LifeWise
Health Plan of Washington

January 6, 2025 – Provider News – LifeWise Washington

Medical Policy and Coding Updates
January 6, 2025

Special notices
Effective April 20, 2025

Updates to Carelon Medical Benefits Management Clinical Appropriateness Guidelines (formerly AIM Specialty Health).

Effective for dates of service on and after April 20, 2025, the following updates will apply to the Carelon Medical Benefits Management, Inc. Radiology Clinical Appropriateness Guidelines. As part of the Carelon guideline annual review process, these updates are focused on advancing efforts to drive clinically appropriate, safe, and affordable health care services.

Updates by section

Oncologic Imaging

- National Comprehensive Cancer Network alignments for Cancer Screening and tumor-specific indications, largely addressing time intervals of screening or surveillance imaging.
- Added fluorodeoxyglucose positron emission tomography allowances for Colorectal Cancer and Lung Cancer (Small Cell) accounting for nondiagnostic standard imaging.

Imaging of the Abdomen and Pelvis

- Tumor or neoplasm:
  - Added requirement for initial evaluation of testicular masses with ultrasound
- Endometriosis:
  - Removed ultrasound requirement for follow-up of patients with established diagnosis
- Obstetric indications:
  - Specified that fetal magnetic resonance imaging (MRI) is indicated in second or third trimester
- Diffuse liver disease:
  - Removed criteria for LiverMultiScan as an alternative to magnetic resonance elastography
- Abdominal and/or pelvic pain, undifferentiated:
  - Clarified language regarding initial imaging and lab evaluation

Imaging of the Chest

- Added indication for dyspnea

Effective for dates of service on and after April 20, 2025, the following updates will apply to the Carelon Medical Benefits Management, Inc. **Genetic Testing Appropriateness Guidelines**. As part of the Carelon guideline annual review process, these updates are focused on advancing efforts to drive clinically appropriate, safe, and affordable health care services.

Updates by section

Carrier Screening in the Reproductive Setting

- Standard carrier screening:
  - Removed complete blood count from the list of acceptable prior testing restrictions for hemoglobinopathy screening
- Expanded carrier screening
- Clarified that medical records should attest to adoption or consanguinity
- Expanded criteria to allow for multigene panels to include conditions with less than 1 in 100 carrier frequencies for individuals in a consanguineous partnership
- Removed requirement that alternate biochemical tests are not available, have provided an indeterminate result, or are less accurate than genetic testing

Genetic Testing for Inherited Conditions

- Added expansive criteria to allow confirmatory genetic testing for individuals identified to have a pathogenic or likely pathogenic germline variant in genes with established clinical utility based on results of institutional review board approved clinical research studies
- Cardiac conditions:
  - Expanded genetic testing criteria for hereditary cardiomyopathy syndromes in the pediatric population
  - Added new expansive medical necessity criteria for hereditary aortopathies
- Neurological conditions:
  - Expanded criteria to allow SOD1 genetic testing in individuals with amyotrophic lateral sclerosis when determined to be a candidate for Food and Drug Administration (FDA) approved Qalsody (tofersen) treatment
- Thrombophilia testing:
  - Removed restriction of low bleeding risk in individuals with an unprovoked venous thromboembolism (VTE) who are planning to stop anticoagulation
  - Removed criterion to allow F5 and F2 genetic testing for individuals contemplating estrogen use when they have a first degree relative with VTE and a known hereditary thrombophilia per American Society of Hematology guidance

Hereditary Cancer Testing

- Removed requirement that alternate biochemical tests are not available, have provided an indeterminate result, or are less accurate than genetic testing
- Listed specific examples of somatic test findings that, per American Society for Clinical Oncology (ASCO) guideline, should generate consideration of germline testing (clarification)
- Expanded criteria to allow confirmatory genetic testing for individuals identified to have a pathogenic or likely pathogenic germline variant in genes with established clinical utility based on results from direct-to-consumer genetic testing or results from an institutional review board approved clinical research study
- Adenomatous polyp syndromes:
    - Added expansive criteria to include individuals with multifocal or bilateral congenital hypertrophy of retinal pigment epithelium
    - Added expansive criteria to include first-, second-, or third-degree relatives with known pathogenic variant or clinical findings suggestive of an inherited polyposis syndrome
- Juvenile polyposis syndrome:
    - Increased testing requirement for number of juvenile polyps in the colon from three to five (restrictive)
- Cowden syndrome:
    - Expanded minor criteria to include colorectal cancer and lipomas to the list of conditions that may be present
- Lynch syndrome:
    - Personal history criteria expanded to include any Lynch syndrome related cancer: colorectal, endometrial, gastric, ovarian, pancreatic, urothelial, central nervous system glioma, biliary tract, small intestine, sebaceous adenomas or carcinomas, keratoacanthomas, or breast carcinomas with medullary features
- Li-Fraumeni syndrome (LFS):
    - Expanded the personal history criteria to include pediatric hypodiploid acute lymphoblastic leukemia
    - Restricted germline testing criteria for testing as follow-up to TP53 positive somatic tumor test results as per ASCO guideline
    - Restricted germline testing criteria for testing of unaffected first-, second-, or third-degree relatives to individuals whose affected relative meets LFS personal history criteria
- Hereditary Breast Cancer:
    - Expanded BRCA1/2 testing criteria to include all women less than 65 years of age with a personal history of breast cancer
    - All individuals who are candidates for poly ADP-ribose polymerase inhibitor therapy are included in scope for testing
    - Clarified the statement about BRCA risk models, eliminating reference to tools that are not examples of validated risk models

