Payment Policy & Coding (PPC) - Monthly Policy Updates

Effective September 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
Bariatric Surgery and Procedures – (0051)	Update	**Posting date 9/15/2024, effective date 12/15/2024** Minor **changes** in coverage criteria/policy: • Added the word initial to both adult and adolescent to the coverage statement to indicate what surgery is approved for a first or initial surgery. • Added CPT codes C9784 and C9785 to the EIU coverage statement for the correct procedures they represent. • Changed the EIU statement for bariatric surgery for primary treatment of any condition other than morbid obesity to NMN because it doesn't meet Cigna's definition of EIU.
Benign Prostatic Hyperplasia (BPH) Surgical Treatments – (0159)	Update	Minor **changes** in coverage criteria/policy: • Removed the three covered procedures from the policy because they're not managed. • Changed the EIU statement for the non-covered procedures to NMN because they don't meet Cigna's definition of EIU.

Breast Reconstruction Following Mastectomy or Lumpectomy – (0178)	Update	Minor **changes** in coverage criteria/policy: • Changed verbiage in the list of non-covered products from NMN to EIU because these products meet Cigna's definition of EIU.
Cardiac Resynchronization Therapy (CRT) and Advanced Cardiac Pacing Technologies - (0174)	Update	**Posting/effective September 1, 2024:** Minor **changes** in coverage criteria/policy: • Removed leadless pacemakers from the policy statement; coverage criteria to be addressed in cobranded Cigna-EviCore Pacemaker Guidelines effective 9/1/2024. • Revised Note to update the name of related policy 0431 from "Implantable Cardioverter Defibrillator (ICD)" to "Cardioverter-Defibrillator Devices" due to policy 0431 title change.
Cardioverter-Defibrillator Devices – (0431)	Update	**Posting 9/15/2024; Effective 12/15/2024** Important **changes** in coverage criteria: • Clarified coverage by moving pediatric wearable cardioverter-defibrillator (WCD) criteria out of the AED section of the policy and into the WCD section of the policy.
Nutritional Support – (0136)	Update	Minor **changes** in coverage criteria/policy: • Removed policy statements for all technologies that are not managed.
Omnibus Codes – (0504)	Update	Important changes: • PT OT Chiro Frequency edit content being removed from CP 0504. Is addressed by ASH CPGs 135, 155, 278. Remove content and no longer review: • Fetal Mesencephalic Transplantation Remove content and place in another policy with no policy statement changes: • Adrenal Tissue Transplant (CP 0572) • Adjustable Continence Therapy (CP 0573)
Remote Physiologic Monitoring (RPM) and Remote Therapeutic	Update	Important **changes** in coverage criteria: • Added coverage for remote physiologic monitoring (RPM) to include gestational diabetes and hypertensive disorders of pregnancy to close a health disparity gap.

Monitoring (RTM) – (0563)		
Medical Coverage Announcement	Retracted	• Medical CP0600 has been retracted indefinitely and pulled back into governance by leadership.
Adjustable Continence Therapy – (0573)	Update	• No change in coverage.
Adrenal Tissue Transplant – (0572)	Update	• No change in coverage.
Ambulance Services – (0555)	Update	• No change in coverage.
Flow cytometry – (0538)	Update	• No change in coverage.
Heart, Lung and Heart-Lung Transplantation – (0129)	Update	• No change in coverage.
Intraocular Lens Implant – (0125)	Update	• No change in coverage.
Intraoperative Monitoring - (0509)	Update	• No change in coverage.
Metatarsophalangeal Joint Replacement - (0446)	Update	• No change in coverage.
Orthotic Devices and Shoes - (0543)	Update	• No change in coverage.
Bioimpedance Spectroscopy – (0572)	Retired	• No longer has business value.
Distraction Osteogenesis (DO)	Retired	• No longer has business value.

for Craniofacial Deformities – (0407)		
ASH Guidelines	**New, Updated, or Retired?**	**Comments**
Spinal Ultrasound – (CPG038)	Update	Minor **changes** in coverage criteria/policy: • Changed language for diagnostic ultrasound of the spine and/or paraspinal tissues from EIU to NMN because it doesn't meet Cigna's definition of EIU.
Electrodiagnostic Testing (EMG/NCV) - (CPG129)	Update	Important **changes** in coverage criteria: • Expand coverage in the NCV only section of the policy to include: suspected tarsal tunnel syndrome, suspected fibular nerve palsy, thoracic outlet syndrome, suspected acute nerve injury within 3 weeks of occurrence.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**

