

UnitedHealthcare Community Plan Medical Policy Update Bulletin: January 2026

In This Issue

Take Note

	Page
• Implementation Delay: Remote Physiologic Monitoring (RPM)	3
• Implementation of Revisions Postponed: Computer-Assisted Surgical Navigation for Musculoskeletal Procedures	3
• Annual HCPCS Code Updates.....	3

Medical Policy Updates

Updated

• Interspinous Fusion and Decompression Devices – Effective Jan. 1, 2026	4
• Liposuction for Lipedema – Effective Jan. 1, 2026.....	4
• Pharmacogenetic Panel Testing – Effective Jan. 1, 2026	4
• Surgery of the Hip – Effective Mar. 1, 2026	4

Revised

• Enteral Nutrition (Oral and Tube Feeding) – Effective Mar. 1, 2026	5
• FDA Cleared or Approved Companion Diagnostic Testing – Effective Mar. 1, 2026.....	6
• Total Artificial Disc Replacement for the Spine – Effective Mar. 1, 2026.....	18

Retired

• Electrical Stimulation for Wounds – Effective Jan. 1, 2026.....	24
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Medical Benefit Drug Policy Updates

New

• Gazyva® (Obinutuzumab) – Effective Feb. 1, 2026.....	25
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Updated

• FcRn Blockers (Rystiggo®, Vyvgart®, & Vyvgart Hytrulo®) – Effective Jan. 1, 2026.....	25
• Subcutaneous Implantable Naltrexone Pellets – Effective Jan. 1, 2026	26
• Uplizna® (Inebilizumab-Cdon) – Effective Jan. 1, 2026.....	26

In This Issue

Revised

• Cimzia [®] (Certolizumab Pegol) – Effective Feb. 1, 2026	26
• Infliximab – Effective Feb. 1, 2026.....	32
• Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer’s Disease – Effective Feb. 1, 2026.....	41
• Ocrevus [®] (Ocrelizumab) and Ocrevus Zunovo [®] (Ocrelizumab and Hyaluronidase-Ocsq) – Effective Feb. 1, 2026.....	47
• Respiratory Interleukins (Cinqair [®] , Fasentra [®] , & Nucala [®]) – Effective Feb. 1, 2026.....	49
• Tezspire [®] (Tezepelumab-Ekko) – Effective Feb. 1, 2026	50

Take Note

Implementation Delay: Remote Physiologic Monitoring (RPM)

The Medical Policy titled *Remote Physiologic Monitoring (RPM)* will not be effective on Jan. 1, 2026, as previously announced; implementation of the new policy has been postponed until further notice.

Implementation of Revisions Postponed: Computer-Assisted Surgical Navigation for Musculoskeletal Procedures

The Medical Policy titled *Computer-Assisted Surgical Navigation for Musculoskeletal Procedures* will not be revised on Feb. 1, 2026, as previously announced. Details on upcoming changes to this policy will be provided in a future edition of the Medical Policy Update Bulletin.

Annual HCPCS Code Updates

Effective **Jan. 1, 2026**, all applicable Medical Benefit Drug Policies will be updated to reflect the 2026 Current Healthcare Common Procedure Coding System (HCPCS) code additions and deletions. Refer to the Centers for Medicare & Medicaid Services: Healthcare Common Procedure Coding System (HCPCS) Quarterly Update for information on the code updates.

Policy Title	Summary of Changes
Denied Drug Codes – Pharmacy Benefit Drugs (for Arizona Only)	<ul style="list-style-type: none"> Added HCPCS code J3387 Removed HCPCS code J0205
FcRn Blockers (Rystiggo [®] , Vyvgart [®] , & Vyvgart Hytrulo [®])	<ul style="list-style-type: none"> Added HCPCS code J9256 Removed HCPCS code C9305
Ketalar [®] (Ketamine) and Spravato [®] (Esketamine)	<ul style="list-style-type: none"> Added HCPCS code J0013 Removed HCPCS code S0013
Maximum Dosage and Frequency	<ul style="list-style-type: none"> Added HCPCS code J1073 Removed HCPCS code S0189
Oncology Medication Clinical Coverage	<ul style="list-style-type: none"> Added HCPCS code J9184
Testosterone Replacement or Supplementation Therapy	<ul style="list-style-type: none"> Added HCPCS code J1073 Removed HCPCS code S0189

Medical Policy Updates

Updated		
Policy Title	Effective Date	Summary of Changes
Interspinous Fusion and Decompression Devices	Jan. 1, 2026	<p>Medical Records Documentation Used for Reviews</p> <ul style="list-style-type: none"> Updated list of Medical Records Documentation Used for Reviews: <ul style="list-style-type: none"> Added “physician treatment plan, including device type and level” Removed “describe the surgical technique(s) planned, including name of interspinous bony fusion device requested and use of an interbody cage” <p>Definitions</p> <ul style="list-style-type: none"> Updated definition of: <ul style="list-style-type: none"> Arthrodesis Interlaminar Lumbar Instrumented Fusion (ILIF) Interlaminar Stabilization Device Neurogenic Claudication <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information
Liposuction for Lipedema	Jan. 1, 2026	<p>Medical Records Documentation Used for Reviews</p> <ul style="list-style-type: none"> Updated list of Medical Records Documentation Used for Reviews; replaced “upon request we may require high-quality color photographs” with “upon request we may require high-quality color photographs <i>that include the transition points</i>” <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information
Pharmacogenetic Panel Testing	Jan. 1, 2026	<p>Definitions</p> <ul style="list-style-type: none"> Updated definition of “Multi-Gene Panel” <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Description of Services</i>, <i>Clinical Evidence</i>, <i>FDA</i>, and <i>References</i> sections to reflect the most current information
Surgery of the Hip	Mar. 1, 2026	<p>Applicable Codes</p> <p>Femoroacetabular Impingement (FAI) Syndrome</p> <ul style="list-style-type: none"> Revised description for CPT codes 27299 and 29999 <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Enteral Nutrition (Oral and Tube Feeding)	Mar. 1, 2026	<p>Coverage Rationale Enteral Nutrition by Tube Feeding</p> <ul style="list-style-type: none"> Replaced language indicating “enteral nutrition administered by tube feeding (e.g., nasogastric, gastrostomy, or jejunostomy tube) is medically necessary in certain circumstances” with “enteral nutrition (<i>standard or Specialized Nutrient Formula</i>) administered by tube feeding (e.g., nasogastric, gastrostomy, or jejunostomy tube) is medically necessary in certain circumstances” Added notation to indicate standard formula may be considered medically necessary when used for tube feeding because standard foods cannot be administered through a tube 	<p>Enteral Nutrition by Tube Feeding</p> <p>Enteral nutrition (standard or Specialized Nutrient Formula) administered by tube feeding (e.g., nasogastric, gastrostomy, or jejunostomy tube) is medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Durable Medical Equipment, Enteral and Parenteral Nutrition Therapy.</p> <p>Click here to view the InterQual® criteria.</p> <p>Note: When used for tube feeding, standard formula may be considered medically necessary because standard foods cannot be administered through a tube.</p> <p>Oral Nutrition</p> <p>Specialized Nutrient Formula administered orally, as a primary or supplementary source of nutrition, is considered medically necessary when all of the following criteria are met:</p> <ul style="list-style-type: none"> A physician, advanced practitioner (NP, CNS, or PA), or registered dietician prescribes the therapy; and The condition is chronic and is expected to last for an undetermined or prolonged period of time; and Adequate nutrition is not possible by dietary adjustment; and The formula used is a Medical Food that is specially formulated for a specific condition; and The individual has one of the following conditions: <ul style="list-style-type: none"> Inborn Errors of Metabolism such as phenylketonuria (PKU), maple syrup urine disease, homocystinuria, methylmalonic acidemia, propionic acidemia, isovaleric acidemia, and other disorders of leucine metabolism; glutaric aciduria type I and tyrosinemia types I and II; or urea cycle disorders; or Chronic kidney disease (CKD) stages 2 to 5 (or on dialysis) for individuals ages less than 24 months; or Crohn's disease; or Severe malabsorption syndrome (such as cystic fibrosis, short bowel syndrome, or intestinal failure); or Malnutrition or individual will become malnourished or suffer from

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Enteral Nutrition (Oral and Tube Feeding) (continued)	Mar. 1, 2026		<p>severe disorders such as physical disability, Intellectual Disability, or death if the nutritional therapy is not instituted; or</p> <ul style="list-style-type: none"> ○ Severe food allergies, including eosinophilic esophagitis, other forms of eosinophilic gastrointestinal diseases, food protein-induced allergic proctocolitis (FPIAP), and food protein-induced enterocolitis syndrome (FPIES) which, if left untreated, will cause life-threatening allergic reactions, malnourishment, or death (mild and moderate food allergies or food intolerance can usually be treated with formula that is readily available in food stores and pharmacies, or by careful food selection; formulas for the treatment of such conditions are not considered medically necessary); or ○ Gastroesophageal reflux with failure to thrive (in children) <p>Note: Refer to the <i>Benefit Considerations</i> section of the policy for additional information on coverage limitations and exclusions.</p>
FDA Cleared or Approved Companion Diagnostic Testing	Mar. 1, 2026	<p>Related Policies</p> <ul style="list-style-type: none"> ● Added reference link to the Medical Policy titled <i>Oncology Medication Clinical Coverage</i> <p>Coverage Rationale</p> <ul style="list-style-type: none"> ● Revised language to indicate: <ul style="list-style-type: none"> ○ This policy applies to tests that have been granted approval as FDA cleared or approved Companion Diagnostic (CDx) tests ○ FoundationOne® CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings: <ul style="list-style-type: none"> ▪ Breast cancer <ul style="list-style-type: none"> – Herceptin® (trastuzumab) – Kadcyła® (ado-trastuzumab) 	<p>This policy applies to tests that have been granted approval as FDA cleared or approved Companion Diagnostic (CDx) tests.</p> <p>FoundationOne® CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings:</p> <ul style="list-style-type: none"> ● Breast cancer <ul style="list-style-type: none"> ○ Herceptin® (trastuzumab) ○ Kadcyła® (ado-trastuzumab emtansine) ○ Perjeta® (pertuzumab) ○ Piqray® (alpelisib) ○ Truqap® (capivasertib) in combination with Faslodex® (fulvestrant) ● Cholangiocarcinoma <ul style="list-style-type: none"> ○ Pemazyre® (pemigatinib) ● Colorectal cancer <ul style="list-style-type: none"> ○ Erbitux® (cetuximab) ○ Vectibix® (panitumumab) ● Glioma (low-grade) <ul style="list-style-type: none"> ○ Ojmeda® (tovorafenib) ● Melanoma <ul style="list-style-type: none"> ○ Mekinist® (trametinib) ○ Tafinlar® (dabrafenib) ○ Tecentriq® (atezolizumab) in combination with Cotellic® (cobimetinib)

