POLICY and FORMULARLY UPDATES

Clinical Policies

TITLE	STATUS	COMMENT
NEW POLICIES & POLICIES WITH SIGNIFICANT CONTENT CHANGES		
1. 226.0 Cranial Protective Helmets	NEW	
2. 227.0 Titanium Rib (VEPTR)	NEW	
3. 228.0 Intrauterine Fetal Surgery	NEW	
4. 229.0 Liposuction for Treatment of Lipedema & Lymphedema	NEW	
5. 230.0 Bone-Anchored Hearing Aids (BAHA) or Auditory Osseointegrated Implants (AOIs)	NEW	
6. 231.0 Corneal Collagen Cross-Linking	NEW	
7. 7.10 Cochlear Implants and Auditory Brain Stem Implants	REVISED	Added criteria for unilateral cochlear implantation coverage. Updated definition section.
8. 8.8 Genetic Testing	REVISED	Significant criteria added for coverage of HBOP (Hereditary Breast, Ovarian, Pancreatic & Prostate Cancers)
9. 11.20 Enteral Feeding/Nutrition Therapy	REVISED	Title change, other significant changes
10. 11.50 Erectile Dysfunction	REVISED	Significant changes
11. 14.8 Contact Lenses and Eye Glasses	REVISED	Title change, change in PA status, other significant changes
12. 15.13 Electrical and Ultrasound Bone Growth Stimulators: Indications	REVISED	Added definitions, added noncovered criteria to Ultrasound BGS
13. 22.19 Prophylactic Mastectomy	REVISED	Added definitions, updated coverage criteria to align with PH, added other types of mastectomy, added federal rights act
POLICIES WITH MINIMAL CONTENT CHANGES – QUICK REVIEW		
1. 11.31 Alternative & Complementary Medicine Exclusion	REVISED	Removed Acupuncture.
2. 12.11 Hospitalization for Ketogenic Diet in Treatment of Seizure Disorders	REVISED	Reorganization of original information, added experimental section
3. 13.10 Therapeutic Abortion	REVISED	Added definition
4. 15.17 Prosthetic Extremity, Accessories, & Supplies (PH 91306)	REVISED	Updated criteria re: repair & replacement. Title updated to denote PH policy.
5. 15.18 Extracorporeal Shock Wave Therapy (ESWT) (eg: Sonorex) for Various Orthopedic Disorders	REVISED	Added definition, removed extra content
6. 15.19 Artificial Intervertebral Disc Prosthesis	REVISED	Added minimal criteria
7. 17.7 Keloids/Hypertrophic Scars	REVISED	Added non-covered criteria, added coverage criteria
8. 17.8 Gynecomastia	REVISED	Added grading scale & coverage criteria
9. 17.9 Vitiligo Treatment	REVISED	Added coverage & non-covered criteria, change in PA status
10. 18.13 Obstructive Sleep Apnea (OSA): Treatments Other Than Continuous Positive Airway Pressure (CPAP)	REVISED	Hypoglossal Nerve Stimulator (HNS) added to procedure list, PSG s/p Implantable HNS criteria added, experimental section added,