Cobranded Cigna-EviCore High-Tech Imaging Guidelines	Update	**Posted/Effective September 1, 2024:**
		
		Important **changes** in coverage criteria.
		• Head Imaging guidelines:
		  ○ Added coverage for imaging before, during and after treatment with Donanemab (Kisunla®)
		  ○ Expanded coverage by increasing upper age limit for imaging related to treatment with Lecenamab (Leqembi®), from ≤ 85 years to ≤ 90 years of age

Cobranded Cigna-EviCore Pacemaker Guidelinesv	Update	**Posted August 1, 2024. Effective September 1, 2024:** Important **changes** in coverage criteria. • Added coverage criteria for leadless pacemakers.
Administrative Policy	**New, Updated,**	**Comments**

	or Retired?	
Preventive Care Services – (A004)	Update	**Effective 8/30/2024** Important change in coverage: • Added mpox as a routine immunization • Removed verbiage related to out of network coverage related to breast feeding
Drug & Biologic Coverage Policy	**New, Updated, or Retired?**	**Comments** **All policy changes effective September 1, 2024, unless otherwise stated**
Attention Deficit Hyperactivity Disorder (ADHD) Stimulants for Employer Group Plans - (IP0477)	Update	**Effective 9/15/2024** • Added criteria for Metadate CD.
Attention Deficit Hyperactivity Disorder (ADHD) Stimulants for Individual and Family Plans - (IP0594)	Update	**Effective 9/15/2024** • Added criteria for Metadate CD.
Bowel Agents – Opioid-Induced Constipation - (IP0401)	Update	**Effective 9/1/2024** *For Relistor tablets, Movantik, and Symproic:* Opioid-induced constipation (OIC). • Updated the criterion for the patient to not be requiring frequent opioid dosage escalation from documentation to attestation. • Removed criterion requiring the failure of laxatives used for a minimum of 4 days within a 2 week period, unless contraindicated or intolerant. *For Relistor injection:* Opioid-induced constipation (OIC).

		• Updated the criterion for the patient to not be requiring frequent opioid dosage escalation from documentation to attestation.
		• Removed criterion requiring the failure of laxatives used for a minimum of 4 days within a 2 week period, unless contraindicated or intolerant.
		• Opioid-induced constipation (OIC) in individuals with advanced illness or pain caused by active cancer.
		  • Added criterion requiring documentation of chronic opioid use.
		  • Updated criterion requiring "Advanced illness or pain caused by active cancer requiring opioid dosage escalation for palliative care" to "According to the prescriber, patient requires opioid dosage escalation for palliative care"
		  • Removed criterion requiring the failure of laxatives used for a minimum of 4 days within a 2 week period, unless contraindicated or intolerant.

Brands with Bioequivalent Generics – (IP0011)	Update	**Effective: 9/1/2024** • Added Myrbetriq to support Employer plans for medical necessity review. • Added Ancobon to support Individual and Family Plans medical necessity review.
Cardiology – Camzyos - (IP0480)	Update	**Effective: 9/1/2024** • Updated policy title from "Mavacamten" to "Cardiology – Camzyos." • Obstructive Hypertrophic Cardiomyopathy. Patient Currently Receiving Camzyos: • Added a requirement that patients should be established on therapy for at least 8 months and added a note stating that a patient who has received < 8 months of therapy or who is restarting therapy is reviewed under criterion A (Initial Therapy)
Complement System Disorders – WHIM Syndrome – Xolremdi - (IP0654)	New	**Effective 9/15/2024** • New coverage policy addressing utilization management of Xolremdi (mavorixafor) capsules.
Cystic Fibrosis – Pulmozyme – (IP0483)	Update	**Effective: 9/1/2024** • Updated policy title from "Dornase Alfa" to "Cystic Fibrosis – Pulmozyme." Cystic Fibrosis. Removed criterion, *"used to improve pulmonary function in cystic fibrosis (CF)."*

