# Coverage Policy Unit (CPU) - Monthly Policy Updates

## Effective February 15, 2026 (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 |
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| Anesthesia Services for Interventional Pain Management Procedures in an Adult - 0551 | Updated | Important change in coverage criteria/policy:<br>• Revised lists of interventional pain procedures in both moderate sedation and monitored anesthesia care sections |
| Autonomic Nerve Function Testing – (0506) | Updated | Minor change in coverage criteria/policy:<br>• Removed policy statement for portable, automated autonomic nerve function testing devices. |

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| Bariatric Surgery and Procedures– (0051) | Updated | Minor change in coverage policy:<br>• No clinical policy statement changes.<br>• Add new code (effective 1-1-2026) to existing coverage statement for endoscopic sleeve gastroplasty which is only indicated for initial treatment of adults |
| Cardiac Ablation of Abnormal Electrical Rhythms in Adults – (0529) | Update | Effective **2/15/2026**<br><br>***Note: changes are reflective of 2 sets of updates:**<br>• **updates that posted 11/15/2025 and effective 2/15/2026**<br>• **AND additional updates that posted 2/15/2026 and effective 2/15/2026**<br><br>Important **changes** in coverage criteria:<br>• Revised title to remove the verbiage "in Adults".<br>• Separated out SVT indications from ventricular indications and identified with applicable coding for improved clarity and distinction.<br>• Revised the policy statement for junctional tachycardia by moving it out of the abnormal ventricular electrical rhythms section and into the SVT section.<br>• Expanded coverage to include transcatheter ablation for the treatment of SVT in the pediatric population as medically necessary.<br>• 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". |
| Cardiac Omnibus Codes - (0574) | Updated | **Effective date 2/15/2026**<br><br>No change in coverage. Revised policy statement to include new CPT code 64654 |
| Complementary and Alternative Medicine - (EN0086) | Updated | • No change in coverage. |
| Diabetes Equipment and Supplies – (0106) | Updated | Minor changes in coverage criteria/policy:<br>• Added coverage statements for Minimed Instinct sensor and Dexcom G7 15-day continuous glucose monitoring system<br>• Removed policy statements for insulin pumps and insulin pens as codes are not managed |

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| Electroencephalo-graphy - (0521) | Updated | **Posted 1/15/2026, Effective 2/15/2026**<br><br>Minor changes in coverage criteria/policy:<br>• Revised policy statement for digital EEG spike analysis performed in conjunction with a specialized EEG for clarity.<br>• Revised policy statement for digital EEG spike analysis performed in conjunction with a sleep study or routine EEG for clarity.<br>• Added policy statement for remote monitoring of sub-scalp implanted EEG monitoring system due to new codes effective 1/1/2026. |
| Intraocular Lens Implant - 0125 | Updated | Important changes in coverage criteria/policy:<br>• Expanded coverage to include aniseikonia as a medically necessary reason for a standard monofocal intraocular lens implant<br>• Added a policy statement for capsular bag prosthesis due to new codes effective 1/1/2026<br>• Revised policy statement for premium intraocular lens implants |
| Lymphedema and Lipedema Surgical Treatments – (0531) | Updated | Minor change in coverage policy:<br>• No clinical policy statement changes. Added new code effective 1-1-2026 to the coding table |
| Nucleaic Acid Pathogen Testing - (0530) | Updated | **Effective date 2/15/2026**<br><br>• No change in coverage. Revised policy statement to include new CPT codes 87494: |
| Peripheral Nerve Destruction for Pain Conditions - 0525 | Updated | **Posted 02/15/2026, Effective 05/15/2026**<br><br>Important change(s) in coverage criteria/policy:<br>• Removed policy statement for peripheral nerve destruction for trigeminal neuralgia<br>• Revised policy statement for percutaneous cryoablation<br>• Added policy statement for pulsed radiofrequency ablation<br>• Revised list of not covered or reimbursable conditions |
| | Updated | **Posted 02/15/2026, Effective 05/15/2026**<br><br>Important change(s) in coverage criteria/policy: |

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| Plantar Fasciitis Treatments – (0097) | | • Revision of policy statement for not medically necessary treatments for plantar fasciitis to remove pulsed radiofrequency electromagnetic field (PREF) therapy<br>• Revision of policy statement for experimental, investigational or unproven treatments for plantar fasciitis to add coblation® (e.g., Topaz™) to the list of EIU procedures |
| Transthoracic Echocardio-graphy in Adults - (0510) | Updated | **Effective date 2/15/2026**<br>• No change in coverage. Editorial update to references listed in policy statement. |
| Transthoracic Echocardio-graphy in Children - (0523) | Updated | **Effective date 2/15/2026**<br>• No change in coverage. Removed redundant language in policy statement. |
| Vagus Nerve Stimulation (VNS) - 0350 | Updated | Important change(s) in coverage criteria/policy:<br>• Revised policy statement for other not medically necessary conditions |
| Bone Graft Substitutes – (0118) | Updated | • No change in coverage. |
| Compression Devices – (0354) | Updated | • No change in coverage. |
| Endometrial Ablation – (0013) | Updated | • No change in coverage. |
| Recurrent Pregnancy Loss: Diagnosis and Treatment – (0284) | Retired | Effective 2/15/2026<br>• This CP is retired because the associated CPT codes are not clinically managed by the coverage policy. |
| **ASH Guidelines** | **New, Updated, or Retired?** | **Comments** |

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| | | • No updates in February 2026 |
| **EviCore Guidelines** | **New, Updated, or Retired?** | **Comments** |
| Cobranded Cigna-EviCore Guidelines | Updated | **Effective 2/3/2026**<br><br>Two informational documents were updated with no clinically impactful changes:<br>• CMS Policy Hierarchies and Application Guidelines<br>• Guideline Definitions<br><br>**Effective 3/3/2026**<br><br>One guideline was updated with no clinically impactful changes:<br>• Clinical Information to Establish Medical Necessity |
| Cobranded Cigna-EviCore Musculoskeletal Management Guidelines | New / Updated | **Posted 11/21/2025, Effective 3/7/2026**<br><br>Important **changes** in coverage criteria.<br><br>• Three guidelines were updated with clinical changes which will limit coverage:<br>  ○ CMM-311: Knee Replacement/Arthroplasty<br>  ○ CMM-313: Hip Replacement/Arthroplasty<br>  ○ CMM-315: Shoulder Surgery-Arthroscopic and Open Procedures<br><br>• Three guidelines were updated with no clinically impactful changes:<br>  ○ CMM-312: Knee Surgery - Arthroscopic and Open Procedures<br>  ○ CMM-314: Hip Surgery - Arthroscopic and Open Procedures<br>  ○ CMM-318: Shoulder Arthroplasty/Replacement/Resurfacing/Revision/Arthrodesis<br><br>**Posted 11/24/2025, Effective 3/7/2026**<br><br>New guideline:<br>• CMM-310: Manipulation of the Spine Under Anesthesia |