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Mar. 1, 2026	<ul style="list-style-type: none"> – emtansine) – Perjeta® (pertuzumab) – Piqray® (alpelisib) – Truqap® (capivasertib) in combination with Faslodex® (fulvestrant) ▪ Cholangiocarcinoma <ul style="list-style-type: none"> – Pemazyre® (pemigatinib) ▪ Colorectal cancer <ul style="list-style-type: none"> – Erbitux® (cetuximab) – Vectibix® (panitumumab) ▪ Glioma (low-grade) <ul style="list-style-type: none"> – Ojmeda® (tovorafenib) ▪ Melanoma <ul style="list-style-type: none"> – Mekinist® (trametinib) – Tafinlar® (dabrafenib) – Tecentriq® (atezolizumab) in combination with Cotellic® (cobimetinib) and Zelboraf® (vemurafenib) – Zelboraf® (vemurafenib) ▪ Non-small cell lung cancer (NSCLC) <ul style="list-style-type: none"> – Alecensa® (alectinib) – Braftovi® (encorafenib) in combination with 	<ul style="list-style-type: none"> and Zelboraf® (vemurafenib) ○ Zelboraf® (vemurafenib) • Non-small cell lung cancer (NSCLC) <ul style="list-style-type: none"> ○ Alecensa® (alectinib) ○ Braftovi® (encorafenib) in combination with Mektovi® (binimetinib) ○ Gilotrif® (afatinib) ○ Iressa® (gefitinib) ○ Lazcluze® (lazertinib) in combination with Rybrevant® (amivantamab) ○ Tabrecta® (capmatinib) ○ Tafinlar® (dabrafenib) in combination with Mekinist® (trametinib) ○ Tagrisso® (osimertinib) ○ Tarceva® (erlotinib) ○ Vizimpro® (dacomitinib) ○ Xalkori® (crizotinib) ○ Zykadia® (ceritinib) • Ovarian cancer <ul style="list-style-type: none"> ○ Lynparza® (olaparib) • Prostate cancer (metastatic castration-resistant) <ul style="list-style-type: none"> ○ Akeega® (niraparib and abiraterone acetate) ○ Lynparza® (olaparib) • Solid tumors <ul style="list-style-type: none"> ○ Keytruda® (pembrolizumab) ○ Retevmo® (selpercatinib) ○ Rozlytrek® (entrectinib) ○ Vitrakvi® (larotrectinib) <p>FoundationOne® Liquid CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings:</p> <ul style="list-style-type: none"> • Breast cancer <ul style="list-style-type: none"> ○ Itovebi® in combination with Ibrance® (palbociclib) and Faslodex® (fulvestrant) ○ Piqray® (alpelisib) • Colorectal cancer (metastatic) <ul style="list-style-type: none"> ○ Braftovi® (encorafenib) in combination with Erbitux® (cetuximab) • Non-small cell lung cancer (NSCLC) <ul style="list-style-type: none"> ○ Alecensa® (alectinib)

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Mar. 1, 2026	<ul style="list-style-type: none"> – Mektovi[®] (binimetinib) – Gilotrif[®] (afatinib) – Iressa[®] (gefitinib) – Lazcluze[®] (lazertinib) in combination with Rybrevant[®] (amivantamab) – Tabrecta[®] (capmatinib) – Tafinlar[®] (dabrafenib) in combination with Mekinist[®] (trametinib) – Tagrisso[®] (osimertinib) – Tarceva[®] (erlotinib) – Vizimpro[®] (dacomitinib) – Xalkori[®] (crizotinib) – Zykadia[®] (ceritinib) ▪ Ovarian cancer <ul style="list-style-type: none"> – Lynparza[®] (olaparib) ▪ Prostate cancer (metastatic castration-resistant) <ul style="list-style-type: none"> – Akeega[®] (niraparib and abiraterone acetate) – Lynparza[®] (olaparib) ▪ Solid tumors <ul style="list-style-type: none"> – Keytruda[®] (pembrolizumab) – Retevmo[®] (selpercatinib) – Rozlytrek[®] (entrectinib) – Vitrakvi[®] (larotrectinib) 	<ul style="list-style-type: none"> ○ Braftovi[®] (encorafenib) in combination with Mektovi[®] (binimetinib) ○ Iressa[®] (gefitinib) ○ Lazcluze[®] (lazertinib) in combination with Rybrevant[®] (amivantamab) ○ Tabrecta[®] (capmatinib) ○ Tagrisso[®] (osimertinib) ○ Tarceva[®] (erlotinib) ○ Tepmetko[®] (tepotinib) ● Prostate cancer (metastatic castration-resistant) <ul style="list-style-type: none"> ○ Akeega[®] (niraparib and abiraterone acetate) ○ Lynparza[®] (olaparib) ○ Rubraca[®] (rucaparib) ● Solid tumors <ul style="list-style-type: none"> ○ Rozlytrek[®] (entrectinib) <p>Guardant360[®] CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings:</p> <ul style="list-style-type: none"> ● Breast cancer <ul style="list-style-type: none"> ○ Orserdu[®] (elacestrant) ● Non-small cell lung cancer (NSCLC) <ul style="list-style-type: none"> ○ Enhertu[®] (fam-trastuzumab deruxtecan-nxki) ○ Lumakras[®] (sotorasib) ○ Rybrevant[®] (amivantamb) ○ Tagrisso[®] (osimertinib) <p>MI Cancer Seek[™] is proven and medically necessary when used to inform management of any of the following indication/drug pairings:</p> <ul style="list-style-type: none"> ● Breast cancer <ul style="list-style-type: none"> ○ Piqray[®] (alpelisib) ● Colorectal cancer <ul style="list-style-type: none"> ○ Braftovi[®] (encorafenib) in combination with Erbitux[®] (cetuximab) ○ Vectibix[®] (panitumumab) ● Melanoma <ul style="list-style-type: none"> ○ Braftovi[®] (encorafenib) in combination with Mektovi[®] (binimetinib) ○ Cotellic[®] (cobimetinib) in combination with Zelboraf[®] (vemurafenib) ○ Mekinist[®] (trametinib) ○ Tafinlar[®] (dabrafenib) ○ Zelboraf[®] (vemurafenib)

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Mar. 1, 2026	<ul style="list-style-type: none"> ○ FoundationOne[®] Liquid CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings: <ul style="list-style-type: none"> ▪ Breast cancer <ul style="list-style-type: none"> – Itovebi[®] in combination with Ibrance[®] (palbociclib) and Faslodex[®] (fulvestrant) – Piqray[®] (alpelisib) ▪ Colorectal cancer (metastatic) <ul style="list-style-type: none"> – Braftovi[®] (encorafenib) in combination with Erbitux[®] (cetuximab) ▪ Non-small cell lung cancer (NSCLC) <ul style="list-style-type: none"> – Alecensa[®] (alectinib) – Braftovi[®] (encorafenib) in combination with Mektovi[®] (binimetinib) – Iressa[®] (gefitinib) – Lazcluze[®] (lazertinib) in combination with Rybrevant[®] (amivantamab) – Tabrecta[®] (capmatinib) – Tagrisso[®] (osimertinib) – Tarceva[®] (erlotinib) – Tepmetko[®] (tepotinib) 	<ul style="list-style-type: none"> ● Non-small cell lung cancer (NSCLC) <ul style="list-style-type: none"> ○ Gilotrif[®] (afatinib) ○ Iressa[®] (gefitinib) ○ Lazcluze[®] (lazertinib) in combination with Rybrevant[®] (amivantamab) ○ Tagrisso[®] (osimertinib) ○ Tarceva[®] (erlotinib) ○ Vizimpro[®] (dacomitinib) ● Solid tumors <ul style="list-style-type: none"> ○ Jemperli[®] (dostarlimab-gxly) ○ Keytruda[®] (pembrolizumab) <p>Oncomine[™] Dx Express Test is proven and medically necessary when used to inform management of NSCLC with Zegfrovy[®] (sunvozertinib).</p> <p>Oncomine[™] Dx Target Test is proven and medically necessary when used to inform management of any of the following indication/drug pairings:</p> <ul style="list-style-type: none"> ● Astrocytoma <ul style="list-style-type: none"> ○ Voranigo[®] (vorasidenib) ● Cholangiocarcinoma <ul style="list-style-type: none"> ○ Tibsovo[®] (ivosidenib) ● Non-small cell lung cancer (NSCLC) <ul style="list-style-type: none"> ○ Enhertu[®] (fam-trastuzumab deruxtecan-nxki) ○ Gavreto[®] (pralsetinib) ○ Hernexeos[®] (zongertinib) ○ Iressa[®] (gefitinib) ○ Retevmo[®] (selpercatinib) ○ Rybrevant[®] (amivantamb) ○ Tafinlar[®] (dabrafenib) ○ Xalkori[®] (crizotinib) ● Oligodendroglioma <ul style="list-style-type: none"> ○ Voranigo[®] (vorasidenib) ● Thyroid cancer, anaplastic <ul style="list-style-type: none"> ○ Tafinlar[®] (dabrafenib) in combination with Mekinist[®] (trametinib) ● Thyroid cancer, medullary <ul style="list-style-type: none"> ○ Retevmo[®] (selpercatinib)

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Mar. 1, 2026	<ul style="list-style-type: none"> ▪ Prostate cancer (metastatic castration-resistant) <ul style="list-style-type: none"> – Akeega® (niraparib and abiraterone acetate) – Lynparza® (olaparib) – Rubraca® (rucaparib) ▪ Solid tumors <ul style="list-style-type: none"> – Rozlytrek® (entrectinib) ○ Guardant360® CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings: <ul style="list-style-type: none"> ▪ Breast cancer <ul style="list-style-type: none"> – Orserdu® (elacestrant) ▪ Non-small cell lung cancer (NSCLC) <ul style="list-style-type: none"> – Enhertu® (fam-trastuzumab deruxtecan-nxki) – Lumakras® (sotorasib) – Rybrevant® (amivantamb) – Tagrisso® (osimertinib) ○ MI Cancer Seek™ is proven and medically necessary when used to inform management of any of the following indication/drug pairings: 	<p>oncoReveal™ CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings:</p> <ul style="list-style-type: none"> • Colorectal cancer <ul style="list-style-type: none"> ○ Erbitux® (cetuximab) ○ Vectibix® (panitumumab) • Non-small cell lung cancer (NSCLC) <ul style="list-style-type: none"> ○ Gilotrif® (afatinib) ○ Iressa® (gefitinib) ○ Lazcluze® (lazertinib) in combination with Rybrevant® (amivantamb) ○ Tagrisso® (osimertinib) ○ Tarceva® (erlotinib) ○ Vizimpro® (dacomitinib) <p>TruSight™ Oncology Comprehensive is proven and medically necessary when used to inform management of any of the following indication/drug pairings:</p> <ul style="list-style-type: none"> • Non-small cell lung cancer (NSCLC) <ul style="list-style-type: none"> ○ Retevmo® (selpercatinib) • Solid tumors <ul style="list-style-type: none"> ○ Vitrakvi® (larotrectinib) <p>xT CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings:</p> <ul style="list-style-type: none"> • Colorectal cancer <ul style="list-style-type: none"> ○ Erbitux® (cetuximab) ○ Vectibix® (panitumumab) <p>FDA cleared or approved CDx tests not listed above or used for indication/drug pairings not listed above are proven and medically necessary when both of the following criteria are met:</p> <ul style="list-style-type: none"> • The test results will be used to inform the use of a targeted oncology therapeutic product or group of products in an individual with the corresponding clinical indication; and • One of the following: <ul style="list-style-type: none"> ○ The test appears in the U.S. Food and Drug Administration (FDA)'s Cleared or Approved Companion Diagnostic Devices Table for use with the intended targeted therapeutic product and clinical indication;