		Treatment of Complicated Pleural Effusions. Removed criteria for coverage of, *Treatment of Complicated Pleural Effusions*.
Dermatology – Hyftor - (IP0511)	Update	**Effective: 9/1/2024** Updated policy title from 'Sirolimus' to 'Dermatology – Hyftor' Added 'Patient is currently Receiving Hyftor' criteria
Dichlorphenamide - (IP0204)	Update	**Effective: 9/1/2024** Added Ormalvi to the policy Updated preferred product criteria for Employer Plans to include step through dichlorphenamide for Ormalvi

Drugs/Biologics Not Covered Unless Approved Under Medical Necessity Review - Employer Group Plans: Standard, Performance, or Legacy Prescription Drug List - (1601)	Update	**Effective: 9/1/2024**
		
		• Added preferred product step requirement for Libervant
		• Added preferred product step requirement for the below insulin glargine products:
		  ○ Basaglar (insulin glargine)
		  ○ Basaglar Tempo Pen (insulin glargine)
		  ○ Insulin glargine, Insulin glargine SoloStar 100 units/mL
		  ○ Insulin Glargine Max Solostar U300 300 units/mL (Toujeo Max Solostar authorized generic)
		  ○ insulin glargine-yfgn 100 units/mL (Semglee-yfgn authorized generic)
		  ○ Lantus, Lantus SoloStar (insulin glargine U-100)
		  ○ Levemir (insulin detemir U-100)
		  ○ Rezvoglar (insulin glargine-AGLR subcutaneous injection)
		  ○ Semglee-yfgn (insulin glargine U-100)
		  ○ Toujeo SoloStar, Toujeo Max SoloStar (insulin glargine U-300)
		• Removed Mepron and Myrbetriq tablets (relocated to IP0011)
		
		Effective: 9/15/2024
		
		• Removed preferred product criteria for Airsupra

Drugs/Biologics Not Covered Unless	Update	**Effective: 9/1/2024**

Approved Under Medical Necessity Review - Employer Group Plans: Value, Advantage, or Cigna Total Savings Prescription Drug List - (1602)		• Added preferred product step requirement for Libervant
		• Added preferred product step requirement for the below insulin glargine products:
		  ○ Basaglar (insulin glargine)
		  ○ Basaglar Tempo Pen (insulin glargine)
		  ○ Insulin glargine, Insulin glargine SoloStar 100 units/mL
		  ○ Insulin Glargine Max Solostar U300 300 units/mL (Toujeo Max Solostar authorized generic)
		  ○ insulin glargine-yfgn 100 units/mL (Semglee-yfgn authorized generic)
		  ○ Lantus, Lantus SoloStar (insulin glargine U-100)
		  ○ Levemir (insulin detemir U-100)
		  ○ Rezvoglar (insulin glargine-AGLR subcutaneous injection)
		  ○ Semglee-yfgn (insulin glargine U-100)
		  ○ Toujeo SoloStar, Toujeo Max SoloStar (insulin glargine U-300)
		• Removed Mepron and Myrbetriq tablets (relocated to IP0011
		
		Effective: 9/15/2024
		
		• Removed preferred product criteria for Airsupra

Enzyme Replacement Therapy – Elfabrio - (IP0570)	Update	**Effective: 9/1/2024** Updated coverage policy title from *Pegunigalsidase Alfa* to *Enzyme Replacement Therapy – Elfabrio*. Removed the language *hemizygous* from criterion B.ii (term that describes having two identical versions of the same gene).
Enzyme Replacement Therapy – Fabrazyme – (IP0406)	Update	**Effective: 9/1/2024** Updated coverage policy title from *Agalsidase* to *Enzyme Replacment Therapy - Fabrazyme*. <u>Fabry disease:</u> Added dosing. Removed reauthorization criteria. Added *Concurrent Use with Elfabrio* as a condition not covered.
Gabapentin Extended-Release - (IP0317)	Update	**Effective 9/1/2024** • Gralise 450 mg, 750 mg and 900 mg added to the policy.