        - Family history criteria for testing related to having a relative with multiple primary breast cancers expanded to first- or second-degree relative
        - Family history criteria for testing related to having a relative with epithelial ovarian, fallopian tube, or primary peritoneal cancer expanded to include first-, second-, or third-degree relatives
        - Family history criteria for testing related to having a relative with breast cancer who is also an individual assigned male sex at birth expanded to include first-, second-, or third-degree relatives
        - Family history criteria for testing related to having a relative less than 50 years of age with breast cancer expanded to be at least one relative who is a first-, second, or third-degree blood relative
    - Hereditary epithelial ovarian cancer:
        - Clarified the statement about BRCA risk models, eliminating reference to tools that are not examples of validated risk models
    - Hereditary pancreatic ductal adenocarcinoma:
        - Clarified the statement about BRCA risk models, eliminating reference to tools that are not examples of validated risk models
    - Multi-gene panel testing for hereditary breast or pancreatic cancer:
        - For pancreatic carcinoma, expanded the multi-gene panel list to include CDK4
        - For breast cancer, removed the following genes from the multi-gene panel list: ATM, BARD1, CHEK2, RAD51C, and RAD51D
    - Melanoma:
        - Gene list expanded to 20 genes and can include CDK4 pathogenic variants
    - Nevoid basal cell carcinoma syndrome:
        - Expanded threshold for number of basal cell carcinomas from 5 in a lifetime to as low as two (multiple) if this is considered out of proportion to prior skin exposure or skin type
        - Removed age restriction for Lamellar calcification of the falx cerebri (major criterion)
    - Endocrine neoplasms:
        - Expanded criteria to include early onset gastrointestinal stromal tumors to account for evaluation for SDHB gene-deficient GIST
    - Kidney cancer:
        - Expanded criteria to include individuals with a personal history of various rare kidney tumors (Birt-Hogge-Dubé syndrome, Hereditary leiomyomatosis and renal cell cancer associated renal cell carcinoma, etc.)
        - Expanded criteria to include unaffected individuals with two or more first- or second-degree relatives with renal cell carcinoma
    - Prostate Cancer:
        - For individuals with low-risk prostate cancer, criteria expanded to include family history of breast cancer in relatives assigned female at birth and aged 50 years or older; family history of pancreatic, gastric, brain, melanoma, intestinal

(colorectal or small bowel), or endometrial cancer diagnosed at aged 50 years or older; family history of upper tract urothelial cancer(s) in first- or second-degree relatives; Ashkenazi Jewish ancestry; intraductal or cribriform histology
- For individuals with intermediate risk prostate cancer, criteria expanded to include family history of breast cancer in relatives assigned female at birth and aged 50 years or older; family history of pancreatic, gastric, brain, melanoma, intestinal (colorectal or small bowel), or endometrial cancer diagnosed at age ≤50; family history of upper tract urothelial cancer(s) in first- or second-degree relatives
- Removed CHEK2 or PALB2 from the multi-panel gene list for prostate cancer
- Expanded family history criteria to first-, second-, or third-degree relatives with multiple primary breast cancers
- Expanded family history criteria of prostate cancer diagnosed before age 60 to include at least one first- or second-degree relative
- For individuals unaffected by prostate cancer, criteria are expanded to include 11 additional family history indicators for risk of BRCA1 or BRCA2 pathogenic variants that match the Hereditary breast cancer family history criteria
- Clarified the statement about BRCA risk models, eliminating reference to tools that are not examples of validated risk models

Effective for dates of service on and after April 20, 2025, the following updates will apply to the Carelon Medical Benefits Management, Inc. **Radiation Oncology Appropriateness Guidelines**. As part of the Carelon guideline annual review process, these updates are focused on advancing efforts to drive clinically appropriate, safe, and affordable health care services.

Updates by section

Radiation therapy

- Special Treatment Procedure and Special Physics Consult:
  - Limited the scenarios where special treatment procedure and special physics consult are indicated, to more closely align with recent American Society for Radiation Oncology guidance.
- Breast cancer:
  - Reduced the minimum age at which patients with invasive disease meet criteria for accelerated partial breast irradiation.
- Head and neck cancer:
  - Removed indication for neutron therapy as it is no longer routinely used.
- Lung cancer:
  - Clarified that the maximum number of fractions for stereotactic body radiation therapy (SBRT) is 5 in both non-small cell lung cancer and small cell lung cancer
- Oligometastatic extracranial disease:
  - Added scenario for oligoprogressive extracranial disease

- Other tumor types:
    - Combined criteria for intensity-modulated radiation therapy (IMRT), stereotactic radiosurgery (SRS), and SBRT
    - Expanded criteria for SRS and SBRT to include any radiosensitive tumor
- Prostate cancer:
    - Modified number of fractions indicated, due to larger dose given in each individual fraction (no change in total dose to be given)
    - Added scenario for salvage treatment after prostatectomy
    - Added max fraction number for salvage radiation therapy

Hydrogel Spacers

- Expanded the use of hydrogel spacers to include them in patients receiving any form of external beam radiation therapy

Proton Beam Therapy

- Added clarifying statement that generic case control plan comparison is insufficient and that patient-specific IMRT isodose comparison is required

For questions related to guidelines, please contact Carelon via email at MedicalBenefitsManagement.guidelines@Carelon.com. Additionally, you may access and download a copy of the current and upcoming guidelines.

