% and 0.1%), Retin-A Micro Gel Pump (0.04%, 0.06%, and 0.1%), tretinoin cream (0.025%, 0.05% and 0.1%), tretinoin 0.05% gel, tretinoin microsphere gel (0.04% and 0.1%), tretinoin microspheres gel pump (0.04%, and 0.1%), Tezruly, Combogesic, Arbli (effective 10/15/2025), bisoprolol fumarate 2.5 mg tablets, Lopressor oral solution, EdurantPED, Symbravo, Crinone 4% Gel, Noritate, and Zilxi • **Updated preferred product step requirement for the following products:** Differin 0.1% cream, Qtern, Steglujan, Fosrenol oral powder, Ermeza, levothyroxine capsules (tirosint generic), Thyquidity, Tirosint, Tirosint-SOL, Zoryve 0.3% cream, and Zoryve 0.3% foam • **Updated** Differin 0.3% gel **to** Differin 0.3% gel pump
Enzyme Replacement Therapy – Strensiq - (IP0308)	Updated	Effective 10/1/2025 • **Added** a policy statement. • **Added** documentation requirements. • **Updated** the conditions not covered statement.
Graft-Versus-Host Disease – Ryoncil - (IP0732)	Updated	**Coding Information Updated:** • **Added HCPCS**: J3402 with a code effective date of 10/1/2025 • **Updated** the description for J3590 to include the note "Code effective until 09/30/2025"

Growth Disorders – Ngenla - (IP0577)	Updated	Effective 10/01/2025 The following statement in the Policy Statement was Updated to include a clinician nurse: "All reviews will be directed to a clinician (i.e., pharmacist or nurse) for verification of criteria." • **Growth Hormone Deficiency in a Pediatric Patient (≥ 3 years of age to < 18 years of age)**: The wording "at least" was added to the requirement for two growth hormone stimulation tests < 10 ng/mL. • **Conditions Not Covered:** Updated Central Precocious Puberty information **Updated** Employer Plans and Individual and Family Plans preferred product table.
Growth Disorders – Skytrofa - (IP0375)	**Updated**	Effective 10/01/2025 The following statement in the Policy Statement was Updated to include a clinician nurse: "All reviews will be directed to a clinician (i.e., pharmacist or nurse) for verification of criteria." • **Growth Hormone Deficiency in a Pediatric Patient (≥ 1 year of age)**: The wording "at least" was added to the requirement for two growth hormone stimulation tests < 10 ng/mL. Added criterion related to continuation of therapy if the patient's mid-parenteral height has not been obtained. • **Growth Hormone Deficiency in an Adult or Transition Adolescent:** Added criterion for this diagnosis. Documentation requirements were also added for this diagnosis. • **Conditions Not Covered:** • Updated Acute Critical Illness Due to Complications Following Surgery, Multiple Accidental Trauma, or with Acute Respiratory Failure, Central Precocious Puberty and Infertility information **Updated** preferred product tablet for Employer Plans and Individual and Family Plans
Hemophilia – Non-Factor Routine Prophylaxis Products – Alhemo - (IP0730)	Updated	Effective Date 10/1/2025 • **Removed** preferred product table from Employer Plans • **Coding Information Updated**: ○ **Added HCPCS Coding Table** with HCPCS Code J7173 with a code effective date of 10/1/2025 Effective Date 10/15/2025

		• **Hemophilia A without Factor VIII Inhibitors:**
		  ○ This condition and criteria for approval were added to the policy. **[documentation required]** added to indication.
		• **Hemophilia B without Factor IX Inhibitors:**
		  ○ This condition and criteria for approval were added to the policy. **[documentation required]** added to indication.
		• **Updated** policy template.

Hemophilia – Non-Factor Routine Prophylaxis Products – Hemlibra - (IP0121)	Updated	Effective Date 10/15/2025 • **Updated** policy template.
Hemophilia – Non-Factor Routine Prophylaxis Products – Hympavzi - (IP0731)	Updated	Effective Date 10/1/2025 • **Removed** preferred product table from Employer Plans • Effective Date 10/15/2025 • **Updated** policy template.
Hemophilia – Non-Factor Routine Prophylaxis Products – Qfitlia - (IP0742)	Updated	Effective 10/1/2025 • **Added** preferred product table for Employer Plans • **Coding Information:** ○ **Added HCPCS Coding Table** with HCPCS Code J7174 with a code effective date of 10/1/2025
Hepatology – Bylvay - (IP0363)	Updated	Effective 10/1/2025 • **Alagille Syndrome:** Fenofibrate was added to the Note with examples of systemic medications that should be tried prior to approval of Bylvay. • **Progressive Familial Intrahepatic Cholestasis**: Fenofibrate was added to the Note with examples of systemic medications that should be tried prior to approval of Bylvay. • **Added** documentation requirements throughout policy
Hepatology – Rezdiffra (IP0642)	**Update**	Effective 10/16/2025