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| Cobranded Cigna-EviCore Radiation Oncology Guidelines | Updated | **Effective 2/25/2026**<br><br>Important changes in coverage criteria:<br><br>• Clinical changes made to the following guidelines will expand coverage:<br>  ○ Breast Cancer<br>  ○ Cervical Cancer<br>  ○ Endometrial Cancer<br>  ○ Extracranial Metastases<br>  ○ Hepatobiliary Cancer<br>  ○ Hodgkin Lymphoma<br>  ○ Non-Hodgkin Lymphoma<br>  ○ Non-Small Cell Lung Cancer<br>  ○ Pancreatic Cancer<br>  ○ Primary Craniospinal Tumors and Neurologic Conditions<br>  ○ Small Cell Lung Cancer<br>  ○ Thymoma and Thymic Cancer |
| Cobranded Cigna-EviCore Sleep Disordered Breathing Diagnosis and Treatment Guidelines | Updated | **Posted 1/30/2026, Effective 5/1/2026**<br><br>Important changes in coverage criteria:<br>• Numerous clinical changes will expand and limit coverage. |
| **Administrative Policy** | **New, Updated, or Retired?** | **Comments** |
| | | • No updates in February 2026 |
| **Cigna Healthcare Drug Coverage Policy** | **New, Updated,** | **Comments** |

| | or Retired? | |
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| Adrenal Hyperplasia – Crenessity - (IP0726) | Updated | **Effective 2/1/2026**<br><br>No changes to criteria. |
| Alzheimer's Disease – Amyloid Beta-Directed Antibodies – Kisunla - (IP0697) | Updated | **Effective 2/1/2026**<br><br>**Policy Name:**<br>**Updated from** "Neurology – Kisunla" to "Alzheimer's Disease – Amyloid Beta-Directed Antibodies – Kisunla."<br><br>**Updated** experimental, investigational or unproven statement with the addition of "regardless of U.S. Food and Drug Administration (FDA) approval status. Criteria will be updated as new published data are available." |
| Antibiotics – Linezolid (Zyvox), Sivextro - (IP0372) | Updated | **Effective 2/15/2026**<br><br>**Linezolid – Other Uses with Supportive Evidence**: **Tuberculosis**: The approval duration for this indication was changed to 1 year. Previously, it was 9 months. |
| Attention Deficit Hyperactivity Disorder (ADHD) Stimulants for Employer Group Plans - (IP0477) | Updated | **Effective 2/15/2026**<br><br>**Added** amphetamine extended-release orally disintegrating tablets (generic for Adzenys XR-ODT) to the policy. |
| Attention Deficit Hyperactivity Disorder (ADHD) Stimulants for Individual and Family Plans - (IP0584) | Updated | **Effective 2/15/2026**<br><br>**Added** Adzenys XR-ODT and Amphetamine extended-release orally disintegrating tablets (generic for Adzenys XR-ODT) to the policy.<br>**Updated** the preferred product statement.<br>**Updated** the Vyvanse capsule and chewable tablet preferred product requirements. |

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| Bone Modifiers – Evenity - (IP0179) | Updated | **Effective 2/1/2026**<br><br>**Osteoporosis Treatment for a Postmenopausal Patient:**<br>• Binosto (alendronate effervescent tablets for oral solution) added as an example of a bisphosphonate.<br>• Added criterion for approval of Evenity where patient cannot take an oral bisphosphonate.<br>• Added criterion for approval of Evenity where patient has severe renal impairment.<br>• Added examples for inadequate efficacy and intolerance.<br><br>**Conditions Not Recommended for Approval:** For Concurrent Use with Other Medications for Osteoporosis, the Note was modified from "this does NOT exclude use of calcium and/or vitamin D supplements in combination with Evenity" to "calcium and/or vitamin D supplements may be used in combination with this medication."<br><br>**Updated Coverage Policy Title:**<br>Changed from "*Romosozumab*" to "*Bone Modifiers – Evenity*."<br><br>**Other Updates:**<br>Updated policy template and criteria format. |
| Bone Modifiers – Teriparatide (IP0330) | Updated | **Effective 2/1/2026**<br><br>**Glucocorticoid-Induced Osteoporosis – Treatment:**<br>• Binosto (alendronate effervescent tablets for oral solution) added as an example of a bisphosphonate.<br>• Added examples for inadequate efficacy and intolerance.<br>• Added criterion for approval of teriparatide where patients cannot take oral bisphosphonates.<br>• Added criterion for approval of teriparatide where patient has severe renal impairment for.<br><br>**Osteoporosis Treatment for a Postmenopausal Patient:**<br>• Binosto (alendronate effervescent tablets for oral solution) added as an example of a bisphosphonate.<br>• Added examples for inadequate efficacy and intolerance.<br>• Added criterion for approval of teriparatide where patients cannot take oral bisphosphonates.<br>• Added criterion for approval of teriparatide where patient has severe renal impairment for.<br><br>**Osteoporosis Treatment (to Increase Bone Mass) for Men with Primary or Hypogonadal Osteoporosis:**<br>• Binosto (alendronate effervescent tablets for oral solution) added as an example of a bisphosphonate. |

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| | | • Added examples for inadequate efficacy and intolerance.<br>• Added criterion for approval of teriparatide where patients cannot take oral bisphosphonates.<br>• Added criterion for approval of teriparatide where patient has severe renal impairment for.<br><br>**Conditions Not Recommended for Approval:**<br>• For Concurrent Use with Other Medications for Osteoporosis, the *Note* was modified to include "calcium and/or vitamin D supplements may be used in combination with this medication."<br>• **Removed** *Acute Post-Surgical Hypoparathyroidism* from Conditions Not Covered.<br>• **Removed** *Hypoparathyroidism Caused by Calcium-Sensing Receptor Mutations* from Conditions Not Covered.<br><br>**Updated Coverage Policy Title:**<br>Changed from "*Teriparatide*" to "*Bone Modifiers – Teriparatide*."<br><br>**Other Updates:**<br>● Updated policy template and criteria format. |
| Bone Modifiers – Tymlos - (IP0329) | Updated | **Effective 2/1/2026**<br><br>**Osteoporosis Treatment for a Postmenopausal Patient:**<br>• Binosto (alendronate effervescent tablets for oral solution) added as an example of a bisphosphonate.<br>• Added examples for inadequate efficacy and intolerance.<br>• Added criterion for approval of teriparatide where patients cannot take oral bisphosphonates.<br>• Added criterion for approval of Tymlos where patient has severe renal impairment for.<br><br>**Osteoporosis Treatment for Men:**<br>• Binosto (alendronate effervescent tablets for oral solution) added as an example of a bisphosphonate.<br>• Added examples for inadequate efficacy and intolerance.<br>• Added criterion for approval of teriparatide where patients cannot take oral bisphosphonates.<br>• Added criterion for approval of Tymlos where patient has severe renal impairment for.<br>**Conditions Not Recommended for Approval:** For Concurrent Use with Other Medications for Osteoporosis, the Note was modified from "this does NOT exclude use of calcium and/or vitamin D supplements in combination with Tymlos" to "calcium and/or vitamin D supplements may be used in combination with this medication."<br><br>**Updated Coverage Policy Title:**<br>Changed from "*Abaloparatide*" to "*Bone Modifiers – Tymlos.*" |

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| | | **Other Updates:**<br>• Updated policy template and criteria format.<br>Added Bonsity to Preferred Product Criteria for Tymlos. |
| Contraceptives - (IP0036) | Updated | **Effective 02/01/2026**<br><br>**Individual and Family Plans Preferred Product Table:**<br>**Removed** Averi |
| Dermatology – Anzupgo Drug Quantity Management Policy – Per Days - (DQM015) | New | **Effective 02/01/2026**<br><br>New policy. |
| Diabetes - Tzield - (IP0537) | Updated | **Effective 02/01/2026**<br><br>**Removed** "intervening postprandial glucose level at 30, 60, or 90 minutes greater than 200 mg/dL."<br><br>**Removed** "results of acute first phase insulin response (FPIR) during an intravenous glucose tolerance test (IVGTT) demonstrate rise in serum insulin below the first percentile of normal during the first 10 minutes after IV glucose challenge."<br><br>**Removed** criteria "i. Adequate hematologic function ii. Adequate hepatic function" from "Prescriber attests to ALL of the following:"<br><br>**Added** "Patient has at least one biological relative with a diagnosis of type 1 diabetes."<br><br>**Added** "At baseline (prior to the initiation of Tzield), patient does NOT have evidence of hematologic compromise, as defined by meeting the following (i, ii, iii, and iv) **[documentation required]**: i. Lymphocyte count ≥ 1,000 lymphocytes/mcL; AND ii. Hemoglobin ≥ 10 g/dL; AND iii. Platelet count ≥ 150,000 platelets/mcL; AND iv. Absolute neutrophil count ≥ 1,500 neutrophils/mcL."<br><br>**Added** "At baseline (prior to the initiation of Tzield), patient does NOT have evidence of hepatic compromise, as defined by meeting the following (i, ii, and iii) **[documentation required]**: i. Alanine aminotransferase (ALT) ≤ 2 times the upper limit of normal (ULN); AND ii. Aspartate aminotransferase (AST) ≤ 2 times the ULN; AND iii. Bilirubin ≤ 1.5 times the ULN." |

