Monthly Policy Updates

Effective November 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
Alveoloplasty – (0586)	New	**Posted 9/1/2025, Effective 12/1/2025** Important **changes** in coverage criteria: • The policy was created to address CPT codes on precert but not in any policy. • This policy is primarily based on benefit language and letter script language.
Ambulatory External and Implantable Electrocardiographic Monitoring – (0547)	Updated	Minor **changes** in coverage criteria/policy: • Add criteria bullet for "individual with hypertrophic cardiomyopathy"

Atrial Fibrillation: Nonpharmacological Treatments – (0469)	Updated	Minor **changes** in coverage criteria/policy: • Removing non-implemented codes and policy statements.
Breast Reduction – (0152)	Updated	**Posting 8/15/2025; Effective 11/15/2025** Important **changes** in coverage criteria • Addition of policy statement for CPT code 15839- Excision, excessive skin and subcutaneous tissue (includes lipectomy); other area
Cardiac Ablation of Abnormal Electrical Rhythms in Adults – (0529)	Updated	**Posting 11/15/2025; Effective 2/15/2026** Important **changes** in coverage criteria: • Separated out SVT indications from ventricular indications and identified with applicable coding for improved clarity and distinction. • Clarified and further limited our EIU position for thoracoscopic epicardial ablation by adding "including when performed as part of a hybrid convergent approach to ablation" and by removing "atrial flutter" and replacing it with "any indication".

Cochlear and Auditory Brainstem Implants – (0190)	Updated	Important **changes** in coverage criteria:
		• Title change because Auditory Brainstem Implants were removed from the policy.
		• Expanded the threshold for limited or no benefit from appropriately fitted hearing aids in adults from ≤ 40 to ≤ 60% correct in the best-aided listening condition in both the traditional cochlear implant section and the contralateral ear section to align with the least restrictive FDA approval indications for cochlear implants.
		• Removed "(e.g., Multi-syllabic Lexical Neighborhood Test [MLNT] or Lexical Neighborhood Test [LNT])" from the sub-bullet criteria for limited or not benefit from a hearing aid trial for traditional cochlear implant for individuals less than 18 years old because the test is outdated and restrictive.
		• Removed the policy statements for the following because they're not clinically implemented:
		  ○ initial and replacement batteries.
		  ○ upgrading of a traditional cochlear implant or component.
		  ○ auditory brainstem implants.
		• Removed the benefit disclaimer addressing aural/speech therapy and replaced with our standard verbiage for benefit coverage.

Corneal Remodeling for Refractive Errors – (0141)	Updated	Minor **changes** in coverage criteria/policy: • Removed keratophakia and orthokeratology from policy statement, as aligned codes are not managed.
Deep Brain, Motor Cortex and Responsive Cortical Stimulation – (0184)	Updated	Minor changes in coverage criteria: • Revised policy statement to remove the word revision to align with the updated coding framework.
Dental Implants – (0585)	New	**Posted 9/1/2025, Effective 12/1/2025** Important **changes** in coverage criteria: • The policy was created to address CPT codes on precert but not in any policy. • This policy is primarily based on benefit language and letter script language.
Extracorporeal Shock Wave Therapy (ESWT) for Musculoskeletal Conditions – (0004)	Updated	Minor **changes** in coverage criteria/policy: • Revised policy statement regarding benefit plans to include most up to date terminology. • Revised policy statement for ESWT as EIU to include musculoskeletal condition.
Intraoral Prostheses – (0584)	New	**Posted 9/1/2025, Effective 12/1/2025** Important **changes** in coverage criteria: • The policy was created to address CPT codes on precert but not in any policy. • This policy is primarily based on benefit language and letter script language.
Open Neuroplasty Lumbar Plexus – (0587)	New	**Posted 9/1/2025, Effective 12/1/2025** Important changes in coverage criteria: • New CP addresses open surgical neuroplasty procedure involving the lumbar plexus (CPT® 64714). • Criteria for when procedure is considered medically necessary and when it is not medically necessary
Orthotic Devices and Shoes – (0543)	Updated	Posted **8/15/2025**; Effective **11/15/2025** Important **changes** in coverage criteria:

		• Added "powered exoskeleton orthosis (e.g., ReWalk Personal Exoskeleton)" to policy statement for orthoses considered experimental, investigational, or unproven. • Minor change: Removed "any orthosis used to treat edema" from list of Not Covered or Reimbursable orthoses.
Laboratory Testing Services – (0604)	Updated	Posted **8/15/2025;** Effective **11/15/2025** Important **changes** in coverage criteria: • Expanding scope of CP by adding section on EIU Lab tests, and adding Codes 0247U, 0261U, 0384U, 0558U, and 0559U • Remove codes - Code 0346U retired on 1/1/2025; Codes 00358U and 0412U are not going to be managed • Removed not covered or reimbursable header and changed not covered or reimbursable to not medically necessary in the statement
Laboratory Testing Services – (0604) – advanced notification version	Updated	Posted **11/15/2025;** Effective **2/15/2026** Important **changes** in coverage criteria: • Additional lab tests added as experimental, investigational or unproven • Multiple CPT codes that are addressed in other Coverage Policies were removed from the Not Medically Necessary coding table.
Sacral Nerve and Tibial Nerve Stimulation for Urinary Voiding Dysfunction, Fecal Incontinence and Constipation - (0404)	Updated	Important **changes** in coverage criteria: • Removed policy statement for a screening trial of sacral nerve stimulation (SNS) for Urinary Voiding Dysfunction, as the codes for this service are no longer implemented. • Revised policy statement for permanent SNS for Urinary Voiding Dysfunction to include the indications and symptoms for a screening trial of SNS that were removed. • Removed policy statement for a screening trial of SNS for Fecal Incontinence, as the codes for this service are no longer implemented.
Staff-Assisted Home Hemodialysis – (0229)	Updated	Minor **changes** in coverage criteria/policy: • Update benefit coverage statement for staff-assisted home hemodialysis.

Transcatheter Closure of Cardiovascular Defects – (0011)	Updated	Important **changes** in coverage criteria: • Clarified criteria by adding a not medically necessary statement for the use of ANY device not approved by the U.S. Food and Drug Administration (FDA) for the specific indication of cardiovascular defect closure.
Unlisted Procedure Codes – (0583)	Updated	Posting/Effective **11/15/2025** Minor **changes** in coverage criteria/policy: • Added code 69949 Unlisted procedure, inner ear, code is on precert. The code is being removed from CP 0190 Cochlear and Auditory Brainstem Implants and added to this policy.
Chromoendoscopy - (0148)	Updated	• No change in coverage.
Gastric Pacing/Gastric Electrical Stimulation (GES) – (0103)	Updated	• No change in coverage.
Hospice Care – (CP0462)	Retired	• No codes are implemented, or codes are implemented via a method not reliant on the CP.
Oral Cancer Screening Systems (0372)	Retired	• This CP is being retired 11/15/25 because the code D0431 is not managed / not implemented.
Pediatric Intensive Feeding Programs – (CP0422)	Retired	• No business value. The unlisted CPT code is being delegated to Evicore March 2026.
Tests for the Evaluation of Preterm Labor and Premature Rupture of Membranes – (CP0099)	Retired	• The single managed code in the policy, 0247U, is being moved to CP 0604 Laboratory Testing Services.

