United Healthcare Community Plan

UnitedHealthcare Community Plan
Medical Policy Update Bulletin: March 2026

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Airway Clearance Devices	Mar. 1, 2026	**Coverage Rationale**
		• Updated language pertaining to medical necessity clinical coverage criteria for a **high-frequency chest wall oscillation (HFCWO) system**; replaced reference to the "InterQual® Client Defined, CP: Durable Medical Equipment, Secretion Clearance Devices (Custom) - UHG" with "InterQual® Client Defined, CP: Durable Medical Equipment, *Airway or* Secretion Clearance Devices (Custom) - UHG"
		Medical Records Documentation Used for Reviews
		• Updated list of Medical Records Documentation Used for Reviews:
		  ○ Added:
		  ▪ Specific device being requested and if request is for initial trial or on-going request
		  ▪ Results of all recent relevant imaging and diagnostic testing
		  ▪ Comorbidities
		  ▪ For continuation beyond the two-month trial, include proper use
		  ○ Removed:
		  ▪ Current prescription from physician
		  ▪ CT scan report confirming diagnosis of Bronchiectasis if applicable
		  ○ Replaced "failed standard treatments to adequately mobilize retained secretions" with "treatments *tried*, failed, or *contraindicated* to adequately mobilize retained secretions; *include the dates, duration, and reason for discontinuation*"
		Supporting Information
		• Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information

Embolization of the Ovarian and Iliac Veins for Pelvic Congestion Syndrome	Mar. 1, 2026	**Definitions**
		• Updated definition of:
		  ○ Internal Iliac Vein (Hypogastric Vein)
		  ○ Ovarian Vein
		Supporting Information
		• Updated *Clinical Evidence* and *References* sections to reflect the most current information

Manipulation Under Anesthesia	Mar. 1, 2026	**Definitions** • Updated definition of "Arthrofibrosis" **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information
Minimally Invasive Spine Surgery Procedures	Mar. 1, 2026	**Definitions** • Added definition of "Transforaminal Lumbar Interbody Fusion" • Removed definition of: ○ Interlaminar Lumbar Instrumented Fusion (ILIF)

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Minimally Invasive Spine Surgery Procedures (continued)	Mar. 1, 2026	○ Nucleoplasty ○ Percutaneous or Endoscopic Lumbar Fusion ○ Transforaminal (TESSYS®) and Interlaminar Endoscopic Surgical Systems ○ Tubular Retractor • Updated definition of: ○ Automated Percutaneous Lumbar Discectomy (APLD) ○ Axial Lumbar Interbody Fusion (AxiaLIF) ○ Endoscope ○ Endoscopic Discectomy ○ Fluoroscopy ○ Image-Guided Minimally Invasive Lumbar Decompression (MILD®) ○ Interbody Fusion ○ Laparoscopic Anterior Lumbar Interbody Fusion (LALIF) ○ Open Spine Surgery ○ Percutaneous Endoscopic Lumbar Discectomy (PELD) ○ Percutaneous Image-Guided Lumbar Decompression (PILD) ○ Posterior Lumbar Spine Surgery ○ Sacroplasty **Applicable Codes** • Updated list of applicable CPT codes to reflect annual edits: ○ Added 62330 and 62331 ○ Removed 0275T ○ Revised description for 62287 **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information
Surgery of the Hip	Apr. 1, 2026	**Application** ***Louisiana*** • Removed content/language pertaining to the state of **Louisiana** **Definitions** • Updated definition of “Radiographic Findings of Osteoarthritis” **Applicable Codes** • Added notation to indicate iliopsoas tendon release surgery, capsular repair, and capsular release surgery are considered integral to the primary hip procedure and not separately reimbursable; debridement during hip arthroscopy is considered integral to the FAI surgery CPT codes 29914, 29915, and 29916 and would therefore not be separately reimbursable

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Surgery of the Hip (continued)	Apr. 1, 2026	**Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information

Surgery of the Knee	Mar. 1, 2026	**Definitions**
		• Added definition of:
		  ○ Disabling Pain
		  ○ Functional Disability
		  ○ Outerbridge Grades
		  ○ Radiographic Findings of Osteoarthritis
		  ○ Western Ontario and McMaster Universities Arthritis Index (WOMAC)
		Applicable Codes
		• Updated list of applicable CPT codes to reflect annual edits; removed 27445
		Supporting Information
		• Updated *References* section to reflect the most current information

Transcranial Magnetic Stimulation for Treating Physical Health Conditions	Mar. 1, 2026	**Title Change** • Previously titled *Transcranial Magnetic Stimulation* **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/ Replacements	May 1, 2026	**Coverage Rationale** • Added language to indicate this policy does not apply to Durable Medical Equipment or supplies used in an outpatient or inpatient facility ***Home Mechanical Ventilators and Respiratory Assist Devices (Applies for 2 Years of Age or Older)*** • Added language to indicate home mechanical ventilators are not medically necessary for individuals with stable COPD with	This Medical Policy does not apply to Durable Medical Equipment or supplies used in an outpatient or inpatient facility. When determining medical necessity, clinical guidelines will be applied in the following order: 1. Federal, state, and contractual requirements 2. UnitedHealthcare Community Plan Medical Policy 3. InterQual® CP: Durable Medical Equipment 4. InterQual® Medicare: Post Acute & Durable Medical Equipment, Ventilators NCD 5. Centers for Medicare & Medicaid Services (CMS) DME Medicare Administrative Contractor (MAC) **Durable Medical Equipment (DME), related supplies, and orthotics are medically necessary when:**

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Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/ Replacements (continued)	May 1, 2026	an arterial $PaCO_2$ of less than 52 mm Hg while awake on room air • Replaced reference to "mechanical ventilators" with "*home* mechanical ventilators" • Replaced language indicating: ○ "*For members 2 years of age and older,* ventilators are not medically necessary when *used only to deliver continuous or intermittent positive airway pressure for adults and children; any type of ventilator would not be medically necessary when* [the listed criteria are met]" with "*home mechanical* ventilators are not medically necessary when [the listed criteria are met]" ○ "A bilevel PAP *device*, with or without backup rate, is considered unproven and not medically necessary due to insufficient *high-quality* evidence of safety and efficacy for individuals with central sleep apnea (CSA) and obstructive sleep apnea (OSA) when adherent use of bilevel PAP is for less than 4 hours during sleep time on at least 21 to 30 consecutive 24-hour periods" with "bilevel PAP, with or without backup rate, is considered unproven and not medically necessary	• Consistent with the state definition of DME and/or orthotic; and • The item(s) meets the plan's definition of medically necessary (refer to the federal, state, or contractual requirements); and • Ordered by a physician or ordered by a nurse practitioner, clinical nurse specialist, or physician assistant acting within the scope of practice under state law; and • The item is not otherwise excluded from coverage **Home Mechanical Ventilators and Respiratory Assist Devices (Applies for 2 Years of Age or Older)** **Home mechanical ventilators are not medically necessary when:** • Used only in a bilevel positive airway pressure (PAP) mode (HCPCS codes E0470 and E0471); or • Used for conditions that qualify for use of a respiratory assistance device that are not life-threatening conditions for which interruption of respiratory support would quickly lead to serious harm or death; or • Used only to deliver continuous or intermittent PAP (HCPCS codes E0465 and E0466) **Home mechanical ventilators (HCPCS codes E0465 and E0466) are considered medically necessary to treat neuromuscular diseases, thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease (COPD) in certain clinical scenarios.** For medical necessity clinical coverage criteria, refer to the InterQual® Client Defined, CP: Durable Medical Equipment Home Mechanical Ventilation Devices: Invasive, Noninvasive, and Multifunction (Custom) – UHG. Click here to view the InterQual® criteria. **Home mechanical ventilators are not medically necessary for individuals with stable COPD, with an arterial $PaCO_2$ of less than 52 mm Hg while awake on room air.** **Bilevel PAP devices (HCPCS codes E0470 and E0471) are considered medically necessary in certain clinical scenarios.** For medical necessity

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Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/ Replacements (continued)	May 1, 2026	due to insufficient evidence of safety and efficacy for individuals with central sleep apnea and obstructive sleep apnea when adherent use of bilevel PAP is for less than 4 hours during sleep time on at least 21 to 30 consecutive 24-hour periods" ○ "Bilevel PAP is *considered* unproven and not medically necessary due to insufficient *high-quality* evidence of safety and efficacy for *patients* with chronic obstructive pulmonary disease (COPD) *when an* arterial $PaCO_2$ *is* less than 52 mm Hg while awake, even when the asleep $PaCO_2$ is at 55 mm Hg or more for at least 10 minutes, or asleep $PaCO_2$ increase of > 10 mm Hg from baseline awake and > 50 mm Hg for at least 10 minutes during sleep time" with "bilevel PAP is unproven and not medically necessary due to insufficient evidence of safety and efficacy for *individuals* with chronic obstructive pulmonary disease (COPD), *with an* arterial $PaCO_2$ *of* less than 52 mm Hg while awake *on room air* (even when the asleep $PaCO_2$ is at 55 mm Hg or more for at least 10 minutes or asleep $PaCO_2$ increase of > 10	clinical coverage criteria, refer to the InterQual® CP: Durable Medical Equipment, Noninvasive Airway Assistive Devices. Click here to view the InterQual® criteria. **Due to insufficient evidence of safety and efficacy, bilevel PAP, with or without backup rate, is considered unproven and not medically necessary for individuals with central sleep apnea and obstructive sleep apnea when adherent use of bilevel PAP is for less than 4 hours during sleep time on at least 21 to 30 consecutive 24-hour periods.** **Due to insufficient evidence of safety and efficacy, bilevel PAP is unproven and not medically necessary for individuals with COPD, with an arterial $PaCO_2$ of less than 52 mm Hg while awake on room air (even when the asleep $PaCO_2$ is at 55 mm Hg or more for at least 10 minutes or asleep $PaCO_2$ increase of > 10 mm Hg from baseline awake and > 50 mm Hg for at least 10 minutes during sleep time).**

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Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/ Replacements (continued)	May 1, 2026	mm Hg from baseline awake and > 50 mm Hg for at least 10 minutes during sleep time)" • Revised list of uses for home mechanical ventilators that are not medically necessary; replaced "ventilators, *such as Trilogy mechanical ventilators* (HCPCS codes E0465 and E0466), used *for the treatment of conditions that* deliver continuous or intermittent positive airway pressure" with "[ventilators] used *only* to deliver continuous or intermittent positive airway pressure (HCPCS codes E0465 and E0466)" • Revised language pertaining to medical necessity clinical coverage criteria: ○ Added reference to the InterQual® Client Defined, CP: Durable Medical Equipment Home Mechanical Ventilation Devices: Invasive, Noninvasive, and Multifunction (Custom) – UHG ○ Removed reference to the InterQual® Medicare: Post Acute & Durable Medical Equipment, Ventilators NCD **Medical Records Documentation Used for Reviews** • Added language to indicate: ○ Benefit coverage for health services is determined by the federal, state, or contractual	