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| | | **Added** "Chronic active infection (other than localized skin infection)" **to** "According to the prescriber, the patient does NOT have any of the following:"<br><br>**Added** "**[verification required by prescriber]**" **to** "Patient has NOT received Tzield in the past. |
| Droxidopa - (IP0110) | Updated | **Effective 02/15/2026**<br><br>**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. All documentation must include patient-specific identifying information."<br><br>**Neurogenic Orthostatic Hypotension:**<br>**Updated from** "Patient has tried two other medications" **to** "Patient has tried two other medications for the treatment of neurogenic orthostatic hypotension."<br>Moved examples of non-pharmacological measures to a Note.<br><br>**Preferred Product Table:**<br>**Updated from** "The patient has tried the bioequivalent generic product, droxidopa capsules, AND cannot take due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the brand and the bioequivalent generic product which would result in a significant allergy or serious adverse reaction" **to** "The patient has tried the bioequivalent generic product, droxidopa capsules [documentation required], AND cannot take due to a formulation difference in the inactive ingredient(s) [e.g., difference in dyes, fillers, preservatives] between the brand and the bioequivalent generic product which would result, per the prescriber, in a significant allergy or serious adverse reaction." |
| Drugs Requiring Medical Necessity Review for Employer Plans - (1602) | Updated | **Effective 02/01/2026**<br><br>**Updated** "**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." **to** "**Documentation**: Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information."<br><br>**Added preferred product step requirement for the following products:**<br>Orlynvah, Brynovin, and Lasix Onyu |

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| Fabry Disease – Galafold - (IP0400) | Updated | **Effective 02/15/2026**<br><br>**Policy Title:**<br>**Updated from** "Migalastat" **to** "Fabry Disease – Galafold."<br><br>**Fabry Disease:**<br>**Updated from** "Diagnosis of Fabry disease confirmed by documentation of ONE of the following: 1. Male individual with a pathogenic, or likely pathogenic, amenable galactosidase alpha gene (GLA) variant based on in vitro assay data OR 2. Female individual with a pathogenic, or likely pathogenic, amenable galactosidase alpha gene (GLA) variant or a male or female with an amenable GLA variant of uncertain significance (VUS) based on in vitro assay data with at least ONE of the following signs or symptoms of Fabry disease - Crises of severe pain in the extremities (acroparesthesia), Appearance of vascular cutaneous lesions (angiokeratomas), Sweating abnormalities (anhidrosis, hypohidrosis or hyperhidrosis), Albuminuria/proteinuria, Renal failure, Cardiomyopathy" **to** "Patient has a pathogenic, or likely pathogenic, amenable galactosidase alpha gene (GLA) variant based on in vitro assay data **[documentation required]**." |
| Familial Chylomicronemia Syndrome - Tryngolza - (IP0733) | Updated | **Effective 02/15/2026**<br><br>**Familial Chylomicronemia Syndrome.** The requirement for a fasting triglyceride level ≥ 880 mg/dL was clarified to state at baseline. A Note was added to clarify that baseline is prior to a triglyceride-lowering medication. For a patient with inconclusive molecular genetic test result, the option for approval for a familial chylomicronemia score ≥ 10 was clarified to state Moulin familial chylomicronemia score. History of pancreatitis, history of eruptive xanthomas, and history of lipemia retinalis were removed as options of approval for a patient with inconclusive genetic test results. Requirements for a clinical diagnosis were added as an alternative to genetic testing if the patient meets all of the following: documentation of a fasting triglyceride level ≥ 880 mg/dL at baseline; history of recurrent episodes of acute pancreatitis not caused by alcohol or cholelithiasis; history of recurrent hospitalizations for severe abdominal pain without other explainable cause; absence of secondary hypertriglyceridemia (for example, obesity, uncontrolled diabetes); and lack of response to traditional triglyceride-lowering medications. A Note of examples of triglyceride-lowering medications was added throughout the policy and includes statins, niacin, fibrates, and omega-3 fatty acids.<br>**Added** Appendix A. *Moulin Familial Chylomicronemia Syndrome Score Diagnostic Criteria (for Patients with Fasting TGs > 885 mg/dL)* and Appendix B. *North American Familial Chylomicronemia Syndrome Score Diagnostic Criteria*<br>**Added** Appendix B. *North American Familial Chylomicronemia Syndrome Score Diagnostic Criteria.* |
| Gonadotropin-Releasing | Retired | **Effective 02/15/2026** |

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| Hormone Agonists – Central Precocious Puberty – Leuprolide (IP0108) | | Relocated to (IP0768) Gonadotropin-Releasing Hormone Agonists-Central Precocious Puberty |
| Gonadotropin-Releasing Hormone Agonists – Central Precocious Puberty – Triptodur (IP0134) | Retired | **Effective 02/15/2026**<br><br>Relocated to (IP0768) Gonadotropin-Releasing Hormone Agonists-Central Precocious Puberty |
| Gonadotropin-Releasing Hormone Agonists – Central Precocious Puberty - (IP0768) | New | **Effective 02/15/2026**<br><br>New policy. |
| Growth Disorders – Voxzogo - (IP0402) | Updated | **Effective 02/01/2026**<br><br>**Updated** title **from** "Vosoritide" **to** "Growth Disorders – Voxzogo"<br><br>**Achondroplasia.**<br>**Added** criterion "The prescriber has confirmed the patient is able to drink approximately 240 to 300 mL of fluid in the hour prior to Voxzogo administration."<br><br>**Patient Has Been Receiving Voxzogo for ≥ 1 Year.**<br>**Added** criteria that matches Initial Therapy criteria with the addition of the following criterion: "Patient's most recent annualized growth velocity continues to be above their baseline annualized growth velocity value (i.e., before the patient started on Voxzogo)." |
| Hepatitis C Virus Direct-Acting Antivirals | Updated | **Effective 02/01/2026** |

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| Preferred Specialty Management Policy for Employer Plans - (PSM025) | | **Sofosbuvir/velpatasvir (generic only):** Updated "the patient has an inability to obtain Epclusa (brand only) due to market availability" to "the Preferred Product, Epclusa (brand), is not available on the market per a verifiable source (for example, FDA Drug Shortage database or ASHP Drug Shortage list)".<br>**Ledipasvir/sofosbuvir (generic only)**: Updated "the patient has an inability to obtain Harvoni (brand only) due to market availability" to "the Preferred Product, Harvoni (brand), is not available on the market per a verifiable source (for example, FDA Drug Shortage database or ASHP Drug Shortage list)". |
| Hepatology – Rezdiffra - (IP0642) | Updated | **Effective 02/01/2026**<br><br>**Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH).** Initial Therapy**.** Criteria for the diagnosis of MASH/NASH were updated such that the patient must have documentation of stage F2 or F3 fibrosis prior to initiating treatment with Rezdiffra or Wegovy confirmed by ONE of the following: Liver biopsy performed within 3 years preceding treatment with Rezdiffra or Wegovy **[documentation required]**, vibration-controlled elastography (VCTE) performed within 6 months preceding treatment with Rezdiffra or Wegovy **[documentation required]**, magnetic resonance imaging (MRE) performed within 6 months preceding treatment with Rezdiffra or Wegovy **[documentation required]**, or Enhanced Liver Fibrosis (ELF) test performed within 6 months preceding treatment with Rezdiffra or Wegovy **[documentation required]** with a score of ≥ 9.2 to ≤ 10.5 **[documentation required].** Previously, the diagnosis of MASH/NASH was confirmed by a either a liver biopsy within 3 years preceding treatment with Rezdiffra **[documentation required]** that showed a non-alcoholic fatty liver disease activity score of ≥ 4 with a score of ≥ 1 in steatosis, ballooning, and lobular inflammation **[documentation required]** OR an imaging exam (i.e., elastography, computed tomography, or magnetic resonance imaging) performed within 6 months preceding treatment with Wegovy **[documentation required].** The separate criterion that the patient have stage F2 or F3 fibrosis **[documentation required]** was removed (this is part of the updated criterion outlined above; patients must still have documentation of F2 or F3 fibrosis). Reference to prior to initiating therapy throughout criteria were updated to include Wegovy (i.e., prior to initiating treatment with Rezdiffra "or Wegovy"); previously only Rezdiffra. Patient is Currently Receiving Rezdiffra. The criterion requiring that according to the prescriber the patient has not progressed to stage F4 (cirrhosis) was modified to state, according to the prescriber, patient does not have cirrhosis (F4).<br><br>**Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH) with Cirrhosis (F4).** This condition not recommended for approval was updated to add "(F4)" in reference to cirrhosis. |
| Idiopathic Pulmonary | New | **Effective 02/01/2026** |