ASH Guidelines	New, Updated, or Retired?	Comments
Biofeedback - (CPG294)	Updated	• No change in coverage.
Physical Performance Test or Measurement - (CPG295)	Updated	• No change in coverage.
eviCore Guidelines	**New, Updated, or Retired?**	**Comments**

Cobranded Cigna-EviCore High-Tech Imaging Guidelines	Updated	Effective **12/1/2025**:
		
		Important **changes** in coverage criteria.
		• One guideline was updated with clinical changes which will expand coverage:
		• Breast Imaging
		
		Posted **10/27/2025**, Effective **2/3/2026**:
		
		Important **changes** in coverage criteria.
		• Five guidelines were updated with clinical changes which will expand coverage:
		  • Neck Imaging
		  • Pediatric Chest Imaging
		  • Pediatric Musculoskeletal Imaging
		  • Pediatric Neck Imaging
		  • Preface to the Imaging Guidelines
		• Twelve guidelines were updated with clinical changes which will expand and limit coverage:
		  • Abdomen Imaging
		  • Breast Imaging
		  • Cardiac Imaging
		  • Chest Imaging

		• Head Imaging • Oncology Imaging • Pediatric Abdomen Imaging • Pediatric and Special Populations Oncology Imaging • Pediatric Head Imaging • Pelvis Imaging • Peripheral Vascular Disease (PVD) Imaging • Spine Imaging • Six guidelines were updated with no clinically impactful changes: • Pediatric and Special Populations Spine Imaging • Pediatric Cardiac Imaging • Pediatric Pelvis Imaging • Pediatric Peripheral Nerve and Neuromuscular Disorders (PNND) Imaging • Pediatric Peripheral Vascular Disease (PVD) Imaging • Peripheral Nerve and Neuromuscular Disorders (PNND) Imaging
Cobranded Cigna-EviCore Musculoskeletal Management Guidelines	Update	Posted **10/27/2025**, Effective **2/12/2026**: Important **changes** in coverage criteria. • Three guidelines were updated with clinical changes which will limit coverage: • CMM-311: Knee Replacement/Arthroplasty • CMM-313: Hip Replacement/Arthroplasty • CMM-315: Shoulder Surgery-Arthroscopic and Open Procedures • Three guidelines were updated with no clinically impactful changes: • CMM-312: Knee Surgery - Arthroscopic and Open Procedures • CMM-314: Hip Surgery - Arthroscopic and Open Procedures • CMM-318: Shoulder Arthroplasty/Replacement/Resurfacing/Revision/Arthrodesis

Cobranded Cigna-EviCore Pacemaker Guidelines	Retired	Guidelines retired 5/30/2025, no further business need.
Administrative Policy	**New, Updated or Retired?**	**Comments**
Preventive Care Services - (A004)	Update	• Expanding coverage for breast cancer screening.
Cigna Healthcare Drug Coverage Policy	**New, Updated or Retired?**	**Comments**
Antifungals – Tolsura (IP0275)	Updated	Effective 11/15/2025 **Updated** policy template **Histoplasmosis – Including Chronic Cavitary Pulmonary Disease and Disseminated, Non-Meningeal Treatment:** The duration of approval for this condition was changed to 6 months. Previously, it was 3 months.
Antiseizure Medications-Rufinamide (IP0048)	Updated	Effective: 11/15/2025 **Policy Title:** **Updated** from "Rufinamide" to "Antiseizure Medications-Rufinamide". **Added** Preferred Product Criteria for Banzel to support non-formulary coverage of under Individual and Family Plans. Throughout the criteria, reference to antiepileptic drugs was changed to antiseizure medications.
Botulinum Toxins – Daxxify - (IP0588)	Updated	Effective 11/15/2025

		Updated policy template
Botulinum Toxins – Dysport - (IP0638)	Updated	Effective 11/15/2025 **Updated** policy template **Hemifacial Spasm:** The dosing limitation was decreased from 1200 units to 220 units.
Botulinum Toxins – Myobloc - (IP0509)	Updated	Effective 11/15/2025 **Updated** policy template
Botulinum Toxins – Xeomin - (IP0639)	Updated	Effective 11/15/2025 **Updated** policy template. • **Cervical Dystonia**: The dosing was updated from a maximum of 120 units to 240 units (not to exceed 120 units for initial dose).
Cardiology – Lodoco - (IP0595)	Updated	Effective 11/1/2025 **Policy Title.** **Updated title from** "Lodoco (colchine tablets) **to** "Cardiology – Lodoco" **Atherosclerotic Disease**: Brilinta was removed from the Note of examples of background regimens for atherosclerotic disease as generic ticagrelor tablets are now available. The criterion about kidney function was removed; previously, the requirement was creatinine clearance is equal to or greater than 50 mL/min. • **Removed** documentation requirements in Atherosclerotic Disease criteria and preferred product table
Complement Inhibitors – Empaveli- (IP0194)	Updated	Effective 11/1/2025 **Complement 3 Glomerulopathy:** This FDA approved indication was added to the policy. **[documentation required]** added to indication.

		• **Immune-Complex Membranoproliferative Glomerulonephritis.** This FDA approved indication was added to the policy. **[documentation required]** added to indication.
Complement Inhibitors – Fabhalta - (IP0614)	Updated	Effective 11/1/2025 • **Complement 3 Glomerulopathy:** Initial Therapy: The requirement that the patient has not received a kidney transplant in the past was removed. The requirement regarding use of an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) at a maximum or maximally tolerated dose for ≥ 90 days was changed to state "at least ONE" of ACE inhibitor or ARB. Also, the number of days that a patient should have received either therapy was changed from ≥ 90 days to ≥ 12 weeks. Patient is Currently Receiving Fabhalta: The requirement that the patient has not received a kidney transplant in the past was removed. **[documentation required]** added to indication.
Complement Inhibitors – Zilbrysq - (IP0622)	Updated	Effective 11/1/2025 • **Updated** policy template.
Contraceptives - (IP0036)	Updated	Effective 11/01/2025 **Updated** Policy Statement Note from "Cigna covers Contraceptives per the Patient Protection and Affordable Care Act (PPACA), Health Resources and Services Administration (HRSA) Guidelines, and Public Health Service (PHS) Act section 2713." to "Note: When compliance with the Affordable Care Act, HRSA Guidelines, and PHS Act section 2713 is required and the conditions for coverage listed under the medically necessary criteria are not met, approval is granted for the prevention of pregnancy or for the improvement of birth outcomes if, according to the prescriber, other contraceptives would not be as medically appropriate for the patient as the requested drug. **Employer Plans Preferred Product Table:** **Updated** statements from "prevention of pregnancy" to "prevention of pregnancy or improvement of birth outcomes" **Annovera** **Added** Note: Examples include, but may not be limited to, drospirenone-ethinyl estradiol, Eluryng, etonogestrel-ethinyl estradiol vaginal ring, Junel Fe, Sprintec, Tri-Sprintec, Xulane.

		Depo-Provera **Added** generic Depo-Provera to alternatives **Femlyv** **Added** Note: Examples include, but may not be limited to, Charlotte 24 Fe, Finzala, Kaitlib Fe, Layolis Fe, Mibelas 24 Fe, norethindrone-ethinyl estradiol, Wymzya Fe. **Added** Finzala, Wymzya, and Layolis to examples of chewable birth control products Lo Loestrin FE **Added** Note: Examples include, but may not be limited to, Hailey Fe, Junel Fe, Larin Fe, Mibelas 24 Fe, Microgestin Fe, norethindrone-ethinyl estradiol-iron. **Natazia** **Added** Note: Examples include, but may not be limited to, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec. **Nextstellis** **Added** Note: Examples include, but may not be limited to, Aurovela Fe, Blisovi Fe, drospirenone-ethinyl estradiol, Estarylla, Junel Fe, Tri-Sprintec, Sprintec. **Twirla** **Added** (e.g., oral contraceptive tablets, Xulane [contraceptive patch], Annovera [contraceptive ring]), NuvaRing or generics [contraceptive ring]) as examples of contraceptive agents. **Added** Note: Examples include, but may not be limited to, Blisovi Fe, Eluryng, etonogestrel-ethinyl estradiol vaginal ring, Hailey Fe, Junel Fe, Larin Fe, Xulane. **Added** Note: A trial of five different oral contraceptive agents would meet the requirement. Tyblume **Added** Note: Examples include, but may not be limited to, Altavera, Aviane, Falmina, Lessina, levonorgestrel-ethinyl estradiol, Portia, Vienva. **Individual and Family Plans Preferred Product Table:** • **Added** Averi to policy
Dermatology – Opzelura (IP0369)	Updated	Effective 11/15/2025 Policy title changed from "Topical Ruxolitinib" to "Dermatology – Opzelura" **Atopic Dermatitis:** Criteria were updated to require that the patient is ≥ 2 years of age. Previously, criteria required the patient to be ≥ 12 years of age. The criterion allowing an exception to a prescription topical corticosteroid trial for patients treating atopic dermatitis affecting the face, eyes/eyelids, skin folds, and/or genitalia was removed.