		• Reconciled Gralise 30-day starter pack and Horizant to ESI standard FEC.
Gastroenterology – Eohilia - (IP0630)	New	**Effective 9/1/2024** New policy aligned to ESI standard PA Policy and standard FEC.
Gout – Krystexxa - (IP0269)	Update	**Effective: 9/1/2024** Updated coverage policy title from "Pegloticase" to "Gout – Krystexxa." Gout, chronic. • Removed *18 years of age or older* requirement. • Removed *combination of a xanthine oxidase inhibitor and a uricosuric agent* requirement. • Added criterion screening for renal insufficiency. • Added leflunomide, mycophenolate mofetil, and azathioprine as immunosuppressive agent options to be used in combination with Krystexxa (in addition to methotrexate). • Removed *Asymptomatic Hyperuricemia* from 'Conditions Not Covered' list. • Updated initial authorization duration from "12 months" to "6 months."
Diabetes – Diabetic Test Strips, Lancets, and Pens – (IP0272)	Update	**Effective: 9/1/2024** • Updated preferred product criteria for Glucose Test Strips including (1) reducing step through from two preferred products to one preferred product, (2) added using non-compatible insulin pump/meter system option, (3) added criteria option if patient is using Freestyle Libre reader • Updated Legacy to include Accu-chek and Accutrend as preferred alternatives • Added Diabetic Pen Needles criteria from Pen Needles IP0569 • Updated title from Glucose Test Strips • Added glucose test strips, lancets and pen needles, and criteria for the related IFP non-formulary classes.
Human Immunodeficiency Virus – Sunlenca - (IP0546)	Update	**Effective: 9/15/2024** • Human Immunodeficiency Virus-1 Infection. • Patient is Currently Receiving Sunlenca:

		• Updated the note with examples of a response to a Sunlenca- containing regimen to add "improvement or stabilization in CD4 T-cell count".
Human Immunodeficiency Virus – Trogarzo - (IP0171)	Update	**Effective: 9/15/2024** • Human Immunodeficiency Virus-1 Infection. • Patient is Currently Receiving Trogarzo: • Updated the criterion that the patient has responded to a Trogarzo-containing regimen (e.g., HIV-1 RNA ≥ 0.5 log10 reduction from baseline in viral load), as determined by the prescriber by removing the example of a treatment response to a note, and to add HIV RNA < 50 cells/mm3 and improvement or stabilization in CD4 T-cell count as examples of a treatment response.
Hyperhidrosis – Qbrexza - (IP0074)	Update	**Effective: 9/15/2024** • **Updated** the title of the policy from ""Qbrexza" to "Hyperhidrosis – Qbrexza." • **Conditions Not Covered**: ○ **Added** concurrent use of Qbrexza with Sofdra (sofpironium 12.45% topical gel) to the Policy.

Immune Disorder – Joenja - (IP0568)	Update	**Effective: 9/1/2024**
		
		Updated policy title from "Leniolisib" to "Immune Disorder – Joenja."
		
		Activated phosphoinositide 3-kinase delta syndrome (APDS).
		• The following specialists were removed from the list of specialists: pulmonologist, gastroenterologist, hematologist, infectious diseases physician, and medical geneticist.
		• For patients currently receiving Joenja,
		  ○ Added the following criteria: Patient has been established on therapy for at least 6 months along with a note to refer to initial therapy criteria if the patient has not been on therapy for at least 6 months or is restarting therapy.
		  ○ Added note including examples of positive clinical response in the signs and manifestations of APDS.

Immune Globulin - (5026)	Update	**Effective: 9/1/2024** Updated policy to add preferred product criteria for Alyglo.

Immunologicals – Dupixent - (IP0453)	Update	**Effective: 9/1/2024**
		
		• Updated policy title from "Dupilumab" to "Immunologicals – Dupixent."
		• Asthma:
		  ○ Updated diagnostic criteria requirements for confirmation of asthma.
		• Atopic Dermatitis:
		  ○ Updated diagnostic criteria requirements for confirmation of atopic dermatitis.
		• Chronic Rhinosinusitis with Nasal Polyps:
		  ○ Added the requirement for systemic steroid use for at least 5 days.
		• Currently Receiving Dupixent:
		  ○ Removed requirement for prescription by or in consultation with a specialist for all indications
		• Authorization Duration:
		
		Updated initial therapy duration from 12 months to 4 months for atopic dermatitis and 6 months for all other indications.

Immunologicals – Fasenra - (IP0421)	Update	**Effective: 9/1/2024**
		
		• Updated policy title from "Benralizumab" to "Immunologicals – Fasenra."
		• Asthma:
		  ○ Age of approval was reduced from ≥ 12 years of age to ≥ 6 years of age.
		  ○ Updated diagnostic criteria requirements for confirmation of asthma.
		  ○ Added dosing information.
		  ○ Authorization Duration:
		  ▪ Updated initial therapy duration from 12 months to 6 months
		• Conditions Not Covered: Removed criterion regarding use in atopic dermatitis.