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| Fibrosis and Related Lung Disease – Jascayd for Individual and Family Plans - (IP0772) | | New policy |
| Idiopathic Pulmonary Fibrosis and Related Lung Disease – Pirfenidone - (IP0311) | Updated | **Effective 02/01/2026**<br><br>Important changes in coverage criteria/policy:<br>**Idiopathic Pulmonary Fibrosis**. A Note was added to clarify that initial therapy refers to a patient who is not currently receiving pirfenidone. The patient may be taking concomitant Jascayd (nerandomilast tablets). The requirement regarding forced vital capacity ≥ 40% was clarified to state at baseline. A Note was added to clarify that baseline is before a patient has started antifibrotic therapies. The examples of antifibrotic therapies were added which Ofev (nintedanib capsules), Jascayd, or pirfenidone capsules and film-coated tablets (Esbriet, generic). |
| Idiopathic Pulmonary Fibrosis and Related Lung Disease – Ofev (IP0312) | Updated | **Effective 02/01/2026**<br><br>Important changes in coverage criteria/policy:<br>**Idiopathic Pulmonary Fibrosis**. A Note was added to clarify that Initial therapy refers to a patient who is not taking Ofev. Patient may be taking concomitant Jascayd. The requirement regarding forced vital capacity ≥ 40% was clarified to state at baseline. A Note was added to clarify that baseline is before a patient has started antifibrotic therapies.<br><br>**Preferred Product Table**<br>**Individual and Family Plan.**<br>**Added** "Note: If the patient tried the brand version of a generic equivalent product, then this trial would count towards the requirement." |
| Infectious Disease – Livtencity Drug Quantity Management Policy - (DQM016) | New | **Effective 02/01/2026**<br><br>New Policy. |
| Inflammatory Conditions – Cimzia Drug Quantity | New | **Effective 02/15/2026**<br><br>New Policy. |

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| Management Policy – Per Days - (DQM018) | | |
| Inflammatory Conditions – Olumiant Drug Quantity Management Policy – Per Days - (DQM019) | New | **Effective 02/15/2026**<br>New Policy. |
| Inflammatory Conditions – Olumiant Prior Authorization Policy - IP0681 | Updated | **Effective 02/01/2026>**<br>**Type 1 Interferonopathy**: This new condition of approval was added under Other Uses with Supportive Evidence.<br>**Appendix**: Added Otezla XR. |
| Inflammatory Conditions – Rinvoq Drug Quantity Management Policy – Per Days - (DQM021) | New | **Effective 02/15/2026**<br><br>New Policy. |
| Inflammatory Conditions – Tocilizumab Intravenous Products Preferred Specialty Management Policy - (PSM012) | Updated | **Effective 02/15/2026>**<br><br>Avtozma intravenous was added as a Preferred product. Also updated Tofidence intravenous Non-preferred product criteria to include documentation of a trial of Avtozma intravenous, in addition to Actemra intravenous and Tyenne intravenous and documentation of an inability to use due to difference in formulation of inactive ingredients which would result in significant allergy or serious adverse reaction is required. |
| Inflammatory Conditions – Tocilizumab Intravenous | Updated | **Effective 02/15/2026**<br><br>Avtozma was added to the policy with the same criteria as the other tocilizumab intravenous products. |

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| Products Prior Authorization Policy - (IP0656) | | **Castleman Disease:** For initial therapy, the requirement for unicentric disease that the patient have relapsed/refractory or progressive disease was removed.<br><br>**Vacuoles E1 Enzyme X-linked Autoinflammatory Somatic (VEXAS) Syndrome:** This was added as a condition of approval. |
| Inflammatory Conditions – Tocilizumab Subcutaneous Products PA - (IP0657) | Updated | **Effective 02/01/2026**<br><br>**Vacuoles E1 Enzyme X-linked Autoinflammatory Somatic (VEXAS) Syndrome:** The new condition of approval was added under other uses with supportive evidence.<br>**Appendix:** Otezla XR (apremilast extended-release tablet) was added under the Oral Therapies/Targeted Synthetic Oral Small Molecular Drugs. |
| Inflammatory Conditions – Ustekinumab Subcutaneous Drug Quantity Management Policy – Per Days - DQM001 | Updated | **Effective 02/01/2026**<br><br>**Otulfi 45 mg vials:** New quantity limits were added to the policy. The same quantity limits and overrides apply to Otulfi as have previously applied to the other ustekinumab products.<br><br>**Ustekinumab-aauz 45 mg prefilled syringes and 90 mg prefilled syringes (unbranded Otulfi):** New quantity limits were added to the policy. The same quantity limits and overrides apply to ustekinumab-aauz as have previously applied to the other ustekinumab products.<br><br>**CDV Pyzchiva 45 mg prefilled syringes, 45 mg autoinjectors, 90 mg prefilled syringes:** Added to the policy as a non-covered product. No exception criteria apply.<br><br>**Pyzchiva 45 mg vials:** New quantity limits were added to the policy. The same quantity limits and overrides apply to Pyzchiva as have previously applied to the other ustekinumab products.<br><br>**Selarsdi 45 mg vials:** New quantity limits were added to the policy. The same quantity limits and overrides apply to Selarsdi as have previously applied to the other ustekinumab products.<br><br>**Wezlana 45 mg prefilled syringes, 45 mg vials, and 90 mg prefilled syringes: Added** to the policy as a non-covered product. No exception criteria apply. |
| Inflammatory Conditions – Velsipity Prior Authorization Policy - (IP0691) | Updated | **Effective 02/15/2026**<br><br>No criteria changes. |

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| Metabolic Disorders – Phenylbutyrate Products - (IP0169) | Updated | **Effective 02/01/2026**<br><br>Throughout the policy, Ravicti was changed to now be referred to as glycerol phenylbutyrate.<br><br>**Employer Group Plans:**<br>**Olpruva**: Added an option to preferred product criteria of approval for a patient that has tried generic glycerol phenylbutyrate.<br><br>**Conditions Not Recommended for Approval**: Removed "Concomitant therapy with another phenylbutyrate product." |
| Metabolic Disorders – Primary Hyperoxaluria – Oxlumo - IP0095 | Updated | **Effective 02/01/2026**<br><br>No changes to criteria. |
| Migraine – Calcitonin Gene-Related Peptide Inhibitors – Ajovy - (IP0504) | Updated | **Effective 02/01/2026**<br><br>**Removed** Individual and Family Plans preferred product criteria. |
| Migraine – Calcitonin Gene-Related Peptide Inhibitors – Aimovig - (IP0503) | Updated | **Effective 02/01/2026**<br><br>**Removed** Individual and Family Plans preferred product criteria. |
| Migraine – Calcitonin Gene-Related Peptide Inhibitors – Emgality - (IP0505) | Updated | **Effective 02/01/2026**<br><br>**Episodic Cluster Headache Treatment.**<br>**Updated** the discontinuation of the standard prophylactic (preventive) pharmacologic therapy statement. |
| Migraine – Calcitonin Gene-Related Peptide | Updated | **Effective 02/01/2026**<br><br>**Updated** Employer Plans and Individual and Family Plans preferred product requirements. |