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Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/ Replacements (continued)	May 1, 2026	requirements, and applicable laws that may require coverage for a specific service ○ Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the guidelines titled Medical Records Documentation Used for Reviews **Benefit Considerations** • Removed language indicating tracheo-esophageal prosthetics and voice aid prosthetics are covered as Durable Medical Equipment **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation	May 1, 2026	**Coverage Rationale** • Revised list of unproven and not medically necessary indications; replaced "pulsed electrical stimulation (PES)" with "*pulsed electromagnetic field stimulation (PEMF)* [*also known as* pulsed electrical stimulation (PES)] **Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews:	**Transcutaneous electrical nerve stimulator (TENS) is proven and medically necessary in certain circumstances.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Durable Medical Equipment, Transcutaneous Electrical Nerve Stimulation (TENS). Click here to view the InterQual® criteria. **Functional electrical stimulation (FES) is proven and medically necessary as a component of a comprehensive ambulation rehabilitation program in individuals with lower limb paralysis due to spinal cord injury (SCI) when all the following criteria are met:** • Demonstration of intact lower motor units (L1 and below) (both muscle and peripheral nerves); and

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Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (continued)	May 1, 2026	***Functional Neuromuscular Stimulation (FES)*** ○ Added "physician treatment plan" ○ Replaced: ▪ "*Date of spinal cord* injury *and/or restorative* surgery" with "*prior relevant* surgery(ies) *and history of condition requiring procedure, including* dates of injury/surgery"" ▪ "Transfer ability and independent standing tolerance" with "independent transfer ability and standing tolerance" ▪ "Absence of hip and knee degenerative disease" with "*presence or* absence of hip and knee degenerative disease" ▪ "Absence of history of long bone fracture secondary to osteoporosis" with "*presence or* absence of history of long bone fracture secondary to osteoporosis" ▪ "*High level of* motivation, commitment, and cognitive ability for device use" with "*member's* motivation level,	• Muscle and joint stability for weight bearing at upper and lower extremities that can demonstrate balance and control to maintain an upright support posture independently; and • Demonstration of brisk muscle contraction; and • Demonstration of sensory perception sufficient for muscle contraction; and • Demonstration of a high level of motivation, commitment, and cognitive ability for device use; and • Ability to transfer independently; and • Demonstration of independent standing tolerance for at least 3 minutes; and • Demonstration of hand and finger function to manipulate controls; and • Post-recovery from SCI and restorative surgery of at least 6 months; and • Absence of hip and knee degenerative disease; and • Absence of history of long bone fracture secondary to osteoporosis **FES is unproven and not medically necessary due to insufficient evidence of efficacy for treating any other indication not listed above.** **Neuromuscular electrical stimulation (NMES) is proven and medically necessary for treating any of the following indications:** • Disuse muscle atrophy if: ○ The nerve supply to the muscle is intact; and ○ The disuse muscle atrophy is not of neurological origin but results from other conditions, such as casting, splinting, or contractures or • When used as part of a comprehensive lower limb rehabilitation program following total knee arthroplasty; or • To improve upper extremity function in persons with partial paralysis following stroke when used as part of a comprehensive rehabilitation program **NMES is unproven and not medically necessary due to insufficient evidence of efficacy for treating any condition not meeting the criteria above.**

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Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (continued)	May 1, 2026	commitment, and cognitive ability for device use" ***Neuromuscular Electrical Stimulators (NMES)*** ○ Added: ▪ Specific device being requested and if request is for initial trial, on-going application, or replacement ▪ Comorbidities ○ Removed "current prescription from physician" ○ Replaced: ▪ "Diagnoses *for the* condition(s) *needing* treatment" with "diagnosis *and history of* condition *requiring* treatment" ▪ "*Clinical notes including history,* physical exam, and *laboratory* testing" with "*relevant* physician exam *and results of all recent relevant imaging and diagnostic* testing" ***Transcutaneous Electrical Nerve Stimulation (TENS)*** ○ Added: ▪ Condition requiring treatment ▪ Specific device being requested and if request is for initial trial, on-going application, or replacement	**The following are unproven and not medically necessary due to insufficient evidence of efficacy:** • Interferential therapy (IFT) for treating musculoskeletal disorders/injuries, or to facilitate healing of nonsurgical soft tissue injuries or bone fractures • Microcurrent electrical nerve stimulation (MENS) • Percutaneous electrical nerve stimulation (PENS) or percutaneous neuromodulation therapy (PNT) • Percutaneous electrical nerve field stimulation (PENFS) • Percutaneous peripheral nerve stimulation (PNS)* • Peripheral subcutaneous field stimulation (PSFS) or peripheral nerve field stimulation (PNFS) • Pulsed electromagnetic field stimulation (PEMF) [also known as pulsed electrical stimulation (PES)] • Restorative neurostimulation • Scrambler therapy • Translingual stimulation for gait rehabilitation *For information regarding percutaneous peripheral nerve stimulation for occipital neuralgia and headache, refer to the Medical Policy titled Occipital Nerve Injections and Ablation (Including Occipital Neuralgia and Headache). **Note**: For information regarding dorsal root ganglion (DRG) stimulation, refer to the Medical Policy titled Implanted Electrical Stimulator for the Spinal Cord.

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Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation (continued)	May 1, 2026	▪ Physician treatment plan ▪ For replacement, also include current device used and reason for replacement **Applicable Codes** • Added CPT code 64567 • Removed CPT code 0720T **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	
Gender Dysphoria Treatment	May 1, 2026	**Coverage Rationale** • Replaced language indicating: ○ "Surgical treatment for Gender Dysphoria may be indicated for individuals who provide the [listed] documentation" with "surgical treatment for Gender Dysphoria may be indicated for individuals who provide documentation *that the individual meets all of the* [listed] *criteria*" ○ "The [listed] surgical procedures and/or therapies to treat Gender Dysphoria are medically necessary and covered as a *proven* benefit when the criteria in the policy are met" with "the [listed] surgical procedures and/or therapies to treat Gender Dysphoria are medically necessary and covered as a	**Note**: This Medical Policy does not apply to individuals with ambiguous genitalia or disorders of sexual development. **Surgical treatment for Gender Dysphoria may be indicated for individuals who provide documentation that the individual meets all of the following criteria:** • Persistent, well-documented Gender Dysphoria; and • Capacity to make a fully informed decision and to consent for treatment; and • Must be at least 18 years of age; and • Favorable psychosocial-behavioral evaluation including screening and identification of risk factors or potential postoperative challenges For **breast surgery** (mastectomy, breast reduction, or breast augmentation), in addition to the above criteria, a written clinical assessment from at least one Qualified Healthcare Professional experienced in treating Gender Dysphoria is required; the assessment must document that an individual meets the following criteria: • For breast augmentation, continued Gender Dysphoria following the completion of 12 months of continuous hormone therapy prior to the breast procedure is required

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Gender Dysphoria Treatment (continued)	May 1, 2026	benefit when the criteria in the policy are met" • Revised coverage criteria for breast surgery (mastectomy, breast reduction, or breast augmentation); replaced criterion requiring "*for mastectomy or breast reduction,* individuals must be at least 18 years of age*, however, individuals within one calendar year of turning 18 can be considered on a case-by-case basis*" with "individuals must be at least 18 years of age" • Revised list of examples of ancillary procedures that are considered cosmetic and not medically necessary when performed as part of surgical treatment for Gender Dysphoria: ○ Added: ▪ Clavicular shortening ▪ Rib reconstruction ○ Replaced: ▪ "Facial bone remodeling *for facial feminization*" with "facial bone remodeling" ▪ "Pectoral implants *for chest masculinization*" with "pectoral implants" **Benefit Considerations** • Updated list of examples of non-covered treatments/services; removed "reproduction services including but not limited to sperm preservation in advance of	For **thyroid cartilage reduction and/or voice modification surgery** (e.g., laryngoplasty, glottoplasty, or shortening of the vocal cords), in addition to the above criteria, a written clinical assessment from at least one Qualified Healthcare Professional experienced in treating Gender Dysphoria is required; the assessment must document that an individual meets **all** of the following criteria: • Completion of 6 months of continuous hormone therapy prior to surgery is required for voice masculinization • For voice modification surgery, documentation of presurgical voice lessons and/or therapy For **genital surgery**, in addition to the above criteria, a written clinical assessment from at least two Qualified Healthcare Professional experienced in treating Gender Dysphoria, who have independently assessed the individual, is required; the assessment must document that an individual meets **all** of the following criteria: • Complete at least 12 months of successful continuous full-time real-life involvement in the identified gender • Complete 12 months of continuous hormone therapy appropriate for the experienced gender (unless medically contraindicated or not indicated for gender) • Treatment plan that includes ongoing follow-up and care by a Qualified Healthcare Professional experienced in treating Gender Dysphoria **When the above criteria are met, the following surgical procedures and/or therapies to treat Gender Dysphoria are medically necessary and covered as a benefit:** • Bilateral mastectomy or breast reduction • Breast augmentation with breast implants or fat transfer • Clitoroplasty (creation of clitoris) • Hysterectomy (removal of uterus) • Labiaplasty (creation of labia) • Laser or electrolysis hair removal in advance of genital reconstruction prescribed by a physician for the treatment of Gender Dysphoria • Metoidioplasty (creation of penis, using clitoris) • Orchiectomy (removal of testicles) • Penectomy (removal of penis)

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Gender Dysphoria Treatment (continued)	May 1, 2026	hormone treatment or Gender Dysphoria surgery, cryopreservation of fertilized embryos, oocyte preservation, surrogate parenting, donor eggs, donor sperm, and host uterus" • Added language for *Fully-Insured Group Policies in New York Only* to indicate: ○ In accordance with the requirements of New York Insurance Law, Section 4902 and the New York State Office of Mental Health (OMH) Memorandum: *Clinical Review Criteria for the Treatment of Gender Dysphoria: New Standards of Care for Transgender Health*, dated May 14, 2024: ▪ Health maintenance organizations and health insurers must apply utilization review criteria consistent with version 8 of the World Professional Association for Transgender Health (WPATH) Standards of Care when conducting utilization review of treatment for Gender Dysphoria ▪ Accordingly, for fully-insured plans in New York, coverage for medically necessary	• Penile prosthesis • Phalloplasty (creation of penis) • Salpingo-oophorectomy (removal of fallopian tubes and ovaries) • Scrotoplasty (creation of scrotum) • Testicular prostheses • Thyroid cartilage reduction/reduction thyroid chondroplasty/tracheal shave (removal or reduction of the Adam's apple) • Urethroplasty (reconstruction of female urethra) • Urethroplasty (reconstruction of male urethra) • Vaginectomy (removal of vagina) • Vaginoplasty (creation of vagina) • Voice lessons and/or voice therapy (with or without surgery) • Voice modification surgery (e.g., laryngoplasty, glottoplasty, or shortening of the vocal cords) • Vulvectomy (removal of vulva) **Gender affirming surgery is considered an irreversible intervention. Although infrequent, reversal of prior gender affirming surgery may be covered when the medical necessity criteria for the requested treatment above are met.** **Certain ancillary procedures, including but not limited to the following, are considered cosmetic and not medically necessary, when performed as part of surgical treatment for Gender Dysphoria.** Check the federal, state, or contractual requirements for benefit coverage*. Refer to the *Benefit Considerations* section of the policy as member specific benefit plan language may vary. • Abdominoplasty (also refer to the Medical Policy titled Panniculectomy Surgery) • Blepharoplasty (also refer to the Medical Policy titled Brow Ptosis and Eyelid Repair) • Body contouring (e.g., fat transfer, lipoplasty, panniculectomy) (also refer to the Medical Policy titled Panniculectomy Surgery) • Brow lift • Calf implants • Cheek, chin, and nose implants