		Metabolic-Dysfunction Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH). Initial Therapy. For the criterion regarding confirmation of the diagnosis of MASH/NASH, the requirement that the diagnosis be "prior to treatment with Rezdiffra" was removed. The number of metabolic risk factors in the following criterion was changed to ONE or more (previously THREE of more): According to the prescriber, the patient has ONE or more of the following metabolic risk factors that are managed according to standard of care: central obesity, hypertriglyceridemia, reduced high-density lipoprotein cholesterol, hypertension, elevated fasting plasma glucose indicative of diabetes or pre-diabetes.
Idiopathic Pulmonary Fibrosis and Related Lung Disease – Ofev - (IP0312)	Updated	Effective 10/15/2025 • **Updated** Policy Statement • **Added** documentation requirements throughout policy.
Idiopathic Pulmonary Fibrosis and Related Lung Disease – Pirfenidone - (IP0311)	Updated	Effective 10/1/2025 • **Updated** Policy Statement. • The requirement that a patient cannot take generic pirfenidone was Updated to state that this was due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the brand and bioequivalent generic product which, per the prescriber, would result in a significant allergy or serious adverse reaction [documentation required]. Previously it stated that patient has experienced inadequate efficacy or significant intolerance, according to the prescriber [documentation required]. • **Added** documentation requirements throughout policy
Immune Globulin – (5026)	Updated	Effective 10/1/2025 • **Conditions Not Covered.** ○ **Updated** "experimental, investigational, or unproven" to "not medically necessary".
Immunologicals – Xolair - (IP0487)	Updated	Effective 10/15/2025 • **Immunoglobulin (Ig)E-Mediated Food Allergy**: Throughout the criteria, references to "epinephrine auto-injectors" were updated to "epinephrine self-

		administered injectable or nasal products." Neffy was added as an example of an epinephrine self-administered injectable or nasal product.
Infectious Disease – Sirturo - (IP0494)	Updated	Effective 10/15/2025 • **Tuberculosis.** The age requirement was changed from ≥ 5 years to ≥ 2 years of age. The weight requirement was changed from ≥ 15 kg to ≥ 8 kg.
Inflammatory Conditions – Leqselvi Prior Authorization Policy - (IP0751)	New	Effective 10/1/2025 New policy
Inflammatory Conditions – Entyvio Intravenous Prior Authorization Policy - (IP0674)	Updated	Effective 10/15/2025 • **Gastrointestinal Toxicity Associated with Checkpoint Inhibitor Therapy:** This condition and criteria and dosing for approval were added to the policy. • **Graft-Versus-Host Disease:** This condition and criteria and dosing for approval were added to the policy. • **Crohn's Disease:** Dosing was divided into an initial therapy and continuation of therapy regimen. Added an option of approval for 300 mg intravenous infusion administered every 4 weeks for a patient currently receiving Entyvio intravenous or subcutaneous. • **Ulcerative Colitis:** Dosing was divided into an initial therapy and continuation of therapy regimen. Added an option of approval for 300 mg intravenous infusion administered every 4 weeks for a patient currently receiving Entyvio intravenous or subcutaneous.
Inflammatory Conditions – Etanercept Products Prior Authorization Policy - (IP0673)	Updated	Effective 10/15/2025 • **Graft-versus-Host Disease:** For initial approvals, modified the requirement that patient has tried at least one conventional systemic treatment to at least one systemic treatment. Imatinib, methotrexate, Rezurock (belumosudil tablets), Niktimvo (axatilimab-csfr intravenous infusion), hydroxychloroquine, a rituximab intravenous product, Jakafi (ruxolitinib tablets), Imbruvica (ibrutinib tablets, capsules, and oral suspension), Simulect (basiliximab intravenous injection), an infliximab