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| Inhibitors – Vyepti - (IP0506) | | |
| Migraine – Nurtec ODT - (IP0147) | Updated | **Effective 02/01/2026**<br><br>**Updated** Individual and family Plans preferred product criteria (Migraine, Acute Treatment): Decreased the number of triptan prerequisite steps from two to one.<br>**Removed** Individual and family Plans preferred product criteria (Preventive Treatment of Episodic Migraine). |
| Migraine – Qulipta - (IP0377) | Updated | **Effective 02/01/2026**<br><br>**Removed** Individual and Family Plans preferred product criteria. |
| Migraine – Ubrelvy - (IP0148) | Updated | **Effective 02/01/2026**<br><br>**Migraine, Acute Treatment.**<br>**Updated** the contraindication to triptan(s) statement. |
| Migraine – Zavzpret - (IP0573) | Updated | **Effective 02/01/2026**<br><br>**Updated** Individual and Family Plans preferred product requirements. |
| Muscular Dystrophy – Deflazacort - (IP0131) | Updated | **Effective 02/15/2026**<br><br>**Added** branded generic Kymbee to the policy with the same criteria applied as the other deflazacort products.<br><br>**Updated** exception criteria to include Kymbee tablets in the Preferred Products Table. |
| Neurology-Gene Therapy-Kebilidi - (IP0725) | Updated | **Effective 02/6/2026**<br><br>No criteria changes. |
| Pharmacy and Medical Prior | Updated | **Effective 02/15/2026** |

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| Authorization - (1407) | | **Updated** "**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." **to** "**Documentation:** Documentation is required where noted in the criteria as **[documentation required]**. Documentation may include, but not limited to, chart notes, laboratory tests, medical test results, claims records, prescription receipts, and/or other information. All documentation must include patient-specific identifying information."<br><br>**Added Individual and Family Plan product-specific medical necessity criteria for the following products:** hydrocortisone 2.5% rectal cream, conjugated estrogens tablets, Tonmya, Zanaflex capsules, Lynkuet, Vyscoxa, Exxua, fluticasone furoate inhalation powder (authorized generic of Arnuity Ellipta), Zoryve 0.05% Cream, opium tincture 10 mg/mL (effective 3/1/2026), Jublia (effective 3/1/2026), Rexulti (effective 3/1/2026), Bevespi Aerosphere (effective 3/1/2026), Duaklir Pressair (effective 3/1/2026), Stiolto Respimat (effective 3/1/2026), umeclidinium and vilanterol inhalation powder (effective 3/1/2026), azelastine and fluticasone propionate nasal spray (generic for Dymista) (effective 3/1/2026), Dymista (effective 3/1/2026), Ryaltris (effective 3/1/2026), Omnaris (effective 3/1/2026), Qnasl (effective 3/1/2026), Qnasl Children's (effective 3/1/2026), paroxetine mesylate 7.5 mg capsules (effective 3/1/2026), Premarin tablets (effective 3/1/2026), Ulesfia (effective 3/1/2026), tizanidine capsules (effective 3/1/2026), tavaborole 5% topical solution (effective 3/1/2026), miconazole-zinc oxide-petrolatum ointment (effective 3/1/2026), and Vusion (effective 3/1/2026)<br><br>**Updated Individual and Family Plan product-specific medical necessity criteria for the following products:** gabapentin extended-release tablets, Gralise, Pokonza, halobetasol propionate topical foam 0.05%, Lexette, adapalene/benzoyl peroxide 0.3-2.5% gel pump (effective 3/1/2026), Epiduo Forte (effective 3/1/2026), Blujepa (effective 3/1/2026), oxcarbazepine extended-release tablets (effective 3/1/2026), Oxtellar XR (effective 3/1/2026), Furoscix (effective 3/1/2026), Xhance (effective 3/1/2026), Veozah (effective 3/1/2026), Vtama (effective 3/1/2026), ArmonAir DigiHaler (effective 3/1/2026), Flovent Diskus (effective 3/1/2026), Flovent HFA (effective 3/1/2026), fluticasone inhalation powder (effective 3/1/2026), fluticasone propionate HFA (effective 3/1/2026), Pulmicort Flexhaler (effective 3/1/2026), Eucrisa (effective 3/1/2026), and Zoryve 0.15% cream (effective 3/1/2026) |
| Oncology – Jakafi - (IP0318) | Updated | **Effective 02/01/2026**<br><br>Important changes in coverage criteria/policy:<br>**Vacuoles E1 Enzyme X-linked Autoinflammatory Somatic Syndrome (VEXAS):** This was added as condition of approval under Other Uses with Supportive Evidence. |

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| Oncology Medications - (CP1403) | Updated | **Effective 02/15/2026**<br><br>Important changes in coverage criteria/policy:<br>**Jemperli.**<br>**Added** for Mismatch Repair Deficient (dMMR) or Microsatellite Instability-High (MSI-H) Endometrial Cancer – Monotherapy "Patient has endometrial carcinosarcoma"<br>**Removed** documentation requirements<br><br>**Kyxata.**<br>**Added** criteria for Kyxata<br><br>**Vectibix.**<br>**Updated from** "Patient has been started on Vectibix" **to** "Patient has been started on Vectibix or has already been started on therapy with Lumakras" |
| Ophthalmology – Vascular Endothelial Growth Factor Inhibitors – Aflibercept Products - (IP0540) | Updated | **Effective 02/01/2026**<br><br>Content from policy:<br>Policy title updated from "Aflibercept " to "Ophthalmology – Vascular Endothelial Growth Factor Inhibitors – Aflibercept Products"<br><br>**Added** a policy statement.<br><br>**Eylea, Pavblu: Other Uses with Supportive Evidence.** Other Neovascular Diseases of the Eye. The Note of examples of other neovascular diseases was revised to remove sickle cell neovascularization and choroidal neovascular conditions and the following examples were added: angioid streaks, iris neovascularization, pachychoroid neovasculopathy, polypoidal choroidal vasculopathy, and presumed ocular histoplasmosis.<br><br>**Eylea HD: Other Uses with Supportive Evidence.** Added **"**Other Neovascular Diseases of the Eye" as a condition of approval.<br><br>**Eylea HD: Dosing.** A note, defining the recommended dosing was added to the dosing for each indication.<br><br>**Conditions Not Covered:** "Concomitant Use with Another Intravitreal Vascular Endothelial Growth Factor Inhibitor" was added.<br><br>**Eylea HD, Macular Edema Following Retinal Vein Occlusion:** This condition of approval was added to the policy. Dosing recommendation for this condition was also added. |