Immunologicals – Nucala - (IP0423)	Update	**Effective: 9/1/2024** • Updated coverage policy title from *Mepolizumab* to *Immunologicals – Nucala.* <u>Asthma:</u> • Updated diagnostic criteria requirements for confirmation of asthma. • Updated initial approval authorization duration from 12 months to 6 months. <u>EGPA:</u> • Updated blood eosinophil count criteria screening AEC greater than or equal to 150 cells/ mcL while stable on oral corticosteroid, only.

		• Updated initial approval authorization duration from 12 months to 6 months. Hypereosinophilic Syndrome: • Updated initial approval authorization duration from 12 months to 8 months.

Immunologicals – Tezspire - (IP0412)	Update	**Effective: 9/1/2024**
		
		• Updated policy title from "Tezepelumab-ekko" to "Immunologicals – Tezspire."
		• Asthma:
		  ○ Updated diagnostic criteria requirements for confirmation of asthma.
		  ○ Authorization Duration:
		  ▪ Updated initial therapy duration from 12 months to 6 months
		• Conditions Not Covered:
		  ○ Removed treatment of Eosinophilic Gastroenteritis (EG), Eosinophilic Esophagitis (EE) or Eosinophilic Colitis.

Immunologicals – Xolair – (IP0487)	Update	**Effective: 9/1/2024** • Updated policy title from Omalizumab to Immunologicals – Xolair. • Asthma: Updated diagnostic criteria requirements for confirmation of asthma. Updated initial authorization duration from 12 months to 4 months. • Chronic Idiopathic Urticaria (Chronic Spontaneous Urticaria): Updated non-sedating H1 antihistamine requirements to add "with symptoms present > 3 days per week" and removed duration of "for at least 2 weeks, unless contraindicated or intolerant". Updated initial authorization duration from 12 months to 4 months. • Chronic Rhinosinusitis with Nasal Polyps: Approval condition updated from "Nasal Polyps" to "Chronic Rhinosinusitis with Nasal Polyps". Duration of the intranasal corticosteroid requirement was changed from 3 months to 4 weeks. Updated initial authorization duration from 12 months to 6 months. • IgE-Mediated Food Allergy: New approval criteria for this indication were added. • Conditions Not Recommended for Approval: "Peanut and Other Food Allergies" was removed as a Condition Not Recommended for Approval.
Inflammatory Conditions – Arcalyst – (IP0437)	Update	**Effective 9/1/2024** Updated title of the policy from Rilonacept to Inflammatory Conditions – Arcalyst.

		All Indications: Criteria were updated to clarify "Initial Therapy" versus "Patient is Currently Receiving Arcalyst". Cryopyrin-Associated Periodic Syndromes. Updated "Treatment of ONE of the following: Chronic infantile neurological cutaneous and articular (CINCA) syndrome, Familial Cold Autoinflammatory Syndrome (FCAS), Muckle-Wells Syndrome (MWS), or Neonatal-Onset Multisystem Inflammatory Disease (NOMID)" and relocated to a Note with all of the conditions included as examples of CAPS. Updated the initial approval duration from 12 months to 6 months. Added "Patient is ≥ 12 years of age." Deficiency of Interleukin-1 Receptor Antagonist. Updated the initial approval duration from 12 months to 6 months. Added "According to the prescriber, patient has demonstrated a clinical benefit with Kineret (anakinra subcutaneous injection)" with examples of a clinical response included in a Note. Pericarditis. Removed "Pericarditis secondary to the following etiologies has been ruled out: systemic autoimmune disease, infection (e.g. tuberculosis), myocarditis, trauma, radiation or cancer." Conditions Not Covered. Removed Adult Onset Still's Disease, Gout, Juvenile Idiopathic Arthritis, Schnitzler Syndrome, and Type 1 or 2 Diabetes for list maintenance and simplification. This does not imply a change in coverage status, and all remain conditions not covered.
Infectious Disease – Sirturo - (IP0494)	Update	**Effective: 9/1/2024** Tuberculosis: • Updated the criterion, "Patient has multidrug-resistant tuberculosis" to "Patient has *Mycobacterium tuberculosis* resistant to rifampin and isoniazid." Overview: • Removed the statement regarding accelerated approval as Sirturo has received traditional approval from the FDA. • Updated the indication for use from "Sirturo is indicated as part of a combination therapy in the treatment of pulmonary multidrug-resistant tuberculosis (TB) in patients ≥ 5 years of age (weighing ≥ 15 kg)" to "Sirturo is indicated as part of a combination therapy in the treatment of pulmonary tuberculosis (TB) due to *Mycobacterium tuberculosis* resistant to at least rifampin and isoniazid in patients ≥ 5 years of age (weighing ≥ 15 kg)." • Removed the statement about limited data on safety and efficacy in HIV patients with multidrug resistant TB.

