Drug Coverage Policy

Effective Date..... 8/1/2025
Coverage Policy Number.....1602

Drugs Requiring Medical Necessity Review for Employer Plans

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

Coverage Policy

Cigna covers products as medically necessary when Product Specific Criteria are met.

Refer to: **<Drugs Requiring Medical Necessity Review for Employer Plans>**

This is an up-to-date list of products alphabetized by *Therapy Class* and *Brand Name*.

Approval duration is 12 months unless otherwise noted.

Conditions Not Covered
Any other exception is considered not medically necessary. Criteria will be updated as new published data are available.

Documentation: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information.

Background

Health benefit plans vary, drugs that are not part of the covered drug list may be approved for coverage when medical necessity criteria are met through the coverage review process. Doctors and health care professionals can log in to CignaForHCP.com to learn more about which medications require prior authorization. Customers can log in to the myCigna App or myCigna.com, or check plan materials, to learn more about how medications are covered.

In general, to be eligible for coverage, a drug must be approved by the Food and Drug Administration (FDA), prescribed by a health care professional, purchased from a licensed pharmacy and be medically necessary. In developing medical necessity exception criteria within coverage policies criteria incorporate information from U.S. Food and Drug Administration-approved labeling[1], the standard medical reference compendia[2-4] and peer-reviewed, evidence-based scientific literature or guidelines.

References

1. U.S. Food and Drug Administration. Drugs@FDA. U.S. Department of Health & Human Services: http://www.accessdata.fda.gov/scripts/cder/drugsatfda/.
2. Clinical Pharmacology powered by ClinicalKey. Philadelphia (PA): Elsevier. c2025- [cited 2025 July 1]. Available from: http://www.clinicalkey.com.
3. Individual Drug Name Entries. Drug Facts and Comparisons. eFacts [online] 2025. Available from Wolters Kluwer Health, Inc.
4. Micromedex® (electronic version). Merative, Ann Arbor, Michigan, USA. Available at: https://www.micromedexsolutions.com/

Revision Details

Type of Revision	Summary of Changes	Date
Selected Revision	**Added preferred product step requirement for the following products:** Aplenzin, bupropion hydrochloride 450 mg extended release tablets, Forfivo XL, Iopidine 1%, baclofen 15 mg tablets, doxycycline monohydrate IR 40 mg, ondansetron ODT, sitagliptin/metformin tablets, Furoscix, Lidocan IV, Lidocan V, Tridacaine, and Sovuna. **Updated preferred product step requirement for the following products:**	10/15/2024

	Cabtreo, Qbrelis, Firvanq, Likmez, Solosec, vancomycin 25 mg/mL oral solution, Primidone 125mg tablets, Sitavig, Auvelity, Karbinal ER, Versacloz, Edecrin, ethacrynic acid, Tekturna HCT, Alkindi Sprinkle, dexamethasone 1.5 mg tablets dose pack, Dxevo 11-Day, TaperDex 6-Day, 7-Day, and 12-Day, Cortifoam, Halog Ointment, Halog Solution, Kenalog Spray, Sernivo, triamcinolone acetonide 0.147 mg/gm topical aerosol, triamcinolone acetonide 0.05% ointment, Verdeso, Novolin 70/30, Novolin N, Novolin R, Novolog Mix 70/30, Rayos, Absorica LD, Kristalose, lactulose packets , Zyflo, Soaanz, GoNitro, Oxytrol, Vesicare LS, Gelnique 10% gel, Tudorza Pressair, desvenlafaxine ER, Lexette, and Ultravate. **Removed the following medications:** Accupril, Altace, Lotensin, Prinivil, Vasotec, Zestril, Lotrel, Tarka, EryPed 400, DDAVP, Elixophyllin, Dutoprol, Aldactazide 25mg/25mg, Aldactazide 50mg/50mg, Accuretic, Lotensin HCT, Vaseretic, Zestoretic, Cardizem CD, Clobex 0.05% Lotion, Clobex 0.05% Shampoo, Clobex 0.05% Spray, Cutivate, Halog 0.1% cream, hydrocortisone butyrate 0.1% cream, Trianex, Impeklo, Vanos, Iopidine 0.05%, Detrol, Detrol LA, Toviaz, Vesicare, Ativan, Parnate, Anafranil, Pamelor, Ditropan XL, Seebri Neohaler, Cymbalta, Lexapro, halobetasol 0.05% foam, and Pexeva.	
Selected Revision	**Added preferred product step requirement for the following products:** Carac, Imiquimod 3.75% cream and cream pump, Klisyri, Zyclara 2.5% cream pump, Zyclara 3.75% cream and cream pump, valsartan oral solution (effective 1/1/2025), Edarbi (effective 1/1/2025), Edarbyclor (effective 1/1/2025), Posfrea, Focinvez, carbinoxamine maleate ER suspension, Fanapt (effective 1/1/2025), Innopran XL, Suflave (effective 1/1/2025), Clenpiq (effective 1/1/2025), Sutab (effective 1/1/2025), Katerzia, Norliqva, Estratest F.S., Tradjenta (effective 1/1/2025), Jentadueto (effective 1/1/2025), Jentadueto XR (effective 1/1/2025), insulin glargine U-300 SoloStar (effective 12/1/2024), Myhibbin, dihydroergotamine mesylate nasal spray (effective 1/1/2025), Migranal (effective 1/1/2025), Trudhesa (effective 1/1/2025), Creon (effective 1/1/2025), Pertzye (effective 1/1/2025), Ohtuvayre (effective 11/15/2024), Ermeza, levothyroxine capsules, Thyquidity, Tirosint, Tirosint-SOL, Adthyza (16.25mg, 32.5mg, 65mg, 97.5mg, and 130mg) tablets, and Armour Thyroid **Updated preferred product step requirement for the following products:**	11/1/2024