		Vitiligo: The criterion allowing an exception to a prescription topical corticosteroid trial for patients treating vitiligo affecting the face, eyes/eyelids, skin folds, and/or genitalia was removed. **Updated** the conditions not covered statement. • The Appendix was updated to include the following biologic agents: biosimilars to Stelara, Bimzelx® (bimekizumab-bkzx SC injection), Cosentyx® (secukinumab IV infusion), Skyrizi® (risankizumab-rzaa IV infusion), Tremfya (guselkumab IV infusion), Entyvio (vedolizumab SC injection), Rinvoq® LQ (upadacitinib oral solution), and Ebglyss™ (lebrikizumab-lbkz SC injection).
Diabetes – Diabetic Supplies - (IP0272)	Updated	Effective 11/1/2025 • **Added** Precision XTRA test strips and meters to coverage policy.
Drugs Requiring Medical Necessity Review for Employer Plans - (1602)	Updated	Effective: 11/1/2025 **Added preferred product step requirement for the following products:** Dapsone gel 7.5 % (brand), Denavir, Xerese, Bucapsol, sitagliptin and metformin hydrochloride extended-release tablets (authorized generic of Zituvimet XR), fluticasone furoate inhalation powder (authorized generic for Arnuity Ellipta), and Hemiclor (chlorthalidone 12.5 mg tablets). **Updated preferred product step requirement for the following products:** Basaglar KwikPen, Basaglar Tempo Pen, insulin glargine U-100 vial (Lantus authorized generic), insulin glargine U-100 SoloStar (Lantus SoloStar authorized generic), insulin glargine U-300 SoloStar Pen (Toujeo Solostar authorized generic), insulin glargine U-300 Max SoloStar (Toujeo Max Solostar authorized generic), insulin glargine-yfgn U-100 vial and pen (Semglee-yfgn authorized generic), Lantus, Lantus SoloStar, Levemir FlexTouch and vial, Rezvoglar, Semglee-yfgn vial and pen, Toujeo SoloStar, and Toujeo Max SoloStar • **Removed** preferred product requirements for Regranex
Enspryng - (IP0078)	Updated	Effective 11/1/2025 • **Updated** policy template.

Hematology - Fibrinogen Products - (IP0357)	Updated	Effective 11/15/2025 • No criteria changes.
Hemophilia – Non-Factor Routine Prophylaxis Products – Qfitlia - (IP0742)	Updated	Effective 11/01/2025 • **Hemophilia A without Factor VIII Inhibitors**: For Initial Therapy, "no later than 7 days following the initial Qfitlia dose" was added to the requirement regarding prophylactic use of Factor VIII products.
Hemophilia – Non-Factor Routine Prophylaxis Products – Qfitlia - (IP0742)	Updated	Effective 11/15/2025 **Updated** policy template • **Updated** preferred product table for Employer Plans
Hepatology – Livmarli - (IP0341)	Updated	Effective 11/01/2025 **Policy Title.** **Updated** from "Maralixibat" **to** "Hepatology – Livmarli" **Alagille Syndrome** **Added** "according to the prescriber" to moderate-to-severe pruritus criteria **Updated** "Documented failure, contraindication, or intolerance to TWO systemic medications for Alagille syndrome (for example, cholestyramine, rifampicin, ursodeoxycholic acid [ursodiol])" **to** "Patient has tried at least two systemic medications for Alagille syndrome, unless contraindicated; AND Note: Systemic medications for Alagille syndrome include cholestyramine, fenofibrate, naltrexone, rifampicin, sertraline, and ursodeoxycholic acid (ursodiol)" **Added** criteria for patients currently receiving Livmarli **Progressive Familial Intrahepatic Cholestasis** **Added** documentation requirements to Diagnosis of progressive familial intrahepatic cholestasis criteria.

		Added fenofibrate to note of systemic medications • **Added** criteria for patients currently receiving Livmarli
Immune Globulin - (5026)	Updated	Effective 11/1/2025 **Removed** preferred product requirements for HyQvia. • **Updated** preferred product requirements for Gammagard Liquid.
Hepatitis C – Mavyret Prior Authorization for Preferred Specialty Management Policy - (IP0737)	Updated	Effective 11/1/2025 • **Acute Hepatitis C Virus (HCV), Genotype 1, 2, 3, 4, 5, or 6.** A new FDA-Approved Indication was added. In a patient that meets criteria, Mavyret is approved for 8 weeks.
Hepatitis C – Hepatitis C Virus Direct-Acting Antivirals Preferred Specialty Management Policy for Employer Plans - (PSM025)	Updated	Effective 11/1/2025 Mavyret • **Acute Hepatitis C Virus (HCV), Genotype 1, 2, 3, 4, 5, or 6.** A new indication was added. Mavyret is approved for the duration specified in the Hepatitis C – Mavyret PA for PSM Policy criteria if the patient has met the Hepatitis C – Mavyret PA for PSM Policy criteria.
Hepatitis C – Hepatitis C Virus Direct-Acting Antivirals Preferred Specialty Management Policy for Individual and Family Plans - (PSM026)	Updated	Effective 11/1/2025 Mavyret • **Acute Hepatitis C Virus (HCV), Genotype 1, 2, 3, 4, 5, or 6.** A new indication was added. Mavyret is approved for the duration specified in the Hepatitis C – Mavyret PA for PSM Policy criteria if the patient has met the Hepatitis C – Mavyret PA for PSM Policy criteria.
Immunologicals – Dupixent - (IP0453)	Updated	Effective 11/15/2025

		• **Atopic Dermatitis:** Criteria were updated to require that the patient either has atopic dermatitis involvement estimated to be ≥ 10% of the body surface area OR the patient is ≥ 12 years of age and has moderate to severe hand and/or foot atopic dermatitis. Previously, criteria required that the patient have atopic dermatitis involvement estimated to be ≥ 10% of the body surface area.
Immunologicals – Nemluvio - (IP0714)	Updated	Effective 11/15/2025 • **Updated** Policy template
Inflammatory Conditions – Adalimumab Products Drug Quantity Management Policy – Per Days - (DQM005)	Updated	Effective 11/1/2025 • **Adalimumab 40 mg pens and syringes (NOT Starter Packages):** Quantity limits were increased to 4 pens/syringes per 28 days at retail or 12 pens/syringes per 84 days at home delivery (previous limits were 2 pens/syringes per 28 days at retail or 6 pens/syringes per 84 days at home delivery). All override criteria that approved 4 pens/syringes per 28 days at retail or 12 pens/syringes per 84 days at home delivery were removed (no longer needed).
Inflammatory Conditions – Bimzelx Prior Authorization Policy - (IP0658)	Updated	Effective 11/15/2025 • **Plaque Psoriasis:** For Initial Therapy, in the Note, a 3-month trial or prior intolerance to Otezla (apremilast tablets), Otezla XR (apremilast extended-release tablets), or Sotyktu (deucravacitinib tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis. For Initial Therapy, the requirement "patient has a contraindication to methotrexate, as determined by the prescriber" was modified to "according to the prescriber, the patient has a contraindication to methotrexate".
Inflammatory Conditions – Entyvio Subcutaneous Drug Quantity Management	New	Effective 11/1/2025 • New policy