		intravenous product, sirolimus, Nipent (pentostatin intravenous injection), a tocilizumab intravenous product, Proleukin (aldesleukin intravenous infusion), and Entyvio (vedolizumab intravenous infusion) were added to the Note of examples of systemic medications.
Inflammatory Conditions – Infliximab Intravenous Products Prior Authorization Policy - (IP0660)	Updated	Effective 10/15/2025 • **Graft-versus-Host Disease:** For initial approvals, added the requirement that patient has acute graft-versus-host disease. Modified the requirement that patient has tried at least one conventional systemic treatment to at least one systemic medication. Jakafi (ruxolitinib), Simulect (basiliximab), an etanercept product, sirolimus, Nipent (pentostatin), a tocilizumab product, and Entyvio (vedolizumab) were added to the Note of examples of systemic medications. • **Immunotherapy-Related Toxicities Associated with Checkpoint Inhibitor Therapy:** "According to the prescriber" was added to the requirement that patient experienced an immunotherapy-related toxicity while receiving a checkpoint inhibitor and specific examples of immunotherapy-related toxicities were removed. Cardiologist, hematologist, nephrologist, and pulmonologist were added as accepted specialists to the specialist requirement.
Inflammatory Conditions – Kineret Prior Authorization Policy - (IP0661)	Updated	Effective 10/15/2025 • **Castleman Disease:** This condition was added to Other Uses with Supportive Evidence. • **Erdheim-Chester Disease:** This condition was added to Other Uses with Supportive Evidence. • **Immunotherapy-Related Toxicities associated with Chimeric Antigen Receptor T-cell Therapy:** This condition was added to Other Uses with Supportive Evidence.
Inflammatory Conditions – Otezla/Otezla XR Prior Authorization Policy - (IP0666)	Updated	Effective 10/15/2025

		• The title of the policy was changed from Inflammatory Conditions – Otezla Prior Authorization Policy to Inflammatory Conditions – Otezla/Otezla XR Prior Authorization Policy. • **Behcet's Disease:** Otezla XR was added with the same criteria as Otezla. • **Plaque Psoriasis and Psoriatic Arthritis:** Otezla XR was added with the same criteria as Otezla with the additional requirement of patient weighs ≥ 50 kg.
Inflammatory Conditions – Tocilizumab Intravenous Products Prior Authorization Policy - (IP0656)	**Updated**	Effective 10/15/2025 • **Cytokine Release Syndrome Associated with Bispecific Antibodies:** This was added as a condition of approval. • **Graft-Versus-Host Disease:** This was added as a condition of approval. • **Immunotherapy-Related Toxicities Associated with Checkpoint Inhibitor Therapy:** This condition was expanded from inflammatory arthritis to immunotherapy-related toxicities associated with checkpoint inhibitors. Requirements were added that, according to the prescriber, the patient developed an immunotherapy-related toxicity, and that the patient developed this immunotherapy-related toxicity while receiving a checkpoint inhibitor. The requirement that the patient has tried at least one non-steroidal anti-inflammatory drug was removed. Gastroenterologist, hepatologist, and pulmonologist were added as accepted specialists to the specialist requirement. For a patient currently receiving tocilizumab, prior use of the subcutaneous product was removed. In addition, the Note of examples of objective measures was modified to include that they are dependent upon organ involvement and laboratory parameters (e.g., liver function tests) were added to the list of examples.
Inflammatory Conditions – Ustekinumab Intravenous Products Prior Authorization Policy – (IP0686)	Updated	Effective 10/15/2025 • **Imuldosa intravenous** was added to the policy; the same criteria apply for all ustekinumab intravenous products. • Coding Information ○ Added: HCPCS code Q5098
Inflammatory Conditions – Ustekinumab	Updated	Effective 10/15/2025

Subcutaneous Products Prior Authorization Policy - (IP0687)		• **Imuldosa subcutaneous** was added to the policy; the same criteria apply for all ustekinumab subcutaneous products. • Coding Information ○ Added: HCPCS code Q5098
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Standard/Performance, Value/Advantage, and Total Savings Prescription Drug Lists - (PSM021)	Updated	Effective 10/15/2025 • **Imuldosa** was added as a Non-Preferred subcutaneous product. A patient is directed to a trial of all the Preferred Products with documentation requirements. Documentation is also required to support the requirement that formulation difference(s) in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Legacy Prescription Drug List Plans - (PSM022)	Updated	Effective 10/15/2025 • **Imuldosa** was added as a Non-Preferred subcutaneous product. A patient is directed to a trial of all the Preferred Products with documentation requirements. Documentation is also required to support the requirement that formulation difference(s) in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction.
Inflammatory Conditions – Ustekinumab Subcutaneous Products Preferred Specialty Management Policy for Individual and Family Plans - (PSM023)	Updated	Effective 10/15/2025 • **Imuldosa** was added as a Non-Preferred subcutaneous product. A patient is directed to a trial of all the Preferred Products with documentation requirements. Documentation is also required to support the requirement that formulation difference(s) in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction.
Inflammatory Conditions – Ustekinumab Intravenous Products	Updated	Effective 10/15/2025