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Gender Dysphoria Treatment (continued)	May 1, 2026	treatment of gender dysphoria is based on version 8 of the WPATH Standards of Care for the Health of Transgender and Gender Diverse People ○ The criteria in the *Coverage Rationale* section of this policy is applicable only to the degree that it does not conflict with version 8 of the WPATH Standards of Care **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	• Clavicular shortening • Injection of fillers or neurotoxins (also refer to the Medical Benefit Drug Policy titled Botulinum Toxins A and B) • Face/forehead lift and/or neck tightening • Facial bone remodeling • Laser or electrolysis hair removal not related to genital reconstruction • Hair transplantation • Lip augmentation • Lip reduction • Liposuction (suction-assisted lipectomy) (also refer to the Medical Policy titled Panniculectomy Surgery) • Mastopexy • Pectoral implants • Rhinoplasty (also refer to the Medical Policy titled Rhinoplasty and Other Nasal Procedures) • Rib reconstruction • Skin resurfacing (e.g., dermabrasion, chemical peels, laser) ***Note**: For New York plans, refer to the *Benefit Considerations* section of the policy for more information.
Genetic Testing for Hereditary Cancer	May 1, 2026	**Coverage Rationale** ***Individuals With a Personal History of a Primary Solid Tumor*** • Revised coverage criteria for genetic testing with a Multigene hereditary cancer Panel for individuals with a personal history of a Primary Solid Tumor (excluding basal or squamous cell skin cancer): ○ Added criterion requiring the: ▪ Individual has serous tubal intraepithelial carcinoma	Pretest genetic counseling is strongly recommended to inform persons being tested about the advantages and limitations of the test, as applied to a unique person. **Single gene testing and known mutation testing for familial cancer are proven and medically necessary.** **Individuals With a Personal History of a Primary Solid Tumor** ***BRCA1/2* gene testing is proven and medically necessary for individuals with a personal history of Breast Cancer diagnosed at age 65 years or younger.** **Genetic testing with a Multigene hereditary cancer Panel for individuals with a personal history of a Primary Solid Tumor (excluding basal or**

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Genetic Testing for Hereditary Cancer (continued)	May 1, 2026	▪ Individual has renal cell carcinoma and any of the following: – Diagnosed at 46 years of age or younger – Diagnosed at any age with bilateral or multifocal tumors – Has one or more first- or second-degree relatives with renal cell carcinoma – Has a personal or family history of mesothelioma or uveal melanoma ▪ Individual has renal cell carcinoma and tumors have the following histological characteristics: – Multifocal papillary histology – Hereditary leiomyomatosis and renal cell cancer-associated renal cell carcinoma, renal cell carcinoma with fumarate hydratase deficiency or other histological features associated with hereditary leiomyomatosis and renal cell cancer	**squamous cell skin cancer) is proven and medically necessary when at least one of the following criteria is met:** • Individual has a personal history of at least one of the following: ○ Breast Cancer diagnosed at age 50 years or younger ○ Metastatic Breast Cancer ○ Multiple primary Breast Cancers (as a prior diagnosis or as a bilateral primary cancer) ○ Triple-Negative Breast Cancer ○ Lobular Breast Cancer and a personal or family history of diffuse gastric cancer ○ Breast Cancer and Ashkenazi Jewish ancestry ○ Breast Cancer and individual was assigned male at birth ○ Breast Cancer and unknown or Limited Family History ○ Breast Cancer or prostate cancer and at least one first- or second-degree relative with a BRCA-Related Cancer ○ Ovarian Cancer (including fallopian tube cancer, primary peritoneal cancer, sex-cord tumors with annular tubules, and/or hypercalcemic-type small cell carcinoma of the ovary) ○ Serous tubal intraepithelial carcinoma ○ Pancreatic cancer ○ Metastatic prostate cancer ○ Lynch Syndrome-Associated Cancer ○ Neuroendocrine tumor (e.g., adrenocortical carcinoma, paraganglioma, pheochromocytoma) ○ Malignant phyllodes tumors ○ Renal cell carcinoma and any of the following: ▪ Diagnosed at 46 years of age or younger ▪ Diagnosed at any age with bilateral or multifocal tumors ▪ Has one or more first- or second-degree relatives with renal cell carcinoma ▪ Has a personal or family history of mesothelioma or uveal melanoma ○ At least two different Primary Solid Tumors (excluding basal or squamous cell skin cancer) or • Individual has a personal history of a Primary Solid Tumor (excluding basal or squamous cell skin cancer) and a family history of cancer, which

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Genetic Testing for Hereditary Cancer (continued)	May 1, 2026	– Birt-Hogg-Dubé syndrome-related histology – Angiomyolipomas of the kidney and one additional tuberous sclerosis complex criterion in the same individual – Succinate dehydrogenase-deficient renal cell carcinoma histology ○ Replaced criterion requiring the "individual has a Tyrer-Cuzick, BRCAPro, or *PENN11* score of 2.5% or greater for a BRCA1/2 pathogenic variant" with "individual has a Tyrer-Cuzick, BRCAPRO, or *CanRisk* score of 2.5% or greater for a BRCA1/2 pathogenic variant" ○ Revised list of examples of Ovarian Cancer; added "sex cord tumors with annular tubules and/or hypercalcemic-type small cell carcinoma of the ovary" ***Individuals With No Personal History of a Primary Solid Tumor*** • Added language to indicate whole-exome and whole-genome sequencing for the purpose of identifying hereditary cancer	includes at least one of the following: ○ At least one Close Blood Relative with a history of a Lynch Syndrome-Associated Cancer ○ At least one Close Blood Relative diagnosed with a Primary Solid Tumor (excluding basal or squamous cell skin cancer) at age 40 years or younger ○ At least two Close Blood Relatives (in addition to affected individual) on the same side of the family diagnosed with any Primary Solid Tumor (excluding basal or squamous cell skin cancer) or • Individual has a personal history of a Primary Solid Tumor (excluding basal or squamous cell skin cancer) and at least one of the following: ○ A pathogenic variant was detected in tumor tissue that has clinical implications if detected in the germline (e.g., *BRCA1, BRCA2, BRIP1, MLH1, MSH2, MSH6, MUTYH, PALB2, PMS2, RAD51C, RAD51D, RET, SDHAF2, SDHB, SDHC, SDHD, TMEM127, TSC2, VHL APC, PTEN, RB1, TP53*) ○ Tumor tissue testing demonstrated that the cancer was microsatellite instability high or had immunohistochemical staining showing the absence of one or more mismatch repair proteins (*MLH1, MSH2, MSH6,* or *PMS2*) ○ Individual has renal cell carcinoma and tumors have the following histological characteristics: ▪ Multifocal papillary histology ▪ Hereditary leiomyomatosis and renal cell cancer-associated renal cell carcinoma, renal cell carcinoma with fumarate hydratase deficiency, or other histological features associated with hereditary leiomyomatosis and renal cell cancer ▪ Birt-Hogg-Dubé syndrome-related histology ▪ Angiomyolipomas of the kidney and one additional tuberous sclerosis complex criterion in the same individual ▪ Succinate dehydrogenase-deficient renal cell carcinoma histology ○ Individual has a Tyrer-Cuzick, BRCAPRO, or CanRisk score of 2.5% or greater for a *BRCA1/2* pathogenic variant ○ Individual has a PREMM$_5$, MMRpro, or MMRpredict score of 2.5% or greater for having a Lynch syndrome gene mutation

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Genetic Testing for Hereditary Cancer (continued)	May 1, 2026	syndromes or hereditary cancer syndrome risk is unproven and not medically necessary • Revised coverage criteria for genetic testing with a Multigene hereditary cancer Panel or testing of *BRCA1/2* for individuals with no personal history of a Primary Solid Tumor (excluding basal or squamous cell skin cancer): ○ Added criterion requiring the individual's family history includes: ▪ Two or more first- or second-degree relatives on the same side of the family with renal cell carcinoma ▪ A first-degree relative meeting criteria for genetic evaluation for renal cell carcinoma but is unwilling/unable to have genetic testing ○ Replaced criterion requiring the "individual has a Tyrer-Cuzick, BRCAPro, or *PENN11* score of 5% or greater for a BRCA1/2 pathogenic variant" with "individual has a Tyrer-Cuzick, BRCAPRO, or *CanRisk* score of 5% or greater for a BRCA1/2 pathogenic variant" **Definitions** • Removed definition of:	**Individuals With No Personal History of a Primary Solid Tumor** **Genetic testing with a Multigene hereditary cancer Panel or testing of *BRCA1/2* for individuals with no personal history of a Primary Solid Tumor (excluding basal or squamous cell skin cancer) is proven and medically necessary if at least one of the following criteria is met:** • At least one first-degree relative with a history of at least one of the following: ○ Two or more different Primary Solid Tumors (excluding basal or squamous cell skin cancer) ○ Lynch Syndrome-Associated Cancer ○ Neuroendocrine tumor (e.g., adrenocortical carcinoma, paraganglioma, pheochromocytoma) or • At least one first- or second-degree relative with a history of at least one of the following: ○ Breast Cancer diagnosed at age 50 years or younger ○ Triple-Negative Breast Cancer ○ Breast Cancer and relative was assigned male at birth ○ Metastatic prostate cancer ○ Ovarian Cancer (including fallopian tube cancer and/or primary peritoneal cancer) ○ Pancreatic cancer or • At least one second-degree relative with a history of at least one of the following: ○ Two or more Lynch Syndrome-Associated Cancers ○ Lynch Syndrome-Associated Cancer diagnosed at age 50 years or younger or • Family history includes at least one of the following: ○ Two or more second-degree relatives on the same side of the family with a Lynch Syndrome-Associated Cancer ○ Two or more first- or second-degree relatives on the same side of the family with renal cell carcinoma ○ At least three Close Blood Relatives on the same side of the family diagnosed with any Primary Solid Tumor (excluding basal or