		age for HNS in adolescents changed from 21 to 17
11. 22.17 Pectus Excavatum-Surgical Repair	REVISED	Minor additions to criteria
12. 23.16 Implantation of Autologous Chondrocytes (ACI), Matrix-Induced Chondrocyte Implantation (MACI), Autograft (OATS), Mosaicplasty, or Osteochondral Allograft for Cartilaginous Defects	REVISED	Addition of definition & classification, added criteria to IC.
13. 24.4 Urinary Catheters	REVISED	Added definition
14. 27.4 Cervical Traction Devices	REVISED	Changed PA status, definitions added
15. 30.6 Benign Prostatic Hyperplasia (BPH)	REVISED	Changed Urolift prostate volume from 80 to 100, added criteria and contraindications
16. 139.0 Orthopedic Surgical Procedures - Arthroscopy Surgery, Rotator Cuff Surgery, Arthroplasty, Neck Surgery and Spinal Surgery	REVISED	Removed “nicotine cessation is recommended” (item 1. G.).
17. 170.0 Electric Tumor Treating Fields	REVISED	Added additional criteria for concurrent use
18. 171.0 Skin & Soft Tissue Substitutes	REVISED	Added “AlloMax” to #1, removed “SimpliDerm” from #1, added criteria for “Grafix PRIME” under #3
19. 177.0 Sacral Nerve Stimulation (SNS) for Fecal Incontinence (FI) and Urinary Incontinence (UI)	REVISED	Changed wording
20. 178.0 Vagus Nerve Stimulation (VNS)-Epilepsy	REVISED	Added replacement criteria.
21. 184.0 Biomarker Testing	REVISED	Added criteria re: Pancreatic CA Biomaker testing.
22. 224.0 Radiofrequency Ablation	REVISED	Intraosseous Basivertebral Radiofrequency Nerve Ablation procedure added
POLICIES WITHOUT CONTENT CHANGES		
1. 4.4 Sclerotherapy Treatment		
2. 6.6 Insulin Pumps, External, and Glucose Monitoring Devices		
3. 15.3 Continuous Passive Motion (CPM) Device		
4. 15.22 Cooling Devices (Therapeutic Cold, Cryoanalgesia)		
5. 22.14 Mastectomy for Fibrocystic Disease		
6. 23.17 Transplants: Solid Organ and Stem Cell		
7. 27.4 Augmentative & Alternative Communication Devices / Speech Generating Devices		
8. 27.8 Enuresis Alarm		
9. 169.0 Actigraphy		
10. 172.0 Genicular Artery Embolization of Knee for OA		
11. 173.0 Osseointegration of Lower and Upper Limbs		
12. 174.0 Transanal Irrigation (TAI) for Patients with Neurogenic Bowel Dysfunction (NBD)		
13. 175.0 Facet Joint Injections		
14. 176.0 Obstructive Sleep Apnea Syndrome (OSAS) in Children		

POLICY and FORMULARLY UPDATES

Drug Policies

TITLE	STATUS	COMMENT
NEW POLICIES & POLICIES WITH SIGNIFICANT CONTENT CHANGES		
1. 233.0 Inflammatory Conditions-Tocilizumab Intravenous Products Med Rx Policy	NEW	
2. 234.0 Inflammatory Conditions – Ustekinumab Intravenous Products Med Rx Policy	NEW	***EFFECTIVE 08/01/2025***
3. 235.0 Proprotein Convertase Subtilisin Kexin Type 9 Related Products Med Rx Policy	NEW	
4. 236.0 Pulmonary Arterial Hypertension – Treprostinil Injection Med Rx Policy	NEW	
5. 237.0 Alpha1-Proteinase Inhibitor Products Utilization Management Medical Policy	NEW	
6. 44.0 PHP Med Rx Preferred Program	REVISED	Updated preferred & non-preferred products
7. 129.0 Inflammatory Conditions Exception Med Rx Policy	REVISED	Cimzia added to preferred for Juvenile Idiopathic Arthritis, Actemra IV and Tyenne IV removed from preferred products for RA and Juvenile Idiopathic Arthritis, trail of tocilizumab subcut removed from list
8. 132.0 Oncology (Injectable)-Bevacizumab Products Exception Med Rx Policy	REVISED	Alymsys to non-preferred, documentation requirement added for step through 2 preferred products, requirement of trial/failure of either Myasi or Zirabev revised
POLICIES WITH MINIMAL CONTENT CHANGES – QUICK REVIEW		
1. 10.12 Mozobil (Plerixafor Injection)	REVISED	Added criteria
2. 14.9 Voretigene neparvovec-rzyl (Luxturna)	REVISED	Added “pathogenic” language to I.B.
3. 31.0 Xiaflex (collagenase clostridium histolyticum)	REVISED	Changed contracture criteria for initiation of Xiaflex therapy
4. 32.0 Gene-Based Therapy for DMD (Amondys, Exondys, Viltepso, Exondys, and future therapies)	REVISED	Added “Elevidys”
5. 122.0 Colony Stimulating Factors – Filgrastim Products Exception Med Rx Policy	REVISED	Nypozi added to non-preferred list, exception criteria added
6. 123.0 Colony Stimulating Factors – Pegfilgrastim Products Exception Med Rx Policy	REVISED	Stimufend added to preferred products w/ exception criteria added, Nyyepria moved to non-preferred products & removed from exception criteria in preferred products
7. 135.0 Rituximab Products Exception Med Rx Policy	REVISED	Rituxan removed option of approval allowing continuation therapy
8. 167.0 Oncology (Injectable) – Trastuzumab Products Med Rx Policy	REVISED	Deleted continuation of therapy exception critera for Herceptin, Herzuma, Ontruzant, & Hercessi.
9. 168.0 Gonadotropin-Releasing Hormone Agonist-Central Precocious Puberty Med Rx Policy	REVISED	Supprelin LA & Lupron Depot-Ped moved to preferred, Fensolvi moved to non-preferred
10. 222.0 Oncology (Injectable) – Gonadotropin-Releasing Hormone Analogs Med Rx Policy	REVISED	Trelstar added "other conditions" in exception criteria for non-Prostate CA approval