Preferred Specialty Management Policy - (PSM024)		• **Imuldosa (ustekinumab-srlf) intravenous** was added to the policy as a Non-Preferred product. A patient is directed to a trial of all the Preferred Products with documentation requirements. Documentation is also required to support the requirement that formulation difference(s) in the inactive ingredient(s) which, according to the prescriber, would result in a significant allergy or serious adverse reaction. • **Pyzchiva intravenous** was Updated to direct to a trial of all the Preferred Products with documentation requirements. The same exception criteria will now apply for all Non-Preferred products.
Metabolic Disorders – Dojolvi - (IP0084)	Updated	Effective 10/1/2025 • **Added** a policy statement. • **Added** documentation requirements. • **Updated** the conditions not covered statement.
Metabolic Disorders – Nulibry - (IP0142)	Updated	• **Coding Information Updated:** **Added HCPCS** J1809 with a code effective date of 10/1/2025 **Updated** the description for C9399, J3490 to include the note "Code effective until 09/30/2025"
Migraine – Calcitonin Gene-Related Peptide Inhibitors – Ajovy - (IP0504)	Updated	• **Migraine Headache Prevention in Adults:** The approval condition was modified to include "in Adults". • **Preventive Treatment of Episodic Migraine in Pediatric Patients:** This was added as a new condition of approval. • **Preferred Product Table:** • **Added** "Patient is ≥ 6 years of age and < 18 years of age and is using Ajovy for the preventive treatment of episodic migraine" step requirement.
Muscular Dystrophy – Viltepso - (IP0066)	Updated	Effective: 10/15/2025 • **Policy Title:** ○ **Updated** from "Viltolarsen" to **"**Muscular Dystrophy – Viltepso." • **Duchenne Muscular Dystrophy (DMD):**

		○ **Updated** criteria to split between "Initial Therapy" and "Patient is Continuing Therapy." ○ **Updated** word "mutation" to "pathogenic or likely pathogenic variant." ○ **Added** criteria for "Patient is Continuing Therapy." Approve for 6 months if the patient meets the following: 1. Diagnosis of Duchenne muscular dystrophy (DMD) **[Documentation Required].** 2. Patient has a confirmed pathogenic or likely pathogenic variant of the DMD gene that is amenable to exon 53 skipping. 3. Patient was less than 10 years of age at start of therapy. 4. Patient is able to walk. 5. The medication is being prescribed by, or in consultation with, a neurologist, neuromuscular specialist, or by a Muscular Dystrophy Association (MDA) clinic.
Nephrology – Jesduvroq - (IP0604)	Updated	Effective: 10/15/2025 • **Updated** "Individual" **to** "Patient" throughout the policy. • **Anemia in a Patient with Chronic Kidney Disease who is on Dialysis – Patient is Continuing Therapy with Jesduvroq.** • **Updated** criteria from "Beneficial response is demonstrated by ONE of the following:" **to** "According to the prescriber, patient has experienced a response to therapy" and moved examples of a response to a Note. **Preferred Product Table – Employer Plans** • **Updated** criteria **from** "Documentation of failure, contraindication, or intolerance to ONE of the following:" **to** "Patient has tried, and according to the prescriber, has experienced inadequate efficacy OR significant intolerance with ONE of the following:" **Conditions Not Covered** • **Added** "Concurrent Use with Vafseo (vadadustat tablets). The safety and efficacy of concurrent use of Jesduvroq and Vafseo have not been established."
Oncology (Injectable – CAR-T) – Tecartus - (IP0199)	Updated	Effective 10/15/2025 • **Policy Title.** ○ **Updated from "**brexucabtagene autoleucel" to "Oncology (Injectable – CAR-T) – Tecartus"

		• **Added "<u>Documentation</u>:** Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but is not limited to, chart notes, laboratory tests, claims records, and/or other information."
Oncology (Injectable – T-Cell Immunotherapy – MAGE-A4) – Tecelra - (IP0699)	Updated	Effective: 10/1/2025 • **Policy Title**: ○ **Updated from** "Oncology (Injectable) – Tecelra" **to** "Oncology (Injectable – T-Cell Immunotherapy – MAGE-A4) – Tecelra" • **Synovial Sarcoma:** In the requirement that the patient has unresectable or metastatic disease, "advanced" was added as another option for approval.
Oncology Medications - (CP1403)	Updated	Effective: 10/1/2025 **Alunbrig.** • **Removed** criteria for Alunbrig for Employer Plans **Bosulif.** • **Removed** "Philadelphia Chromosome Positive" • **Updated from** "Tasigna" **to** "nilotinib" for Employer Plans for Chronic Myeloid Leukemia (CML); **Added** "Tasigna" to prior use counting **Danziten.** • **Removed** "Philadelphia Chromosome Positive" • **Added** "nilotinib" as an alternative for Chronic Myeloid Leukemia (CML); **Added** "Tasigna" to prior use counting for Employer Plans **Fruzaqla.** • **Removed** criteria for Fruzaqla. **Iclusig.** • **Removed** "Philadelphia Chromosome Positive" • **Updated from** "Tasigna" **to** "nilotinib" for Employer Plans for Chronic Myeloid Leukemia (CML); **Added** "Tasigna" to prior use counting