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Genetic Testing for Hereditary Cancer (continued)	May 1, 2026	○ High Penetrance Breast Cancer Susceptibility Genes ○ Penetrance • Updated definition of: ○ Age Guidelines ○ BRCA-Related Cancers ○ Gleason Scoring ○ Lynch Syndrome-Associated Cancer ○ Ovarian Cancer ○ Personal and Family History Documentation ○ PREMM5 ○ Primary Solid Tumor **Applicable Codes** ***Multigene Panel*** • Removed CPT codes 0131U, 0132U, and 0135U ***Whole Exome and Whole Genome Sequencing*** • Added CPT codes 0212U, 0213U, 0214U, 0215U, 0265U, 0266U, 81415, 81416, 81417, 81425, 81426, and 81427 **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information	squamous cell skin cancer) ○ Ashkenazi Jewish ancestry and at least one Close Blood Relative with a BRCA-Related Cancer ○ Family member who meets diagnostic criteria (personal history of at least 10 cumulative adenomas) for a polyposis syndrome and affected family member(s) is unwilling/unable to have genetic testing ○ First-degree relative meeting criteria for genetic evaluation for renal cell carcinoma but is unwilling/unable to have genetic testing or • A personal history of colorectal polyposis with at least 10 adenomas; or • Any of the following: ○ Individual has a Tyrer-Cuzick, BRCAPRO, or CanRisk score of 5% or greater for a *BRCA1/2* pathogenic variant; or ○ Individual has a PREMM5, MMRpro, or MMRpredict score of 5% or greater for having a Lynch syndrome gene mutation **Genetic testing with a Multigene hereditary cancer Panel for individuals diagnosed with cancer at age 18 years or younger is proven and medically necessary.** **Multigene hereditary cancer Panels are unproven and not medically necessary for all other indications.** **RNA panel testing for hereditary cancers is unproven and not medically necessary for all indications.** **Genetic testing for the purpose of polygenic risk scoring for hereditary cancers is unproven and not medically necessary for all indications.** **Whole-exome and whole-genome sequencing for the purpose of identifying hereditary cancer syndromes or hereditary cancer syndrome risk is unproven and not medically necessary.**
Intensity-Modulated Radiation Therapy	May 1, 2026	**Coverage Rationale** • Revised list of conditions for which **Intensity-Modulated Radiation Therapy (IMRT) for Definitive Therapy** for the	**Note**: This policy applies to individuals 19 years of age or older. Intensity-modulated radiation therapy (IMRT) is covered without further review for individuals younger than 19 years of age. **The following are proven and medically necessary:**

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Intensity-Modulated Radiation Therapy (continued)	May 1, 2026	primary site is proven and medically necessary: ○ Replaced "breast cancer *in* the [listed] *circumstances*" with "breast cancer *when any of* the [listed] *criteria are met*" ○ Added: ▪ Hepatocellular carcinoma, unresectable ▪ Hodgkin lymphoma ▪ Intrahepatic cholangiocarcinoma, unresectable ▪ Rectal cancer when treatment involves inguinal lymph nodes ▪ Small cell lung cancer, limited stage ▪ Soft tissue sarcoma, retroperitoneal/intra-abdominal location ▪ Stage I to II non-small cell lung cancer undergoing hypofractionated radiation therapy up to 10 fractions ○ Revised list of treatment areas for head and neck cancers; replaced "larynx *(stage III or IV cancer)*" with "larynx" ○ Revised list of examples of mediastinal tumors; added "thyroid" ● Removed language indicating compensator based beam	● IMRT for Definitive Therapy for the primary site of the following conditions: ○ Anus/anal canal cancer ○ Breast cancer when any of the following criteria are met: ▪ When the left-sided internal mammary nodes are being treated; or ▪ Accelerated partial-breast irradiation of up to five fractions ○ Central nervous system tumors (primary or benign), including the brain, brainstem, and spinal cord ○ Cervical cancer ○ Endometrial cancer ○ Esophageal cancer ○ Head and neck cancers, including lymphoma and solitary plasmacytomas, when treatment includes the following areas: pharynx (nasopharynx, oropharynx, and hypopharynx), larynx, salivary glands, oral cavity (includes the tongue), nasal cavity, and paranasal sinuses ○ Hepatocellular carcinoma, unresectable ○ Intrahepatic cholangiocarcinoma, unresectable ○ Hodgkin lymphoma ○ Mediastinal tumors (e.g., lymphomas, thyroid, thymomas, tracheal cancer) ○ Non-small cell lung cancer when any of the following criteria are met: ▪ Stage I to II undergoing hypofractionated radiation therapy up to 10 fractions; or ▪ Stage III, undergoing chemoradiation therapy ○ Pancreatic cancer ○ Prostate cancer ○ Rectal cancer when treatment involves inguinal lymph nodes ○ Small cell lung cancer, limited stage ○ Soft tissue sarcoma, retroperitoneal/intra-abdominal location ○ Vulvar cancer ● Hippocampal-avoidance whole-brain radiation therapy of up to 10 fractions is considered proven and medically necessary when all the following criteria are met: ○ Brain metastasis; and ○ Eastern Cooperative Oncology Group performance status of ≤ 2 or

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Intensity-Modulated Radiation Therapy (continued)	May 1, 2026	modulation treatment is proven and medically necessary when done in combination with an IMRT indication listed [in the policy] as proven • Replaced language indicating: ○ "Hippocampal-avoidance whole brain radiation therapy of up to 10 fraction is proven and medically necessary [when] all the [listed criteria are met]" with "hippocampal-avoidance whole brain radiation therapy of up to 10 fractions is *considered* proven and medically necessary when all the [listed] criteria are met" ○ "IMRT may be *covered* for a condition that is not *listed* [in the policy] *as proven*, including recurrences or metastases in selected cases" with "IMRT may be *considered medically necessary* for a condition that is not *defined* [as proven and medically necessary in the policy], including recurrences or metastases in selected cases" **Definitions** • Updated definition of "Definitive Therapy" **Applicable Codes** • Added CPT codes 77407 and 77412	Karnofsky performance status of ≥ 70; and ○ Prognosis of 4 months or greater; and ○ Absence of leptomeningeal disease • IMRT may be considered medically necessary for a condition that is not defined above, including recurrences or metastases in selected cases. Requests for an exception will be evaluated on a case-by-case basis when at least one of the following conditions is present: ○ Use of clinically appropriate radiation dose and a non-IMRT technique would increase the probability of clinically meaningful normal tissue toxicity (i.e., as specified by the Radiation Therapy Oncology Group or QUANTEC guidelines) and is demonstrated on a comparison of treatment plans for the IMRT and non-IMRT technique (e.g., 3D conformal treatment plan) ○ The same or an immediately adjacent area has been previously irradiated, and the dose distribution in the individual must be sculpted to avoid exceeding the cumulative tolerance dose of nearby normal tissue **The following is unproven and not medically necessary due to insufficient evidence of efficacy:** • IMRT used in conjunction with proton beam radiation therapy

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Intensity-Modulated Radiation Therapy (continued)	May 1, 2026	• Removed CPT/HCPCS codes 77385, 77386, G6015, G6016, and G6017
		• Added notation to indicate:
		  ○ Standard single-isocenter IMRT or VMAT should be billed under CPT code 77407 (radiation treatment delivery, intermediate)
		  ○ CPT code 77412 (radiation treatment delivery, complex) should be used for treatments that require multiple isocenters or single-isocenter delivery with active motion-management techniques; when CPT code 77412 is reported, documentation must clearly describe the circumstances that justify level 3 rather than level 2 treatment delivery
		Supporting Information
		• Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information	

Percutaneous Vertebroplasty and Kyphoplasty	May 1, 2026	**Coverage Rationale**
		• Revised list of examples of causes of spinal pain to be ruled out by computed tomography (CT) or magnetic resonance imaging (MRI); removed:
		  ○ Facet arthropathy
		  ○ Other spinal degenerative disease
			Percutaneous vertebroplasty and kyphoplasty are proven and medically necessary for treating pain causing Functional or Physical Impairment in cervical, thoracic, or lumbar vertebral bodies, within 4 months of pain onset, that has failed to respond to Optimal Medical Therapy for the following indications:
			• Osteoporotic vertebral compression fracture (VCF)
			• Steroid-induced vertebral fracture
			• Osteolytic metastatic disease involving a vertebral body
			• Multiple myeloma involving a vertebral body

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Percutaneous Vertebroplasty and Kyphoplasty (continued)	May 1, 2026	**Medical Records Documentation Used for Reviews**
		• Updated list of Medical Records Documentation Used for Reviews:
		  ○ Added "condition requiring procedure"
		  ○ Replaced:
		  ▪ "Onset of the condition, *length,* and duration" with "onset of the condition, *including dates* and duration"
		  ▪ "*Documentation of member's* symptoms, pain, location, and severity, including functional impairment that is interfering with activities of daily living *(meals, walking, getting dressed, driving)*" with "*signs and* symptoms, including pain, location, and severity, and functional impairment that interferes with activities of daily living"
		  ▪ "*History and* comorbid medical condition(s)" with "comorbidities"
		  ▪ "*No* evidence of spinal cord compression" with "*presence or absence of* evidence of spinal cord compression"
		  ▪ "Treatments tried and failed" with "treatments
			• Vertebral Hemangioma with aggressive features
			• Unstable fractures due to Osteonecrosis (e.g., Kummel disease)
			and
			Computed tomography (CT) or magnetic resonance imaging (MRI) has ruled out other causes of spinal pain, including but not limited to:
			• Foraminal stenosis
			• Herniated intervertebral disk
			• Other significant coexistent spinal or bony pain generators
			and
			The following are not present:
			• Clinical evidence of spinal cord compression, as confirmed by CT or MRI; or
			• Significant vertebral collapse or destruction (e.g., vertebra reduced to less than one-third of its original height), as confirmed by CT or MRI; or
			• Healed VCF, as confirmed by CT or MRI; or
			• Lesions of the sacrum or coccyx (refer to the Medical Policy titled Minimally Invasive Spine Surgery Procedures for additional information on percutaneous sacral augmentation); or
			• Asymptomatic VCFs; or
			• VCFs responding appropriately to conservative therapy
			
			Percutaneous vertebroplasty and kyphoplasty are unproven and not medically necessary for treating indications other than those listed above due to insufficient evidence of efficacy.