Policy – Per Days - (DQM006)		
Inflammatory Conditions – Kineret Drug Quantity Management Policy – Per Days - (DQM008)	New	Effective 11/1/2025 • New policy.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Standard/Performance, Value/Advantage, Total Savings Prescription Drug Lists - (PSM001)	Updated	Effective 11/1/2025 **Cimzia:** For **Crohn's Disease**, a patient is directed to one Step 1 Product; previously, a patient was directed to adalimumab specifically. A previous trial of an infliximab intravenous product, Omvoh intravenous, Skyrizi intravenous, Tremfya intravenous, or an ustekinumab intravenous product also counts. **Simponi Subcutaneous:** For **Ulcerative Colitis**, a patient is directed to one Step 1 Product; previously, a patient was directed to adalimumab specifically. A previous trial of an infliximab intravenous product, Omvoh intravenous, Skyrizi intravenous, Tremfya intravenous, or an ustekinumab intravenous product also counts. **Cosentyx SC:** For **Psoriatic Arthritis**, Otezla was added as an agent that counts towards a trial of a Preferred Product for patients < 18 years of age. • **Orencia SC:** For **Psoriatic Arthritis**, Otezla was added as an agent that counts towards a trial of a Preferred Product for patients < 18 years of age.
Inflammatory Conditions Preferred Specialty Management Policy for Employer Plans: Legacy Prescription Drug Lists - (PSM017)	Updated	Effective 11/1/2025 **Cimzia:** For **Crohn's Disease**, a patient is directed to one Step 1 Product; previously, a patient was directed to adalimumab specifically. A previous trial of an infliximab intravenous product, Omvoh intravenous, Skyrizi intravenous, Tremfya intravenous, or an ustekinumab intravenous product also counts. **Simponi Subcutaneous:** For **Ulcerative Colitis**, a patient is directed to one Step 1 Product; previously, a patient was directed to adalimumab specifically. A previous trial of an infliximab intravenous product, Omvoh intravenous, Skyrizi intravenous, Tremfya intravenous, or an ustekinumab intravenous product also counts. **Cosentyx SC:** For **Psoriatic Arthritis**, Otezla was added as an agent that counts towards a trial of a Preferred Product for patients < 18 years of age. • **Orencia SC:** For **Psoriatic Arthritis**, Otezla was added as an agent that counts towards a trial of a Preferred Product for patients < 18 years of age.

Inflammatory Conditions Preferred Specialty Management Policy for Individual and Family Plans - (PSM002)	Updated	Effective 11/1/2025 **Cimzia:** For **Crohn's Disease**, a patient is directed to one Step 1 Product; previously, a patient was directed to adalimumab specifically. A previous trial of an infliximab intravenous product, Skyrizi intravenous, Tremfya intravenous, or an ustekinumab intravenous product also counts. **Simponi Subcutaneous:** For **Ulcerative Colitis**, a patient is directed to one Step 1 Product; previously, a patient was directed to adalimumab specifically. A previous trial of an infliximab intravenous product, Skyrizi intravenous, Tremfya intravenous, or an ustekinumab intravenous product also counts. • **Orencia SC:** For **Psoriatic Arthritis**, Otezla was added as an agent that counts towards a trial of a Preferred Product for patients < 18 years of age.
Inflammatory Conditions – Simponi Subcutaneous Prior Authorization Policy - (IP0667)	Updated	Effective 11/15/2025 • **Ulcerative Colitis:** For initial therapy, the requirement that patient is ≥ 18 years of age was removed. A requirement was added that patient weighs ≥ 15 kilograms (kg).
Inflammatory Conditions – Sotyktu Prior Authorization Policy - (IP0671)	Updated	Effective 11/1/2025 **Plaque Psoriasis:** For Initial Therapy, in the Note, a 3-month trial or prior intolerance to Otezla (apremilast tablets) or Otezla XR (apremilast extended-release tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis. For Initial Therapy, the requirement "patient has a contraindication to methotrexate, as determined by the prescriber" was modified to "according to the prescriber, the patient has a contraindication to methotrexate". • **Conditions Not Recommended for Approval:** For concurrent use with a biologic or with a targeted synthetic oral small molecule drug, the Note was removed stating "this does NOT exclude the use of conventional synthetic DMARDs (e.g., methotrexate, leflunomide, hydroxychloroquine, or sulfasalazine) in combination with this medication."
Inflammatory Conditions – Tremfya Prior Authorization Policy - (IP0689)	Updated	Effective 11/1/2025 **Ulcerative Colitis:** For initial therapy, removed the requirement the patient will receive three induction doses of Tremfya intravenous within three months of initiating therapy with Tremfya subcutaneous.

		Plaque Psoriasis: For Initial Therapy: an option of approval in a patient ≥ 6 years to ≤ 17 years of age and weighing ≥ 40 kg was added; in the Note, a 3-month trial or prior intolerance to Otezla (apremilast tablets), Otezla XR (apremilast extended-release tablets), or Sotyktu (deucravacitinib tablets) was added as an exception to the requirement for a trial of one traditional systemic agent for psoriasis; and "patient has a contraindication to methotrexate, as determined by the prescriber" was modified to "according to the prescriber, the patient has a contraindication to methotrexate". • **Psoriatic Arthritis:** An option of approval in a patient ≥ 6 years to ≤ 17 years of age and weighing ≥ 40 kg was added.
Inflammatory Conditions – Zymfentra Drug Quantity Management Policy – Per Days - (DQM007)	New	Effective 11/1/2025 • New policy
Metabolic Disorders – Xuriden - (IP0307)	Updated	Effective 11/1/2025 **Policy Title.** **Title updated from** "Uridine triacetate" **to** "Metabolic Disorders – Xuriden" • **Added** "**Documentation:** 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."
Multiple Sclerosis (Injectable – Beta Interferon) – Avonex - (IP0254)	Updated	Effective 11/1/2025 The Policy name was changed to add "Injectable – Beta Interferon". **Added** a policy statement. **Removed** documentation requirements. **Updated** the conditions not covered statement. • **Removed** Extavia from the Appendix.
Multiple Sclerosis (Injectable – Beta	Updated	Effective 11/1/2025 The Policy name was changed to add "Injectable – Beta Interferon".

Interferon) – Betaseron - (IP0256)		Extavia was removed from the Policy, as well as from the Appendix. **Removed** documentation requirements. **Added** a policy statement. **Updated** the Individual and Family Plans preferred product criteria. • **Updated** the conditions not covered statement.
Multiple Sclerosis (Injectable – Beta Interferon) – Plegridy - (IP0263)	Updated	Effective 11/1/2025 The Policy name was changed to add "Injectable – Beta Interferon". **Added** a policy statement. **Removed** documentation requirements. **Updated** the Individual and Family Plans preferred product criteria. **Updated** the conditions not covered statement. • **Removed** Extavia from the Appendix.
Multiple Sclerosis (Injectable – Beta Interferon) – Rebif - (IP0265)	Updated	Effective 11/1/2025 The Policy name was changed to add "Injectable – Beta Interferon". **Added** a policy statement. **Removed** documentation requirements. **Updated** the Individual and Family Plans preferred product criteria. **Updated** the conditions not covered statement. • **Removed** Extavia from the Appendix.
Multiple Sclerosis (Injectable – CD20-Directed Cytolytic Antibody) – Briumvi - (IP0545)	Updated	Effective 11/1/2025 The Policy name was changed to add "Injectable – CD20-Directed Cytolytic Antibody". **Added** a policy statement. **Removed** documentation requirements. **Updated** the conditions not covered statement. • **Removed** Extavia from the Appendix.
Multiple Sclerosis (Injectable – CD20-Directed Cytolytic	Updated	Effective 11/1/2025 The Policy name was changed to add "Injectable – CD20-Directed Cytolytic Antibody". **Added** a policy statement.

Antibody) – Kesimpta- (IP0260)		**Removed** documentation requirements. **Updated** the conditions not covered statement. • **Removed** Extavia from the Appendix.
Multiple Sclerosis (Injectable – CD20-Directed Cytolytic Antibody) – Ocrevus - (IP0212)	Updated	Effective 11/1/2025 The Policy name was changed to add "Injectable – CD20-Directed Cytolytic Antibody". **Added** a policy statement. **Removed** documentation requirements. **Updated** the conditions not covered statement. **Removed** Extavia from the Appendix. • Dosing for Multiple Sclerosis (Relapsing Forms) and Multiple Sclerosis (Primary Progressive) were revised to divide into Initial Dosing and Maintenance Dosing. Also, instead of approve one of the following cited regimens, wording was changed from "A or B" to "A and/or B" to allow both dosing regimens to be approved.
Multiple Sclerosis – Dalfampridine (IP0024)	Updated	Effective 11/15/2025 Policy title updated from "Dalfampridine" to "Multiple Sclerosis – Dalfampridine". **Added** a policy statement. **Updated** the dalfampridine use to improve or maintain mobility requirement. **Updated** the impaired ambulation requirement. **Added** criteria for a patient currently receiving dalfampridine. **Updated** the preferred product requirements. • **Updated** the Conditions Not Covered statement.
Multiple Sclerosis (Injectable) – Glatiramer - (IP0257)	Updated	Effective 11/1/2025 The Policy name was changed to add "Injectable". **Added** a policy statement. **Removed** documentation requirements. **Updated** the Employer Plans and Individual and Family Plans preferred product criteria. **Updated** the conditions not covered statement. • **Removed** Extavia from the Appendix.