		• **Added** for Acute Lymphoblastic Leukemia **"**Patient is ≥ 18 years of age, has newly diagnosed disease, and is taking the requested medication with chemotherapy; Patient has T315I-positive mutation" **Ivra.** • **Added** criteria for Ivra **Nilotinib.** • **Added** criteria for Nilotinib for Individual and Family Plans **Provenge.** • **Removed** criteria for Provenge. **Scemblix.** • **Removed** "Philadelphia Chromosome Positive" **Tasigna.** • **Removed** "Philadelphia Chromosome Positive" • **Updated** criteria to "Documented trial of **nilotinib** (the bioequivalent generic product) [may require prior authorization] AND cannot take due to a formulation difference in the inactive ingredient(s) which would result in a significant allergy or serious adverse reaction" **Tepylute.** • **Added** criteria for Tepylute (Effective 11/1/2025) **Zykadia.** • **Added** "Or Alunbrig" to the Zykadia step for Employer Plans
Ophthalmology – Dry Eye Disease – Tryptyr - (IP0760)	New	Effective: 10/15/2025 New Policy.
Ophthalmology – Gene Therapy – Encelto - (IP0744)	Updated	**Coding Information Updated:** • **Added HCPCS**: J3403 with a code effective date of 10/1/2025 • **Updated** the description for C9399, J3490 & J3590 to include the note "Code effective until 09/30/2025"

Ophthalmology – Oxervate - (IP0302)	Updated	Effective: 10/1/2025 • **Neurotrophic Keratitis.** For initial therapy, the word "previously" was removed from the number of weeks of treatment received. A Note was added to clarify that each course of Oxervate is 8 weeks is added. For recurrence, the word "previously" was removed from the number of weeks of treatment received and the duration "> 8 weeks and < 16 weeks" was revised to < 16 weeks. A Note that "Each course of Oxervate for the treatment of recurrent neurotrophic keratitis is 8 weeks; total of 16 weeks for initial and recurrent neurotrophic keratitis" was added.
Oteseconazole - (IP0513)	Updated	Effective 10/1/2025 • The approval duration for this condition was Updated to state 4 months. Previously, it stated "one treatment course." • **Removed** documentation requirements
Pharmacy Prior Authorization - (1407)	Updated	Effective: 10/1/2025 • **Added Individual and Family Plan product-specific medical necessity criteria for the following products:** Dapsone gel 7.5% (brand), Atralin, Differin cream, Differin gel pump, Retin-A Cream (0.025%, 0.05%, and 0.1%), Retin-A Gel (0.025% and 0.01%), Retin-A Micro Gel (0.04% and 0.1%), Retin-A Micro Gel Pump (0.04%, 0.08%, and 0.1%), bisoprolol fumarate 2.5 mg tablets, Bucapsol capsules, Khindivi, Admelog, Admelog SoloStar, Apidra, Apidra SoloStar, Fiasp, Fiasp PumpCart, Lyumjev, Lyumjev KwikPen, Lyumjev Tempo Pen, Merilog, Merilog SoloStar, budesonide extended release 9mg tablets, budesonide rectal foam, Uceris rectal foam, Uceris tablets, Crinone 4% Gel, Crinone 8% Gel, Noritate, and Zilxi • **Updated Individual and Family Plan product-specific medical necessity criteria for the following products:** Glyxambi, Qtern, Steglujan, Trijardy XR, insulin aspart (authorized generic for NovoLog), NovoLog, Ermeza, levothyroxine capsules (tirosint generic), Thyquidity, Tirosint, Tirosint-SOL, Zoryve 0.3% cream, and Zoryve 0.3% foam
Pilocarpine 1.25% Ophthalmic - (IP0343)	Updated	Effective 10/15/2025 • **Added** generic pilocarpine 1.25% ophthalmic solution to policy.