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Mar. 1, 2026	<ul style="list-style-type: none"> ▪ Breast cancer <ul style="list-style-type: none"> – Piqray® (alpelisib) ▪ Colorectal cancer <ul style="list-style-type: none"> – Braftovi® (encorafenib) in combination with Erbitux® (cetuximab) – Vectibix® (panitumumab) ▪ Melanoma <ul style="list-style-type: none"> – Braftovi® (encorafenib) in combination with Mektovi® (binimetinib) – Cotellic® (cobimetinib) in combination with Zelboraf® (vemurafenib) – Mekinist® (trametinib) – Tafinlar® (dabrafenib) – Zelboraf® (vemurafenib) ▪ Non-small cell lung cancer (NSCLC) <ul style="list-style-type: none"> – Gilotrif® (afatinib) – Iressa® (gefitinib) – Lazcluze® (lazertinib) in combination with Rybrevant® (amivantamab) – Tagrisso® (osimertinib) – Tarceva® (erlotinib) – Vizimpro® (dacomitinib) ▪ Solid tumors 	<p>or</p> <ul style="list-style-type: none"> ○ The test has an approval order designating it as an FDA cleared or approved CDx test for use with the intended targeted therapeutic product and clinical indication in the FDA Premarket Approval Database, but the approval does not yet appear in the U.S. Food and Drug Administration (FDA)'s Cleared or Approved Companion Diagnostic Devices Table <p>Subsequent use of an FDA cleared or approved CDx test on a new specimen for the purpose of assisting with therapy selection is considered proven and medically necessary when both of the following criteria are met:</p> <ul style="list-style-type: none"> • The criteria above for the CDx test are met; and • One of the following: <ul style="list-style-type: none"> ○ The individual is experiencing disease recurrence; or ○ The individual's cancer has progressed or did not respond to the most recent systemic therapy <p>Concurrent Testing using an FDA cleared or approved tissue-based CDx test and a Liquid Biopsy-based CDx test is considered proven and medically necessary for the following cancer types when the criteria above for the CDx test are met:</p> <ul style="list-style-type: none"> • Advanced or metastatic (stage IV) breast cancer • Advanced or metastatic (stage IV) NSCLC <p>Due to insufficient evidence of efficacy, all other uses of the above FDA cleared or approved CDx tests are unproven and not medically necessary.</p> <p>Note: For molecular oncology tests that have not been cleared or approved by the FDA as CDx tests, refer to the Medical Policy titled Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions or Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions.</p>

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Mar. 1, 2026	<ul style="list-style-type: none"> – Jemperli[®] (dostarlimab-gxly) – Keytruda[®] (pembrolizumab) ○ Oncomine[™] Dx Express Test is proven and medically necessary when used to inform management of NSCLC with Zegfrovy[®] (sunvozertinib) ○ Oncomine[™] Dx Target Test is proven and medically necessary when used to inform management of any of the following indication/drug pairings: <ul style="list-style-type: none"> ▪ Astrocytoma <ul style="list-style-type: none"> – Voranigo[®] (vorasidenib) ▪ Cholangiocarcinoma <ul style="list-style-type: none"> – Tibsovo[®] (ivosidenib) ▪ Non-small cell lung cancer (NSCLC) <ul style="list-style-type: none"> – Enhertu[®] (fam-trastuzumab deruxtecan-nxki) – Gavreto[®] (pralsetinib) – Hernexeos[®] (zongertinib) – Iressa[®] (gefitinib) – Retevmo[®] (selpercatinib) – Rybrevant[®] (amivantamb) – Tafinlar[®] (dabrafenib) – Xalkori[®] (crizotinib) ▪ Oligodendroglioma 	

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Mar. 1, 2026	<ul style="list-style-type: none"> – Voranigo[®] (vorasidenib) ▪ Thyroid cancer, anaplastic <ul style="list-style-type: none"> – Tafinlar[®] (dabrafenib) in combination with Mekinist[®] (trametinib) ▪ Thyroid cancer, medullary <ul style="list-style-type: none"> – Retevmo[®] (selpercatinib) ○ oncoReveal[™] CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings: <ul style="list-style-type: none"> ▪ Colorectal cancer <ul style="list-style-type: none"> – Erbitux[®] (cetuximab) – Vectibix[®] (panitumumab) ▪ Non-small cell lung cancer (NSCLC) <ul style="list-style-type: none"> – Gilotrif[®] (afatinib) – Iressa[®] (gefitinib) – Lazcluze[®] (lazertinib) in combination with Rybrevant[®] (amivantamab) – Tagrisso[®] (osimertinib) – Tarceva[®] (erlotinib) – Vizimpro[®] (dacomitinib) ○ TruSight[™] Oncology Comprehensive is proven and medically necessary when 	

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Mar. 1, 2026	<ul style="list-style-type: none"> used to inform management of any of the following indication/drug pairings: <ul style="list-style-type: none"> ▪ Non-small cell lung cancer (NSCLC) <ul style="list-style-type: none"> – Retevmo[®] (selpercatinib) ▪ Solid tumors <ul style="list-style-type: none"> – Vitrakvi[®] (larotrectinib) ○ xT CDx is proven and medically necessary when used to inform management of any of the following indication/drug pairings: <ul style="list-style-type: none"> ▪ Colorectal cancer <ul style="list-style-type: none"> – Erbitux[®] (cetuximab) – Vectibix[®] (panitumumab) ○ FDA cleared or approved CDx tests not listed above or used for indication/drug pairings not listed above are proven and medically necessary when both of the following criteria are met: <ul style="list-style-type: none"> ▪ The test results will be used to inform the use of a targeted oncology therapeutic product or group of products in an individual with the corresponding clinical indication ▪ One of the following: <ul style="list-style-type: none"> – The test appears in the <i>U.S. Food and</i> 	

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Mar. 1, 2026	<p><i>Drug Administration (FDA)'s Cleared or Approved Companion Diagnostic Devices Table</i> for use with the intended targeted therapeutic product and clinical indication</p> <ul style="list-style-type: none"> – The test has an approval order designating it as an FDA cleared or approved CDx test for use with the intended targeted therapeutic product and clinical indication in the FDA Premarket Approval Database, but the approval does not yet appear in the <i>U.S. Food and Drug Administration (FDA)'s Cleared or Approved Companion Diagnostic Devices Table</i> ○ Subsequent use of an FDA cleared or approved CDx test on a new specimen for the purpose of assisting with therapy selection is considered proven and medically necessary when both of the following criteria are met: <ul style="list-style-type: none"> ▪ The criteria above for the 	

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Mar. 1, 2026	<ul style="list-style-type: none"> CDx test are met <ul style="list-style-type: none"> ▪ One of the following: <ul style="list-style-type: none"> – The individual is experiencing disease recurrence; or – The individual's cancer has progressed or did not respond to the most recent systemic therapy ○ Concurrent Testing using an FDA Cleared or Approved tissue-based CDx test and a Liquid Biopsy-based CDx test is considered proven and medically necessary for the following cancer types when the criteria above for the CDx test are met: <ul style="list-style-type: none"> ▪ Advanced or metastatic (stage IV) breast cancer ▪ Advanced or metastatic (stage IV) NSCLC ○ Due to insufficient evidence of efficacy, all other uses of the above FDA cleared or approved CDx tests are unproven and not medically necessary ○ For molecular oncology tests that have not been cleared or approved by the FDA as CDx tests, refer to the Medical Policy titled <i>Molecular Oncology Testing for Solid Tumor Cancer Diagnosis</i>, 	

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Mar. 1, 2026	<p><i>Prognosis, and Treatment Decisions or Molecular Oncology Testing for Hematologic Cancer Diagnosis, Prognosis, and Treatment Decisions</i></p> <p>Medical Records Documentation Used for Reviews</p> <ul style="list-style-type: none"> • Updated list of Medical Records Documentation Used for Reviews: <ul style="list-style-type: none"> ○ Added “disease response to most recent systemic therapy and/or disease recurrence or progression, if applicable” ○ Removed “line of therapy being considered” ○ Replaced “results of prior Companion Diagnostic Testing comprehensive genomic profiling, if applicable” with “results <i>and dates</i> of prior Companion Diagnostic Testing <i>and/or</i> comprehensive genomic profiling, if applicable” <p>Definitions</p> <ul style="list-style-type: none"> • Added definition of “Concurrent Testing” • Removed definition of: <ul style="list-style-type: none"> ○ Comprehensive Genomic Profiling (CGP) ○ Next Generation Sequencing (NGS) • Updated definition of: <ul style="list-style-type: none"> ○ Advanced Cancer ○ Companion Diagnostic ○ Liquid Biopsy 	

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FDA Cleared or Approved Companion Diagnostic Testing (continued)	Mar. 1, 2026	<p>Applicable Codes</p> <ul style="list-style-type: none"> Added CPT codes 0211U and 0523U Removed CPT codes 0179U, 81445, 81449, 81450, 81451, 81455, 81456, and 81599 <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Description of Services</i>, <i>Clinical Evidence</i>, and <i>References</i> sections to reflect the most current information 	
Total Artificial Disc Replacement for the Spine	Mar. 1, 2026	<p>Coverage Rationale</p> <ul style="list-style-type: none"> Revised language to indicate: <ul style="list-style-type: none"> Cervical <ul style="list-style-type: none"> Cervical total artificial disc replacement (TADR) is proven and medically necessary when all of the following are present and InterQual® criteria are met: <ul style="list-style-type: none"> An FDA-approved prosthetic intervertebral disc is utilized Individual diagnosed with only one or two Contiguous Levels of cervical degenerative disc disease (C3-C7) Skeletally Mature individual with radiculopathy and/or myelopathy The arthroplasty will be performed at all symptomatic Contiguous Levels (up to two levels) 	<p>Cervical</p> <p>Cervical total artificial disc replacement (TADR) is proven and medically necessary when all of the following are present and InterQual® criteria are met:</p> <ul style="list-style-type: none"> An FDA-approved prosthetic intervertebral disc is utilized Individual diagnosed with only one or two Contiguous Levels of cervical degenerative disc disease (C3-C7) Skeletally Mature individual with radiculopathy and/or myelopathy The arthroplasty will be performed at all symptomatic Contiguous Levels (up to two levels between C3-C7) <p>Note: For two-level contiguous cervical total artificial disc replacement, the device being utilized must be FDA-approved for two levels. When a cervical total artificial disc replacement was previously performed, the second Contiguous Level artificial disc must be FDA approved for two levels.</p> <p>Cervical total artificial disc replacement in an individual with a history of prior cervical spinal fusion is proven and medically necessary when all of the following are present and InterQual® criteria are met:</p> <ul style="list-style-type: none"> An FDA-approved prosthetic intervertebral disc is utilized Treating individuals with only one level or two Contiguous Levels of cervical degenerative disc disease (C3-C7) Skeletally Mature individual with radiculopathy and/or myelopathy The arthroplasty will be performed at all symptomatic Contiguous Levels (up to two levels between C3-C7)