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Percutaneous Vertebroplasty and Kyphoplasty (continued)	May 1, 2026	tried, failed, *or contraindicated; include the dates, duration, and reason for discontinuation*" ▪ "*Complete report(s) of diagnostic* imaging *(MRI, CT Scan, X-rays, and/or* bone scan)" with "*results of all recent relevant* imaging, *including assessment of* bone density" **Definitions** • Updated definition of: ○ Functional or Physical Impairment ○ Optimal Medical Therapy ○ Osteonecrosis ○ Vertebral Hemangiomas **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	
Proton Beam Radiation Therapy	May 1, 2026	**Related Policies** • Removed reference link to the Medical Policy titled *Intensity-Modulated Radiation Therapy* **Coverage Rationale** • Revised list of proven and medically necessary indications for proton beam radiation therapy (PBT) for Definitive Therapy: ○ Added: ▪ Primary Head and Neck Cancers [not listed in the	**Note**: This policy applies to individuals 19 years of age and older. Proton beam radiation therapy (PBRT, PBT) is covered without further review for individuals younger than 19 years of age. **Proton beam radiation therapy is proven and medically necessary for the following:** • Definitive Therapy for the following indications: ○ Base of Skull Tumors (e.g., chordomas, chondrosarcomas, paranasal sinus, or nasopharyngeal tumors) ○ Primary Head and Neck Cancers (not included above) when all the following criteria are met: ▪ The tumors are near critical anatomical structures, such as the orbit, skull base, or cavernous sinus or with intracranial

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Proton Beam Radiation Therapy (continued)	May 1, 2026	policy] when all the following criteria are met: – The tumors are near critical anatomical structures, such as the orbit, skull base, or cavernous sinus or with intracranial extension or perineural invasion – When documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard photon radiation therapy techniques ▪ Primary Central Nervous System Tumors (e.g., brain or spinal cord) when all the following criteria are met: – The tumors are near critical anatomical structures such as the optic nerve, brainstem, or spinal cord – When documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard photon	extension or perineural invasion; and ▪ When documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard photon radiation therapy techniques o Primary Central Nervous System Tumors (e.g., brain or spinal cord) when all the following criteria are met: ▪ The tumors are near critical anatomical structures such as the optic nerve, brainstem, or spinal cord; and ▪ When documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard photon radiation therapy techniques o Intracranial arteriovenous malformations o Ocular tumors, including intraocular/uveal melanoma (includes the iris, ciliary body, and choroid) o Primary liver malignancies, such as hepatocellular carcinoma and intrahepatic cancer (localized, unresectable) in the curative setting when documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard radiation therapy techniques, including intensity-modulated radiation therapy (IMRT), stereotactic body radiation therapy, and selective internal radiation spheres, and transarterial therapy (for example, chemoembolization) is contraindicated or not technically feasible o Primary mediastinal tumors (e.g., thymomas, mediastinal lymphomas, thoracic sarcomas) o Reirradiation when all the following criteria are met: ▪ Individuals have previously undergone radiation therapy to a specific anatomical site and now require an additional course of radiation to the same specific anatomical site; and ▪ Documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard photon radiation therapy techniques **PBT and IMRT are proven and considered clinically equivalent for treating prostate cancer. As a result, the principles of medical necessity will be applied.**

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Proton Beam Radiation Therapy (continued)	May 1, 2026	radiation therapy techniques ▪ Primary mediastinal tumors (e.g., thymomas, mediastinal lymphomas, thoracic sarcomas) ▪ Reirradiation when all the following criteria are met: – Individuals have previously undergone radiation therapy to a specific anatomical site and now require an additional course of radiation to the same specific anatomical site – Documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard photon radiation therapy techniques ○ Replaced "hepatocellular carcinoma (HCC) (localized, unresectable) in the curative setting when documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard radiation therapy techniques, including intensity-modulated radiation therapy (IMRT), stereotactic body radiation therapy	**PBT is unproven and not medically necessary due to insufficient evidence of efficacy for treating all other indications; however, PBT may be covered for a diagnosis that is not listed above as proven, including recurrences or metastases in selected cases. Requests for exceptions will be evaluated on a case-by-case basis when both of the following criteria are met:** • Documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard radiation therapy techniques; and • Evaluation includes a comparison of treatment plans for PBT and photon-based radiation therapy (such as IMRT or stereotactic body radiation therapy) for the specific individual

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Proton Beam Radiation Therapy (continued)	May 1, 2026	(SBRT), and selective internal radiation spheres, and transarterial therapy (for example, chemoembolization) is contraindicated or not technically feasible" with "*primary liver malignancies, such as* hepatocellular carcinoma *and intrahepatic cancer* (localized, unresectable) in the curative setting when documentation is provided that sparing of the surrounding normal tissue cannot be achieved with standard radiation therapy techniques, including intensity-modulated radiation therapy (IMRT), stereotactic body radiation therapy, and selective internal radiation spheres, and transarterial therapy (for example, chemoembolization) is contraindicated or not technically feasible • Revised coverage criteria for evaluation of exception requests for a covered diagnosis of PBT that is not listed [in the policy] as proven; replaced criterion requiring the "evaluation includes a comparison of treatment plans for PBT, IMRT, and stereotactic body radiation therapy for the specific individual" with "evaluation includes a	

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Proton Beam Radiation Therapy (continued)	May 1, 2026	comparison of treatment plans for PBT *and photon-based radiation therapy (such as* PBT, IMRT, or stereotactic body radiation therapy) for a specific individual"
		Medical Records Documentation Used for Reviews
		• Updated list of Medical Records Documentation Used for Reviews; added "history of prior radiation therapy and need for the additional course of radiation therapy to the same anatomical site for re-irradiation"
		Definitions
		• Added definition of:
		  ○ Base of Skull Tumors
		  ○ Central Nervous System Tumors
		  ○ Head and Neck Cancer
		• Updated definition of "Definitive Therapy"
		Applicable Codes
		• Removed CPT/HCPCS codes 77385, 77386, G6015, G6016, and G6017
		Supporting Information
		• Updated *Clinical Evidence* and *References* sections to reflect the most current information	

Spinal Fusion and Decompression	May 1, 2026	**Related Policies** • Added reference link to the Medical Policy titled *Interspinous Fusion and Decompression Devices*	**Spinal procedures for the treatment of spine pain are proven and medically necessary in certain circumstances.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures: • Decompression +/- Fusion, Cervical • Decompression +/- Fusion, Lumbar

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Spinal Fusion and Decompression (continued)	May 1, 2026	**Coverage Rationale**
		• Revised list of unproven and not medically necessary indications:
		  ○ Added "vertebral joint implants that replace the disc and facet joints (e.g., MOTUS) for the treatment of spine pain"
		  ○ Replaced:
		  ▪ "Dynamic Stabilization systems for the treatment *of degenerative Spondylolisthesis*" with "Dynamic Stabilization systems for the treatment *of spine pain*"
		  ▪ "Isolated Facet Joint Fusion, with or without instrumentation" with "Isolated Facet Joint Fusion, with or without instrumentation, *for the treatment of spine pain*"
		  ▪ "*Total* Facet Joint *Arthroplasty*" with "Facet Joint *Replacement for treatment of spine pain*"
		Definitions
		• Added definition of "Facet Joint Replacement"
		• Removed definition of:
		  ○ Disabling Symptoms
		  ○ Lumbar Spinal Stenosis (LSS)
		  ○ Progressive
		  ○ Radicular Pain
		  ○ Spinal Fusion
			• Decompression +/- Fusion, Thoracic
			• Fusion, Cervical Spine
			• Fusion, Lumbar Spine
			• Fusion, Thoracic Spine
			• Scoliosis or Kyphosis Surgery
			• Scoliosis or Kyphosis Surgery (Pediatric)
			
			Click here to view the InterQual® criteria.
			
			Dividing treatment of symptomatic, multisite spinal pathology via anterior or posterior approach into serial or Staged Multiple Sessions **when one session can address all sites is unproven and not medically necessary due to insufficient evidence of safety and efficacy.**
			
			The following procedures for the treatment of spine pain are unproven and not medically necessary due to insufficient evidence of efficacy:
			• Dynamic Stabilization systems
			• Facet Joint Replacement
			• Isolated Facet Joint Fusion, with or without instrumentation
			• Vertebral joint implants that replace the disc and facet joints (e.g., MOTUS)

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Spinal Fusion and Decompression (continued)	May 1, 2026	○ Spondylolisthesis ○ Spondylolysis ○ Total Facet Arthroplasty ○ Unremitting • Updated definition of: ○ Dynamic Stabilization ○ Isolated Facet Joint Fusion ○ Staged Multiple Sessions **Applicable Codes** • Removed CPT codes 63170, 63172, 63173, 63185, 63190, 63191, 63197, 63200, 63250, 63251, 63252, and 63265 **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	
Vertebral Body Tethering for Scoliosis	May 1, 2026	**Coverage Rationale** • Revised language to indicate: ○ Vertebral body tethering (VBT) surgery may be medically necessary for idiopathic scoliosis when all the following criteria are met: ▪ The individual meets all the following clinical criteria: – There is physician documentation to establish failed conservative management (e.g., bracing, observation, or physical therapy) prior to the initial procedure with	**Vertebral body tethering (VBT) surgery may be medically necessary for idiopathic scoliosis when all the following criteria are met:** • The individual meets all the following clinical criteria: ○ There is physician documentation to establish failed conservative management (e.g., bracing, observation, or physical therapy) prior to the initial procedure with curvature progression to at least 45 degrees; and ○ The Cobb Angle of the major coronal curve is 45 to 65 degrees for the single curve planned for surgery and none of the spinal curves present are greater than 65 degrees; and ○ Skeletal immaturity is defined by the Sanders Maturity Score of 2 to 5; and ○ The Cobb Angle decreases in magnitude to 30 degrees or less on bending films; and ○ Osseous structure is dimensionally adequate to accommodate screw fixation; and ○ The VBT instrumentation does not extend above T4 or below L4 and

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Vertebral Body Tethering for Scoliosis (continued)	May 1, 2026	curvature progression to at least 45 degrees – The Cobb Angle of the major coronal curve is 45 to 65 degrees for the single curve planned for surgery and none of the spinal curves present are greater than 65 degrees – Skeletal immaturity is defined by the Sanders Maturity Score of 2 to 5 – The Cobb Angle decreases in magnitude to 30 degrees or less on bending films – Osseous structure is dimensionally adequate to accommodate screw fixation – The VBT instrumentation does not extend above T4 or below L4 ▪ The facility where the surgical procedure will be performed has all the following: – An established, on-site surgical pediatric scoliosis program	• The facility where the surgical procedure will be performed has all the following: ○ An established, on-site surgical pediatric scoliosis program; and ○ Inpatient pediatric physical therapy is available for post-operative training; and ○ Intraoperative advanced imaging capability; and ○ A pediatric anesthesiologist on staff; and ○ A pediatric intensive care unit and • The surgery will be performed by the pediatric orthopedic spine surgeon with experience in scoliosis and surgical procedures such as VBT and who has determined that the procedure is appropriate for the individual; and • The pediatric orthopedic spine surgeon is listed as an investigator on a prospective research study being performed at the pediatric spine center that has an approved Institutional Review Board protocol that is actively recruiting participants for VBT utilizing The Tether™ Vertebral Body Tethering System, which has FDA approval under a Humanitarian Device Exemption and for which the member is a study cohort candidate; and • The individual and family have engaged in a Shared Decision-Making conversation with the pediatric orthopedic spine surgeon **Revision surgery for VBT may be medically necessary when one or more of the following are present:** • Tether breakage or other hardware failure; or • Under- or over-correction of curves; or • Removal of tether and/or anchor screws for surgical complication (e.g., impingement on vital organs, infection, intractable pain) **VBT surgery is not medically necessary when the above criteria are not met.** Refer to the *U.S. Food and Drug Administration (FDA)* section in the policy for information regarding FDA labeling and Humanitarian Device Exemption for VBT.