	Hemangeol, Inderal XL, Kapspargo Sprinkle, and Allopurinol 200 mg tablets.	
Selected Revision	**Added preferred product step requirement for the following products:** MoviPrep, Plenvu, Suprep, Zituvimet (effective 2/1/2025), Zituvimet XR (effective 2/1/2025), Dolobid (effective 2/1/2025), and clobetasol propionate ophthalmic suspension 0.05% (effective 1/15/2025)	1/1/2025
Selected Revision	**Added preferred product step requirement for the following products:** Neffy (effective 2/1/2025), Estratest H.S. (effective 2/1/2025), Zoryve 0.3% cream, and Zoryve 0.3% topical foam	1/15/2025
Selected Revision	**Added preferred product step requirement for the following product:** Zoryve 0.15% cream **Removed** preferred product requirements for Syndros (effective 4/1/2025)	2/15/2025
Selected Revision	**Added** preferred product step requirement for Cobenfy **Updated** preferred product step requirement for Gemtesa	3/15/2025
Selected Revision	**Added "<u>Documentation</u>**: Documentation is required where noted in the criteria. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information." **Added preferred product step requirement for the following products:** Admelog, Apidra, Fiasp, Fiasp PumpCart, insulin aspart 100 units/mL injection (authorized generic for NovoLog), NovoLog, and Vtama	4/1/2025
Selected Revision	**Added preferred product step requirement for the following products:** Azelex, Epiduo, Epiduo Forte, adapalene 0.1% swab, Differin cream, Differin gel, Differin lotion, clonidine extended-release tablet (authorized generic for Nexiclon XR), Nexiclon XR, Adlarity, Arakoda, Coartem, Krintafel, Opipza, topiramate 50 mg sprinkle capsules, Aspruzyo Sprinkle, clobetasol propionate 0.025% cream, Halog 0.1% cream, auranofin 3mg capsules, Omeclamox-Pak, Pylera, Talicia, Voquezna DualPak, Voquezna TriplePak, Finacea foam, Finacea gel, Emrosi, and Regranex (effective 6/1/2025). **Updated preferred product step requirement for the following products:** Fanapt, Basaglar KwikPen, Ridaura, and Zyflo.	5/1/2025

	Removed preferred product step requirement for the following products: Focinvez (effective 5/30/2025), Posfrea (effective 5/30/2025), Halog 0.1% Solution, and Zoryve 0.15% cream (effective 5/15/2025).	
Selected Revision	**Added** preferred product step requirement for the Iluvien **Updated preferred product step requirement for the following products:** Cabtreo, nitrofurantoin 50 mg/5 mL oral suspension, Dhivy, Primidone 125 mg tablets (brand), Serevent Diskus, Furoscix, Nevanac, Atropine sulfate 1% ophthalmic solution (preservative free) [brand], clobetasol propionate 0.05% ophthalmic suspension, FML Forte, Maxidex, Pred Mild, Carospir, Pokonza, and meclizine 50 mg tablets	6/15/2025
Selected Revision	**Added preferred product step requirement for the following products:** Journavx, metronidazole 125 mg tablets, Lybalvi, metformin immediate-release 750 mg tablets, Estring, Gabarone, Glucagon Emergency Kit, GlucaGen HypoKit, Gvoke HypoPen Auto-Injector, Kit, or Prefilled Syringe, Zegalogue, Otrexup, Rasuvo, Fenopron, Alrex, Zerviate, TobraDex ST, Zylet, Acuvail, Flarex, Inveltys, Lotemax, Lotemax SM, Cetraxal, Cipro HC Otic Suspension, and ferric citrate tablets. **Updated preferred product step requirement for the following products:** Neffy, ArmonAir DigiHaler, Arnuity Ellipta, Flovent Diskus, Flovent HFA, fluticasone propionate Diskus (authorized generic of Flovent Diskus), fluticasone propionate HFA (authorized generic of Flovent HFA), Pulmicort Flexhaler, Ohtuvayre, and Tudorza Pressair. **Removed** preferred product requirements for Iluvien	7/1/2025
Selected Revision	**Added** preferred product step requirement for Fulvicin P/G **Updated preferred product step requirement for the following products:** Kristalose, lactulose packet, and Gemtesa	7/15/2025
Selected Revision	**Added preferred product step requirement for the following products:** Zunveyl, halcinonide 0.1% cream, Afrezza, Climara Pro, Elestrin, metaxalone 640 mg tablet, Konvomep, omeprazole/sodium bicarbonate capsules, omeprazole/sodium bicarbonate powder for oral suspension, Voquezna, Zegerid capsules, Zegerid powder for oral suspension, Siklos, Xromi, Inzirqo, and Thalitone.	8/1/2025

	Updated preferred product step requirement for the following products: Halog Cream, Halog Ointment, Furoscix, Veozah, and Yosprala.	

The policy effective date is in force until updated or retired.