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| | | Eylea HD, Dosing section was revised to align with the updated Eylea HD prescribing information (PI).<br><br>**Diabetic Macular Edema:** The dosing interval was revised to read "not more frequent than once every 21 days for each eye being treated"; previously the dosing interval was "not more frequent than once every 21 days for the first three doses, followed by not more frequent that once every 7 weeks for each eye being treated". The revised PI notes that some patients may benefit from every 4-week dosing (approximately every 28 days, +/- 7 days).<br>**Diabetic Retinopathy:** The dosing interval was revised to read "not more frequent than once every 21 days for each eye being treated"; previously the dosing interval was "not more frequent than once every 21 days for the first three doses, followed by not more frequent that once every 7 weeks for each eye being treated". The revised PI notes that some patients may benefit from every 4-week dosing (approximately every 28 days, +/- 7 days).<br><br>**Neovascular (Wet) Age-Related Macular Degeneration:** The dosing interval was revised to read "not more frequent than once every 21 days for each eye being treated"; previously the dosing interval was "not more frequent than once every 21 days for the first three doses, followed by not more frequent that once every 7 weeks for each eye being treated". The revised PI notes that some patients may benefit from every 4-week dosing (approximately every 28 days, +/- 7 days).<br>**Added** preferred product requirements. |
| Opioids - Fentanyl Transmucosal Drugs - (IP0381) | Updated | **Effective 02/01/2026**<br><br>Content from policy:<br>Policy title updated from "Fentanyl Transmucosal Products" to "Opioids - Fentanyl Transmucosal Drugs".<br><br>**Added** a policy statement.<br>**Removed** the age requirement.<br>**Added** notes defining examples of short-acting and long-acting narcotics.<br>**Removed** all preferred product requirements.<br>**Removed** the site of care and sample statements.<br>**Removed** the reauthorization Criteria and Authorization Duration sections.<br>**Updated** the Conditions Not Covered statement.<br><br>Note: All products are obsolete in drug file, except for two strengths of generic Actiq. |
| Pain – Journavx Drug Quantity | Updated | **Effective 2/1/2026** |

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| Management Policy – Per Days - (DQM004) | | Aligned the policy to current standards. |
| Progesterone (Vaginal) for Individual and Family Plans - (IP0091) | Updated | **Effective 02/15/2026**<br><br>**Policy Title**:<br>**Updated from** "Progesterone (Endometrin) for Individual and Family Plans" **to** "Progesterone (Vaginal) for Individual and Family Plans."<br><br>**Infertility:**<br>**Updated** criterion **from** "Use is indicated as part of an Assisted Reproductive Technology (ART) treatment program" **to** "The medication is to be used to support embryo implantation and early pregnancy by supplementation of corpus luteal function AND use is indicated as part of an Assisted Reproductive Technology (ART) treatment program."<br>**Updated** duration of therapy from 6 months to 9 months.<br><br>**Prevention of Preterm Birth:**<br>**Updated** duration of therapy from 6 months to 1 year. |
| Proprotein Convertase Subtilisin Kexin Type 9 Related Products – Leqvio - (IP0380) | Updated | **Effective 02/01/2026**<br><br>Content from policy:<br>**Updated** the policy statement.<br>**Removed** Employer Plans preferred product requirements. |
| Pulmonary Arterial Hypertension – Endothelin Receptor Antagonists (IP0631) | Updated | **Effective 02/01/2026**<br><br>**Employer Plans:**<br>**Added** preferred product criteria for Tracleer® (bosentan tablets for oral suspension)**.** |
| Pulmonary – Brinsupri for Employer Plans – (IP0775) | New | **Effective 02/15/2026**<br><br>New policy. |

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| Quantity Limitations – (1201) | Updated | **Effective 02/15/2026**<br><br>**Removed** Cimzia and relocated to a new policy, *Inflammatory Conditions – Cimzia Drug Quantity Management Policy – Per Days – (DQM018).*<br>**Removed** Rinvoq/Rinvoq LQ and relocated to new policy, *Inflammatory Conditions – Rinvoq Drug Quantity Management Policy – Per Days – (DQM021)* |
| Rituximab Intravenous Products for Non-Oncology Indications (IP0319) | Updated | **Effective 02/01/2026**<br><br>**Pemphigus Vulgaris**<br>**Maintenance Therapy: Added** ”every 6 months” to dosing regimen<br><br>**Autoimmune Hemolytic Anemia**<br>**Updated from** ”Refractory Autoimmune Hemolytic Anemia” **to** ”Autoimmune Hemolytic Anemia”<br>**Updated** authorization duration **from** 12 months **to** 1 month<br>**Removed** ” Documented failure, contraindication, or intolerance to conventional treatments (for example, corticosteroids, immunosuppressants, or immunoglobulin”<br>**Added** ”The medication is prescribed by or in consultation with a hematologist”<br>**Added** dosing for this use<br><br>**Immune Thrombocytopenia (ITP)**<br>**Updated** for a patient that has already received a course of a rituximab product for ITP, the requirements that the patient has responded to therapy and that the patient has relapsed were modified **from** "as determined by the prescriber" **to** "according to the prescriber"<br><br>**Interstitial Lung Disease Associated with Systemic Autoimmune Rheumatic Disease**<br>**Added** criteria and dosing for this use<br><br>**Membranous Nephropathy**<br>**Updated from** ”Membranous Nephropathy/Membranous Glomerular Nephropathy” **to** ”Membranous Nephropathy”<br>**Updated** authorization duration **from** 12 months **to** 1 month<br>**Removed** individual has ONE of the following: Membranous nephropathy and eGFR < 60 ml/min or declining renal function not otherwise explained, Membranous nephropathy with nephrotic syndrome (nephrotic proteinuria, peripheral edema, hypoalbuminemia), Membranous nephropathy with nephrotic proteinuria (> 3.5 gm/day after 6 months conservative therapy with ACEi or ARB), |

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| | | or Recurrent membranous nephropathy with proteinuria > 1 gm/day in a kidney transplant recipient<br>**Added** "According to the prescriber, the patient is at moderate risk or high risk for the progressive loss of kidney function"<br>**Added** criteria for Patient has already Received a Course of a Rituximab Product for Membranous Nephropathy<br>**Added** dosing for this use<br><br>**Minimal Change Disease**<br>**Added** criteria and dosing for this use<br><br>**Myasthenia Gravis**<br>**Updated** authorization duration **from** 12 months **to** 6 months<br>**Added** "Patient has confirmed anti-muscle-specific tyrosine kinase antibody-positive myasthenia gravis"<br>**Added** "Patient meets ONE of the following (a or b): a.Patient previously received or is currently receiving pyridostigmine b. Patient has had inadequate efficacy, contraindication, or significant intolerance to pyridostigmine"<br>**Updated from** "Documented failure, contraindication, or intolerance to at least TWO immunosuppressive agents (for example, azathioprine, cyclosporine, or methotrexate)" **to** "Patient has tried at least one immunosuppressant therapy. Note: Examples of immunosuppressant therapies include azathioprine, cyclosporine, mycophenolate mofetil, methotrexate, tacrolimus, and cyclophosphamide. A trial of Imaavy (nipocalimab-aahu intravenous infusion) or Rystiggo (rozanolixizumab-noli subcutaneous infusion) also counts."<br>**Added** "Patient has evidence of unresolved symptoms of myasthenia gravis. Note: Evidence of unresolved symptoms of myasthenia gravis includes difficulty swallowing, difficulty breathing, or a functional disability resulting in the discontinuation of physical activity (e.g., double vision, talking, impairment of mobility)"<br>**Added** "The medication is prescribed by or in consultation with a neurologist"<br>**Added** criteria for Patient has Already Received a Course of a Rituximab Product for Myasthenia Gravis<br>**Added** dosing for this use<br><br>**Pediatric Nephrotic Syndrome**<br>**Updated** authorization duration **from** 12 months **to** 1 month |