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Total Artificial Disc Replacement for the Spine (continued)	Mar. 1, 2026	<p>between C3-C7)</p> <ul style="list-style-type: none"> ○ For two-level Contiguous cervical total artificial disc replacement, the device being utilized must be FDA-approved for two levels; when a cervical total artificial disc replacement was previously performed, the second Contiguous Level artificial disc must be FDA approved for two levels ○ Cervical total artificial disc replacement in an individual with a history of prior cervical spinal fusion is proven and medically necessary when all of the following are present and InterQual® criteria are met: <ul style="list-style-type: none"> ▪ An FDA-approved prosthetic intervertebral disc is utilized ▪ Treating individuals with only one level or two Contiguous Levels of cervical degenerative disc disease (C3-C7) ▪ Skeletally Mature individual with radiculopathy and/or myelopathy ▪ The arthroplasty will be performed at all symptomatic Contiguous Levels (up to two levels between C3-C7) 	<ul style="list-style-type: none"> ● Radiographically Confirmed Complete Arthrodesis of a previous cervical spinal fusion at another level (adjacent or non-adjacent) <p>For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Artificial Disc Replacement, Cervical.</p> <p>Click here to view the InterQual® criteria.</p> <p>Cervical artificial disc removal or replacement with an FDA-approved (one or two-level) prosthetic intervertebral disc is proven and medically necessary in individuals with implant failure after prior disc replacement.</p> <p>Cervical total artificial disc replacement is unproven and not medically necessary when performed at one level combined with cervical spinal fusion surgery at another level (adjacent or non-adjacent), as part of the same surgical plan (Hybrid Cervical Surgery).</p> <p>Lumbar</p> <p>Lumbar total artificial disc replacement is proven and medically necessary when all of the following are present and InterQual® criteria are met:</p> <ul style="list-style-type: none"> ● An FDA-approved prosthetic intervertebral disc is utilized ● Treating individuals with only single level of lumbar degenerative disc disease ● Skeletally Mature individual ● Symptomatic intractable discogenic low back pain attributable to that level <p>For medical necessity clinical coverage criteria, refer to the InterQual® Client Defined, CP: Procedures, Artificial Disc Replacement, Lumbar (Custom) - UHG.</p> <p>Click here to view the InterQual® criteria.</p> <p>Lumbar total artificial disc replacement is unproven and not medically necessary due to insufficient evidence of efficacy when:</p>

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Total Artificial Disc Replacement for the Spine (continued)	Mar. 1, 2026	<ul style="list-style-type: none"> ▪ Radiographically Confirmed Complete Arthrodesis of a previous cervical spinal fusion at another level (adjacent or non-adjacent) ○ For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Artificial Disc Replacement, Cervical ○ Cervical artificial disc removal or replacement with an FDA-approved (one or two-level) prosthetic intervertebral disc is proven and medically necessary in individuals with implant failure after prior disc replacement ○ Cervical total artificial disc replacement is unproven and not medically necessary when performed at one level combined with cervical spinal fusion surgery at another level (adjacent or non-adjacent), as part of the same surgical plan (Hybrid Cervical Surgery) <p>Lumbar</p> <ul style="list-style-type: none"> ○ Lumbar total artificial disc replacement is proven and medically necessary when all of the following are present and InterQual® criteria are met: <ul style="list-style-type: none"> ▪ An FDA-approved 	<ul style="list-style-type: none"> ● Performed at one level combined with an existing lumbar spinal fusion surgery at another level (adjacent or non-adjacent); or ● Performed with lumbar spinal fusion surgery as part of the same surgical plan (Hybrid Lumbar Surgery); or ● Performed at more than one spinal level

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Total Artificial Disc Replacement for the Spine (continued)	Mar. 1, 2026	<p>prosthetic intervertebral disc is utilized</p> <ul style="list-style-type: none"> ▪ Treating individuals with only single level of lumbar degenerative disc disease ▪ Skeletally Mature individual ▪ Symptomatic intractable discogenic low back pain attributable to that level <ul style="list-style-type: none"> ○ For medical necessity clinical coverage criteria, refer to the InterQual® Client Defined, CP: Procedures, Artificial Disc Replacement, Lumbar (Custom) - UHG ○ Lumbar total artificial disc replacement is unproven and not medically necessary due to insufficient evidence of efficacy when: <ul style="list-style-type: none"> ▪ Performed at one level combined with an existing lumbar spinal fusion surgery at another level (adjacent or non-adjacent) ▪ Performed with lumbar spinal fusion surgery as part of the same surgical plan (Hybrid Lumbar Surgery) ▪ Performed at more than one spinal level 	

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Total Artificial Disc Replacement for the Spine (continued)	Mar. 1, 2026	<p>Medical Records Documentation Used for Reviews</p> <ul style="list-style-type: none"> • Updated list of Medical Records Documentation Used for Reviews: <ul style="list-style-type: none"> ○ Added: <ul style="list-style-type: none"> ▪ Relevant imaging and diagnostic testing, including documentation of instability ▪ For total artificial disc removal or replacement, also include: <ul style="list-style-type: none"> – Details of complication – Surgical plan ○ Replaced: <ul style="list-style-type: none"> ▪ “Physical exam, including <i>spasticity, including investigation for other etiologies</i>” with “physical exam, including <i>detailed neurological findings</i>” ▪ “Treatments tried, failed, or contraindicated; include the dates and reason for discontinuation” with “treatments tried, failed, or contraindicated; include the dates, <i>duration</i>, and reason for discontinuation” ▪ “Physician treatment plan” with “physician treatment plan, <i>including surgical technique to be used and the number of</i> 	

Medical Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Total Artificial Disc Replacement for the Spine (continued)	Mar. 1, 2026	<p style="text-align: center;"><i>levels involved and their location</i></p> <ul style="list-style-type: none"> ▪ “For lumbar surgery, in addition to the [listed documentation requirements], <i>provide medical notes documenting the following, when applicable: provide psychosocial-behavioral, documentation of instability (listhesis-, spondylolisthesis and grade), and provide the surgical technique to be used and the number of levels involved and their location</i>” with “for lumbar surgery, in addition to the [listed documentation requirements], <i>also include psychosocial-behavioral evaluation</i>” <p>Definitions</p> <ul style="list-style-type: none"> • Added definition of: <ul style="list-style-type: none"> ○ Contiguous Levels ○ Hybrid Cervical Surgery ○ Hybrid Lumbar Surgery ○ Radiographically Confirmed Complete Arthrodesis • Updated definition of “Skeletally Mature” <p>Supporting Information</p> <ul style="list-style-type: none"> • Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information 	

Medical Policy Updates

Retired

Policy Title	Effective Date	Summary of Changes
Electrical Stimulation for Wounds	Jan. 1, 2026	<ul style="list-style-type: none">Retired policy; electrical stimulation for wounds no longer requires clinical review

Medical Benefit Drug Policy Updates

New		
Policy Title	Effective Date	Coverage Rationale
Gazyva® (Obinutuzumab)	Feb. 1, 2026	<p>This policy refers to Gazyva (obinutuzumab) for intravenous infusion for non-oncology indications. Refer to the Medical Benefit Drug Policy titled Oncology Medication Clinical Coverage for updated information based upon the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium® (NCCN Compendium®) for oncology indications.</p> <p>Active Lupus Nephritis</p> <p>Gazyva (obinutuzumab) is proven and medically necessary for the treatment of active lupus nephritis when all of the following criteria are met:</p> <ul style="list-style-type: none"> • For initial therapy, all of the following: <ul style="list-style-type: none"> ○ Diagnosis of active lupus nephritis; and ○ Provider attestation that diagnosis is biopsy proven or biopsy is contraindicated in the patient; and ○ Currently receiving at least one standard of care treatment for active systemic lupus erythematosus (e.g., antimalarials, corticosteroids, or immunosuppressants); and ○ Patient is not receiving Gazyva in combination with Benlysta (belimumab) or Lupkynis (voclosporin); and ○ Gazyva is dosed according to US Food and Drug Administration labeled dosing; and ○ Prescribed by or in consultation with a rheumatologist or nephrologist; and ○ Initial authorization is for no more than 12 months • For continuation of therapy, all of the following: <ul style="list-style-type: none"> ○ Patient has previously received Gazyva injection for intravenous infusion; and ○ Documentation of positive clinical response; and ○ Currently receiving at least one standard of care treatment for active systemic lupus erythematosus (e.g., antimalarials, corticosteroids, or immunosuppressants; that is not a biologic); and ○ Patient is not receiving Gazyva in combination with Benlysta (belimumab) or Lupkynis (voclosporin); and ○ Gazyva is dosed according to US Food and Drug Administration labeled dosing; and ○ Prescribed by or in consultation with a rheumatologist or nephrologist; and ○ Authorization is for no more than 12 months
Updated		
Policy Title	Effective Date	Summary of Changes
FcRn Blockers (Rystiggo®, Vyvgart®, & Vyvgart Hytrulo®)	Jan. 1, 2026	<p>Application Florida</p> <ul style="list-style-type: none"> • Added instruction to refer to the state’s Medicaid clinical policy for Vyvgart Hytrulo <p>Applicable Codes</p> <ul style="list-style-type: none"> • Updated list of applicable HCPCS codes to reflect annual edits: <ul style="list-style-type: none"> ○ Added J9256 ○ Removed C9305

Medical Benefit Drug Policy Updates

Updated			
Policy Title	Effective Date	Summary of Changes	
Subcutaneous Implantable Naltrexone Pellets	Jan. 1, 2026	Applicable Codes <ul style="list-style-type: none"> Added notation to indicate this policy does not apply to HCPCS code J2315 [Vivitrol® (naltrexone powder for suspension for injection, extended-release)] 	
Uplizna® (Inebilizumab-Cdon)	Jan. 1, 2026	Application Florida <ul style="list-style-type: none"> Added language to indicate this Medical Benefit Drug Policy does not apply to the state of Florida; refer to the state's Medicaid clinical policy 	
Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Cimzia® (Certolizumab Pegol)	Feb. 1, 2026	Coverage Rationale <ul style="list-style-type: none"> Added language to clarify this policy refers to Cimzia (certolizumab pegol) <i>lyophilized powder for subcutaneous use after reconstitution by a healthcare provider</i>; Cimzia (certolizumab pegol) <i>prefilled syringe</i> for self-administered subcutaneous injection is obtained under the pharmacy benefit Replaced references to “targeted immunomodulator” with “<i>systemic</i> targeted immunomodulator” Revised coverage criteria: <ul style="list-style-type: none"> Added coverage criterion requiring prescriber attestation that the patient or caregiver is not able to be trained or are physically unable to administer Cimzia U.S. FDA labeled for self-administration (the prescriber must submit the explanation) Crohn's Disease (CD) <ul style="list-style-type: none"> Updated list of examples of 	<p>This policy refers to Cimzia (certolizumab pegol) lyophilized powder for subcutaneous use after reconstitution by a healthcare provider. Cimzia (certolizumab pegol) prefilled syringe for self-administered subcutaneous injection is obtained under the pharmacy benefit.</p> <p>Refer to the policy for complete details.</p>

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Cimzia® (Certolizumab Pegol) (continued)	Feb. 1, 2026	<p>systemic targeted immunomodulators the patient must not be receiving in combination with Cimzia for treatment of the same indication:</p> <ul style="list-style-type: none"> ▪ Added: <ul style="list-style-type: none"> – Entyvio (vedolizumab) – Omvoh (mirikizumab-mrkz) – Tremfya (guselkumab) ▪ Removed: <ul style="list-style-type: none"> – Enbrel (etanercept) – Olumiant (baricitinib) – Orencia (abatacept) – Simponi (golimumab) – Xeljanz (tofacitinib) ▪ Replaced “Stelara (ustekinumab)” with “ustekinumab” <p>○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of Crohn’s disease with which the patient has been previously treated for initial therapy:</p> <ul style="list-style-type: none"> ▪ Added: <ul style="list-style-type: none"> – Entyvio (vedolizumab) – Omvoh (mirikizumab-mrkz) – Tremfya (guselkumab) 	

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Cimzia® (Certolizumab Pegol) (continued)	Feb. 1, 2026	<ul style="list-style-type: none"> ▪ Replaced “Stelara (ustekinumab)” with “ustekinumab” <p>Rheumatoid Arthritis (RA)</p> <ul style="list-style-type: none"> ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with Cimzia for treatment of the same indication; replaced “Xeljanz (tofacitinib)” with “Xeljanz/Xeljanz XR (tofacitinib)” ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of rheumatoid arthritis with which the patient has been previously treated for initial therapy; replaced “Xeljanz (tofacitinib)” with “Xeljanz/Xeljanz XR (tofacitinib)” <p>Psoriatic Arthritis (PsA)</p> <ul style="list-style-type: none"> ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with Cimzia for treatment of the same indication: <ul style="list-style-type: none"> ▪ Added Bimzelx (bimekizumab-bkzx) ▪ Removed Olumiant (baricitinib) 	