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Vertebral Body Tethering for Scoliosis (continued)	May 1, 2026	– Inpatient pediatric physical therapy is available for post-operative training – Intraoperative advanced imaging capability – A pediatric anesthesiologist on staff – A pediatric intensive care unit ▪ The surgery will be performed by the pediatric orthopedic spine surgeon with experience in scoliosis and surgical procedures such as VBT and who has determined that the procedure is appropriate for the individual ▪ The pediatric orthopedic spine surgeon is listed as an investigator on a prospective research study being performed at the pediatric spine center that has an approved Institutional Review Board protocol that is actively recruiting participants for VBT utilizing The Tether™ Vertebral Body Tethering System, which has FDA approval under a	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Vertebral Body Tethering for Scoliosis (continued)	May 1, 2026	Humanitarian Device Exemption and for which the member is a study cohort candidate ▪ The individual and family have engaged in a Shared Decision-Making conversation with the pediatric orthopedic spine surgeon ○ Revision surgery for VBT may be medically necessary when one or more of the following are present: ▪ Tether breakage or other hardware failure ▪ Under- or over-correction of curves ▪ Removal of tether and/or anchor screws for surgical complication (e.g., impingement on vital organs, infection, intractable pain) ○ VBT surgery is not medically necessary when the above criteria are not met ○ Refer to the *U.S. Food and Drug Administration (FDA)* section [of the policy] for information regarding FDA labeling and Humanitarian Device Exemption for VBT **Medical Records Documentation Used for Reviews** ● Added language to indicate:	

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Vertebral Body Tethering for Scoliosis (continued)	May 1, 2026	○ Benefit coverage for health services is determined by the federal, state, or contractual requirements, and applicable laws that may require coverage for a specific service ○ Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the guidelines titled Medical Records Documentation Used for Reviews **Definitions** • Added definition of: ○ Cobb Angle ○ Lenke Classification System ○ Institutional Review Board (IRB) ○ Sanders Skeletal Maturity Staging System ○ Shared Decision-Making **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	

Replaced

Policy Title	Effective Date	Summary of Changes
Walkers	May 1, 2026	• Replaced policy; refer to the Medical Policy titled Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements for applicable guidelines

Medical Benefit Drug Policy Updates

Updated

Policy Title	Effective Date	Summary of Changes
Evkeeza® (Evinacumab-Dgnb)	Apr. 1, 2026	**Application** ***Louisiana*** • Removed content/language pertaining to the state of **Louisiana** **Applicable Codes** • Removed ICD-10 diagnosis codes E78.011, E78.019, and Z83.42 **Supporting Information** • Updated *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information
Ryplazim® (Plasminogen, Human-Tvmh)	Apr. 1, 2026	**Application** ***Indiana*** • Removed language indicating this Medical Benefit Drug Policy does not apply to the state of **Indiana** ***Louisiana*** • Removed content/language pertaining to the state of **Louisiana** **Supporting Information** • Updated *References* section to reflect the most current information

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Complement Inhibitors	Apr. 1, 2026	**Application** ***Louisiana*** • Removed content/language pertaining to the state of **Louisiana** **Coverage Rationale** • Revised coverage criteria for: ***Generalized Myasthenia Gravis in Patients who are Anti-Acetylcholine Receptor (AChR) Antibody Positive*** ○ Added criterion requiring the patient is not receiving the requested product in combination with the following for treatment of the same indication: ▪ B-cell depletion therapy	This policy refers only to the following complement inhibitor drug products: • Bkemv™ (eculizumab-aeeb) • Epysqli® (eculizumab-aagh) • PiaSky® (crovalimab-akkz) • Soliris® (eculizumab) • Ultomiris® (ravulizumab-cwvz) Refer to the policy for complete details.

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Complement Inhibitors (continued)	Apr. 1, 2026	[e.g., Uplizna (inebilizumab)] ▪ An immune globulin (e.g., Hizentra, Privigen, Gammagard) ***Neuromyelitis Optica Spectrum Disorder (NMOSD)*** ○ Removed criterion for initial therapy requiring one of the following: ▪ History of at least two relapses during the previous 12 months prior to initiating the requested product ▪ History of at least three relapses during the previous 24 months, at least one relapse occurring within the past 12 months prior to initiating the requested product	
FcRn Blockers	Apr. 1, 2026	**Title Change** • Previously *FcRn Blockers (Rystiggo®, Vyvgart®, & Vyvgart Hytrulo®)* **Application** ***Florida*** • Added language to indicate this Medical Benefit Drug Policy does not apply to the state of **Florida** for Imaavy ***Indiana*** • Removed language indicating this Medical Benefit Drug Policy does not apply to the state of **Indiana**	This policy refers to the following drug products for administration by a healthcare professional: • Imaavy (nipocalimab-aahu) for intravenous (IV) route • Rystiggo (rozanolixizumab-noli) for subcutaneous (SC) route • Vyvgart (efgartigimod alfa-fcab) for intravenous (IV) route • Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) vial for subcutaneous (SC) route Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc) prefilled syringe for self-administered subcutaneous injection is obtained under the pharmacy benefit. **Myasthenia Gravis** **Imaavy is proven and medically necessary for the treatment of**

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FcRn Blockers (continued)	Apr. 1, 2026	***Louisiana*** • Removed content/language pertaining to the state of **Louisiana** **Coverage Rationale** • Revised list of applicable drug products for administration by a healthcare professional: ○ Added Imaavy (nipocalimab-aahu) for intravenous (IV) route ○ Replaced "Rystiggo (rozanolixizumab-noli) for *intravenous (IV)* route" with "Rystiggo (rozanolixizumab-noli) for *subcutaneous (SC)* route" ***Imaavy*** • Added language to indicate Imaavy is proven and medically necessary for the treatment of generalized myasthenia gravis in patients who are anti-acetylcholine receptor (AChR) antibody positive or antimuscle-specific tyrosine kinase (MuSK) antibody positive when all of the following criteria are met: Initial Therapy ○ Submission of medical records (e.g., chart notes, laboratory values, etc.) confirming all of the following: ▪ Patient has not failed a previous course of Imaavy therapy	**generalized myasthenia gravis in patients who are anti-AChR antibody positive or anti-MuSK antibody positive when all of the following criteria are met:** • **Initial Therapy** ○ Submission of medical records (e.g., chart notes, laboratory values, etc.) confirming **all** of the following: ▪ Patient has not failed a previous course of Imaavy therapy; **and** ▪ Diagnosis of generalized myasthenia gravis (gMG); **and** ▪ **One** of the following: – Positive serologic test for anti-AChR antibodies; **or** – Positive serologic test for anti-MuSK antibodies **and** ▪ Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy; **and** ▪ Patient has a Myasthenia Gravis Activities of Daily Living scale (MG-ADL) total score ≥ 5 at initiation of therapy **and** ○ **One** of the following: ▪ If anti-acetylcholine receptor (AChR) antibody positive, **one** of the following: – History of failure of at least **two** immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.); **or** – Patient has a history of failure of at least one immunosuppressive therapy and has required four or more courses of plasmapheresis/plasma exchanges and/or immune globulin over the course of at least 12 months without symptom control **or** ▪ If anti-muscle-specific tyrosine kinase (MuSK) antibody positive: – History of failure of at least one immunosuppressive agent over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.) **and**

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FcRn Blockers (continued)	Apr. 1, 2026	▪ Diagnosis of generalized myasthenia gravis (gMG) ▪ One of the following: – Positive serologic test for anti-AChR antibodies – Positive serologic test for anti-MuSK antibodies ▪ Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy ▪ Patient has a Myasthenia Gravis Activities of Daily Living scale (MG-ADL) total score ≥ 5 at initiation of therapy ○ One of the following: ▪ If anti-acetylcholine receptor (AChR) antibody positive, one of the following: – History of failure of at least two immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.)	○ Patient is **not** receiving Imaavy in combination with any of the following: ▪ A CD19-directed cytolytic antibody [e.g., Uplizna (inebilizumab)]; **and** ▪ A complement inhibitor [e.g., eculizumab, Ultomiris (ravulizumab), Zilbrysq (zilucoplan)]; **and** ▪ An FcRn blocker [e.g., Rystiggo (rozanolixizumab-noli), Vyvgart (efgartigimod alfa-fcab), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)]; **and** ▪ An immune globulin (e.g., Hizentra, Privigen, Gammagard) **and** ○ Imaavy is dosed according to the U.S. FDA labeled dosing for gMG; **and** ○ Prescribed by, or in consultation with, a neurologist; **and** ○ Initial authorization will be for no more than 12 months • **Continuation of Therapy** ○ Patient has previously been treated with Imaavy; **and** ○ Submission of medical records (e.g., chart notes, laboratory tests) demonstrating **all** of the following: ▪ Improvement and/or maintenance of at least a 2-point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline; **and** ▪ Reduction in signs and symptoms of myasthenia gravis; **and** ▪ Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting Imaavy (**Note**: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on Imaavy therapy will be considered as treatment failure.) **and** ○ Patient is **not** receiving Imaavy in combination with any of the following: ▪ A CD19-directed cytolytic antibody [e.g., Uplizna (inebilizumab)]; **and** ▪ A complement inhibitor [e.g., eculizumab, Ultomiris (ravulizumab), Zilbrysq (zilucoplan)]; **and**

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FcRn Blockers (continued)	Apr. 1, 2026	– Patient has a history of failure of at least one immunosuppressive therapy and has required four or more courses of plasmapheresis/plasma exchanges and/or immune globulin over the course of at least 12 months without symptom control ▪ If anti-muscle-specific tyrosine kinase (MuSK) antibody positive, history of failure of at least one immunosuppressive agent over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.) ○ Patient is not receiving Imaavy in combination with any of the following: ▪ A CD19-directed cytolytic antibody [e.g., Uplizna (inebilizumab)] ▪ A complement inhibitor [e.g., eculizumab, Ultomiris (ravulizumab), Zilbrysq (zilucoplan)] ▪ An FcRn blocker [e.g., Rystiggo	▪ An FcRn blocker [e.g., Rystiggo (rozanolixizumab-noli), Vyvgart (efgartigimod alfa-fcab), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)]; **and** ▪ An immune globulin (e.g., Hizentra, Privigen, Gammagard) **and** ○ Imaavy is dosed according to the U.S. FDA labeled dosing for gMG; **and** ○ Prescribed by, or in consultation with, a neurologist; **and** ○ Reauthorization will be for no more than 12 months **Rystiggo is proven and medically necessary for the treatment of generalized myasthenia gravis in patients who are anti-AChR antibody positive or anti-MuSK antibody positive when all of the following criteria are met:** • **Initial Therapy** ○ Submission of medical records (e.g., chart notes, laboratory values, etc.) confirming **all** of the following: ▪ Patient has not failed a previous course of Rystiggo therapy; **and** ▪ Diagnosis of generalized myasthenia gravis (gMG); **and** ▪ **One** of the following: – Positive serologic test for anti-AChR antibodies; **or** – Positive serologic test for anti-MuSK antibodies **and** ▪ Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy; **and** ▪ Patient has a Myasthenia Gravis Activities of Daily Living scale (MG-ADL) total score ≥ 5 at initiation of therapy **and** ○ **One** of the following: ▪ If anti-acetylcholine receptor (AChR) antibody positive, **one** of the following: – History of failure of at least **two** immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.); **or** – Patient has a history of failure of at least one