Multiple Sclerosis (Injectable – Other) – Lemtrada - (IP0213)	Updated	Effective 11/1/2025 The Policy name was changed to add "Injectable – Other". **Added** a policy statement. **Removed** documentation requirements. **Added** the documentation to the highly-active or aggressive multiple sclerosis criteria. **Updated** the conditions not covered statement. • **Removed** Extavia from the Appendix.
Multiple Sclerosis (Oral – Fumarate) – Bafiertam - (IP0255)	Updated	Effective 11/1/2025 The Policy name was changed to add "Oral – Fumarate". **Added** a policy statement. **Removed** documentation requirements. **Updated** the conditions not covered statement. • **Removed** Extavia from the Appendix.
Multiple Sclerosis (Oral – Fumarate) – Dimethyl Fumarate - (IP0266)	Updated	Effective 11/1/2025 The Policy name was changed to add "Oral – Fumarate". **Added** a policy statement. **Removed** documentation requirements. **Updated** the Employer Plans and Individual and Family Plans preferred product criteria. **Updated** the conditions not covered statement. • **Removed** Extavia from the Appendix.
Multiple Sclerosis (Oral – Fumarate) – Vumerity - (IP0253)	Updated	Effective 11/1/2025 The Policy name was changed to add "Oral Fumarate". **Added** a policy statement. **Removed** documentation requirements. **Updated** the Individual and Family Plans preferred product criteria. **Updated** the conditions not covered statement. • **Removed** Extavia from the Appendix.

Multiple Sclerosis (Oral - Other)– Teriflunomide for Employer Plans: Standard/ Performance, Value/Advantage, Legacy, Total Savings Prescription Drug Lists - (IP0252)	Updated	Effective 11/1/2025 The Policy name was changed to add "Oral - Other". **Added** a policy statement. **Removed** documentation requirements. **Updated** the preferred product criteria. **Updated** the conditions not covered statement. • **Removed** Extavia from the Appendix.
Multiple Sclerosis (Oral – Other) - Teriflunomide for Individual and Family Plans - (IP0560)	Updated	Effective 11/1/2025 The Policy name was changed to add "Oral - Other". **Added** a policy statement. **Removed** documentation requirements. **Updated** the preferred product criteria. **Updated** the conditions not covered statement. • **Removed** Extavia from the Appendix.
Multiple Sclerosis (Oral – Other) – Mavenclad - (IP0261)	Updated	Effective 11/1/2025 The Policy name was changed to add "Oral - Other". **Added** a policy statement. **Removed** documentation requirements. **Multiple Sclerosis, Initial Therapy** **Added** criteria for patients with highly-active or aggressive multiple sclerosis. **Updated** the conditions not covered statement. • **Removed** Extavia from the Appendix.
Multiple Sclerosis (Oral – Sphingosine 1-Phosphate Receptor Modulator) – Fingolimod - (IP0259)	Updated	Effective 11/1/2025 The Policy name was changed to add "Oral – Sphingosine 1-Phosphate Receptor Modulator". **Added** a policy statement. **Removed** documentation requirements. **Updated** the Employer Plans and Individual and Family Plans preferred product criteria. **Updated** the conditions not covered statement.

		• **Removed** Extavia from the Appendix.
Multiple Sclerosis (Oral – Sphingosine 1-Phosphate Receptor Modulator) – Mayzent - (IP0262)	Updated	Effective 11/1/2025 The Policy name was changed to add "Oral – Sphingosine 1-Phosphate Receptor Modulator". **Added** a policy statement. **Removed** documentation requirements. **Updated** the Individual and Family Plans preferred product criteria. **Updated** the conditions not covered statement. • **Removed** Extavia from the Appendix.
Multiple Sclerosis – (Oral – Sphingosine 1-Phosphate Receptor Modulator) – Ponvory - (IP0264)	Updated	Effective 11/1/2025 The Policy name was changed to add "Oral – Sphingosine 1-Phosphate Receptor Modulator". **Removed** documentation requirements. **Updated** the policy statement. **Updated** the Employer Plans and Individual and Family Plans preferred product criteria. **Removed** Extavia from the Appendix. •
Multiple Sclerosis (Oral – Sphingosine 1-Phosphate Receptor Modulator) – Tascenso ODT - (IP0514)	Updated	Effective 11/1/2025 The Policy name was changed to add "Oral – Sphingosine 1-Phosphate Receptor Modulator". **Added** a policy statement. **Removed** documentation requirements. **Updated** the Employer Plans and Individual and Family Plans preferred product criteria. **Updated** the conditions not covered statement. **Removed** Extavia from the Appendix. •
Muscular Dystrophy – Deflazacort - (IP0131)	Updated	Effective 11/15/2025 **Added** branded generic Jaythari to the policy with the same criteria applied as the other deflazacort products.

		Added branded generic Pyquvi to the policy with the same requirements as the other deflazacort products. • **Added** Jaythari and Pyquvi to the preferred product table for Employer Plans.
Neurology – Imaavy - (IP0743)	Updated	Effective 11/1/2025 • **Updated** policy template.
Neurology – Leqembi - (IP0547)	Updated	Effective 11/1/2025 • **Leqembi IQLIK**: Added to the policy with no Recommended Authorization Criteria.
Neurology – Oxybate Products - (IP0103)	Updated	Effective 11/15/2025 • **Updated** policy template.
Neurology – Rystiggo - (IP0575)	Updated	Effective 11/1/2025 • **Updated** policy template.
Neurology – Vyvgart Hytrulo - (IP0574)	Updated	Effective 11/1/2025 • **Updated** policy template.
Neurology – Vyvgart Intravenous - (IP0376)	Updated	Effective 11/1/2025 • **Updated** policy template.
Non-Steroidal Mineralocorticoid Receptor Antagonist - (IP0314)	Updated	Effective 11/15/2025 **Policy Title.**

		The policy name was changed to Non-Steroidal Mineralocorticoid Receptor Antagonist – Kerendia, previously Finerenone. **Chronic Kidney Disease in a Patient with Type 2 Diabetes.** This condition was updated, previously "Diabetic Kidney Disease". Initial Therapy. The following criterion was modified to add "or significant intolerance": According to the prescriber, the patient has a contraindication or significant intolerance to ACE or ARB therapy. Added criteria for Patient is Currently Receiving Kerendia. **Heart Failure.** This indication was added to the policy as an approvable condition. Other criteria apply. **Conditions Not Covered.** **Removed** Heart Failure (Treatment) **Preferred Product Table.** **Added** "According to the prescriber, the patient has a contraindication or has experienced significant intolerance to SGLT-2 inhibitor therapy." for Chronic kidney disease in a patient ≥ 18 years of age with type 2 diabetes for Individual and Family Plans • **Added** criteria for "Heart failure with left ventricular ejection fraction (LVEF) ≥ 40% in a patient ≥ 18 years of age." for Employer Plans and Individual and Family Plan
Ophthalmology – Oxervate - (IP0302)	Updated	Effective 11/1/2025 **Neurotrophic Keratitis:** The Note was revised to indicate if the patient has already received at least 8 weeks of treatment in the affected eye, review under "Patient Who Has Previously Received Oxervate". Previously, it stated to review under "Recurrence". • The term "Initial Course" is now "Initial Therapy" and the term "Recurrence" is now "Patient Who Has Previously Received Oxervate". • Initial Therapy, the Note regarding approval of up to 8 weeks per affected eye(s) was clarified: "If the patient has started treatment but did not receive 8 weeks, approve enough Oxervate to complete 8 weeks of treatment"; previously the note provided an example of approving 6 weeks for a patient who had already received 2 weeks of treatment. The Note for the requirement that patient has received < 8 weeks of treatment in the affected eye(s) was clarified such that the 8 weeks is for initial neurotrophic keratitis and it's per affected eye(s). The new Note reads: Each course of Oxervate for the treatment of initial neurotrophic keratitis is 8 weeks (per affected eye[s]).