PHP

POLICY and FORMULARLY UPDATES

RETIRED POLICIES
POLICIES WITHOUT CONTENT CHANGES
1. 9.9 Lutetium Lu 177 Dotatate (Lutathera)
2. 10.9 Arzerra (Ofatumaumab)
3. 11.27 Injectable Drug Treatment for Osteoporosis (Osteopenia), Chemotherapy Induced Bone Mineral Loss and Paget's Disease
4. 11.40 Implantable Testosterone Hormone Pellets
5. 11.53 Signifor and Signifor Lar
6. 33.0 Strensiq (Asofotase alfa)
7. 34.0 Evkeeza (evinacumab)
8. 42.0 Susvimo (ranibizumab intravitreal Injection via ocular implant)
9. 43.0 Enjaymo
10. 46.0 Amyloidosis-Onpattro Utilization Management Medical Policy
11. 47.0 Amyloidosis-Tegsedi Utilization Management Medical Policy
12. 53.0 Colony Stimulating Factors-Filgrastim Products Utilization Management Medical Policy
13. 54.0 Colony Stimulating Factors-Granix Utilization Management Medical Policy
14. 55.0 Colony Stimulating Factors-Pegfilgrastim Products Utilization Management Medical Policy
15. 56.0 Colony Stimulating Factors-Rolvedon Utilization Management Medical Policy
16. 57.0 Complement Inhibitors-Soliris Utilization Management Medical Policy
17. 59.0 Erythropoiesis-Stimulating Agents-Aranesp Utilization Management Medical Policy
18. 65.0 Gonadotropin-Releasing Hormone Agonist-Central Precocious Puberty Utilization Management Medical Policy
19. 66.0 Gonadotropin-Releasing Hormone Agonist-Injectable Long-Acting Products Utilization Management Medical Policy
20. 68.0 Hemophilia-Factor VIII Products Utilization Management Medical Policy
21. 70.0 Hepatology-Givlaari Utilization Management Medical Policy
22. 71.0 Hepatology-Panhematin Utilization Management Medical Policy
23. 72.0 Hyaluronic Acid Derivatives Intraarticular Utilization Management Medical Policy
24. 73.0 Immune Globulin Subcutaneous Utilization Management Medical Policy
25. 77.0 Immunologicals-Tezspire Utilization Management Medical Policy
26. 78.0 Immunologicals-Xolair Utilization Management Medical Policy
27. 79.0 Inflammatory Conditions-Actemra Intravenous Utilization Management Medical Policy
28. 88.0 Iron Replacement-Feraheme Utilization Management Medical Policy
29. 89.0 Iron Replacement-Ferrlecit Utilization Management Medical Policy
30. 90.0 Iron Replacement-INFeD Utilization Management Medical Policy
31. 91.0 Iron Replacement-Injectafer Utilization Management Medical Policy
32. 92.0 Iron Replacement-Monoferric Utilization Management Medical Policy
33. 93.0 Iron Replacement-Venofer Utilization Management Medical Policy
34. 95.0 Lupus-Saphnelo Utilization Management Medical Policy
35. 97.0 Metabolic Disorders-Oxlumo Utilization Management Medical Policy
36. 98.0 Multiple Sclerosis-Lemtrada Utilization Management Medical Policy
37. 99.0 Multiple Sclerosis-Ocrevus Utilization Management Medical Policy
38. 103.0 Oncology (Injectable)-Bevacizumab Products Utilization Management Medical Policy
39. 104.0 Oncology (Injectable)-Herceptin Hylecta Utilization Management Medical Policy
40. 106.0 Oncology (Injectable)-Rituxan Hycela Utilization Management Medical Policy