		• IFP to now direct to IP0434 (Previously in CM)
Proprotein Convertase Subtilisin Kexin Type 9 Related Products – Leqvio - (IP0380)	Updated	Effective 10/15/2025 • **Heterozygous Familial Hypercholesterolemia:** For initial therapy the requirement that the patient has tried one high-intensity statin along with ezetimibe (as a single-entity or as a combination product) for ≥ 8 continuous weeks was removed. The requirement remains that the patient has tried one high-intensity statin therapy (i.e., atorvastatin ≥ 40 mg daily; rosuvastatin ≥ 20 mg daily [as a single entity or as a combination product]) and the qualifier of "for ≥ 8 continuous weeks" was added for clarification. • **Established Cardiovascular Disease:** For initial therapy the requirement that the patient has tried one high-intensity statin along with ezetimibe (as a single-entity or as a combination product) for ≥ 8 continuous weeks was removed. The requirement remains that the patient has tried one high-intensity statin therapy (i.e., atorvastatin ≥ 40 mg daily; rosuvastatin ≥ 20 mg daily [as a single entity or as a combination product]) and the qualifier of "for ≥ 8 continuous weeks" was added for clarification. • **Primary Hyperlipidemia:** Added "**[documentation required]**" to the following criteria: Patient has a coronary artery calcium or calcification score ≥ 300 Agatston units [may require prior authorization].
Quantity Limitations - (1201)	Updated	Effective 10/1/2025 • **Added** quantity limits for Qelbree • **Added** quantity limits for Symbravo. • **Added** quantity limits for Zoryve foam.

Rituximab Intravenous Products for Non-Oncology Indications - (IP0319)	Updated	• **Updated "Pemphigus Vulgaris and Other Refractory Autoimmune Blistering Diseases" to "Pemphigus Vulgaris"**
		• Initial Treatment:
		  ○ **Updated** approval duration **from** 12 months **to** 1 month
		  ○ **Removed** "Note: Examples of other autoimmune blistering diseases include pemphigus foliaceus, bullous pemphigoid, cicatricial pemphigoid, epidermolysis bullosa acquisita, and paraneoplastic pemphigus"

		○ **Updated from** Patient who is being treated for a relapse or for maintenance **to** Patient is being treated for a relapse and a patient is being treated for maintenance. • <u>Patient is Being Treated for a Relapse of Pemphigus Vulgaris:</u> ○ **Updated** approval duration **from** 1 year **to** 1 month (which is adequate duration to administer one course of therapy). ○ **Added** "Note: For example, there will be a minimum of 16 weeks since the first dose of the previous course and the first dose of the next course of a rituximab product" • <u>Patient is Being Treated for Maintenance of Pemphigus Vulgaris:</u> ○ Added criteria that subsequent infusions will be administered no sooner than 16 weeks following the previous infusion of a rituximab product, and the medication is prescribed by or in consultation with a dermatologist. • <u>Dosing:</u> • **Removed** "at month 12 and every 6 months thereafter or based on clinical evaluation" • **Rheumatoid Arthritis** • <u>Initial Therapy:</u> ○ **Updated** approval duration from 12 months **to** 1 month • <u>Patient has already received one course of a Rituximab Product for Rheumatoid Arthritis:</u> ○ **Updated** approval duration from 12 months **to** 1 month ○ **Added criteria for "Patient has already received two or more courses of a Rituximab Product for Rheumatoid Arthritis"** **Other Uses with Supportive Evidence** **Graft-Versus-Host Disease** <u>Initial Therapy:</u> • **Updated** approval duration **from** 12 months **to** 1 month • **Added** "Patient has chronic graft-versus-host disease" • Updated "Documentation of failure, contraindication, or intolerance to ONE conventional systemic treatment for graft-versus-host disease [for example, systemic

		corticosteroids (methylprednisolone, prednisone), cyclosporine, tacrolimus, mycophenolate mofetil, Imbruvica (ibrutinib capsules and tablets), imatinib, antithymocyte globulin, Nipent (pentostatin infusion), or an infliximab product]" **to** "Patient has tried at least one systemic medication for graft-versus-host disease. Note: Examples of systemic medications include systemic corticosteroids (methylprednisolone, prednisone), Jakafi (ruxolitinib), Rezurock (belumosudil), Niktimvo (axatilimab-csfr), cyclosporine, tacrolimus, mycophenolate mofetil, Imbruvica (ibrutinib), imatinib, hydroxychloroquine, methotrexate, Nipent (pentostatin), interleukin-2 (e.g., Proleukin [aldesleukin]), sirolimus, or an etanercept product" **Added** criteria for "Patient has already Received a Course of a Rituximab Product for Graft-Versus-Host Disease" **Hematopoietic Cell Transplantation** **Added** criteria for this indication **Added** dosing for this indication **Updated from "Immune or Idiopathic Thrombocytopenia (ITP)" to "Immune Thrombocytopenia (ITP)"** <u>Initial Therapy:</u> **Updated** approval duration **from** 12 months **to** 1 month **Updated from** "Documentation of failure, contraindication, or intolerance to ONE other therapy for ITP (for example, intravenous immunoglobulin (IVIG), anti-D (RHO) immunoglobulin, corticosteroids, or splenectomy)" **to** "Patient has tried one other therapy. Note: Examples of therapies for ITP include intravenous immunoglobulin (IVIG), anti-D (RHO) immunoglobulin, corticosteroids, Alvaiz (eltrombopag), Doptelet (avatrombopag), Nplate (romiplostim), Promacta (eltrombopag), Tavalisse (fostamatinib) and splenectomy." <u>Patient has Already Received a Course of a Rituximab Product for ITP:</u> **Updated** approval duration **from** 12 months **to** 1 month **Updated from** "Documentation that the individual responded to therapy (for example, a platelet count increase from baseline following treatment with a rituximab product)" **to** "Patient responded to therapy as determined by the prescriber. Note: Examples of a response include a platelet count increase from baseline following treatment with a rituximab product" **Removed** "The medication is prescribed by or in consultation with a hematologist" **Immunotherapy-Related Toxicities Associated with Checkpoint Inhibitors** • **Added** "Note: Examples of checkpoint inhibitors are Keytruda (pembrolizumab intravenous infusion), Opdivo (nivolumab intravenous infusion), Yervoy (ipilimumab