Effective April 6, 2025

Adjunctive Techniques for Screening, Surveillance, and Risk Classification of Barrett Esophagus and Esophageal Dysplasia, 7.01.596 Individual | Group

Policy renumbered

- This policy replaces Adjunctive Techniques for Screening and Surveillance of Barrett Esophagus and Esophageal Dysplasia, 7.01.167, which is now deleted

Investigational criteria added

- TissueCypher and Esopredict are considered investigational for assessing the risk of progression to high-grade dysplasia or esophageal adenocarcinoma in individuals with Barrett esophagus

Amyloid Antibodies for the Treatment of Alzheimer's Disease, 5.01.626 Individual | Group

Medical necessity criteria updated

- Leqembi criteria updated with inclusion of test results that indicate mild cognitive impairment or mild Alzheimer's Disease (AD) dementia
- Added requirement to Leqembi criteria for testing for ApoE ε4 status and that potential ARIA risks have been discussed

Evaluation of Biomarkers for Alzheimer Disease, 2.04.521 Individual | Group
Investigational criteria added

- Measurement of biochemical markers of AD is considered investigational in individuals with mild cognitive impairment or mild dementia caused by AD in the following instances:
  - Cerebrospinal fluid testing for neural thread proteins to evaluate the need for amyloid beta-targeting therapy
  - Cerebrospinal fluid biomarker testing to support clinical diagnosis
  - Cerebrospinal fluid biomarker testing as part of an evaluation for the continuation of amyloid beta targeting therapy

Percutaneous Revascularization Procedures for Lower Extremity Peripheral Arterial Disease, 7.01.594 Individual | Group
New policy

- Percutaneous revascularization procedures are considered medically necessary for the treatment of chronic symptomatic lower extremity peripheral arterial disease (PAD) with guideline-based criteria, chronic limb-threatening ischemia, and acute limb ischemia
- Percutaneous revascularization procedures are considered not medically necessary for the treatment of asymptomatic lower extremity PAD
- Percutaneous revascularization procedures using lithotripsy is considered investigational for the treatment of lower extremity PAD

Effective March 5, 2025

Surgical Treatments for Lymphedema and Lipedema, 7.01.567 Individual | Group
Medical necessity criteria added

- Evidence of cuff phenomenon (sparing of feet if lower extremities are affected, or sparing of hands if upper extremities are affected) is present, body mass index (BMI) less than or equal to 35 kg/m², the requested surgical intervention will be performed by a plastic surgeon
- Staged liposuction procedures may be considered medically necessary when there is a large total volume of aspirate (i.e. 5000 cc) during the initial procedure, and they are completed within a 12-month period

Investigational criteria added

- Liposuction or lipectomy for the treatment of lipedema in the trunk or back is considered investigational
- Retreatment of a previously treated area using the same procedure is considered investigational

Effective February 7, 2025

Gonadotropin Releasing Hormone (GnRH) Analogs, 5.01.625 Individual | Group

Drug added

- Synarel (nafarelin) to central precocious puberty, endometriosis and gender dysphoria criteria

Medical necessity criteria updated

- Initial gender dysphoria criteria updated to clarify that:
  - Puberty onset at Tanner stage 2 or higher is determined by serum testosterone level, serum estradiol level, serum estrone level, serum luteinizing hormone level, or serum follicle stimulating hormone for individuals assigned female at birth
  - Potential adverse effects have been discussed, including possible effects on fertility, bone mineralization and bone density
  - GnRH agonist is necessary to suppress characteristics of the gender assigned at birth that are not evident by observation or on physical examination in certain individuals aged 23 and older, or after reaching Tanner stage 5, or after irreversible physical/anatomic secondary sexual characteristics are developed
  - Documentation is required demonstrating that cross-sex hormone/gender affirming hormone treatment is not effective when starting a GnRH agonist
- Updated initial gender dysphoria criteria notes to clarify confirmation of Tanner stages due to overlapping values
- Initial authorization duration updated from up to 6 months to up to 12 months
- Re-authorization gender dysphoria criteria updated to clarify that:
  - Documentation of suppression of secondary sex characteristics based on physical examination OR documentation of suppression of characteristics of the gender assigned at birth that are not evident by observation or on physical examination is required
  - Documentation of annual testing of bone age or bone density is required in certain individuals
  - For the first re-authorization request, if the previous coverage was under a non-Company plan, documentation that the initial authorization requirements have also been met is required
- Updated re-authorization gender dysphoria criteria notes to clarify acceptable documentation of suppression of characteristics of the gender assigned at birth

Investigational criteria added

- Use of GnRH analogs that does not meet the age or diagnosis requirements within the Medical Necessity section is considered investigational
- Use of GnRH analogs that meets the age and diagnosis requirements within the Medical Necessity section but does not meet other policy criteria within the Medical Necessity section is considered not medically necessary

Medical Necessity Criteria for Pharmacy Edits, 5.01.605 **Individual | Group**

Drug/medical necessity criteria added

- CytoGam (cytomegalovirus immune globulin) for the prophylactic treatment of cytomegalovirus (CMV) disease or CMV pneumonitis associated with transplantation in certain individuals

Miscellaneous Oncology Drugs, 5.01.540 Individual | Group
Drugs/medical necessity criteria added

- Brand bendamustine, Belrapzo (bendamustine), Bendeka (bendamustine), and Vivimusta (bendamustine) for the treatment of certain individuals with chronic lymphocytic leukemia or non-Hodgkin lymphoma
- Nipent (pentostatin) for the treatment of certain individuals with hairy cell leukemia
- Oncaspar (pegaspargase) for the treatment of certain individuals with acute lymphoblastic leukemia
- Vyxeos (cyatarabine-daunorubicin) coverage criteria for the treatment of certain individuals with acute myeloid leukemia

Medical policies

New medical policies

No updates this month.