41. 108.0 Ophthalmology-Vascular Endothelial Growth Factor Inhibitors-Beovu Utilization Management Medical Policy
42. 109.0 Ophthalmology-Vascular Endothelial Growth Factor Inhibitors-Eylea Utilization Management Medical Policy
43. 110.0 Ophthalmology-Vascular Endothelial Growth Factor Inhibitors-Ranibizumab Products Utilization Management Medical Policy
44. 117.0 Spinal Muscular Atrophy-Zolgensma Utilization Management Medical Policy
45. 119.0 Ophthalmology-Vascular Endothelial Growth Factor Inhibitors-Vabysmo Utilization Management Medical Policy
46. 124.0 Erythropoiesis Stimulating Agents Exception Med Rx Policy
47. 131.0 Lupus Exception Med Rx Policy
48. 152.0 Amyloidosis-Wainua Utilization Management Medical Policy
49. 153.0 Colony Stimulating Factors-Ryzneuta Utilization Management Medical Policy
50. 154.0 Dermatology-Ycanth Utilization Management Medical Policy
51. 156.0 Gonadotropin-Releasing Hormone Agonist-Implants Utilization Management Medical Policy
52. 158.0 Hematology-Gene Therapy-Lyfgenia Utilization Management Medical Policy
53. 163.0 Metabolic Disorders-Primary Hyperoxaluria Medications-Rivfloza Utilization Management Medical Policy
54. 164.0 Multiple Sclerosis-Briumvi Utilization Management Medical Policy
55. 166.0 Inflammatory Conditions-Stelara Subcutaneous Prior Authorization Policy with Dosing
56. 179.0 Ophthalmology-Growth Factor Inhibitor-Tepezza (teprotumumab-trbw)

Pharmacy Drug Changes

Drug (brand)	Generic	Alternatives	Prior Authorization Status
Alhemo 60mg/1.5mL, 150mg/1.5mL, 300mg/3mL Pens	Concizumab-mtci	Hemlibra	Prior Authorization required
Alyftrek 4-20-50mg, 10-50-125 mg tab	Vanzacaftor/tezacaf/deutivacaf	Trikifta	Prior Authorization required
Attruby 356mg tab	Acoramidis HCl	Vyndamax, Vyndaqel	Prior Authorization required
Crenessity 50mg/mL solution, 50mg, 100mg cap	Crinecerfont		Prior Authorization required
Ctexli 250mg tab	Chenodiol	Chenodal	Prior Authorization required
Emrosi ER 40mg cap	Minocycline HCl	Azelaic Acid, Doxycycline IR-DR, Ivermectin, Metronidazole, Minocycline	Contract exclusion: Extended Release Tetracyclines Non-Covered
Revuforj 110mg, 160mg tab	Revumenib citrate		Prior Authorization required
Romvimza 14mg, 20mg, 30mg cap	Vimseltinib		Prior Authorization required
Trynogolza 80mg/0.8mL autoinjector	Olezarsen sodium		Prior Authorization required
Vimkunya 40mcg/0.8 syringe	Chikungunya vaccine, recomb/pf		Plan exclusion: Travel Vaccines Non-Covered