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| | | **Updated from** "Documentation of failure, contraindication, or intolerance to corticosteroid or immunosuppressive medication (for example, cyclophosphamide, cyclosporine, mycophenolate mofetil)" **to** "Patient has tried at least one glucocorticoid-sparing agent for nephrotic syndrome. Note: Examples of glucocorticoid-sparing agents for nephrotic syndrome include oral calcineurin inhibitors (e.g., tacrolimus, cyclosporine), cyclophosphamide, or mycophenolate mofetil"<br>**Updated from** "Disease is relapsing and steroid-dependent" **to** "Patient has tried at least one systemic corticosteroid. Note: Examples of systemic corticosteroids include prednisone or prednisolone"<br>**Added** "The medication is prescribed by or in consultation with a nephrologist"<br>**Added** criteria for Patient has Already Received a Course of a Rituximab Product for Pediatric Nephrotic Syndrome.<br>**Added** dosing for this use<br><br>**Solid Organ Transplantation**<br>**Updated from** "Desensitization for highly-allosensitized transplant candidates (to reduce HLA antibodies)" **to** "The medication will be used for desensitization therapy prior to or immediately after transplantation"<br>**Updated from** "Antibody-mediated rejection (AMR)" **to** "The medication will be used for antibody-mediated rejection"<br>**Added** "The medication will be prescribed by or in consultation with a physician affiliated with a transplant center"<br>**Added** dosing for this use<br><br>**Thrombotic Thrombocytopenic Purpura**<br>**Updated** authorization duration **from** 12 months **to** 1 month<br>**Removed** "Diagnosis of thrombotic thrombocytopenic purpura"<br>**Updated from** "Individual is receiving concurrent therapy with glucocorticoids unless there is a documented failure, contraindication, or intolerance to glucocorticoids" **to** "The medication will be used in combination with systemic corticosteroids. Note: Examples of systemic corticosteroids include prednisone and methylprednisolone"<br>**Updated from** "Rituximab will be used in combination with plasma exchange therapy" **to** "The medication will be used in combination with therapeutic plasma exchange"<br>**Added** dosing for this use<br><br>**Factor Inhibitors in an Individual with Hemophilia** |

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| | | This use was removed |
| Somatostatin Analogs – Octreotide Immediate-Release Products (IP0490) | Updated | **Effective 02/01/2026**<br><br>**Preferred Product Table - Individual and Family Plans:**<br>**Added** step through octreotide acetate generic requirement for Bynfezia. |
| Spinal Muscular Atrophy – Gene Therapy – Itvisma (IP0790) | New | **Effective 2/12/2026**<br><br>New policy |
| Spinal Muscular Atrophy – Gene Therapy – Zolgensma (IP0185) | Updated | **Effective 2/5/2026**<br><br>**Spinal Muscular Atrophy – Treatment:** Changed the approval duration from 30 days to 90 days. Itvisma was added as gene therapy that the patient should not have received in the past. The Note now includes that if no claim for Itvisma is present (or if claims history is not available), the prescribing physician confirms that the patient has not previously received Itvisma. The requirement that the patient has hemoglobin levels between 8 g/dL and 18 g/dL was changed to the hemoglobin level is within the normal reference range. A Note was added that reference ranges for hemoglobin levels vary among laboratories and are dependent upon age and gender. |
| Testosterone (Oral, Topical, and Nasal) Products (IP0350) | Updated | **Effective 2/15/2026**<br><br>**Updated** the policy title from "Testosterone (Oral, Topical, and Nasal)" to "Testosterone (Oral, Topical, and Nasal) Products"<br>**Added** a policy statement.<br>**Added** a documentation statement.<br>**Hypogonadism (Primary or Secondary) in Males* [Testicular Hypofunction/Low Testosterone with Symptoms]. Initial Therapy**<br>**Added** a note defining the pretreatment timeframe.<br>**Hypogonadism (Primary or Secondary) in Males* [Testicular Hypofunction/Low Testosterone with Symptoms]. Patient Currently Receiving Testosterone Therapy**<br>**Removed** the no concurrent use with other testosterone products statement**.**<br>**Removed** the "Loss of records" criteria.<br><br>**Employer Plans Preferred Product Requirements**<br>**Fortesta:** Removed from the preferred product table. |

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| | | **Jatenzo:** Removed Androgel 1% and 1.62% as alternative options.<br>**Kyzatrex:** Removed Androgel 1% and 1.62% as alternative options.<br>**Natesto :** Removed Androgel 1% and 1.62% as alternative options.<br>**Testim:** Updated the criteria to multi-source brand criteria.<br>**Tlando:** Removed Androgel 1% and 1.62% as alternative options.<br>**Vogelxo:** Updated the criteria to multi-source brand criteria.<br><br>**Individual and Family Plans Preferred Product Requirements**<br>**Androgel:** Updated the criteria to multi-source brand criteria.<br>**Fortesta:** Removed from the preferred product table.<br>**Testim:** Updated the criteria to multi-source brand criteria.<br>**Vogelxo:** Updated the criteria to multi-source brand criteria.<br>**Removed** the Reauthorization Criteria and Authorization Duration sections.<br>**Updated** the conditions not covered statement. |
| Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 30 (IP0206) | Updated | **Effective 2/15/2026**<br><br>**Updated** the policy statement.<br>**Changed** each "Patient is Continuing Therapy" to "Patient is Currently Receiving"<br><br>Wegovy<br>**Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH).**<br>Initial Therapy**.** The requirement that the patient does not have cirrhosis was clarified that the patient does not have cirrhosis "(F4)". Criteria for the diagnosis of MASH/NASH were updated such that the patient must have documentation of stage F2 or F3 fibrosis prior to initiating treatment with Rezdiffra or Wegovy confirmed by ONE of the following: Liver biopsy performed within 3 years preceding treatment with Rezdiffra or Wegovy **[documentation required]**, vibration-controlled elastography (VCTE) performed within 6 months preceding treatment with Rezdiffra or Wegovy **[documentation required]**, magnetic resonance imaging (MRE) performed within 6 months preceding treatment with Rezdiffra or Wegovy **[documentation required]**, or Enhanced Liver Fibrosis (ELF) test performed within 6 months preceding treatment with Rezdiffra or Wegovy **[documentation required]** with a score of ≥ 9.2 to ≤ 10.5 **[documentation required].** Previously, the diagnosis of MASH/NASH was confirmed by a either a liver biopsy within 3 years preceding treatment with Wegovy **[documentation required]** that showed a non-alcoholic fatty liver disease activity score of ≥ 4 with a score of ≥ 1 in steatosis, ballooning, and lobular inflammation **[documentation required]** OR an imaging exam (i.e., elastography, computed tomography, or magnetic resonance imaging) performed within 6 months preceding treatment with |

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| | | Wegovy **[documentation required].** The separate criterion that the patient have stage F2 or F3 fibrosis **[documentation required]** was removed (this is part of the updated criterion outlined above; patients must still have documentation of F2 or F3 fibrosis). Reference to prior to initiating therapy throughout criteria were updated to include Rezdiffra(i.e., prior to initiating treatment with Rezdiffra or Wegovy); previously only Wegovy.<br>Patient is Currently Receiving Wegovy. The criterion requiring that according to the prescriber the patient has not progressed to stage F4 (cirrhosis) was modified to state, according to the prescriber, patient does not have cirrhosis (F4).<br><br>Zepbound<br>**Obstructive Sleep Apnea, Moderate to Severe, in a Patient with Obesity.**<br>Initial Therapy. The criterion excluding coverage of a patient with central sleep apneas was modified to remove the additional requirement that the percent of central apneas/hypopneas is ≥ 50%. |
| Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 32 (IP0621) | Updated | **Effective 2/15/2026**<br><br>**Updated** the policy statement.<br>**Changed** each "Patient is Continuing Therapy" to "Patient is Currently Receiving"<br><br>Wegovy<br>**Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH).**<br>Initial Therapy**.** The requirement that the patient does not have cirrhosis was clarified that the patient does not have cirrhosis "(F4)". Criteria for the diagnosis of MASH/NASH were updated such that the patient must have documentation of stage F2 or F3 fibrosis prior to initiating treatment with Rezdiffra or Wegovy confirmed by ONE of the following: Liver biopsy performed within 3 years preceding treatment with Rezdiffra or Wegovy **[documentation required]**, vibration-controlled elastography (VCTE) performed within 6 months preceding treatment with Rezdiffra or Wegovy **[documentation required]**, magnetic resonance imaging (MRE) performed within 6 months preceding treatment with Rezdiffra or Wegovy **[documentation required]**, or Enhanced Liver Fibrosis (ELF) test performed within 6 months preceding treatment with Rezdiffra or Wegovy **[documentation required]** with a score of ≥ 9.2 to ≤ 10.5 **[documentation required].** Previously, the diagnosis of MASH/NASH was confirmed by a either a liver biopsy within 3 years preceding treatment with Wegovy **[documentation required]** that showed a non-alcoholic fatty liver disease activity score of ≥ 4 with a score of ≥ 1 in steatosis, ballooning, and lobular inflammation **[documentation required]** OR an imaging exam (i.e., elastography, computed tomography, or magnetic resonance imaging) performed within 6 months preceding treatment with |