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FcRn Blockers (continued)	Apr. 1, 2026	(rozanolixizumab-noli), Vyvgart (efgartigimod alfa-fcab), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)] ▪ An immune globulin (e.g., Hizentra, Privigen, Gammagard) ○ Imaavy is dosed according to the U.S. FDA labeled dosing for gMG ○ Prescribed by, or in consultation with, a neurologist ○ Initial authorization will be for no more than 12 months Continuation of Therapy ○ Patient has previously been treated with Imaavy ○ Submission of medical records (e.g., chart notes, laboratory tests) demonstrating all of the following: ▪ Improvement and/or maintenance of at least a 2 point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline ▪ Reduction in signs and symptoms of myasthenia gravis ▪ Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive	immunosuppressive therapy and has required four or more courses of plasmapheresis/plasma exchanges and/or immune globulin over the course of at least 12 months without symptom control **or** ▪ If anti-muscle-specific tyrosine kinase (MuSK) antibody positive: – History of failure of at least one immunosuppressive agent over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.) **and** ○ Patient is **not** receiving Rystiggo in combination with any of the following: ▪ A CD19-directed cytolytic antibody [e.g., Uplizna (inebilizumab)]; **and** ▪ A complement inhibitor [e.g., eculizumab, Ultomiris (ravulizumab), Zilbrysq (zilucoplan)]; **and** ▪ An FcRn blocker [e.g., Imaavy (nipocalimab-aahu), Vyvgart (efgartigimod alfa-fcab), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)]; **and** ▪ An immune globulin (e.g., Hizentra, Privigen, Gammagard) **and** ○ Patient will be given Rystiggo no sooner than 63 days from the start of the previous treatment cycle; **and** ○ Rystiggo is dosed according to the U.S. FDA labeled dosing for gMG; **and** ○ Prescribed by, or in consultation with, a neurologist; **and** ○ Initial authorization will be for no more than 12 months • **Continuation of Therapy** ○ Patient has previously been treated with Rystiggo; **and** ○ Submission of medical records (e.g., chart notes, laboratory tests) demonstrating **all** of the following: ▪ Improvement and/or maintenance of at least a 2-point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline; **and** ▪ Reduction in signs and symptoms of myasthenia gravis; **and** ▪ Maintenance, reduction, or discontinuation of dose(s) of baseline

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FcRn Blockers (continued)	Apr. 1, 2026	therapy (IST) prior to starting Imaavy (note: add on, dose escalation of IST, or additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on Imaavy therapy will be considered as treatment failure) ○ Patient is not receiving Imaavy in combination with any of the following: ▪ A CD19-directed cytolytic antibody [e.g., Uplizna (inebilizumab)] ▪ A complement inhibitor [e.g., eculizumab, Ultomiris (ravulizumab), Zilbrysq (zilucoplan)] ▪ An FcRn blocker [e.g., Rystiggo (rozanolixizumab-noli), Vyvgart (efgartigimod alfa-fcab), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)] ▪ An immune globulin (e.g., Hizentra, Privigen, Gammagard) ○ Imaavy is dosed according to the U.S. FDA labeled dosing for gMG ○ Prescribed by, or in consultation with, a neurologist	immunosuppressive therapy (IST) prior to starting Rystiggo (**Note**: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on Rystiggo therapy will be considered as treatment failure) **and** ○ Patient is **not** receiving Rystiggo in combination with any of the following: ▪ A CD19-directed cytolytic antibody [e.g., Uplizna (inebilizumab)]; **and** ▪ A complement inhibitor [e.g., eculizumab, Ultomiris (ravulizumab), Zilbrysq (zilucoplan)]; **and** ▪ An FcRn blocker [e.g., Imaavy (nipocalimab-aahu), Vyvgart (efgartigimod alfa-fcab), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)]; **and** ▪ An immune globulin (e.g., Hizentra, Privigen, Gammagard) **and** ○ Patient is not being given Rystiggo sooner than 63 days from the start of the previous treatment cycle; **and** ○ Rystiggo is dosed according to the U.S. FDA labeled dosing for gMG; **and** ○ Prescribed by, or in consultation with, a neurologist; **and** ○ Reauthorization will be for no more than 12 months **Vyvgart and Vyvgart Hytrulo are proven and medically necessary for the treatment of generalized myasthenia gravis in patients who are anti-AChR antibody positive when all of the following criteria are met:** • **Initial Therapy** ○ Submission of medical records (e.g., chart notes, laboratory values, etc.) confirming **all** of the following: ▪ Patient has not failed a previous course of Vyvgart therapy; **and** ▪ Patient has not failed a previous course of Vyvgart Hytrulo therapy; **and** ▪ Diagnosis of generalized myasthenia gravis (gMG); **and** ▪ Positive serologic test for anti-AChR antibodies; **and** ▪ Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy;

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
FcRn Blockers (continued)	Apr. 1, 2026	○ Reauthorization will be for no more than 12 months ***Rystiggo*** • Revised list of drug products the patient must not be receiving in combination with Rystiggo: ○ Added "a CD19-directed cytolytic antibody [e.g., Uplizna (inebilizumab)]" ○ Replaced: ▪ "*Another* FcRn blocker [e.g., Vyvgart (efgartigimod alfa-fcab), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)]" with "*an* FcRn blocker [e.g., *Imaavy (nipocalimab-aahu)*, Vyvgart (efgartigimod alfa-fcab), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase-qvfc)]" ▪ "An immune globulin" with "an immune globulin *(e.g., Hizentra, Privigen, Gammagard)*" ***Vyvgart and Vyvgart Hytrulo for Generalized Myasthenia Gravis*** • Revised list of drug products the patient must not be receiving in combination with Vyvgart or Vyvgart Hytrulo: ○ Added "a CD19-directed cytolytic antibody [e.g., Uplizna (inebilizumab)]"	**and** ▪ Patient has a Myasthenia Gravis Activities of Daily Living scale (MG-ADL) total score ≥ 5 at initiation of therapy **and** ○ **One** of the following: ▪ History of failure of at least **two** immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.); **or** ▪ Patient has a history of failure of at least one immunosuppressive therapy and has required four or more courses of plasmapheresis/plasma exchanges and/or immune globulin over the course of at least 12 months without symptom control **and** ○ Patient is **not** receiving Vyvgart or Vyvgart Hytrulo in combination with any of the following: ▪ A CD19-directed cytolytic antibody [e.g., Uplizna (inebilizumab)]; **and** ▪ A complement inhibitor [e.g., eculizumab, Ultomiris (ravulizumab), Zilbrysq (zilucoplan)]; **and** ▪ An FcRn blocker [e.g., Imaavy (nipocalimab-aahu), Rystiggo (rozanolixizumab-noli)]; **and** ▪ An immune globulin (e.g., Hizentra, Privigen, Gammagard) **and** ○ Vyvgart or Vyvgart Hytrulo is dosed according to the U.S. FDA labeled dosing for gMG; **and** ○ Prescribed by, or in consultation with, a neurologist; **and** ○ Initial authorization will be for no more than 12 months • **Continuation of Therapy** ○ Patient has previously been treated with Vyvgart or Vyvgart Hytrulo; **and** ○ Submission of medical records (e.g., chart notes, laboratory tests) demonstrating **all** of the following: ▪ Improvement and/or maintenance of at least a 2-point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline; **and**

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FcRn Blockers (continued)	Apr. 1, 2026	○ Replaced: ▪ "*Another* FcRn blocker [e.g., Rystiggo (rozanolixizumab-noli)]" with "*an* FcRn blocker [e.g., *Imaavy (nipocalimab-aahu)*, Rystiggo (rozanolixizumab-noli)]" ▪ "An immune globulin" with "an immune globulin *(e.g., Hizentra, Privigen, Gammagard)*" ● Revised coverage criteria; removed criterion requiring the patient is not being given Vyvgart or Vyvgart Hytrulo sooner than 50 days from the start of the previous treatment cycle **Supporting Information** ● Updated *Background*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	▪ Reduction in signs and symptoms of myasthenia gravis; **and** ▪ Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting Vyvgart or Vyvgart Hytrulo (**Note**: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on Vyvgart® or Vyvgart Hytrulo therapy will be considered as treatment failure.) **and** ○ Patient is **not** receiving Vyvgart or Vyvgart Hytrulo in combination with any of the following: ▪ A CD19-directed cytolytic antibody [e.g., Uplizna (inebilizumab)]; **and** ▪ A complement inhibitor [e.g., eculizumab, Ultomiris (ravulizumab), Zilbrysq (zilucoplan)]; **and** ▪ An FcRn blocker [e.g., Imaavy (nipocalimab-aahu), Rystiggo (rozanolixizumab-noli)]; **and** ▪ An immune globulin (e.g., Hizentra, Privigen, Gammagard) **and** ○ Vyvgart or Vyvgart Hytrulo is dosed according to the U.S. FDA labeled dosing for gMG; **and** ○ Prescribed by or in consultation with a neurologist; **and** ○ Reauthorization will be for no more than 12 months **Vyvgart Hytrulo is proven and medically necessary for the treatment of chronic inflammatory demyelinating polyneuropathy (CIDP) when all of the following criteria are met:** ● **Initial Therapy** ○ Patient has not failed a previous course of Vyvgart Hytrulo therapy; **and** ○ Diagnosis of chronic inflammatory demyelinating polyneuropathy (CIDP) as confirmed by **all** of the following: ▪ Progressive symptoms present for at least 2 months; **and** ▪ Symptomatic polyradiculoneuropathy as indicated by progressive or relapsing motor or sensory impairment of more than one limb; **and** ▪ Electrodiagnostic findings (consistent with EFNS/PNS guidelines for definite CIDP) indicating the presence of at least **one** of the

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FcRn Blockers (continued)	Apr. 1, 2026		following: – Motor distal latency prolongation in 2 nerves; **or** – Reduction of motor conduction velocity in 2 nerves; **or** – Prolongation of F-wave latency in 2 nerves; **or** – Absence of F-waves in at least 1 nerve; **or** – Partial motor conduction block of at least 1 motor nerve; **or** – Abnormal temporal dispersion in at least 2 nerves; **or** – Distal CMAP duration increase in at least 1 nerve **and** ○ Trial and failure (after a trial of at least two months), contraindication, or intolerance to corticosteroids; **and** ○ **One** of the following: ▪ Trial and failure (after a trial of at least three months) to an immune globulin (i.e., intravenous immunoglobulin or subcutaneous immunoglobulin); **or** ▪ **Both** of the following: – Intolerance to all immune globulins (i.e., intravenous immunoglobulin or subcutaneous immunoglobulin); **and** – Dose has been adjusted or escalated to the maximally allowable and/or tolerated dose **or** ▪ Contraindication to **all** immune globulins (i.e., intravenous immunoglobulin or subcutaneous immunoglobulin) **and** ○ Patient is not receiving Vyvgart Hytrulo in combination with an immune globulin; **and** ○ Vyvgart Hytrulo is dosed according to the U.S. FDA labeled dosing for CIDP; **and** ○ Prescribed by, or in consultation with, a neurologist; **and** ○ Initial authorization will be for no more than 12 months • **Continuation of Therapy** ○ Patient has previously been treated with Vyvgart Hytrulo; **and** ○ Documentation of positive clinical response to therapy as measured by an objective scale [e.g., Rankin, Modified Rankin, Medical Research Council (MRC) scale]; **and** ○ Patient is not receiving Vyvgart Hytrulo in combination with an immune globulin; **and**