		intravenous infusion), Tecentriq (atezolizumab intravenous infusion), Bavencio (avelumab intravenous infusion), Imfinzi (durvalumab intravenous infusion), and Libtayo (cemiplimab-rwlc intravenous infusion)." <u>Initial Therapy:</u> • **Updated** approval duration **from** 12 months **to** 1 month • **Added** "According to the prescriber, patient developed an immunotherapy-related toxicity" • **Added** "Patient developed this immunotherapy-related toxicity while receiving a checkpoint inhibitor" • **Added** hematologist and nephrologist to specialty requirement <u>Patient has Already Received a Course of a Rituximab Product:</u> • **Updated** approval duration **from** 12 months **to** 1 month • **Added** hematologist and nephrologist to specialty requirement <u>Dosing:</u> Updated "Up to 500 mg/m2 administered intravenously for 2 doses separated by at least 14 days" **to** "Approve up to 500 mg/m2 or up to 1,000 mg administered intravenously for 2 doses separated by at least 14 days" **Multiple Sclerosis** <u>Initial Therapy:</u> ○ **Updated from** "Documentation of failure, contraindication, or intolerance to at least ONE other disease-modifying agent for multiple sclerosis" to "According to the prescriber, the patient has experienced inadequate efficacy or significant intolerance to at least TWO other disease-modifying agents for multiple sclerosis. Note: See Appendix B for examples of disease-modifying agents used for multiple sclerosis." ○ **Added** criteria for "Patient is Currently Receiving Rituximab" **Neuromyelitis Optica Spectrum Disorder** • **Updated** approval duration **from** 12 months **to** 1 month

		• **Removed** "Diagnosis was confirmed by a positive blood serum test for anti-aquaporin-4 antibody [documentation required]" **Updated from "Systemic Lupus Erythematous (SLE) [Lupus]" to "Systemic Lupus Erythematosus (SLE) [Lupus]"** <u>Initial Therapy:</u> • **Updated** approval duration **from** 12 months **to** 1 month • **Updated from** "Documentation of failure, contraindication, or intolerance to ONE standard immunomodulating or immunosuppressant agent [for example, hydroxychloroquine, corticosteroids (e.g., prednisone, methylprednisolone), methotrexate, azathioprine, mycophenolate, or cyclophosphamide]" **to** "Patient has tried at least ONE standard immunomodulating or immunosuppressant agent. Note: Examples of standard immunomodulating or immunosuppressant agents include hydroxychloroquine, corticosteroids (e.g., prednisone, methylprednisolone), methotrexate, azathioprine, mycophenolate, and cyclophosphamide." <u>Individual has Already Received a Course of a Rituximab Product for SLE:</u> • **Updated** approval duration **from** 12 months **to** 1 month • **Removed** "The individual has had a documented beneficial response to therapy. Examples of a beneficial response include: reduction in flares; • reduction in corticosteroid dose; decrease of anti-dsDNA titer; improvement in specific organ dysfunction (for example, musculoskeletal, blood, hematologic, vascular, others)" • **Removed** "The medication is prescribed by or in consultation with a rheumatologist, nephrologist, or neurologist." • **Added** dosing for this indication
Somapacitan - (IP0576)	Updated	Effective 10/01/2025 • The following statement in the Policy Statement was Updated to include a clinician nurse: "All reviews will be directed to a clinician (i.e., pharmacist or nurse) for verification of criteria." • **Growth Hormone Deficiency in a Child or Adolescent**: The wording "at least" was added to the requirement for two growth hormone stimulation tests < 10 ng/mL. • **Growth Hormone Deficiency in Adult or Transition Adolescent:** The criterion "THREE or more of the following pituitary hormone deficiencies" was Updated to "Has