Inflammatory Conditions – Spevigo Subcutaneous Prior Authorization Policy - (IP0649)	New	**Effective: 9/15/2024** • New policy to support medical necessity review for Spevigo subcutaneous.
Lupus – Benlysta Intravenous - (IP0429)	Update	**Effective: 9/1/2024** Updated policy title from "Belimumab Intravenous" to "Lupus – Benlysta Intravenous." Lupus Nephritis: • Updated the requirement that the patient is taking with standard therapy to more generally require that the patient is taking an immunosuppressive regimen. • Removed the exception for a patient who is intolerant to standard therapy due to significant toxicity as determined by the prescriber. . • Updated initial therapy duration from 12 months to 6 months. Systemic Lupus Erythematosus: • Updated initial therapy duration from 12 months to 4 months. Conditions Not Covered: • Removed severe active central nervous system lupus.
Lupus – Benlysta Subcutaneous - (IP0430)	Update	**Effective: 9/1/2024** Updated policy title from "Belimumab Subcutaneous" to "Lupus – Benlysta Subcutaneous." Lupus Nephritis: • Updated the requirement that the medication is used concurrently with "other standard therapy" to "immunosuppressive regimen"; • Removed the exception for a patient who is intolerant to standard therapy due to significant toxicity as determined by the prescriber • Updated initial therapy duration from 12 months to 6 months. Systemic Lupus Erythematosus: • For initial therapy, the age requirement was updated to ≥ 5 years of age. Previously, the requirement was ≥ 18 years of age. • Updated initial therapy duration from 12 months to 4 months. Conditions Not Covered: • Removed Severe Active Central Nervous System Lupus.
Oncology – Imbruvica for Non-Oncology Uses - (IP0320)	Update	**Effective: 9/15/2024**

		• Graft-Versus-Host Disease: Updated conventional systemic treatment criteria from 'inadequate response, unless contraindicated or intolerant' to 'tried' • Updated policy title from 'Ibrutinib for Non-Oncology Uses' to 'Imbruvica for Non-Oncology Uses'
Oncology Medications – (1403)	Update	**Effective: 9/1/2024** • Preferred Product Criteria. • Removed Pomalyst preferred product criteria requirement.
Vijoice – (IP0481)	Update	**Effective: 9/1/2024** • Updated coverage policy title from *Alpelsib* to *Vijoice*. • NO criteria changes.
Migraine – Zavzpret – (IP0573)	Update	**Effective: 9/1/2024** Updated coverage policy title from *Zavegepant* to *Migraine – Zavzpret*. Migraine, Acute Treatment: Removed reauthorization criteria. Removed concurrent use of two CGRP inhibitors as a condition not covered.
Neurology – Aduhelm - (IP0200)	Update	**Effective: 9/1/2024** Updated policy title from 'Aducanumab' to 'Neurology – Aduhelm' Conditions Not Covered. Updated from 'Alzheimer's disease, mild cognitive impairment or dementia stage of disease' and 'Alzheimer's disease, moderate or severe cognitive impairment or dementia stage of disease' into single Alzheimer's Disease aggregate.
Neurology – Kisunla - (IP0697)	New	**Effective 9/1/2024** • New policy addressing Kisunla (donanemb-azbt) intravenous infusion.