Revised medical policies Effective January 1, 2024

Cochlear Implant, 7.01.586 Individual | Group
Medical necessity criteria updated

- Cochlear implant for treatment of unilateral hearing loss changed from investigational to medically necessary when criteria are met

Durable Medical Equipment, 1.01.529 Individual | Group
Non-covered devices added

- Remote hand-held devices for intermittent monitoring of intraocular pressure (e.g., iCare HOME2)
- Walker, battery powered, wheeled

Irreversible Electroporation of Tumors Located in the Liver, Pancreas, Kidney, or Lung, 6.01.68 Individual | Group
Policy renumbered

- This policy replaces Irreversible Electroporation (NanoKnife System), 7.01.572, which is now deleted

Investigational criteria added

- Irreversible electroporation is investigational for treatment of liver, pancreatic, kidney and lung cancer

Investigational criteria removed

- Irreversible electroporation for the treatment of prostate cancer moved to Focal Treatments for Prostate Cancer, 8.01.61

Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions, 2.01.543 Individual | Group

Policy renumbered

- This policy replaces Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions, 2.01.16, which is now deleted

Investigational criteria updated

- Use of platelet-rich plasma for fat graft retention (aka fat graft take) is considered investigational

Therapeutic Radiopharmaceuticals in Oncology, 6.01.525 Individual | Group

Drug/medical necessity criteria removed

- Policy statements were removed related to iobenguane I 123 as the product has been withdrawn from the market by the manufacturer

Medical necessity criteria updated

- Lutathera indication expanded from 18 years of age or older, to 12 years of age or older

Dosing for concomitant medications added

- Long-acting octreotide 30 mg intramuscular should be given 4 to 24 hours after each Lutathera dose

Pharmacy policies

New pharmacy policies Effective January 1, 2024

Insulin Therapy, 5.01.648 Individual | Group

New policy

- Novolog, Fiasp, insulin aspart, Humalog, insulin lispro, Apidra, Admelog, Admelog Solostar, Lyumjev, Novolin R, Humulin R, Novolin R, Humulin N, Novolin Mix 70/30, Humulin Mix 70/30, Novolog Mix 70/30, insulin aspart protamine-insulin aspart mix 70/30, Humalog Mix 75/25, Humalog Mix 50/50, Lantus, Levemir, Toujeo, Tresiba, Basaglar, insulin degludec, insulin glargine (insulin glargine), insulin glargine (insulin glargine-yfgn), Rezvoglar, and Semglee moved from Pharmacotherapy of Type I and Type II Diabetes Mellitus, 5.01.569 to 5.01.648
    - No changes to Section 1 (non-individual formulary plans) coverage criteria

- Section 2 added for individual/small group/student ISHIP Metallic formulary plans to outline separate coverage criteria added for Metallic (individual/small group/student ISHIP plans) formulary members
- Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information

Medical Necessity Criteria for Custom Incentive and Open Formularies, 5.01.647 Individual | Group

New policy

- Developed for specific custom incentive and open formulary members and indicated throughout the policy as applicable to members on one Open formulary (Formulary ID: 6062; Rx Plan F1) and one Incentive formulary (Formulary ID: 6064; Rx Plan G3)
  - Includes medical necessity criteria for Abrilada (adalimumab-afzb), adalimumab-aacf (Idacio unbranded), adalimumab-aaty (Yuflyma unbranded), adalimumab-adaz (Hyrimoz unbranded), adalimumab-adbm (Cyltezo unbranded), adalimumab-fkjp (Hulio unbranded), adalimumab-ryvk (Simlandi unbranded), Amjevita (adalimumab-atto), Cyltezo (adalimumab-adbm), Hadlima (adalimumab-bwwd), Hulio (adalimumab-fkjp), Humira (adalimumab) (AbbVie) [NDCs starting with 00074], Humira (adalimumab) (Cordavis) [NDCs starting with 83457], Hyrimoz (adalimumab-adaz) (Cordavis) [NDCs starting with 83457], Hyrimoz (adalimumab-adaz) (Sandoz) [NDCs starting with 61314], Idacio (adalimumab-aacf), Simlandi (adalimumab-ryvk), Yuflyma (adalimumab-aaty), and Yusimry (adalimumab-aqvh)
- Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information

SGLT2 Inhibitors, 5.01.646 Individual | Group

New policy

- Farxiga, Jardiance, Brenzavvy, brand bexagliflozin, brand dapagliflozin, Invokana, Steglatro, Synjardy, Synjardy XR, Xigduo XR, brand dapagliflozin-metformin, Invokamet, Invokamet XR, and Segluromet moved from Pharmacotherapy of Type I and Type II Diabetes Mellitus, 5.01.569 to 5.01.646
- Section 1 includes coverage criteria for all plans non-individual formulary plans (Rx Plan A1, A2, B3, B4, E1, E3, E4, F1, and G3)
- Section 2 includes separate coverage criteria for Metallic (individual/small group/student ISHIP plans) formulary members
- Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information

Revised pharmacy policies Effective January 1, 2024

Amyloid Antibodies for the Treatment of Alzheimer's Disease, 5.01.626 Individual | Group

Drug/medical necessity criteria added

- Kisunla (donanemab-azbt) added for the treatment of AD when criteria are met

Investigational criteria added

- Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information

Antidepressants: Pharmacy Medical Necessity Criteria for Brands, 5.01.520 Individual | Group