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Cimzia® (Certolizumab Pegol) (continued)	Feb. 1, 2026	<ul style="list-style-type: none"> ▪ Replaced: <ul style="list-style-type: none"> – “Stelara (ustekinumab)” with “ustekinumab” – “Xeljanz (tofacitinib)” with “Xeljanz/Xeljanz XR (tofacitinib)” ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of psoriatic arthritis with which the patient has been previously treated for initial therapy: <ul style="list-style-type: none"> ▪ Added Bimzelx (bimekizumab-bkzx) ▪ Removed Olumiant (baricitinib) ▪ Replaced: <ul style="list-style-type: none"> – “Stelara (ustekinumab)” with “ustekinumab” – “Xeljanz (tofacitinib)” with “Xeljanz/Xeljanz XR (tofacitinib)” <p>Ankylosing Spondylitis (AS) and Non-Radiographic Axial Spondyloarthritis (nr-axSpA)</p> <ul style="list-style-type: none"> ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with Cimzia for treatment of the same indication; added: <ul style="list-style-type: none"> ▪ Bimzelx (bimekizumab- 	

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Cimzia® (Certolizumab Pegol) (continued)	Feb. 1, 2026	<ul style="list-style-type: none"> bkzx) <ul style="list-style-type: none"> ▪ Cosentyx (secukinumab) ▪ Taltz (ixekizumab) ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of ankylosing spondylitis or nr-axSpA with which the patient has been previously treated for initial therapy: <ul style="list-style-type: none"> ▪ Added: <ul style="list-style-type: none"> – Bimzelx (bimekizumab-bkzx) – Cosentyx (secukinumab) – Enbrel (etanercept) – Olumiant (baricitinib) – Orenzia (abatacept) – Taltz (ixekizumab) ▪ Replaced “Xeljanz (tofacitinib)” with “Xeljanz/Xeljanz XR (tofacitinib)” <p>Plaque Psoriasis (PS)</p> <ul style="list-style-type: none"> ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with Cimzia for treatment of the same indication: <ul style="list-style-type: none"> ▪ Added: <ul style="list-style-type: none"> – Bimzelx (bimekizumab-bkzx) – Sotyktu (deucravacitinib) 	

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Cimzia® (Certolizumab Pegol) (continued)	Feb. 1, 2026	<ul style="list-style-type: none"> ▪ Removed: <ul style="list-style-type: none"> – Olumiant (baricitinib) – Orencia (abatacept) – Rinvoq (upadacitinib) – Simponi (golimumab) – Xeljanz (tofacitinib) ▪ Replaced “<i>Stelara</i> (ustekinumab)” with “ustekinumab” ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of plaque psoriasis with which the patient has been previously treated for initial therapy: <ul style="list-style-type: none"> ▪ Added: <ul style="list-style-type: none"> – Bimzelx (bimekizumab-bkzx) – Cosentyx (secukinumab) – Enbrel (etanercept) – Ilumya (tildrakizumab) – Siliq (brodalumab) – Sotyktu (deucravacitinib) – Taltz (ixekizumab) ▪ Replaced “<i>Stelara</i> (ustekinumab)” with “ustekinumab” <p><i>Polyarticular Juvenile Idiopathic Arthritis</i></p> <ul style="list-style-type: none"> ○ Removed criterion for initial therapy requiring Cimzia is prescribed by or in 	

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Cimzia® (Certolizumab Pegol) (continued)	Feb. 1, 2026	<p>consultation with a rheumatologist</p> <ul style="list-style-type: none"> Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with Cimzia for treatment of the same indication; replaced “Xeljanz (tofacitinib)” with “Xeljanz/ Xeljanz XR (tofacitinib)” <p>Applicable Codes</p> <ul style="list-style-type: none"> Removed CPT codes 96372 and 96401 <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information 	
Infliximab	Feb. 1, 2026	<p>Coverage Rationale</p> <ul style="list-style-type: none"> Revised coverage criteria: <ul style="list-style-type: none"> Replaced references to: <ul style="list-style-type: none"> “Biologic disease-modifying antirheumatic drug (DMARD)/Janus kinase inhibitor/phosphodiesterase 4 (PDE4) inhibitor” with “systemic targeted immunomodulator” “Targeted immunomodulator “with “systemic targeted immunomodulator” <p>Ankylosing Spondylitis</p> <ul style="list-style-type: none"> Updated list of examples of systemic targeted 	<p>This policy refers to infliximab products administered by intravenous (IV) route.</p> <p>Infliximab for self-administered subcutaneous injection [i.e., Zymfentra (infliximab-dyyb)] is obtained under the pharmacy benefit.</p> <p>This policy refers to the following infliximab products:</p> <ul style="list-style-type: none"> Avsola® (infliximab-axxq) Inflectra® (infliximab-dyyb) Remicade® (infliximab) Renflexis® (infliximab-abda) Any FDA-approved infliximab biosimilar product not listed here <p>Refer to the policy for complete details.</p>

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Infliximab (continued)	Feb. 1, 2026	<p>immunomodulators the patient must not be receiving in combination with infliximab for treatment of the same indication:</p> <ul style="list-style-type: none"> ▪ Added: <ul style="list-style-type: none"> – Bimzelx (bimekizumab-bkzx) – Cosentyx (secukinumab) – Orencia (abatacept) – Rinvoq (upadacitinib) – Taltz (ixekizumab) ▪ Replaced “<i>Humira</i> (adalimumab)” with “adalimumab” <p>○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of ankylosing spondylitis with which the patient has been previously treated for initial therapy; added:</p> <ul style="list-style-type: none"> ▪ Bimzelx (bimekizumab-bkzx) ▪ Cosentyx (secukinumab) ▪ Olumiant (baricitinib) ▪ Orencia (abatacept) ▪ Taltz (ixekizumab) <p>Crohn’s Disease</p> <p>○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with infliximab for treatment of the same</p>	

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Infliximab (continued)	Feb. 1, 2026	<p>indication:</p> <ul style="list-style-type: none"> ▪ Added: <ul style="list-style-type: none"> – Omvoh (mirikizumab-mrkz) – Rinvoq (upadacitinib) – Skyrizi (risankizumab) – Tremfya (guselkumab) – Ustekinumab ▪ Removed: <ul style="list-style-type: none"> – Enbrel (etanercept) – Olumiant (baricitinib) – Xeljanz (tofacitinib) ▪ Replaced “<i>Humira</i> (adalimumab)” with “adalimumab” <p>○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of Crohn’s disease with which the patient has been previously treated for initial therapy:</p> <ul style="list-style-type: none"> ▪ Added: <ul style="list-style-type: none"> – Entyvio (vedolizumab) – Omvoh (mirikizumab-mrkz) – Tremfya (guselkumab) ▪ Replaced “<i>Stelara</i> (ustekinumab)” with “ustekinumab” <p><i>Noninfectious Uveitis</i></p> <p>○ Updated list of examples of</p>	

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Infliximab (continued)	Feb. 1, 2026	<p>systemic targeted immunomodulators the patient must not be receiving in combination with infliximab for treatment of the same indication:</p> <ul style="list-style-type: none"> ▪ Removed: <ul style="list-style-type: none"> – Enbrel (etanercept) – Cimzia (certolizumab) – Olumiant (baricitinib) – Simponi (golimumab) – Xeljanz (tofacitinib) ▪ Replaced “<i>Humira</i> (adalimumab)” with “adalimumab” <p>Plaque Psoriasis</p> <ul style="list-style-type: none"> ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with infliximab for treatment of the same indication: <ul style="list-style-type: none"> ▪ Added: <ul style="list-style-type: none"> – Bimzelx (bimekizumab-bkzx) – Cosentyx (secukinumab) – Ilumya (tildrakizumab) – Siliq (brodalumab) – Skyrizi (risankizumab) – Sotyktu (deucravacitinib) – Taltz (ixekizumab) – Tremfya 	

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Infliximab (continued)	Feb. 1, 2026	<ul style="list-style-type: none"> (guselkumab) – Ustekinumab ▪ Removed: <ul style="list-style-type: none"> – Olumiant (baricitinib) – Simponi (golimumab) – Xeljanz (tofacitinib) ▪ Replaced “<i>Humira</i> (adalimumab)” with “adalimumab” ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of plaque psoriasis with which the patient has been previously treated for initial therapy: <ul style="list-style-type: none"> ▪ Added: <ul style="list-style-type: none"> – Bimzelx (bimekizumab-bkzx) – Sotyktu (deucravacitinib) ▪ Removed Orenzia (abatacept) ▪ Replaced “<i>Stelara</i> (ustekinumab)” with “ustekinumab” <p>Psoriatic Arthritis</p> <ul style="list-style-type: none"> ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with infliximab for treatment of the same indication: <ul style="list-style-type: none"> ▪ Added: <ul style="list-style-type: none"> – Bimzelx 	

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Infliximab (continued)	Feb. 1, 2026	<ul style="list-style-type: none"> (bimekizumab-bkzx) – Cosentyx (secukinumab) – Orencia (abatacept) – Rinvoq (upadacitinib) – Skyrizi (risankizumab) – Taltz (ixekizumab) – Tremfya (guselkumab) – Ustekinumab ▪ Removed Olumiant (baricitinib) ▪ Replaced: <ul style="list-style-type: none"> – “<i>Humira</i> (adalimumab)” with “adalimumab” – “Xeljanz (tofacitinib)” with “Xeljanz/<i>Xeljanz XR</i> (tofacitinib)” ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of psoriatic arthritis with which the patient has been previously treated for initial therapy: <ul style="list-style-type: none"> ▪ Added Bimzelx (bimekizumab-bkzx) ▪ Removed Olumiant (baricitinib) ▪ Replaced: <ul style="list-style-type: none"> – “<i>Stelara</i> (ustekinumab)” with “ustekinumab” – “Xeljanz (tofacitinib)” 	

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Infliximab (continued)	Feb. 1, 2026	<p>with “Xeljanz/<i>Xeljanz XR</i> (tofacitinib)”</p> <p>Rheumatoid Arthritis</p> <ul style="list-style-type: none"> ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with infliximab for treatment of the same indication: <ul style="list-style-type: none"> ▪ Added: <ul style="list-style-type: none"> – Orenzia (abatacept) – Rinvoq (upadacitinib) ▪ Replaced: <ul style="list-style-type: none"> – “<i>Humira</i> (adalimumab)” with “adalimumab” – “Xeljanz (tofacitinib)” with “Xeljanz/<i>Xeljanz XR</i> (tofacitinib)” ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of rheumatoid arthritis with which the patient has been previously treated for initial therapy; replaced “Xeljanz (tofacitinib)” with “Xeljanz/<i>Xeljanz XR</i> (tofacitinib)” <p>Sarcoidosis</p> <ul style="list-style-type: none"> ○ Removed list of examples of Biologic disease-modifying antirheumatic drugs (DMARD)/Janus kinase inhibitors the patient must not 	