		• Patient Who Has Previously Received Oxervate, the Note regarding approval of up to 8 weeks per affected eye(s) was clarified: "If the patient has started treatment but did not receive 8 weeks, approve enough Oxervate to complete 8 weeks of treatment"; previously, the note stated that if the patient already received 8 weeks of treatment, an additional 8 weeks may be approved, for a total of 16 weeks of treatment. The requirement that the patient has received < 16 weeks of treatment per affected eye(s) was revised to include the qualifiers "total" and "per lifetime"; the new requirement reads: Patient has received < 16 weeks (total) of treatment per affected eye(s) [per lifetime]. The Note was clarified that a total of two 8-week treatment courses can be approved for initial and recurrent neurotrophic keratitis per affected eye(s) per lifetime; previously, the note stated a total of 16 weeks for initial and recurrent neurotrophic keratitis. A new requirement that the patient has recurrence of neurotrophic keratitis was added. **Conditions Not Recommended for Approval**, for Treatment duration of > 16 weeks per affected eye(s) per episode, the term "per lifetime" replaced the term "per episode" and "total" was added; it now reads: Treatment Duration of > 16 weeks Total Per Affected Eye(s) Per Lifetime. • **Policy Statement.** The statement that a total of 16 weeks of Oxervate can be approved for treatment of initial and recurrent neurotrophic keratitis was clarified that this is per lifetime and that the 16 weeks entails two 8-week treatment courses.
Ophthalmology – Vizz - (IP0763)	New	Effective 11/01/2025 New Policy •
Phenylketonuria – Palynziq - (IP0294)	Updated	Effective 11/01/2025 **Policy Title.** **Updated** from "Pegvaliase-pqpz" **to** "Phenylketonuria – Palynziq" **Phenylketonuria** **Removed** "Documented diagnosis of phenylketonuria (PKU) confirmed by documentation of ONE of the following: A. Plasma phenylalanine concentration persistently above 120 µmol/L (2 mg/dL) and altered ratio of phenylalanine to tyrosine in the untreated state with normal BH4 cofactor metabolism B. Molecular genetic test demonstrating biallelic pathogenic or likely pathogenic variants in the PAH gene."

		Updated from "Documentation of uncontrolled blood phenylalanine concentrations of greater than 600 micromol/L on existing management (for example, phenylalanine restricted diet, sapropterin [Kuvan])" **to** "Patient has uncontrolled blood phenylalanine concentrations greater than 600 micromol/L on at least one existing treatment modality; AND Note: Examples of treatment modalities include restriction of dietary phenylalanine and protein intake and prior treatment with sapropterin (Kuvan, Javygtor, generic)" **Updated** from "Blood phenylalanine levels are being maintained within an acceptable range (120-600 µmol/L) " **to** "Patient's blood phenylalanine concentration is ≤ 600 micromol/L" • **Updated** from "Patient is not receiving concomitant therapy with sapropterin (Kuvan)" **to** "Patient is not receiving concomitant therapy with sapropterin (Kuvan, Javygtor, generic)"
Pharmacy and Medical Prior Authorization - (1407)	Updated	Effective 11/1/2025 **Added Individual and Family Plan product-specific medical necessity criteria for the following products:** valsartan oral solution (previously Prexxartan), Fanapt titration pack, topiramate oral solution (authorized generic for Eprontia), Denavir, penciclovir 1% cream, Xerese, Lopressor oral solution, Micort HC 2.5 % rectal cream, dicyclomine 40 mg tablets, baclofen 10 mg/5 mL oral solution, ibuprofen 300 mg tablets, and Tri-Vitamin Drops with Fluoride **Updated Individual and Family Plan product-specific medical necessity criteria for the following product:** • topiramate 50 mg oral sprinkle capsule
Phenylketonuria – Sapropterin - (IP0295)	Updated	Effective 11/01/2025 **Policy Title.** **Updated** from "Sapropterin" **to** "Phenylketonuria – Sapropterin" **Added** documentation required statement **Phenylketonuria** **Updated** authorization approval from 12 months **to** 12 weeks

		Removed "Diagnosis of phenylketonuria (PKU) confirmed by documentation of ONE of the following: Plasma phenylalanine concentration persistently above 120 µmol/L (2 mg/dL) and altered ratio of phenylalanine to tyrosine in the untreated state with normal BH4 cofactor metabolism. Finding of biallelic pathogenic or likely pathogenic variants in the PAH gene." **Updated** "Patient has had a clinical response (e.g., cognitive and/or behavioral improvements) as determined by the prescriber" **to** "According to the prescriber, patient has had a clinical response; OR Note: Examples of clinical response may include cognitive and/or behavioral improvements" **Updated** "NOT receiving concomitant therapy with Palynziq (pegvaliase-pqpz subcutaneous injection) at a stable maintenance dose" **to** "Patient is not receiving concomitant Palynziq (pegvaliase-pqpz subcutaneous injection) at a stable maintenance dose. Note: Concomitant use with Palynziq is permitted during Palynziq dose titration." **Employer Plans and Individual and Family Plans Preferred Product Table:** **Added [documentation required]** to criteria **Conditions Not Covered** • **Added** Concurrent Use with Sephience
Phenylketonuria – Sephience for Individual and Family Plans - (IP0764)	New	Effective 11/15/2025 • New policy.
Pulmonary Arterial Hypertension and Related Lung Disease – Inhaled Prostacyclin Products - (IP0753)	New	Effective 11/15/2025 • New policy.
Pulmonary Arterial Hypertension – Adempas – (IP0600)	Updated	Effective 11/15/2025 **Added** a policy statement and a documentation statement. **Pulmonary Arterial Hypertension (PAH) [World Health Organization {WHO} Group 1].** Initial Therapy **Added** documentation to the right heart catheterization requirement.

		• **Updated** the Conditions Not Covered statement.
Pulmonary Arterial Hypertension - Endothelian Receptor Antagonists - (IP0631)	Updated	Effective 11/15/2025 **Pulmonary Arterial Hypertension (PAH) [World Health Organization {WHO} Group 1]:** **[documentation required]** added to indication. Bosentan tablets for oral suspension are now available as generic. • **Updated** policy template.
Pulmonary Arterial Hypertension – Epoprostenol Products - (IP0762)	New	Effective 11/15/2025 • New policy.
Pulmonary Arterial Hypertension – Orenitram (IP0616)	Updated	Effective 11/15/2025 **Added** a policy statement and a documentation statement. **Pulmonary Arterial Hypertension (PAH) [World Health Organization {WHO} Group 1].** Initial Therapy **Added** documentation to the right heart catheterization requirement. **Updated** the oral prerequisite medication requirement. **Updated** the note for the oral prerequisite medication requirement. • **Updated** the Conditions Not Covered statement.
Pulmonary Arterial Hypertension – Phosphodiesterase Type 5 Inhibitors - (IP0626)	Updated	Effective 11/15/2025 **Added** a policy statement and a documentation statement. **Pulmonary Arterial Hypertension (PAH) [World Health Organization {WHO} Group 1].** Initial Therapy **Added** documentation to the right heart catheterization requirement.