Medical necessity criteria updated

- Drug names for brand antidepressants added to policy
- Criteria for Auvelity (dextromethorphan and bupropion) added

Investigational criteria added

- Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information

Coverage Criteria for Excluded and Non-Formulary Drugs, 5.01.572 Individual | Group

Title change

- Changed title from “Coverage Criteria for Excluded Drugs” to “Coverage Criteria for Excluded and Non-Formulary Drugs”

Medical necessity criteria added

- Updated criteria to include non-formulary drugs

Cutaneous T-Cell Lymphomas (CTCL): Systemic Therapies, 5.01.532 Individual | Group

Medical necessity criteria added

- Lymphir (denileukin diftitox-cxdl) added for the treatment of relapsed or refractory Stage I-III CTCL when criteria are met

Investigational criteria added

- Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information

Drugs for Rare Diseases, 5.01.576 Individual | Group

Medical necessity criteria added

- Aqneursa (levacetylleucine) and Miplyffa (arimoclomol) added for the treatment of neurological manifestations of Niemann-Pick Disease Type C (NPC) when criteria are met
- Generic miglustat, Opfolda (miglustat), Yargesa (generic miglustat), and Zavesca (miglustat) added for the treatment of neurological manifestations of NPC when used in combination with Miplyffa (arimoclomol)

Investigational criteria added

- Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information

Hepatitis C Antiviral Therapy, 5.01.606 Individual | Group

Policy reformatted

- Section 1 added for non-individual formulary plans criteria
- Section 2 added for individual/small group/student ISHIP Metallic formulary plans with separate coverage criteria added for Metallic (individual/small group/student ISHIP plans) formulary members

Medical necessity criteria updated

- Clarified that Sovaldi (sofosbuvir) and Vosevi (sofosbuvir-velpatasvir-voxilaprevir) are preferred products in Section 1 (non-individual formulary plans)
- Zepatier (elbasvir-grazoprevir) added to list of direct-acting antiviral agents
- FDA approved uses added for brand sofosbuvir-velpatasvir, brand ledipasvir-sofosbuvir, Sovaldi (sofosbuvir) and Zepatier (elbasvir-grazoprevir)

Investigational criteria added

- Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information.

Medical Necessity Criteria for Pharmacy Edits, 5.01.605 Individual | Group

Medical necessity criteria added/updated

- New indication added to Voquezna (vonoprazan) for the relief of heartburn associated with non-erosive gastroesophageal reflux disease
- New section added for antihistamines, oral
  - Karbinal ER (carbinoxamine), Ryclora (dexchlorpheniramine), and Ryvent (carbinoxamine)
- Humatin (paromomycin) criteria updated to remove requirement to use generic paromomycin first due to generic paromomycin no longer being available
- Brand Calcium Channel Blockers (CCBs) added:
  - Levamlodipine, Cardizem (diltiazem), Cardizem CD (diltiazem extended-release), Cardizem LA (diltiazem extended-release), Katerzia (amlodipine suspension), Norliqva (amlodipine solution) Norvasc (amlodipine), Procardia XL (nifedipine extended-release), Sular (nisoldipine extended-release), Tiazac (diltiazem extended-release), and Verelan PM (verapamil extended-release)
- Generic gabapentin extended release (generic of Gralise) added for the treatment of neuropathic pain
- Ohtuvayre (ensifentrine) added to chronic obstructive pulmonary disease medications
- Quazepam and Doral (quazepam) added to hypnotics
- Lithostat (acetohydroxamic acid) added to miscellaneous infectious disease agents
- Generic dexlansoprazole added to proton pump inhibitors
- Prescribed dose limit added to Qbrexza (glycopurronium cloth) and to Sofdra (sofpironium)
- Norgesic (orphenadrine, aspirin, and caffeine) and Norgesic Forte (orphenadrine, aspirin, and caffeine) added to muscle relaxants
- Mestinon (pyridostigmine) added to myasthenia gravis agents

- Xdemvy (lotilaner) criteria updated to specify initial approval is for 6 weeks and that re-authorization beyond 6 weeks is investigational
- Emrosi (minocycline) and Orlynvah (sulopenem etzadroxil and probenecid) added to brand oral antibiotics and their generics
- Pivya (pivmecillinam) criteria to require a trial of three generic antibiotics first
- Vivlodex (meloxicam) added to brand oral nonsteroidal anti-inflammatory drugs
- Myhibbin (mycophenolate mofetil oral suspension) added to transplant agents
- Zemplar (paricalcitol) added to vitamin agents
- Airsupra added to short-acting beta agonists quantity limit
- Clarified that brand and generic albuterol sulfate HFA are included in short-acting beta agonists quantity limit
- Step therapy criteria added to Airsupra (albuterol sulfate-budesonide), brand albuterol sulfate HFA, brand levalbuterol tartrate HFA, ProAir RespiClick (albuterol sulfate), Ventolin HFA (albuterol sulfate), and Xopenex HFA (levalbuterol tartrate)

Medical necessity criteria removed

- Azor and Exforge names removed from angiotensin II receptor blocker combinations as they are already included under CCBs
- Farxiga and Jardiance moved to new policy SGLT2 Inhibitors, 5.01.646
- Entresto moved to Medical Necessity Criteria and Dispensing Quantity Limits for Exchange Formulary Benefits, 5.01.547
- Xyrosa (doxycycline) removed from brand oral antibiotics and their generics as the product has been discontinued