Oncology (Injectable – CAR-T) – Breyanzi - (IP0130)	Update	**Effective 9/1/2024** B-Cell Lymphoma: Mantle cell lymphoma added as new condition of approval for patients who have received at least one prior line of therapy. Classic follicular lymphoma added as new condition of approval for patients who have received at least two prior lines of therapy. Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma: Added new condition of approval.
Pharmacy Prior Authorization – (1407)	Update	**Effective: 9/1/2024** Supports Pharmacy benefit standard prior authorization criteria or products requiring medical necessity review and/or formulary exception criteria for Individual and Family Plans (IFP) not addressed in any other coverage policy. 1. Added criteria for Mirabegron ER 25 mg tablet 2. Updated Myrbetriq to redirect to multisource brand product 3. Updated Gemtesa product criteria 4. Updated Myrbetriq granules product criteria 5. Updated Nevanac product criteria 6. Updated Ilvero product criteria 7. Updated Alrex product criteria 8. Updated loteprednol product criteria 9. Updated Xcopri product criteria 10. Added criteria for insulin glargine, insulin glargine SoloStar 100 units/ mL 11. Added criteria for insulin glargine-yfgn 12. Added criteria for insulin glargine Max SoloStar U300 300 units/ mL 13. Added criteria for Lantus, Lantus SoloStar 14. Added criteria for Rezvoglar 15. Added criteria for Semglee-yfgn 16. Added criteria for Toujeo SoloStar, Toujeo Max SoloStar 17. Removed criteria for glucose test strips from coverage policy 18. Removed criteria for lancets from coverage policy
Pharmacy Prior Authorization – (1407)	Update	**Effective: 9/15/2024**

		Supports Pharmacy benefit standard prior authorization criteria or products requiring medical necessity review and/or formulary exception criteria for Individual and Family Plans (IFP) not addressed in any other coverage policy. 1. Added new criteria for: Libervant and Rextovy; new criteria redirect to formulary alternatives
Vesicular Monoamine Transporter Type 2 Inhibitors – Austedo - (IP0079)	Update	**Effective: 9/1/2024** Tardive Dyskinesia. Updated "Individual has a history of treatment with a dopamine receptor blocking agent (for example, antipsychotics, metoclopramide, prochlorperazine)" to now be "Patient has a history of use of dopamine receptor blocking agent" with the examples moved to a Note. Updated title from Deutetrabenazine.

Vesicular Monoamine Transporter Type 2 Inhibitors – Ingrezza Products - (IP0080)	Update	**Effective: 9/1/2024**
		
		• Updated policy title from "Valbenazine" to "Vesicular Monoamine Transporter Type 2 Inhibitors – Ingrezza Products".
		• Added Ingrezza Sprinkle to the policy with the same criteria applied as for Ingrezza.
		• Tardive Dyskinesia:
		  ○ Removed the requirement for a documented diagnosis of tardive dyskinesia.
		  ○ Updated the statement from "individual has a history of treatment with a dopamine receptor blocking agent" to now specifically say "patient has a history of use of dopamine receptor blocking agent."
		• Removed the statement specifying the conditions for the medical necessity of the Ingrezza 4-week Initiation Pack.

Vesicular Monoamine Transporter Type 2 Inhibitors – Tetrabenazine - (IP0208)	Update	**Effective 9/1/2024** Updated the title of the policy from Tetrabenazine to Vesicular Monoamine Transporter Type 2 Inhibitors – Tetrabenazine. Tardive Dyskinesia. Updated "Individual has a history of treatment with a dopamine receptor blocking agent (for example, antipsychotics, metoclopramide, prochlorperazine)" to now be "Patient has a history of use of dopamine receptor blocking agent" with the examples moved to a Note.

Winlevi – (IP0173)	Update	**Effective: 9/15/2024** Acne Vulgaris. • Added *notes* under the criteria for trials with topical retinoids and topical non-retinoids with examples of products to satisfy criteria • Removed *documentation* language from criteria • Removed *Reauthorization Criteria*
Ophthalmic – Glaucoma – Prostaglandins - (IP0027)	Update	**Effective 9/1/2024** No change in criteria
Pen Needles - (IP0569)	Retired	**Effective 9/1/2024**
Insulin Glargine – (P0023)	Retired	**Effective 9/1/2024**
CareAllies Medical Necessity Guideline	**New, Updated, or Retired?**	**Comments**
		• All above updates apply
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
		• No updates for September 2024
Reimbursement Policy*	**New, Updated, or Retired?**	**Comments**
Procedure and Place of Service - (R43)	Update	**Effective 09/14/2024**

		• Adding place of service (POS) 23 to codes 99221, 99222, and 99223.
Other Coding and Reimbursement Documents	**New, Updated, or Retired?**	**Comments**
		• No updates for September 2024
ClaimsXten Documents*	**New, Updated, or Retired?**	**Comments**
		• No updates for September 2024