		Pulmonary Arterial Hypertension (PAH) [World Health Organization {WHO} Group 1]. Patients Currently Receiving the Requested Phosphodiesterase Type 5 (PDE5) Inhibitor **Removed** the preferred product requirement. • **Updated** the Conditions Not Covered statement.
Pulmonary Arterial Hypertension – Treprostinil Injection - (IP0757)	New	Effective 11/15/2025 • New policy.
Pulmonary Arterial Hypertension – Uptravi - (IP0627)	Updated	Effective 11/15/2025 **Added** a policy statement. **Pulmonary Arterial Hypertension (PAH) [World Health Organization {WHO} Group 1].** Initial Therapy **Added** documentation to the right heart catheterization requirement. **Added** Opsynvi (macitentan/tadalafil tablets) as an example of other oral medications for PAH. **Pulmonary Arterial Hypertension (PAH) [World Health Organization {WHO} Group 1].** Patients Currently Receiving Uptravi **Added** a note clarifying the right heart catheterization requirement. • **Updated** the Conditions Not Covered statement.
Pulmonary Arterial Hypertension – Winrevair - (IP0645)	Updated	Effective 11/15/2025 **Pulmonary Arterial Hypertension (PAH) [World Health Organization {WHO} Group 1:** Initial Therapy Clarified documentation requirements. • **Added** Yutrepia as an example of an inhaled prostacyclin.
Pulmonary-Brinsupri for Individual and	New	Effective: 11/15/2025

Family Plans - (IP0758)		• New standalone coverage policy.
Pulmonary Hypertension (PH) Therapy - (6121)	Updated	Effective 11/15/2025 **Removed** Flolan, Remodulin, treprostinil injection, Tyvaso, Tyvaso DPI, Veletri, and Ventavis from the policy. **Added** a documentation statement. **Updated** the right heart catheterization statement. **Added** documentation to the right heart catheterization statement. **Updated** the specialist prescribing requirement. • **Updated** the Conditions Not Covered statement.
Pulmonary Arterial Hypertension – Winrevair - (IP0645)	Updated	Effective 11/15/2025 **Pulmonary Arterial Hypertension (PAH) [World Health Organization {WHO} Group 1:** Initial Therapy Clarified documentation requirements. • **Added** Yutrepia as an example of an inhaled prostacyclin.
Quantity Limitations - (1201)	Updated	Effective 11/15/2025 **Added** a policy statement. • **Removed** Kineret from the policy.
Regranex - (IP0495)	Updated	Effective 11/1/2025 **Policy Title**: **Updated from** "Becaplermin" **to** "Regranex" **Diabetic Lower Extremity foot Ulcers** **Updated from** "Diabetic foot ulcer" **to** "Diabetic Lower Extremity Ulcers." **Updated** authorization duration **from** "12 months" **to** "5 months." **Added** criterion "Patient is ≥ 16 years of age" **Added** criterion "Ulcers are classified as Stage III or IV" and also **added** "Note: This refers to the International Association of Enterostomal Therapy (IAET) classification system for wounds."

		Removed criterion "Use for the treatment of diabetic neuropathic ulcer of the lower extremity." **Conditions Not Covered:** **Added** "Pressure Ulcers – Treatment" **Added** "Venous Stasis Ulcers – Treatment" • **Added** "Prevention of Ulcers/Wounds"
Somatostatin Analogs – Lanreotide Products - (IP0323)	Updated	Effective 11/1/2025 • **Small bowel bleeds/angiodysplasia related bleeding:** The condition small bowel bleeds/angiodysplasia related bleeding was added under "Other Uses with Supportive Evidence".
Somatostatin Analogs – Octreotide Immediate-Release Products - (IP0490)	Updated	Effective 11/1/2025 • **Small bowel bleeds/angiodysplasia related bleeding:** The condition small bowel bleeds/angiodysplasia related bleeding was added under "Other Uses with Supportive Evidence".
Somatostatin Analogs – Octreotide Long-Acting Products - (IP0489)	Updated	Effective 11/1/2025 • **Small bowel bleeds/angiodysplasia related bleeding:** The condition small bowel bleeds/angiodysplasia related bleeding was added under "Other Uses with Supportive Evidence".
Somavert - (IP0291)	Updated	Effective 11/1/2025 • **Removed** documentation requirements from Acromegaly criteria.
Step Therapy – Legacy Prescription Drug Lists (Employer Group Plans) – (1803)	Updated	Effective 11/1/2025 **Added** Fluticasone furoate (generic for Arnuity Ellipta) as a Step Three Inhaled Corticosteroid (ICS) Medication

		• **Added** an exception to the Inhaled Corticosteroid (ICS) step therapy requirements for a patient who is pregnant and is currently receiving the requested product for asthma.
Synagis - (IP0321)	Updated	Effective 11/01/2025 **Policy Title** **Updated** from "Palivizumab" to "Synagis" **Added** dosing for all Indications **Respiratory Syncytial Virus (RSV), Prevention in a Patient with Chronic Lung Disease.** **Updated** "Individual required supplemental oxygen for at least the first 28 days after birth" **to** "Patient required > 21% oxygen for at least the first 28 days after birth" **Respiratory Syncytial Virus (RSV), Prevention in a Patient with Congenital Heart Disease. Updated** "Individual has hemodynamically significant congenital heart defects that have been adequately corrected by surgery **"to "**Patient has lesions that have been adequately corrected by surgery" **Updated** "Individual meets ONE of the following" **to** "According to the prescriber, patient meets ONE of the following" **Removed** neonatologist and pulmonologist from specialty requirement. **Updated** pediatric cardiologist **to** cardiologist. **Added** intensivist to specialty requirement **Respiratory Syncytial Virus (RSV), Prevention in a Patient Born Prematurely** **Added** "(≤ 28 weeks, 6 days gestation)" to "Patient was born before 29 weeks, 0 days gestation" **Other Uses with Supportive Evidence** **Respiratory Syncytial Virus (RSV), Prevention in a Patient with Anatomic Pulmonary Abnormalities or a Neuromuscular Disorder** **Updated "**Individual has a congenital abnormality of the airway or a neuromuscular disease (for example, cerebral palsy, muscular dystrophy, neurological diseases of the brain and spinal cord [Tay Sachs, spinal muscular dystrophy]) that compromises the handling of respiratory secretions" **to** "According to the prescriber, the patient's condition compromises the handling of respiratory secretions. **Respiratory Syncytial Virus (RSV), Prevention in an Immunocompromised Patient.**

		Added "Note: Examples of immunocompromised patients include those receiving chemotherapy and those with hematopoietic stem cell transplant or solid organ transplant." **Updated** "Individual is/will be profoundly immunocompromised (for example, severe combined immunodeficiency or severe acquired immunodeficiency syndrome) during the RSV season" **to** "According to the prescriber, the patient is/will be profoundly immunocompromised during the RSV season" **Respiratory Syncytial Virus (RSV), Prevention in a Patient with Cardiac Transplant.** **Added "**Note: A patient with cardiac transplant may also be immunocompromised. In a patient who does not meet criteria for cardiac transplant below, please see criterion 5 above (Respiratory Syncytial Virus [RSV], Prevention in an Immunocompromised Patient)." **Removed** neonatologist and pulmonologist from specialty requirement. **Added** intensivist to specialty requirement. **Respiratory Syncytial Virus (RSV), Prevention in an Individual with Cystic Fibrosis.** This use was removed **Respiratory Syncytial Virus (RSV), Prevention in an Alaska Native or American Indian (Navajo, White Mountain Apache).** • This use was removed
Testosterone (Injectable) Products - (IP0351)	Updated	Effective 11/15/2025 **Updated** the policy statement. **Hypogonadism (Primary or Secondary) in Males* [Testicular Hypofunction/Low Testosterone with Symptoms].** Initial Therapy **Updated** Employer Plans and Individual and Family plans preferred product criteria. • **Updated** the Conditions Not Covered statement.
Thrombocytopenia – Doptelet - (IP0152)	Updated	Effective 11/01/2025 Doptelet® Sprinkle was added to the policy. The criteria were divided into two sections (Doptelet tablets and Doptelet Sprinkle). **Immune Thrombocytopenia, Chronic or Persistent:** For criteria that address Doptelet tablets, the indication was changed to as stated, previously, it was "Chronic Immune