Investigational criteria added

- Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information

Miscellaneous Oncology Drugs, 5.01.540 Individual | Group

Medical necessity criteria updated

- Ibrance (palbociclib) criteria updated to include a requirement to have an inadequate response or intolerance to Verzenio (abemaciclib), Kisqali (ribociclib), or Kisqali Femara Co-Pack (letrozole-ribociclib)

Investigational criteria added

- Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information

Pharmacologic Treatment of Neuropathy, Fibromyalgia, and Seizure Disorders, 5.01.521
Individual | Group

Medical necessity criteria updated

- Criteria for all medications in this policy updated to specify that the prerequisite medication tried is a generic dosage form

Investigational criteria added

- Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information

Pharmacotherapy of Arthropathies, 5.01.550 **Individual | Group**

Note added to all adalimumab products

- This medical necessity criteria does not apply to one Open formulary (Formulary ID: 6062; Rx Plan F1) and one Incentive formulary (Formulary ID: 6064; Rx Plan G3). The criteria for members with these custom Open and Incentive formulary plans can be found in policy 5.01.647 Medical Necessity Criteria for Custom Incentive and Open Formularies.

Drug/medical necessity criteria added

- Bimzelx (bimekizumab-bkzx) added as a non-preferred product for the treatment of psoriatic arthritis, non-radiographic axial spondyloarthritis, or ankylosing spondylitis when criteria are met
- Cimzia (certolizumab pegol) as a non-preferred product for the treatment of polyarticular juvenile idiopathic arthritis when criteria are met

Investigational criteria added

- Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information

Pharmacotherapy of Inflammatory Bowel Disorder, 5.01.563 **Individual | Group**

Note added to all adalimumab products

- This medical necessity criteria does not apply to one Open formulary (Formulary ID: 6062; Rx Plan F1) and one Incentive formulary (Formulary ID: 6064; Rx Plan G3). The criteria for members with these custom Open and Incentive formulary plans can be found in policy 5.01.647 Medical Necessity Criteria for Custom Incentive and Open Formularies.

Medical necessity criteria updated

- Omvoh (mirikizumab-mrkz) updated from nonpreferred to preferred product
  - Brand step therapy requirement removed
- Age requirement added to Skyrizi (risankizumab-rzaa) IV/SC and Tremfya (guselkumab) IV/SC for the treatment of ulcerative colitis in adults aged 18 years and older
- Velsipity (etrasimod) updated from nonpreferred to preferred product
  - Brand step therapy requirement removed
- Clarified that Tremfya (guselkumab) SC and Velsipity (etrasimod) are brand step therapy option for Entyvio (vedolizumab) SC and Zeposia (ozanimod)

Investigational criteria added

- Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information

Pharmacotherapy of Miscellaneous Autoimmune Diseases, 5.01.564 **Individual | Group**

Note added to all adalimumab products

- This medical necessity criteria does not apply to one Open formulary (Formulary ID: 6062; Rx Plan F1) and one Incentive formulary (Formulary ID: 6064; Rx Plan G3). The criteria for members with these custom Open and Incentive formulary plans can be found in policy 5.01.647 Medical Necessity Criteria for Custom Incentive and Open Formularies.

Investigational criteria updated

- Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information

Pharmacotherapy of Multiple Sclerosis, 5.01.565 Individual | Group

Medical necessity criteria removed

- Section 1 (Non-Individual Formulary Plans):
  - Age requirement and prescriber requirement removed from criteria for Ocrevus Zunovo (ocrelizumab-hyaluronidase-ocsq).
- Section 2 (Individual/Small Group/Student ISHIP Metallic Formulary Plans):
  - Age requirement removed from criteria for Briumvi (ublituximab-xiiy), generic fingolimod, Gilenya (fingolimod), Kesimpta (ofatumumab), Lemtrada (alemtuzumab), Ocrevus (ocrelizumab), Ocrevus Zunovo (ocrelizumab-hyaluronidase-ocsq), Tascenso ODT (fingolimod), Tyruko (natalizumab-sztn), and Tysabri (natalizumab)
  - Prescriber requirement removed from criteria for Aubagio (teriflunomide), Avonox (interferon-β 1a), Bafiertam (monomethyl fumarate), Betaseron (interferon-β 1b), Briumvi (ublituximab-xiiy), Copaxone (glatiramer), generic dimethyl fumarate, Extavia (interferon-β 1b), generic fingolimod, Gilenya (fingolimod), generic glatiramer, Glatopa (glatiramer), Kesimpta (ofatumumab), Lemtrada (alemtuzumab), Mavenclad (cladribine), Mayzent (siponimod), Ocrevus (ocrelizumab), Ocrevus Zunovo (ocrelizumab-hyaluronidase-ocsq), Plegridy (interferon-β 1a), Ponvory (ponesimod), Rebif (interferon-β 1a), Tascenso ODT (fingolimod), Tecfidera (dimethyl fumarate), generic teriflunomide, Tyruko (natalizumab-sztn), Tysabri (natalizumab), Vumerity (diroximel fumarate), and Zeposia (ozanimod).
  - Requirement added to have a documented inadequate response or intolerance to generic glatiramer, Glatopa (glatiramer), generic dimethyl fumarate, generic fingolimod, or generic teriflunomide removed from criteria for Avonox (interferon-β 1a), Bafiertam (monomethyl fumarate), Betaseron (interferon-β 1b), Kesimpta (ofatumumab), Mayzent (siponimod), Plegridy (interferon-β 1a), Ponvory (ponesimod), Rebif (interferon-β 1a), Vumerity (diroximel fumarate), and Zeposia (ozanimod)
  - Requirement added to have a documented inadequate response or intolerance to generic glatiramer or Glatopa (glatiramer) removed from criteria for Aubagio (teriflunomide), Extavia (interferon-β 1b), Gilenya (fingolimod), and Tascenso ODT (fingolimod)
  - Requirement added to have a documented inadequate response or intolerance to generic fingolimod removed from criteria for Aubagio (teriflunomide)