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Infliximab (continued)	Feb. 1, 2026	<p>be receiving in combination with infliximab for treatment of the same indication</p> <p>Ulcerative Colitis</p> <ul style="list-style-type: none"> ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with infliximab for treatment of the same indication: <ul style="list-style-type: none"> ▪ Added: <ul style="list-style-type: none"> – Omvoh (mirikizumab-mrkz) – Rinvoq (upadacitinib) – Simponi (golimumab) – Skyrizi (risankizumab) – Tremfya (guselkumab) – ustekinumab – Zeposia (ozanimod) ▪ Removed: <ul style="list-style-type: none"> – Enbrel (etanercept) – Cimzia (certolizumab) – Olumiant (baricitinib) ▪ Replaced: <ul style="list-style-type: none"> – Replaced “<i>Humira</i> (adalimumab)” with “adalimumab” – “Xeljanz (tofacitinib)” with “Xeljanz/<i>Xeljanz XR</i> (tofacitinib)” ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of 	

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Infliximab (continued)	Feb. 1, 2026	<p>ulcerative colitis with which the patient has been previously treated for initial therapy:</p> <ul style="list-style-type: none"> ▪ Added: <ul style="list-style-type: none"> – Entyvio (vedolizumab) – Omvoh (mirikizumab-mrkz) – Skyrizi (risankizumab) – Tremfya (guselkumab) – Zeposia (ozanimod) ▪ Replaced: <ul style="list-style-type: none"> – “Stelara (ustekinumab)” with “ustekinumab” – “Xeljanz (tofacitinib)” with “Xeljanz/Xeljanz XR (tofacitinib)” <p>Immune Checkpoint Inhibitor-Related Toxicities</p> <ul style="list-style-type: none"> ○ Added criterion requiring diagnosis of an immune checkpoint inhibitor-related toxicity ○ Removed criterion for initial therapy requiring diagnosis of one of the following: <ul style="list-style-type: none"> ▪ Moderate (G2) or severe (G3-4) immunotherapy-related diarrhea or colitis ▪ Severe (G3-4) immunotherapy-related pneumonitis ▪ Severe (G3) or life- 	

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Infliximab (continued)	Feb. 1, 2026	<p>threatening (G4) immunotherapy-related acute renal failure/elevated serum creatinine</p> <ul style="list-style-type: none"> ▪ Severe (G3-4) immunotherapy-related uveitis ▪ Life threatening (G4) immunotherapy-related myocarditis, pericarditis, arrhythmias, impaired ventricular function, or conduction abnormalities ▪ Severe immunotherapy- related inflammatory arthritis ▪ Moderate, severe, or life- threatening immunotherapy-related, steroid-refractory myalgias or myositis (muscle weakness) <p>Supporting Information</p> <ul style="list-style-type: none"> • Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information • Removed <i>Documentation Requirements</i> section 	
Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer’s Disease	Feb. 1, 2026	<p>Coverage Rationale</p> <ul style="list-style-type: none"> • Changed initial authorization duration from “no more than 6 months” to “no more than 12 months” <p>Kisunla</p> <ul style="list-style-type: none"> • Revised coverage criteria for continuation of therapy: 	<p>This policy refers to the following drug products:</p> <ul style="list-style-type: none"> • Kisunla™ (donanemab-azbt) • Leqembi® (lecanemab-irmb) <p>Kisunla (donanemab-azbt) is medically necessary for the treatment of Alzheimer’s disease (AD) when all of the following criteria are met:</p> <ul style="list-style-type: none"> • For initial therapy, all of the following: <ul style="list-style-type: none"> ○ Diagnosis of one of the following based on National Institute on

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (continued)	Feb. 1, 2026	<ul style="list-style-type: none"> ○ Removed criterion requiring one of the following: <ul style="list-style-type: none"> ▪ The patient has mild cognitive impairment (MCI) due to Alzheimer's disease ▪ The patient has mild dementia due to Alzheimer's disease ▪ The patient has progressed into moderate or severe stages of dementia due to Alzheimer's disease and the prescriber attests that the patient has shared in decision-making to continue Kisunla therapy ○ Replaced criterion requiring: <ul style="list-style-type: none"> ▪ "The patient has received Kisunla therapy for less than or equal to 6 months" with "the patient has received Kisunla therapy for less than or equal to 18 months" ▪ "The patient has received Kisunla therapy for greater than 6 months, <i>post-treatment amyloid PET brain imaging obtained between 12 and 18 months of total treatment is positive for amyloid based on visual read, and for treatment beyond 18 months of</i> 	Aging and the Alzheimer's Association (NIA-AA) criteria: <ul style="list-style-type: none"> ▪ Mild cognitive impairment (MCI) due to Alzheimer's disease; or ▪ Mild dementia due to Alzheimer's disease and <ul style="list-style-type: none"> ○ Submission of medical records (e.g., chart notes, laboratory values) documenting one of the following: <ul style="list-style-type: none"> ▪ Mini-Mental State Examination (MMSE) score of 20 to 30; or ▪ Montreal Cognitive Assessment (MoCA) score of 17 to 30; or ▪ Saint Louis University Mental Status (SLUMS) score of 17 to 30 and ○ Submission of medical records (e.g., chart notes, laboratory values) documenting the presence of amyloid beta pathology, as evidenced by positive amyloid positron emission tomography (PET) brain imaging; and ○ Other differential diagnoses [e.g., dementia with Lewy bodies (DLB), frontotemporal dementia (FTD), vascular dementia, pseudodementia due to mood disorder, vitamin B12 deficiency, encephalopathy, etc.] have been ruled out; and ○ One of the following: <ul style="list-style-type: none"> ▪ Patient is not currently taking an anticoagulant (e.g., warfarin, dabigatran); or ▪ Both of the following: <ul style="list-style-type: none"> – Patient is currently taking an anticoagulant (e.g., warfarin, dabigatran); and – Counseling has been provided that the combined use of Kisunla with anti-coagulant drugs may increase the risk of cerebral macrohemorrhage and prescriber attests that the patient has shared in decision-making to initiate Kisunla therapy and ○ Patient has no history of intracerebral hemorrhage within the previous year prior to initiating treatment; and ○ Counseling has been provided on the risk of amyloid-related imaging abnormalities [ARIA characterized as ARIA with edema (ARIA-E) and ARIA with hemosiderin (ARIA-H)] and patient is aware to monitor for headache, dizziness, visual disturbances, nausea, and vomiting; and

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (continued)	Feb. 1, 2026	<p><i>therapy</i>, post-treatment amyloid PET brain imaging is performed at least once per 12 months and is positive for amyloid based on visual read" with "the patient has received Kisunla therapy for greater than 18 months and post-treatment amyloid PET brain imaging is performed at least once per 12 months and is positive for amyloid based on visual read"</p> <p>Leqembi</p> <ul style="list-style-type: none"> • Revised coverage criteria for continuation of therapy; removed criterion requiring one of the following: <ul style="list-style-type: none"> ○ The patient has mild cognitive impairment (MCI) due to Alzheimer's disease ○ The patient has mild dementia due to Alzheimer's disease ○ The patient has progressed into moderate or severe stages of dementia due to Alzheimer's disease and the prescriber attests that the patient has shared in decision-making to continue Leqembi therapy 	<ul style="list-style-type: none"> ○ All of the following: <ul style="list-style-type: none"> ▪ Counseling has been provided on how testing for apolipoprotein E (ApoE) epsilon 4 (ϵ 4) status informs the risk of developing ARIA when deciding to initiate treatment with Kisunla; and ▪ Testing for ApoE ϵ4 status has been offered to the patient and prescriber attests that the patient has shared in decision-making to initiate Kisunla therapy and ○ A baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment; and ○ Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's disease (e.g., Leqembi); and ○ Prescribed by a neurologist, geriatric psychiatrist, or geriatrician who specializes in treating dementia; and ○ Kisunla dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Initial authorization will be for no more than 12 months • For continuation of therapy, all of the following: <ul style="list-style-type: none"> ○ One of the following: <ul style="list-style-type: none"> ▪ Both of the following: <ul style="list-style-type: none"> – Patient has received Kisunla therapy for less than or equal to 18 months; and – One of the following: <ul style="list-style-type: none"> • Post-treatment amyloid PET brain imaging is positive for amyloid based on visual read; or • Prescriber attests that amyloid PET imaging will be performed prior to 18 months of total treatment to assess for the effect of Kisunla treatment on amyloid plaque or ▪ Both of the following: <ul style="list-style-type: none"> – Patient has received Kisunla therapy for greater than 18 months; and – Post-treatment amyloid PET brain imaging is performed at least once per 12 months and is positive for amyloid based on visual read and ○ Both of the following:

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (continued)	Feb. 1, 2026		<ul style="list-style-type: none"> ▪ Submission of medical records (e.g., chart notes) confirming follow-up brain magnetic resonance imaging (MRI) has been completed after the initiation of therapy; and ▪ One of the following: <ul style="list-style-type: none"> – ARIA has not been observed on MRI; or – All of the following: <ul style="list-style-type: none"> • ARIA has been observed on MRI; and • Prescriber attests that continuation of therapy with Kisunla is appropriate based on the severity of the patient's clinical symptoms; and • One of the following: <ul style="list-style-type: none"> ○ Follow-up MRI demonstrates radiographic resolution and/or stabilization; or ○ Prescriber attests that continuation of therapy with Kisunla is appropriate based on the radiographic severity of ARIA <p>and</p> <ul style="list-style-type: none"> ○ Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's disease (e.g., Leqembi); and ○ Prescribed by a neurologist, geriatric psychiatrist, or geriatrician who specializes in treating dementia; and ○ Kisunla dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Reauthorization is for no more than 12 months <p>Kisunla (donanemab-azbt) is unproven and not medically necessary for any indication other than Alzheimer's disease.</p> <p>Leqembi (lecanemab-irmb) is medically necessary for the treatment of Alzheimer's disease (AD) when all of the following criteria are met:</p> <ul style="list-style-type: none"> • For initial therapy, all of the following: <ul style="list-style-type: none"> ○ Diagnosis of one of the following based on National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria: <ul style="list-style-type: none"> ▪ Mild cognitive impairment (MCI) due to Alzheimer's disease; or ▪ Mild dementia due to Alzheimer's disease <p>and</p> <ul style="list-style-type: none"> ○ Submission of medical records (e.g., chart notes, laboratory values)

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (continued)	Feb. 1, 2026		<p>documenting one of the following:</p> <ul style="list-style-type: none"> ▪ Mini-Mental State Examination (MMSE) score of 20 to 30; or ▪ Montreal Cognitive Assessment (MoCA) score of 17 to 30; or ▪ Saint Louis University Mental Status (SLUMS) score of 17 to 30 <p>and</p> <ul style="list-style-type: none"> ○ Submission of medical records (e.g., chart notes, laboratory values) documenting the presence of amyloid beta pathology, as evidenced by one of the following: <ul style="list-style-type: none"> ▪ Positive amyloid positron emission tomography (PET) brain imaging; or ▪ Cerebrospinal fluid (CSF) biomarker testing documents abnormalities suggestive of beta-amyloid accumulation in the brain (e.g., Aβ42/40 ratio, p-tau 181/Aβ42 ratio, t-tau/Aβ 42 ratio) <p>and</p> <ul style="list-style-type: none"> ○ Other differential diagnoses [e.g., dementia with Lewy bodies (DLB), frontotemporal dementia (FTD), vascular dementia, pseudodementia due to mood disorder, vitamin B12 deficiency, encephalopathy, etc.] have been ruled out; and ○ One of the following: <ul style="list-style-type: none"> ▪ Patient is not currently taking an anticoagulant (e.g., warfarin, dabigatran); or ▪ Both of the following: <ul style="list-style-type: none"> – Patient is currently taking an anticoagulant (e.g., warfarin, dabigatran); and – Counseling has been provided that the combined use of Leqembi with anti-coagulant drugs may increase the risk of cerebral macrohemorrhage and prescriber attests that the patient has shared in decision-making to initiate Leqembi therapy <p>and</p> <ul style="list-style-type: none"> ○ Patient has no history of intracerebral hemorrhage within the previous year prior to initiating treatment; and ○ Counseling has been provided on the risk of amyloid-related imaging abnormalities [ARIA characterized as ARIA with edema (ARIA-E) and ARIA with hemosiderin (ARIA-H)] and patient is aware to monitor for headache, dizziness, visual disturbances, nausea, and vomiting; and