		Thrombocytopenia." For initial therapy, the requirement that the patient is ≥ 18 years of age was removed. In the Note related to the requirement that the patient has tried one other therapy, Alvaiz (eltrombopag choline tablets) was added and it was noted that Promacta (eltrombopag olamine tablets and oral suspension) is available in generic formulations. Removed documentation requirements for patients currently receiving Doptelet. • **Immune Thrombocytopenia, Chronic or Persistent:** New criteria were added to address Doptelet Sprinkle
Thrombocytopenia – Eltrombopag Products - (IP0153)	Updated	Effective 11/01/2025 **Updated** policy template. • **Removed** documentation requirements for patients currently receiving eltrombopag.
Thrombocytopenia – Nplate - (IP0155)	Updated	Effective 11/01/2025 • **Removed** documentation requirements for patients currently receiving Nplate
Thrombocytopenia – Tavalisse - (IP0154)	Updated	Effective 11/01/2025 • **Removed** documentation requirements for patients currently receiving Tavalisse.
Topical Acyclovir Products - (IP0752)	New	Effective 11/1/2025 *Topical Antivirals (IP0276) and Acyclovir 5% Ointment for Individual and Family Plans (IP0498) was consolidated into IP0752* **Genital Herpes** **Removed** age requirement of 18 years of age or older **Limited Non-Life-Threatening Mucocutaneous Herpes Simplex Virus Infections** **Updated from** "Mucocutaneous Herpes Simplex Virus infections" **to** "Limited Non-Life-Threatening Mucocutaneous Herpes Simplex Virus Infections" **Removed** age requirement of 18 years of age or older. **Preferred Product Table:**

		Added the following criteria "Patient has an intolerance to an oral antiviral agent and cannot take any other oral antiviral" and also added a note with examples of oral antivirals. **Added** the following criteria "Patient cannot swallow or has difficulty swallowing tablets or capsules AND has tried acyclovir oral suspension." • **Removed** preferred product step requirement criteria for Denavir and Xerese for Employer Plans
Transplantation – Nulojix (IP0219)	Updated	Effective 11/15/2025 **Policy Title** **Updated from** "belatacept" **to** "Transplantation – Nulojix" **Kidney Transplantation – Prophylaxis of Organ Rejection:** Updated authorization duration from 4 months to 1 year. Dosing was changed to divide into Initial Dosing and Maintenance Dosing, with the option to approve both cited regimens for up to 1 year. For Initial Dosing, the dosing is either up to 10 mg/kg by intravenous infusion no more than four times in the first 4 weeks, followed by no more frequently than once every 4 weeks for the next 8 weeks; AND/OR up to 5 mg/kg by intravenous infusion no more frequently than once every 2 weeks for up to 8 weeks. Maintenance Dosing is up to 5 mg/kg administered by intravenous infusion no more frequently than once every 4 weeks. Previously, dosing was that each individual dose must not exceed 10 mg/kg administered by intravenous infusion; AND Nulojix is administered no more than four times in the first 4 weeks (day of transplant, Day 5, end of Week 2, and end of Week 4), and then no more frequently than once every 4 weeks. • **Organ Transplantation Other Than Kidney – Prophylaxis of Solid Organ Rejection in a Patient Currently Receiving Nulojix:** Dosing was changed to up to 5 mg/kg administered by intravenous infusion no more frequently than once every 4 weeks. Previously, dosing was that each individual dose must not exceed 10 mg/kg administered by intravenous infusion; AND Nulojix is administered no more than four times in the first 4 weeks (day of transplant, Day 5, end of Week 2, and end of Week 4), and then no more frequently than once every 4 weeks.
Wakefulness-Promoting Agents – Armodafinil, Modafinil - (IP0075)	Updated	Effective: 11/15/2025 **Excessive Daytime Sleepiness Associated with Obstructive Sleep Apnea.** Criterion requiring use in conjunction with continuous positive airway pressure or patient is unable to initiate or tolerate continuous positive airway pressure was changed to use in conjunction with

		positive airway pressure or patient is unable to initiate or tolerate positive airway pressure with a Note that positive airway pressure can include continuous positive airway pressure (CPAP), auto-titrating positive airway pressure (APAP), or bilevel positive airway pressure (BPAP). **Updated** documentation verbiage to "**[documentation required].**" **Idiopathic Hypersomnia.** • **Removed** documentation requirement **from** "Documented diagnosis is confirmed by a sleep specialist physician or at an institution that specializes in sleep disorders (i.e., sleep center)."
Wakefulness-Promoting Agents – Sunosi - (IP0102)	Updated	Effective 11/15/2025 **Excessive Daytime Sleepiness Associated with Obstructive Sleep Apnea.** Requirement regarding use in conjunction with continuous positive airway pressure or patient is unable to initiate or tolerate continuous positive airway pressure was changed to use in conjunction with positive airway pressure or patient is unable to initiate or tolerate positive airway pressure with a Note that positive airway pressure can include continuous positive airway pressure (CPAP), auto-titrating positive airway pressure (APAP), or bilevel positive airway pressure (BPAP). • **Updated** documentation verbiage to "**[documentation required].**"
Wakefulness-Promoting Agents – Wakix - (IP0292)	Updated	Effective: 11/15/2025 • **Updated** policy template.
Weight Loss – Appetite Suppressants and Orlistat - (IP0420)	Updated	Effective: 11/1/2025 **Removed** generic Qsymia from the policy. **Added** preferred product requirements for Qsymia. **Added** generic Lomaira to the policy. **Updated** the conditions not covered statement. •
Hematology – Plerixafor - (IP0139)	Updated	Effective: 11/15/2025

		• No changes to coverage policy criteria.
Hypoparathyroidism - Yorvipath - (IP0712)	Updated	Effective 11/1/2025 • No change in coverage
Hepatitis C – Vosevi Prior Authorization Policy - (IP0736)	Updated	Effective 11/1/2025 • No criteria changes.
Hepatitis C – Harvoni Prior Authorization Policy - (IP0735)	Updated	Effective 11/15/2025 • No criteria changes.
Immunologicals – Ebglyss - (IP0708)	Updated	Effective 11/15/2025 • No change in coverage
Inflammatory Conditions – Orencia Subcutaneous Prior Authorization Policy - (IP0665)	Updated	Effective 11/1/2025 • No criteria changes.
Inflammatory Conditions – Tremfya Intravenous Prior Authorization Policy - (IP0704)	Updated	Effective 11/1/2025 • No criteria changes.

Acyclovir 5% Ointment for Individual and Family Plans (IP0498)	Retired	Effective 11/1/2025 • acyclovir 5% ointment for IFP has been relocated to Topical Acyclovir Products (IP0752)
Topical Antivirals (IP0276)	Retired	Effective 11/1/2025 • acyclovir 5% cream and 5% ointment, Zovirax 5% cream and 5% ointment relocated to Topical Acyclovir Products (IP0752) • Denavir and Xerese will be relocated to Drugs Requiring Medical Necessity Review (1602) for Employer Plans
Nembutal [pentobarbital] injection - (IP0557)	Retired	Effective 11/1/2025
CareAllies Medical Necessity Guideline	**New, Updated, or Retired?**	**Comments**
		• All above updates apply
Precertification Policy*	**New, Updated, or Retired?**	**Comments**
	Updated	• Updated prior authorization requirements are available on our websites, CignaforHCP.com and Cigna.com. Updates include existing codes that have been added and removed from prior authorization. **Updates:** • For November 20, 2025, Cigna added 3 CPT codes to prior authorization. • For November 20, 2025, 4 CPT codes were removed from prior authorization.

Reimbursement Policy*	New, Updated, or Retired?	Comments
Robotic Assisted Surgery - (R04)	Updated	
Retail Pharmacy Reimbursement Policy - (R48)	Updated	
DRG Review Program - (R20)	Updated	
Facility Services Supplies and Equipment - (R12)	Updated	
Evaluation and Management Services - (R30)	Updated	
Modifier - Increased Procedural Services - (M22)	Updated	
Modifier - Multiple Procedures - (M51)	Updated	
Multiple Procedure Reduction Radiology - (R01)	Updated	
Professional Bundled Services - (R44)	Updated	
Preventive Medicine Evaluation and	Updated	

Management Service and Problem Based Evaluation and Management on the Same Day - (R02)		
Laboratory Services - (R17)	Updated	
Other Coding and Reimbursement Documents*	**New, Updated, or Retired?**	**Comments**
		• No updates November 2025
ClaimsXten Documents*	**New, Updated, or Retired?**	**ClaimsXten Documents**
		• No updates November 2025