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| | | Wegovy **[documentation required].** The separate criterion that the patient have stage F2 or F3 fibrosis **[documentation required]** was removed (this is part of the updated criterion outlined above; patients must still have documentation of F2 or F3 fibrosis). Reference to prior to initiating therapy throughout criteria were updated to include Rezdiffra( i.e., prior to initiating treatment with Rezdiffra or Wegovy); previously only Wegovy.<br>Patient is Currently Receiving Wegovy. The criterion requiring that according to the prescriber the patient has not progressed to stage F4 (cirrhosis) was modified to state, according to the prescriber, patient does not have cirrhosis (F4).<br><br>Zepbound<br>**Obstructive Sleep Apnea, Moderate to Severe, in a Patient with Obesity.**<br>Initial Therapy. The criterion excluding coverage of a patient with central sleep apneas was modified to remove the additional requirement that the percent of central apneas/hypopneas is ≥ 50%. |
| Weight Loss – Glucagon-Like Peptide-1 Agonists BMI ≥ 35 (IP0739) | Updated | **Effective 2/15/2026**<br><br>**Updated** the policy statement.<br>**Changed** each "Patient is Continuing Therapy" to "Patient is Currently Receiving"<br><br>Wegovy<br>**Metabolic Dysfunction-Associated Steatohepatitis (MASH)/Non-Alcoholic Steatohepatitis (NASH).**<br>Initial Therapy**.** The requirement that the patient does not have cirrhosis was clarified that the patient does not have cirrhosis "(F4)". Criteria for the diagnosis of MASH/NASH were updated such that the patient must have documentation of stage F2 or F3 fibrosis prior to initiating treatment with Rezdiffra or Wegovy confirmed by ONE of the following: Liver biopsy performed within 3 years preceding treatment with Rezdiffra or Wegovy **[documentation required]**, vibration-controlled elastography (VCTE) performed within 6 months preceding treatment with Rezdiffra or Wegovy **[documentation required]**, magnetic resonance imaging (MRE) performed within 6 months preceding treatment with Rezdiffra or Wegovy **[documentation required]**, or Enhanced Liver Fibrosis (ELF) test performed within 6 months preceding treatment with Rezdiffra or Wegovy **[documentation required]** with a score of ≥ 9.2 to ≤ 10.5 **[documentation required].** Previously, the diagnosis of MASH/NASH was confirmed by a either a liver biopsy within 3 years preceding treatment with Wegovy **[documentation required]** that showed a non-alcoholic fatty liver disease activity score of ≥ 4 with a score of ≥ 1 in steatosis, ballooning, and lobular inflammation **[documentation required]** OR an imaging exam (i.e., elastography, computed tomography, or magnetic resonance imaging) performed within 6 months preceding treatment with |

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| | | Wegovy **[documentation required].** The separate criterion that the patient have stage F2 or F3 fibrosis **[documentation required]** was removed (this is part of the updated criterion outlined above; patients must still have documentation of F2 or F3 fibrosis). Reference to prior to initiating therapy throughout criteria were updated to include Rezdiffra(i.e., prior to initiating treatment with Rezdiffra or Wegovy); previously only Wegovy.<br>Patient is Currently Receiving Wegovy. The criterion requiring that according to the prescriber the patient has not progressed to stage F4 (cirrhosis) was modified to state, according to the prescriber, patient does not have cirrhosis (F4).<br><br>Zepbound<br>**Obstructive Sleep Apnea, Moderate to Severe, in a Patient with Obesity.**<br>Initial Therapy. The criterion excluding coverage of a patient with central sleep apneas was modified to remove the additional requirement that the percent of central apneas/hypopneas is ≥ 50%. |
| Injectable – CD20-Directed Antibody – Gazyva for Non-Oncology Uses (IP0770) | New | **Effective 02/01/2026** |
| Oncology (Injectable – CAR-T) – Breyanzi (IP0130) | Updated | **Effective 02/01/2026**<br><br>Important changes in coverage criteria/policy:<br>**B-Cell Lymphoma**<br>**Added** dosing<br><br>**Chronic Lymphocytic Leukemia/Small Lymphocytic Lymphoma:** Added requirement patient has relapsed or refractory disease. In reference to trial of other therapies, changed wording from "patient has received" to "patient has tried" Bruton tyrosine kinase inhibitor or B-cell Lymphoma-2 (BCL-2) inhibitor. For BCL-2 inhibitor requirement, added new Note with examples of Venclexta containing regimens. For requirements referring to histologic transformation to diffuse large B-cell lymphoma, deleted "Patient has del(17p)/TP53 mutation positive disease". Added "Patient has disease progression on non-chemoimmunotherapy regimen" and included Note with examples. "Patient is chemotherapy refractory" has been modified to "Patient has refractory disease". "Patient is unable to receive chemoimmunotherapy" has been modified to "Patient has disease progression on chemoimmunotherapy". Updated dosing.<br><br>**Coding Information** |

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| | | **Removed** code effective date 1/1/25 from CPT codes: 38225 38226 38227 38228<br>**Removed** CPT codes: 0537T 0538T 0539T 0540T |
| Oncology (Injectable – CAR-T) – Aucatzyl - (IP0734) | Updated | **Effective 02/01/2026**<br>• No change in coverage. |
| Psychiatry – Spravato (IP0220) | Updated | **Effective 02/01/2026**<br><br>Important changes in coverage criteria/policy:<br>**Added** documentation instructions.<br><br>**Major Depressive Disorder with Acute Suicidal Ideation or Behavior:** Changed requirement that the medication was prescribed "by a psychiatrist" to "by or in consultation with a psychiatrist or a mental health provider".<br>**Removed** documentation requirements from: Patient has major depressive disorder that is considered to be severe, according to the prescriber<br>**Treatment-Resistant Depression:** Changed requirement that the medication was prescribed "by a psychiatrist" to "by or in consultation with a psychiatrist or a mental health provider".<br>**Removed** documentation requirements from: Each antidepressant was used at therapeutic dosages for at least 6 weeks in the current episode of depression, according to the prescriber<br><br>**Coding Information**<br>• **Added** HCPCS code J0013 with an effective date of 1/1/2026<br>• **Updated** the description for S0013 to include the note "Code effective until 12/31/2025" |
| Psychiatry – Zurzuvae - (IP0607) | Updated | **Effective 02/01/2026**<br>• No change in coverage. |
| **Precertification Policy Commercial** | **No Adds/ Updates** | **Comments:** No prior authorization adds or updates were made for the month of February. Prior authorization requirements are available on our websites, CignaforHCP.com and Cigna.com. |
| | New or Updated | • No updated in February 2026 |

| Reimbursement Policy | New, Updated, or Retired? | Comments |
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| | New or Updated | • No updated in February 2026 |
| **Other Coding and Reimbursement Documents** | **New, Updated, or Retired?** | **Comments** |
| | Updated | • Updates made |
| **ClaimsXten Documents** | **New, Updated or Retired?** | **ClaimsXten Documents** |
| | | • Updates made |