- Requirement added to have a documented inadequate response to two or more disease modifying drugs indicated for the treatment of multiple sclerosis removed from criteria for Mavenclad (cladribine)

Investigational criteria added

- Clarified that the medications listed in this policy are subject to the product's FDA dosage and administration prescribing information

Archived policies

Effective January 1, 2025

Immune Prophylaxis for Respiratory Syncytial Virus, 5.01.639

- Policy archived due to low utilization

Deleted policies

Effective April 6, 2025

Adjunctive Techniques for Screening and Surveillance of Barrett Esophagus and Esophageal Dysplasia, 7.01.167

- This policy is replaced with Adjunctive Techniques for Screening and Surveillance of Barrett Esophagus and Esophageal Dysplasia, 7.01.596

Effective January 1, 2025

Irreversible Electroporation (NanoKnife System), 7.01.572

- This policy is replaced with Irreversible Electroporation of Tumors Located in the Liver, Pancreas, Kidney, or Lung, 6.01.68

Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions, 2.01.16

- This policy is replaced with Recombinant and Autologous Platelet-Derived Growth Factors for Wound Healing and Other Non-Orthopedic Conditions, 2.01.543

Coding updates

Added codes
Effective March 5, 2025

Non-covered Experimental/Investigational Services, 10.01.533 Individual | Group
Now requires review for investigational.

92972

Effective January 1, 2025

Ablation of Peripheral Nerves to Treat Pain, 7.01.565 Individual | Group
Now requires review for investigational.

C9808, C9809

Amniotic Membrane and Amniotic Fluid, 7.01.583 Individual | Group
Now requires review for investigational.

Q4353, Q4346, Q4347, Q4348, Q4349, Q4350, Q4351, Q4352

Amyloid Antibodies for the Treatment of Alzheimer's Disease, 5.01.626 Individual | Group
Now requires review for medical necessity and prior authorization.

J0175

Bioengineered Skin and Soft Tissue Substitutes, 7.01.113 Individual | Group
Now requires review for investigational.

15011, 15012, 15013, 15014, 15015, 15016, 15017, 15018

C3 and C5 Complement Inhibitors, 5.01.571 Individual | Group
Now requires review for medical necessity and prior authorization.

J1307

Cardiac Hemodynamic Monitoring for the Management of Heart Failure in the Outpatient Setting, 2.02.24 Individual | Group
Now requires review for investigational.

G0555

Chimeric Antigen Receptor Therapy for Leukemia and Lymphoma, 8.01.63 Individual | Group
Chimeric Antigen Receptor Therapy for Multiple Myeloma, 8.01.66 Individual | Group
No longer covered.

38225, 38226, 38227

Chimeric Antigen Receptor Therapy for Leukemia and Lymphoma, 8.01.63 Individual | Group

Chimeric Antigen Receptor Therapy for Multiple Myeloma, 8.01.66 Individual | Group
Now requires review for medical necessity and prior authorization.

38228

Coronary Angiography for Known or Suspected Coronary Artery Disease in Adults, 2.02.507 Individual | Group
Now requires review for medical necessity.

C7562

Evaluation of Biomarkers for Alzheimer Disease, 2.04.521 Individual | Group
Now requires review for investigational.

82233, 82234, 84393, 84394

Folate Antimetabolites, 5.01.617 Individual | Group
Now requires review for medical necessity and prior authorization.

J9292

Gene Therapies for Thalassemia, 5.01.42 Individual | Group
Pharmacologic Treatment of Sickle Cell Disease, 5.01.640 Individual | Group
Now requires review for medical necessity and prior authorization.

J3392

Herceptin (trastuzumab) and Other HER2 Inhibitors, 5.01.514 Individual | Group
Now requires review for medical necessity and prior authorization.

Q5146

Immune Globulin Therapy, 8.01.503 Individual | Group
Site of Service: Infusion Drugs and Biologic Agents, 11.01.523 Individual | Group
Now requires review for medical necessity, including site of service and prior authorization.

J1552

Laboratory Testing Investigational Services, 2.04.520 Individual | Group
Now requires review for investigational.

0521U, 0522U, 0525U, 0526U, 0528U, 81515

Magnetic Resonance Imaging-Guided Focused Ultrasound, 7.01.109 Individual | Group
Now requires review for investigational.

51721, 55881, 55882, 61715

Maternal Serum Biomarkers for Prediction of Adverse Obstetric Outcomes, 2.04.152 Individual | Group
Now requires review for investigational.

0524U

Medical Necessity Criteria for Pharmacy Edits, 5.01.605 Individual | Group
Now requires review for medical necessity and prior authorization.

J0901

Microwave Tumor Ablation, 7.01.133 Individual | Group
Now requires review for investigational.

0944T

Miscellaneous Oncology Drugs, 5.01.540 Individual | Group
Now requires review for investigational.

J9026, J9259

Non-covered Experimental/Investigational Services, 10.01.53 Individual | Group
Now requires review for investigational.