		or had THREE or more of the following pituitary hormone deficiencies prior to hormone replacement therapy (if hormone therapy is required)" • The criterion "The age and gender adjusted serum insulin-like growth factor-1 is below the lower limit of the normal reference range for the reporting laboratory" was Updated to "The age and gender adjusted serum insulin-like growth factor-1 is or was below the lower limit of the normal reference range for the reporting laboratory prior to growth hormone therapy". • **Conditions Not Covered:** Updated information for Central Precocious Puberty and Infertility • **Updated** Employer Plans and Individual and Family Plan preferred product table
Somatropin - (IP0452)	Updated	Effective 10/01/2025 • The following statement in the Policy Statement was Updated to include a clinician nurse: "All reviews will be directed to a clinician (i.e., pharmacist or nurse) for verification of criteria." • **Updated** Employer Plans and Individual and Family Plan preferred product requirements.
Transplantation – Grafapex - (IP0727)	Updated	**Coding Information was Updated:** • **Added HCPCS**: J0614 with a code effective date of 10/1/2025 • **Updated** the description for C9175 to include the note "Code effective until 09/30/2025"
Cardiology – Tryvio (IP0713)	Updated	Effective 10/15/2025 • No change in coverage
Cardiology – Ivabradine (IP0286)	Updated	Effective 10/15/2025 • No change in coverage

Diabetes – Symlin for Individual and Family Plans (IP0698)	Updated	Effective 10/1/2025 • No criteria changes
Hepatology – Ocaliva – (IP0304)	Updated	Effective 10/1/2025 • No criteria changes
Human Immunodeficiency Virus – Rukobia – (IP0083)	Updated	Effective 10/1/2025 • No criteria changes
Inflammatory Conditions – Xeljanz/Xeljanz XR Prior Authorization Policy - (IP0692)	Updated	Effective 10/15/2025 • No criteria changes
Migraine – Reyvow (IP0114)	Updated	Effective 10/1/2025 • No criteria changes
Nephrology – Xphozah (IP0608)	Updated	Effective 10/15/2025 • No criteria changes
Nephrology – Vafseo (IP0706)	Updated	Effective 10/15/2025 • No criteria changes
Progesterone – Employer Group Plans (IP0548)	Retired	Effective 10/1/2025 • **Relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602):** Noritate and Zilxi

		• **Relocated to Brands with Bioequivalent Generics (IP0011):** MetroCream, MetroGel, and MetroLotion
Proprotein Convertase Subtilisin Kexin Type 9 Inhibitors – Repatha (IP0195)	Retired	Effective 10/1/2025
Topical Rosacea Products (IP0003)	Retired	Effective 10/1/2025 • Crinone 4% gel relocated to Relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602) (Employer Plans)
Topical Tretinoin Products (IP0167)	Retired	Effective 10/1/2025 • **Relocated to Drugs Requiring Medical Necessity Review for Employer Plans (1602):** Altreno, Atralin, Retin-A Cream (0.025%, 0.05%, 0.1%), Retin-A Gel (0.025% and 0.01%), Retin-A Micro Gel (0.04% and 0.1%), Retin-A Micro Gel Pump (0.04%, 0.06%, 0.08%, and 0.1%), tretinoin 0.025%, 0.05% and 0.1% cream, tretinoin 0.05% gel, tretinoin microsphere 0.04% and 0.1% gel, tretinoin microspheres gel 0.04% and 0.1% pump • **Relocated to Brands with Bioequivalent Generics (IP0011):** Retin-A Gel (0.025% and 0.01%), Veltin, and Ziana
CareAllies Medical Necessity Guideline	**New, Updated, or Retired?**	**Comments**
		• All above updates apply
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
Precertification Policies	New and Updated	Updated prior authorization requirements are available on our websites, CignaforHCP.com and Cigna.com. Additions consist of new codes released by CMS and the AMA that have been selected for our prior authorization program. Updates include existing codes that have been added and removed from prior authorization.

		New Codes: • For October 1, 2025, Cigna added 10 CPT, and 34 HCPCS newly released codes to prior authorization. • For September 30, 2025, CMS/AMA deleted/terminated 12 codes, 2 CPT and 10 HCPCS. **Updates:** • For October 17, 2025, Cigna added 3 CPT, and 1 HCPCS existing codes to prior authorization. • • For October 17, 2025, 18 codes were removed from prior authorization, 16 CPT and 2 HCPCS.
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
Ambulance Services - (R18)	Updated	
Facility Services, Supplies, and Equipment - (R12)	Updated	
Professional Services Performed by a Facility Owned Practices - (R40)	Retired	
Evaluation and Management Services - (R30)	Updated	
Evaluation and Management Coding Accuracy - (R49)	Updated	
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**

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