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (continued)	Feb. 1, 2026		<ul style="list-style-type: none"> ○ All of the following: <ul style="list-style-type: none"> ▪ Counseling has been provided on how testing for apolipoprotein E (ApoE) epsilon 4 (ϵ 4) status informs the risk of developing ARIA when deciding to initiate treatment with Leqembi; and ▪ Testing for ApoE ϵ4 status has been offered to the patient and prescriber attests that the patient has shared in decision-making to initiate Leqembi therapy and ○ A baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment; and ○ Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's disease (e.g., Kisunla); and ○ Prescribed by a neurologist, geriatric psychiatrist, or geriatrician who specializes in treating dementia; and ○ Leqembi dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Initial authorization will be for no more than 12 months ● For continuation of therapy, all of the following: <ul style="list-style-type: none"> ○ Both of the following: <ul style="list-style-type: none"> ▪ Submission of medical records (e.g., chart notes) confirming follow-up brain magnetic resonance imaging (MRI) has been completed after the initiation of therapy; and ▪ One of the following: <ul style="list-style-type: none"> – ARIA has not been observed on MRI; or – All of the following: <ul style="list-style-type: none"> ● ARIA has been observed on MRI; and ● Prescriber attests that continuation of therapy with Leqembi is appropriate based on the severity of the patient's clinical symptoms; and ● One of the following: <ul style="list-style-type: none"> ○ Follow-up MRI demonstrates radiographic resolution and/or stabilization; or ○ Prescriber attests that continuation of therapy with Leqembi is appropriate based on the radiographic severity of ARIA and ○ Not used in combination with other Aβ monoclonal antibodies (mAbs)

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Monoclonal Antibodies Directed Against Amyloid for the Treatment of Alzheimer's Disease (continued)	Feb. 1, 2026		<ul style="list-style-type: none"> ○ for Alzheimer's disease (e.g., Kisunla); and ○ Prescribed by a neurologist, geriatric psychiatrist, or geriatrician who specializes in treating dementia; and ○ Leqembi dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Reauthorization is for no more than 12 months <p>Leqembi (lecanemab-irmb) is unproven and not medically necessary for any indication other than Alzheimer's disease.</p>
Ocrevus® (Ocrelizumab) and Ocrevus Zunovo® (Ocrelizumab and Hyaluronidase-Ocsq)	Feb. 1, 2026	<p>Coverage Rationale</p> <ul style="list-style-type: none"> ● Changed initial authorization duration from “no more than 6 months” to “no more than 12 months” <p>Supporting Information</p> <ul style="list-style-type: none"> ● Updated <i>References</i> section to reflect the most current information 	<p>Primary Progressive Multiple Sclerosis</p> <p>Ocrevus or Ocrevus Zunovo are proven and medically necessary for the treatment of primary progressive multiple sclerosis (PPMS) when all of the following criteria are met:</p> <ul style="list-style-type: none"> ● For initial therapy, all of the following: <ul style="list-style-type: none"> ○ Diagnosis of primary progressive multiple sclerosis (PPMS); and ○ Patient is not receiving Ocrevus or Ocrevus Zunovo in combination with any of the following: <ul style="list-style-type: none"> ▪ Disease modifying therapy (e.g., interferon beta preparations, dimethyl fumarate, glatiramer acetate, natalizumab, fingolimod, cladribine, siponimod, or teriflunomide) ▪ B-cell targeted therapy (e.g., rituximab, belimumab, ofatumumab, ublituximab-xiiy) ▪ Lymphocyte trafficking blockers (e.g., alemtuzumab, mitoxantrone) and ○ Ocrevus or Ocrevus Zunovo dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Initial authorization is for no more than 12 months ● For continuation of therapy, all of the following: <ul style="list-style-type: none"> ○ Patient has previously received treatment with Ocrevus or Ocrevus Zunovo; and ○ Documentation of positive clinical response to Ocrevus or Ocrevus Zunovo therapy; and ○ Patient is not receiving Ocrevus or Ocrevus Zunovo in combination with any of the following: <ul style="list-style-type: none"> ▪ Disease modifying therapy (e.g., interferon beta preparations, dimethyl fumarate, glatiramer acetate, natalizumab, fingolimod,

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Ocrevus® (Ocrelizumab) and Ocrevus Zunovo® (Ocrelizumab and Hyaluronidase-Ocsq) (continued)	Feb. 1, 2026		<p>cladribine, siponimod, or teriflunomide)</p> <ul style="list-style-type: none"> ▪ B-cell targeted therapy (e.g., rituximab, belimumab, ofatumumab, ublituximab-xiiy) ▪ Lymphocyte trafficking blockers (e.g., alemtuzumab, mitoxantrone) <p>and</p> <ul style="list-style-type: none"> ○ Ocrevus or Ocrevus Zunovo dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Authorization is for no more than 12 months <p>Relapsing Forms of Multiple Sclerosis</p> <p>Ocrevus or Ocrevus Zunovo are proven and medically necessary for the treatment of relapsing forms of multiple sclerosis (MS) when the following criteria are met:</p> <ul style="list-style-type: none"> • For initial therapy, all of the following: <ul style="list-style-type: none"> ○ Diagnosis of relapsing forms of multiple sclerosis (MS) (e.g., relapsing-remitting MS, secondary-progressive MS with relapses, progressive-relapsing MS with relapses); and ○ Patient is not receiving Ocrevus or Ocrevus Zunovo in combination with any of the following: <ul style="list-style-type: none"> ▪ Disease modifying therapy (e.g., interferon beta preparations, glatiramer acetate, natalizumab, fingolimod, cladribine, siponimod, or teriflunomide) ▪ B-cell targeted therapy (e.g., rituximab, belimumab, ofatumumab, ublituximab-xiiy) ▪ Lymphocyte trafficking blockers (e.g., alemtuzumab, mitoxantrone) <p>and</p> <ul style="list-style-type: none"> ○ Ocrevus or Ocrevus Zunovo dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Initial authorization is for no more than 12 months <ul style="list-style-type: none"> • For continuation of therapy, all of the following: <ul style="list-style-type: none"> ○ Patient has previously received treatment with Ocrevus or Ocrevus Zunovo; and ○ Documentation of positive clinical response to Ocrevus or Ocrevus Zunovo therapy; and ○ Patient is not receiving Ocrevus or Ocrevus Zunovo in combination

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Ocrevus® (Ocrelizumab) and Ocrevus Zunovo® (Ocrelizumab and Hyaluronidase-Ocsq) (continued)	Feb. 1, 2026		<p>with any of the following:</p> <ul style="list-style-type: none"> ▪ Disease modifying therapy (e.g., interferon beta preparations, dimethyl fumarate, glatiramer acetate, natalizumab, fingolimod, cladribine, siponimod, or teriflunomide) ▪ B-cell targeted therapy (e.g., rituximab, belimumab, ofatumumab, ublituximab-xiiy) ▪ Lymphocyte trafficking blockers (e.g., alemtuzumab, mitoxantrone) <p>and</p> <ul style="list-style-type: none"> ○ Ocrevus or Ocrevus Zunovo dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Authorization is for no more than 12 months <p>Ocrevus or Ocrevus Zunovo are unproven and not medically necessary for the treatment of:</p> <ul style="list-style-type: none"> ● Lupus nephritis ● Rheumatoid arthritis ● Systemic lupus erythematosus
Respiratory Interleukins (Cinqair®, Fasenra®, & Nucala®)	Feb. 1, 2026	<p>Coverage Rationale Chronic Obstructive Pulmonary Disorder (COPD)</p> <ul style="list-style-type: none"> ● Revised medical necessity criteria: <ul style="list-style-type: none"> ○ Replaced criterion requiring “diagnosis of chronic obstructive pulmonary disorder (COPD) defined by post-bronchodilator FEV1 % predicted greater than or equal to 30% and less than or equal to 70%” with “diagnosis of chronic obstructive pulmonary disorder (COPD) defined by post-bronchodilator FEV1 % predicted greater than or equal to 20% and less than or 	<p>This policy refers to the following drug products for administration by a healthcare professional:</p> <ul style="list-style-type: none"> ● Cinqair® (reslizumab) for intravenous (IV) route ● Fasenra® (benralizumab) for subcutaneous (SC) route ● Nucala® (mepolizumab) for subcutaneous (SC) route <p>Fasenra® (benralizumab) and Nucala® (mepolizumab) for self-administered subcutaneous injection are obtained under the pharmacy benefit.</p> <p>Refer to the policy for complete details.</p>

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Respiratory Interleukins (Cinqair®, Fasenra®, & Nucala®) (continued)	Feb. 1, 2026	<ul style="list-style-type: none"> ○ equal to 80%" ○ Removed criterion requiring symptoms of chronic productive cough for at least 3 months in the past year 	
Tezspire® (Tezepelumab-Ekko)	Feb. 1, 2026	<p>Coverage Rationale Chronic Rhinosinusitis With Nasal Polyps (CRSwNP)</p> <ul style="list-style-type: none"> ● Added language to indicate Tezspire, for provider administration, is proven and medically necessary for patients who meet the following criteria: <p>Initial Therapy</p> <ul style="list-style-type: none"> ○ Diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) defined by all of the following: <ul style="list-style-type: none"> ▪ Two or more of the following symptoms for longer than 12 weeks duration: nasal mucopurulent discharge, nasal obstruction/blockage/congestion, facial pain/pressure/fullness, and/or reduction or loss of sense of smell ▪ One of the following findings using nasal endoscopy and/or sinus computed tomography (CT): purulent mucus or edema in the middle meatus or ethmoid regions, polyps in the 	<p>This policy refers to Tezspire (tezepelumab-ekko) vial and pre-filled syringe for administration by a healthcare professional. Tezspire (tezepelumab-ekko) pre-filled pen for self-administration is obtained under the pharmacy benefit.</p> <p>Severe Asthma Tezspire, for provider administration, is proven and medically necessary when all of the following criteria is met:</p> <ul style="list-style-type: none"> ● For initial therapy, all of the following: <ul style="list-style-type: none"> ○ Diagnosis of severe asthma; and ○ Classification of asthma as uncontrolled or inadequately controlled as defined by at least one of the following: <ul style="list-style-type: none"> ▪ Poor symptom control (e.g., ACQ score consistently greater than 1.5 or ACT score consistently less than 20); or ▪ Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months; or ▪ Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment); or ▪ Airflow limitation [e.g., after appropriate bronchodilator withhold FEV1 less than 80% predicted (in the face of reduced FEV1/FVC defined as less than the lower limit of normal)]; or ▪ Patient is currently dependent on maintenance therapy with oral corticosteroids for the treatment of asthma <p>and</p> <ul style="list-style-type: none"> ○ Used in combination with one of the following: <ul style="list-style-type: none"> ▪ One maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta₂ agonist (LABA) product [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]; or ▪ Combination therapy including both of the following:

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Tezspire® (Tezepelumab-Ekko) (continued)	Feb. 1, 2026	<p>nasal cavity or the middle meatus, or radiographic imaging demonstrating mucosal thickening or partial or complete opacification of paranasal sinuses</p> <ul style="list-style-type: none"> ▪ Presence of bilateral nasal polyposis or the patient has previously required surgical removal of bilateral nasal polyps ▪ Patient has required prior sinus surgery, has required systemic corticosteroids (e.g., prednisone, methylprednisolone) for CRSwNP in the previous 2 years, or has been unable to obtain symptom relief after trial of two of the following classes of agents: <ul style="list-style-type: none"> – Nasal saline irrigations – Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone) – Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton) <ul style="list-style-type: none"> ○ One of the following: <ul style="list-style-type: none"> ▪ History of failure, 	<ul style="list-style-type: none"> – One maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco®), mometasone furoate (Asmanex®), beclomethasone dipropionate (QVAR®)]; and – One additional asthma controller medication [e.g., LABA - olodaterol (Striverdi®) or indacaterol (Arcapta®), leukotriene receptor antagonist – montelukast (Singulair®), theophylline] <p>and</p> <ul style="list-style-type: none"> ○ One of the following: <ul style="list-style-type: none"> ▪ Both of the following: <ul style="list-style-type: none"> – Tezspire will be used to treat eosinophilic asthma; and – History of failure, contraindication, or intolerance to a 4-month trial of both of the following: <ul style="list-style-type: none"> • Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab), Fasentra (benralizumab)]; and • Anti-interleukin 4 [e.g., Dupixent (dupilumab)] or ▪ Both of the following: <ul style="list-style-type: none"> – Tezspire will be used to treat persistent allergic asthma; and – History of failure, contraindication, or intolerance to a 4-month trial of Xolair (omalizumab) or ▪ Both of the following: <ul style="list-style-type: none"> – Tezspire will be used to treat oral corticosteroid dependent asthma; and – History of failure, contraindication, or intolerance to a 4-month trial of Dupixent (duplimab) or ▪ Patient’s asthma is not of the eosinophilic allergic or oral corticosteroid dependent phenotype; or ▪ Patient is currently on Tezspire <p>and</p> <ul style="list-style-type: none"> ○ Patient is not receiving Tezspire in combination with any of the following for treatment of the same indication: <ul style="list-style-type: none"> ▪ Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasentra (benralizumab), Nucala (mepolizumab)]; or ▪ Anti-IgE therapy [e.g., Xolair (omalizumab)]; or ▪ Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Tezspire® (Tezepelumab-Ekko) (continued)	Feb. 1, 2026	<ul style="list-style-type: none"> contraindication, or intolerance to a 4-month trial of two of the following: <ul style="list-style-type: none"> – Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab)]; – Anti-interleukin 4 [e.g., Dupixent (dupilumab)]; – Anti-IgE therapy [e.g., Xolair (omalizumab)] ▪ Patient is currently on Tezspire therapy ○ Patient will receive Tezspire as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone) ○ Patient is not receiving Tezspire in combination with any of the following for treatment of the same indication: <ul style="list-style-type: none"> ▪ Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)] ▪ Anti-IgE therapy [e.g., Xolair (omalizumab)] ▪ Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] ○ Dosing is in accordance with the U.S. FDA approved 	<ul style="list-style-type: none"> and ○ One of the following: <ul style="list-style-type: none"> ▪ Physician attestation that the patient or caregiver is not competent or is physically unable to administer the Tezspire product FDA labeled for self-administration; or ▪ Patient has documented history of severe hypersensitivity reactions (e.g., anaphylaxis, angioedema, bronchospasm, or hypotension) to Tezspire within the past 6 months and requires administration and direct monitoring by a healthcare professional; or ▪ Patient is new to therapy with Tezspire and requires initial dose to be directly monitored by a healthcare professional before continued self-administration (Note: Authorization will be for 1 dose) and ○ Tezspire dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Tezspire is prescribed by a pulmonologist or allergist/immunologist; and ○ Initial authorization will be for no more than 12 months ● For continuation of therapy, all of the following: <ul style="list-style-type: none"> ○ Documentation of a positive clinical response as demonstrated by at least one of the following: <ul style="list-style-type: none"> ▪ Reduction in the frequency of exacerbations; or ▪ Decreased utilization of rescue medications; or ▪ Increase in percent predicted FEV1 from pretreatment baseline; or ▪ Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.) and ○ Used in combination with an ICS-containing maintenance medication; and ○ Patient is not receiving Tezspire in combination with any of the following for treatment of the same indication: <ul style="list-style-type: none"> ▪ Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)]; or ▪ Anti-IgE therapy [e.g., Xolair (omalizumab)]; or

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Tezspire® (Tezepelumab-Ekko) (continued)	Feb. 1, 2026	<ul style="list-style-type: none"> ○ labeling ○ Prescribed by an allergist/immunologist/otolaryngologist/ pulmonologist ○ Initial authorization will be for no more than 12 months <p>Continuation of Therapy</p> <ul style="list-style-type: none"> ○ Documentation of positive clinical response to Tezspire therapy ○ Patient will continue to receive Tezspire as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone) ○ Patient is not receiving Tezspire in combination with any of the following for treatment of the same indication: <ul style="list-style-type: none"> ▪ Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasentra (benralizumab), Nucala (mepolizumab)] ▪ Anti-IgE therapy [e.g., Xolair (omalizumab)] ▪ Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] ○ Dosing is in accordance with the U.S. FDA approved labeling ○ Reauthorization will be for no more than 12 months 	<ul style="list-style-type: none"> ▪ Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] <p>and</p> <ul style="list-style-type: none"> ○ One of the following: <ul style="list-style-type: none"> ▪ Physician attestation that the patient or caregiver is not competent or is physically unable to administer the Tezspire product FDA labeled for self-administration; or ▪ Patient has documented history of severe hypersensitivity reactions (e.g., anaphylaxis, angioedema, bronchospasm, or hypotension) to Tezspire within the past 6 months and requires administration and direct monitoring by a healthcare professional <p>and</p> <ul style="list-style-type: none"> ○ Tezspire dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Reauthorization will be for no more than 12 months <p>Chronic Rhinosinusitis With Nasal Polyps (CRSwNP) Tezspire, for provider administration, is proven and medically necessary when all of the following criteria are met:</p> <ul style="list-style-type: none"> ● For initial therapy, all of the following: <ul style="list-style-type: none"> ○ Diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) defined by all of the following: <ul style="list-style-type: none"> ▪ Two or more of the following symptoms for longer than 12 weeks duration: <ul style="list-style-type: none"> – Nasal mucopurulent discharge – Nasal obstruction, blockage, or congestion – Facial pain, pressure, and/or fullness – Reduction or loss of sense of smell <p>and</p> <ul style="list-style-type: none"> ▪ One of the following findings using nasal endoscopy and/or sinus computed tomography (CT): <ul style="list-style-type: none"> – Purulent mucus or edema in the middle meatus or ethmoid regions; or – Polyps in the nasal cavity or the middle meatus; or – Radiographic imaging demonstrating mucosal thickening or partial or complete opacification of paranasal sinuses <p>and</p> <ul style="list-style-type: none"> ▪ One of the following:

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Tezspire® (Tezepelumab-Ekko) (continued)	Feb. 1, 2026	<p>Applicable Codes</p> <ul style="list-style-type: none"> Added ICD-10 diagnosis codes J31.0, J32.0, J32.1, J32.2, J32.3, J32.4, J32.8, J32.9, J33.0, J33.1, J33.8, and J33.9 <p>Supporting Information</p> <ul style="list-style-type: none"> Updated <i>Background, Clinical Evidence, FDA, and References</i> sections to reflect the most current information 	<ul style="list-style-type: none"> Presence of bilateral nasal polyposis; or Patient has previously required surgical removal of bilateral nasal polyps <p>and</p> <ul style="list-style-type: none"> One of the following: <ul style="list-style-type: none"> Patient has required prior sinus surgery; or Patient has required systemic corticosteroids (e.g., prednisone, methylprednisolone) for CRSwNP in the previous 2 years; or Patient has been unable to obtain symptom relief after trial of two of the following classes of agents: <ul style="list-style-type: none"> Nasal saline irrigations Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone) Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton) <p>and</p> <ul style="list-style-type: none"> One of the following: <ul style="list-style-type: none"> History of failure, contraindication, or intolerance to a 4-month trial of two of the following: <ul style="list-style-type: none"> Anti-interleukin 5 therapy [e.g., Nucala (mepolizumab)] Anti-interleukin 4 [e.g., Dupixent (dupilumab)] Anti-IgE therapy [e.g., Xolair (omalizumab)] or Patient is currently on Tezspire therapy <p>and</p> <ul style="list-style-type: none"> Patient will receive Tezspire as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone); and Patient is not receiving Tezspire in combination with any of the following for treatment of the same indication: <ul style="list-style-type: none"> Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasentra (benralizumab), Nucala (mepolizumab)] Anti-IgE therapy [e.g., Xolair (omalizumab)] Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] <p>and</p> <ul style="list-style-type: none"> Dosing is in accordance with the United States Food and Drug

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Tezspire® (Tezepelumab-Ekko) (continued)	Feb. 1, 2026		<ul style="list-style-type: none"> ○ Administration approved labeling; and ○ Prescribed by an allergist/immunologist/otolaryngologist/pulmonologist; and ○ Initial authorization will be for no more than 12 months ● For continuation of therapy, all of the following: <ul style="list-style-type: none"> ○ Documentation of positive clinical response to Tezspire therapy; and ○ Patient will continue to receive Tezspire as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone); and ○ Patient is not receiving Tezspire in combination with any of the following for treatment of the same indication: <ul style="list-style-type: none"> ▪ Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)] ▪ Anti-IgE therapy [e.g., Xolair (omalizumab)] ▪ Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] and ○ Dosing is in accordance with the United States Food and Drug Administration approved labeling; and ○ Reauthorization will be for no more than 12 months

General Information

The inclusion of a health service (e.g., test, drug, device, or procedure) in this bulletin indicates only that UnitedHealthcare is adopting a new policy and/or updated, revised, replaced, or retired an existing policy; it does not imply that UnitedHealthcare provides coverage for the health service. Note that most benefit plan documents exclude from benefit coverage health services identified as investigational or unproven/not medically necessary. Physicians and other health care professionals may not seek or collect payment from a member for services not covered by the applicable benefit plan unless first obtaining the member's written consent, acknowledging that the service is not covered by the benefit plan and that they will be billed directly for the service.

Note: The absence of a policy does not automatically indicate or imply coverage. As always, coverage for a health service must be determined in accordance with the member's benefit plan and any applicable federal or state regulatory requirements. Additionally, UnitedHealthcare reserves the right to review the clinical evidence supporting the safety and effectiveness of a medical technology prior to rendering a coverage determination.

UnitedHealthcare respects the expertise of the physicians, health care professionals, and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Medical Policy Update Bulletin was developed to share important information regarding changes to our Community Plan Medical Policies and Medical Benefit Drug Policies. When information in this bulletin conflicts with applicable state and/or federal law, UnitedHealthcare follows such applicable federal and/or state law.

Policy Update Classifications

New

New clinical coverage criteria have been adopted for a health service (e.g., test, drug, device, or procedure)

Updated

An existing policy has been reviewed and changes have not been made to the clinical coverage criteria; however, items such as the clinical evidence, FDA information, and/or list(s) of applicable codes may have been updated

Revised

An existing policy has been reviewed and revisions have been made to the clinical coverage criteria

Replaced

An existing policy has been replaced with a new or different policy

Retired

The health service(s) addressed in the policy are no longer being managed or are considered to be proven/medically necessary and are therefore not excluded as unproven/not medically necessary services, unless coverage guidelines or criteria are otherwise documented in another policy



The complete library of UnitedHealthcare Community Plan Medical Policies and Medical Benefit Drug Policies is available at UHCprovider.com > Policies and Protocols > Community Plan Policies > Medical & Drug Policies.