0901T, 0902T, 0903T, 0904T, 0905T, 0906T, 0907T, 0908T, 0909T, 0910T, 0911T, 0912T, 0913T, 0914T, 0915T, 0916T, 0917T, 0918T, 0919T, 0920T, 0921T, 0922T, 0923T, 0924T, 0925T, 0926T, 0927T, 0928T, 0929T, 0930T, 0931T, 0932T, 0933T, 0934T, 0935T, 0936T, 0937T, 0938T, 0939T, 0940T, 0941T, 0942T, 0943T, 0945T, 0946T, 0947T, 25448, A9615, C1735, C1736, C1737, C8001, C8003, G0562, G0563

Non-covered Services and Procedures, 10.01.517 Individual | Group
No longer covered.

76014, 76015, 76016, 76017, 76018, 76019

Peripheral Subcutaneous Field Stimulation, 7.01.139 Individual | Group

Now requires review for medical necessity.

C9807

Pharmacologic Treatment of Bladder Cancer, 5.01.632 **Individual | Group**
Now requires review for medical necessity and prior authorization.

J9028

Pharmacologic Treatment of Hemophilia, 5.01.581 **Individual | Group**
Now requires review for medical necessity and prior authorization.

J1414

Pharmacologic Treatment of Psoriasis, 5.01.629 **Individual | Group**
Pharmacotherapy of Arthropathies, 5.01.550 **Individual | Group**
Pharmacotherapy of Inflammatory Bowel Disorder, 5.01.563 **Individual | Group**
Pharmacotherapy of Miscellaneous Autoimmune Diseases, 5.01.564 **Individual | Group**
Now requires review for medical necessity and prior authorization.

J0139, Q5140, Q5141, Q5142, Q5143, Q5144, Q5145
Pharmacotherapy of Thrombocytopenia, 5.01.566 **Individual | Group**
Now requires review for medical necessity and prior authorization.

J2802

Prescription Digital Therapeutics, 13.01.500 **Individual | Group**
Now requires review for investigational.

G0552, G0553, G0554

Radiofrequency Ablation of Miscellaneous Solid Tumors, 7.01.95 **Individual | Group**
Now requires review for medical necessity and prior authorization.

60660, 60661

Temporarily Implanted Nitinol Device (iTind) for Benign Prostatic Hyperplasia, 7.01.175
Individual | Group
Now requires review for medical necessity and prior authorization.

53865, 53866

Use of Granulocyte Colony-Stimulating Factors (G-CSF), 5.01.551 Individual | Group
Now requires review for medical necessity.

C9173

Carelon Management Genetic Testing
Now requires review for medical necessity and prior authorization.

0523U, 0529U, 0530U, 81195, 81558

Revised codes Effective January 1, 2025

Durable Medical Equipment, 1.01.529 Individual | Group
No longer covered.

E0152

Removed codes Effective January 1, 2025

Chimeric Antigen Receptor Therapy for Leukemia and Lymphoma, 8.01.63 Individual | Group
Code terminated.

0537T, 0538T, 0539T, 0540T

Coronary Angiography for Known or Suspected Coronary Artery Disease in Adults, 2.02.507 Individual | Group
Code terminated.

C7558

Cosmetic and Reconstructive Services, 10.01.514 Individual | Group
Code terminated.

15819

Evaluation of Biomarkers for Alzheimer Disease, 2.04.521 Individual | Group
Code terminated.

0346U

Immune Prophylaxis for Respiratory Syncytial Virus, 5.01.639 **Individual | Group**
No longer requires review.

90378

Magnetic Resonance Imaging-Guided Focused Ultrasound, 7.01.109 **Individual | Group**
Code terminated.

0398T, C9734

Miscellaneous Oncology Drugs, 5.01.540 **Individual | Group**
Code terminated.

C9170

Non-covered Experimental/Investigational Services, 10.01.533 **Individual | Group**
Code terminated.

96003, C9795

Non-covered Services and Procedures, 10.01.517 **Individual | Group**
Now covered as part of the standard benefit.

96161

Non-covered Services and Procedures, 10.01.517 **Individual | Group**
Code terminated.

Q0516, Q0517, Q0518, Q0519, Q0520

Pharmacologic Treatment of Bladder Cancer, 5.01.632 **Individual | Group**
Code terminated.

C9169

Pharmacologic Treatment of Hemophilia, 5.01.581 **Individual | Group**
Code terminated.

C9172

Pharmacologic Treatment of Psoriasis, 5.01.629 **Individual | Group**

Pharmacotherapy of Inflammatory Bowel Disorder, 5.01.563 Individual | Group
Pharmacotherapy of Miscellaneous Autoimmune Diseases, 5.01.564 Individual | Group
Code terminated.

J0135

Pharmacotherapy of Arthropathies, 5.01.550 Individual | Group
Code terminated.

J0135, Q5131, Q5132

Pharmacotherapy of Thrombocytopenia, 5.01.566 Individual | Group
Code terminated.

J2796

Preventive Care, 10.01.523 Individual | Group
Code terminated.

G0106, G0120, G0122

Carelon Management Genetic Testing
Code terminated.

0380U, 0428U, 0448U, 0456U, 81257, 81361, 81433, 81436, 81438

Carelon Management Genetic Testing
No longer requires review.

81257, 81361

Updates for group plans only

Special notices

No updates this month.

Revised medical policies

No updates this month.

Deleted medical policies

No updates this month.

Archived medical policies

No updates this month.

Coding updates

No updates this month.

Updates for individual plans only

Special notices

No updates this month.

Revised medical policies

No updates this month.

Deleted medical policies

No updates this month.

Archived medical policies

No updates this month.

Coding updates

Added codes
Effective March 5, 2025

Non-covered Experimental/Investigational Services, 10.01.533 Individual
Now requires review for investigational.

92972

Revised codes

No updates this month.