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FcRn Blockers (continued)	Apr. 1, 2026		○ Vyvgart Hytrulo is dosed according to the U.S. FDA labeled dosing for CIDP; **and** ○ Prescribed by, or in consultation with, a neurologist; **and** ○ Reauthorization will be for no more than 12 months
Oncology Medication Clinical Coverage	Apr. 1, 2026	**Application** ***Louisiana*** • Removed content/language pertaining to the state of **Louisiana** **Coverage Rationale** ***Oncology Products*** • Revised list of UnitedHealthcare preferred and non-preferred oncology products; added: All Oncology Indications ○ Beizray (HCPCS code J9174) (non-preferred) ○ Carboplatin (HCPCS code J9045) (preferred) ○ Jobevne (bevacizumab-nwgd) (non-preferred) ○ Kyxata (non-preferred) Non-Small Cell Lung Cancer ○ Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) (preferred) Head and Neck Cancers ○ Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) (non-preferred) Squamous Cell Skin Cancer ○ Keytruda (pembrolizumab) (non-preferred)	**Description** This policy provides parameters for coverage of injectable oncology medications (including, but not limited to, octreotide acetate, leuprolide acetate, leucovorin, and levoleucovorin), including therapeutic radiopharmaceuticals, covered under the medical benefit based upon the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium® (NCCN Compendium®). The Compendium lists the appropriate drugs and biologics for specific cancers using U.S. Food and Drug Administration (FDA)-approved disease indications and specific NCCN panel recommendations. Each recommendation is supported by a level of evidence category. Refer to the Medical Benefit Drug Policy titled White Blood Cell Colony Stimulating Factors or Erythropoiesis-Stimulating Agents, for information on those agents. This policy does not provide coverage criteria for chimeric antigen receptor (CAR) T-cell or tumor-infiltration lymphocyte (TIL) cell products. Coverage determinations are based on the member's benefits and the OptumHealth Transplant Solutions criteria for covered transplants in the Clinical Guideline titled Chimeric Antigen Receptor T-Cell (CAR T) Therapy or Tumor-Infiltrating Lymphocyte (TIL) Cell Therapy. **Coverage Rationale** The Oncology Products table in the policy lists the UnitedHealthcare preferred oncology products and respective non-preferred products. Coverage will be provided for the UnitedHealthcare preferred oncology product contingent on the coverage criteria in the *Diagnosis-Specific Criteria* section of the policy. Coverage for any respective non-preferred oncology product will be provided contingent on the criteria in the *Preferred Product Criteria* and the *Diagnosis-Specific Criteria* sections of the policy. ***Preferred Product Criteria*** **Treatment with the respective non-preferred product specified in the Oncology Products table in the policy is medically necessary for**

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Oncology Medication Clinical Coverage (continued)	Apr. 1, 2026	○ Keytruda Qlex (pembrolizumab and berahyaluronidase alfa-pmph) (non-preferred) ○ Libtayo (cemiplimab-rwlc) (preferred) ○ Opdivo (nivolumab) (non-preferred) ○ Opdivo Qvantig (nivolumab and hyaluronidase-nvhy) (non-preferred) ○ Unloxcyt (cosibelimab-ipdl) (non-preferred) ***Injectable Oncology Medications*** • Added language to indicate coverage determinations shall be based upon U.S. FDA labelling when there is no NCCN Drugs and Biologics Compendium with Categories of Evidence and Consensus **Applicable Codes** • Added HCPCS codes J9045, J9174, and J9275 **Supporting Information** • Updated *References* section to reflect the most current information	**oncology indications when both of the following are met:** • History of intolerance or contraindication to one of UnitedHealthcare's preferred oncology products; and • Physician attests that, in their clinical opinion, the same intolerance, contraindication, or adverse event would not be expected to occur with the respective non-preferred product **Oncology Products** Refer to the policy for a list of UnitedHealthcare preferred and non-preferred oncology products and corresponding indications. Any U.S. Food and Drug Administration approved product that may belong to the UnitedHealthcare Preferred or Non-Preferred Oncology Product categories and/or are approved via FDA 505(b)(2) approval process, but not listed by name in this policy will be considered non-preferred until reviewed by UnitedHealthcare P&T committee. ***Diagnosis-Specific Criteria*** **Injectable Oncology Medications** UnitedHealthcare recognizes indications and uses of injectable oncology medications, including therapeutic radiopharmaceuticals, in the NCCN Drugs and Biologics Compendium with Categories of Evidence and Consensus of 1, 2A, and 2B as proven and Categories of Evidence and Consensus of 3 as unproven and not medically necessary. (However, refer to the *Benefit Considerations* section of the policy.) When there is no NCCN Drugs and Biologics Compendium with Categories of Evidence and Consensus, coverage determinations shall be based upon FDA labelling. UnitedHealthcare will cover all chemotherapy agents for individuals under the age of 19 years for oncology indications. The majority of pediatric patients receive treatments on national pediatric protocols that are quite similar in concept to the NCCN patient care guidelines. Refer to *Preferred Product Criteria* above for the UnitedHealthcare preferred oncology products and indications.

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Ophthalmologic Vascular Endothelial Growth Factor (VEGF) Inhibitors	Apr. 1, 2026	**Application** ***Louisiana*** • Removed content/language pertaining to the state of **Louisiana** **Coverage Rationale** • Revised list of applicable vascular endothelial growth factor (VEGF) inhibitors and dual VEGF/angiopoietin-2 (Ang-2) inhibitors; added "any U.S. FDA-approved ophthalmologic VEGF or dual VEGF/Ang-2 inhibitor product not listed [in this policy]" • Added language to indicate any U.S. FDA-approved ophthalmologic VEGF inhibitor product not listed by name in this policy will be considered non-preferred until reviewed by UnitedHealthcare ***General Requirements*** • Added language to indicate authorization is for no more than 12 months ***Diagnosis-Specific Requirements*** • Revised list of proven and medically necessary indications for: Avastin (bevacizumab) ○ Added: ▪ Diabetic retinopathy (DR) ▪ Myopic choroidal neovascularization (mCNV)	This policy provides information about the use of certain specialty pharmacy medications administered by the intravitreal route for ophthalmologic conditions. This policy refers to the following vascular endothelial growth factor (VEGF) inhibitors and dual VEGF/angiopoietin-2 (Ang-2) inhibitors: • Avastin® (bevacizumab) • Beovu® (brolucizumab-dbll) • Byooviz™ (ranibizumab-nuna) • Cimerli® (ranibizumab-eqrn) • Eylea® (aflibercept) • Eylea® HD (aflibercept) • Lucentis® (ranibizumab) • Pavblu™ (aflibercept-ayyh) • Susvimo™ (ranibizumab) • Vabysmo® (faricimab-svoa) • Any FDA-approved ophthalmologic VEGF or dual VEGF/Ang-2 inhibitor product not listed here* *Any U.S. Food and Drug Administration approved ophthalmologic VEGF inhibitor product not listed by name in this policy will be considered non-preferred until reviewed by UnitedHealthcare. **Note**: For requests that require medical necessity review, also refer to the *General Requirements* and *Diagnosis-Specific Requirements* sections below. **Coverage for Avastin®, Beovu®, Byooviz™, Cimerli®, Eylea®, Lucentis®, Pavblu™, and Vabysmo® is contingent on criteria in the *General Requirements* and *Diagnosis-Specific Requirements* sections.** **General Requirements (Applicable to all Medical Necessity Requests)** • For **initial therapy**, **all** of the following: ○ Diagnosis; **and** ○ Intravitreal VEGF or dual VEGF/Ang-2 inhibitor administration is no more than 12 doses per year per eye, regardless of diagnosis; **and**

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Ophthalmologic Vascular Endothelial Growth Factor (VEGF) Inhibitors (continued)	Apr. 1, 2026	○ Removed: ▪ Choroidal neovascularization secondary to pathologic myopia, angioid streaks/pseudoxanthoma elasticum, or ocular histoplasmosis syndrome (OHS) ▪ Proliferative diabetic retinopathy ○ Replaced: ▪ "Macular edema *secondary to branch retinal vein occlusion (BRVO) or central* retinal vein occlusion (*CRVO*)" with "macular edema *following* retinal vein occlusion (*RVO*)" ▪ "Neovascularization of the iris (NVI) *(rubeosis iridis)*" with "neovascularization of the iris (NVI)" Eylea (aflibercept) ○ Replaced "macular edema *secondary to branch retinal vein occlusion (BRVO) or central* retinal vein occlusion (*CRVO*)" with "macular edema *following* retinal vein occlusion (*RVO*)" Eylea HD (aflibercept) ○ Added "macular edema following retinal vein occlusion (RVO)"	○ Authorization is for no more than 12 months • For **continuation of therapy**, **all** of the following: ○ Documentation of positive clinical response to anti-VEGF therapy; **and** ○ Intravitreal VEGF or dual VEGF/Ang-2 inhibitor administration is no more than 12 doses per year per eye, regardless of diagnosis; **and** ○ Authorization is for no more than 12 months **Preferred Product** ***Neovascular (Wet) Age-Related Macular Degeneration (AMD)*** The preferred VEGF inhibitors for AMD are re-packaged Avastin (bevacizumab), followed by Eylea, Eylea HD, or Pavblu. **Coverage for Beovu, Byooviz, Cimerli, Eylea, Eylea HD, Lucentis, Pavblu, Susvimo, and Vabysmo will be provided contingent on the criteria in the *Preferred Product* and the *Diagnosis-Specific Requirements* sections.** ***Retinal Conditions Other Than Neovascular (Wet) Age-Related Macular Degeneration (AMD)*** Eylea, Eylea HD, and Pavblu are the preferred VEGF inhibitors for retinal conditions other than neovascular (wet) age-related macular degeneration. Coverage will be provided for Eylea, Eylea HD, and Pavblu contingent on the coverage criteria in the *Diagnosis-Specific Requirements* section. **Coverage for Beovu, Byooviz, Cimerli, Lucentis, Susvimo, and Vabysmo will be provided contingent on the criteria in the *Preferred Product* and the *Diagnosis-Specific Requirements* sections.** ***Preferred Product Criteria*** **Treatment with Eylea, Eylea HD, or Pavblu are medically necessary for the treatment of neovascular (wet) age-related macular degeneration (AMD) when one of the following are met:** • History of a trial of at least 3 doses, resulting in minimal clinical response to re-packaged Avastin (bevacizumab); **or**

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Ophthalmologic Vascular Endothelial Growth Factor (VEGF) Inhibitors (continued)	Apr. 1, 2026	Lucentis (ranibizumab) ○ Added "myopic choroidal neovascularization (mCNV)" ○ Removed "choroidal neovascularization secondary to pathologic myopia, angioid streaks/pseudoxanthoma elasticum, or ocular histoplasmosis syndrome (OHS)" ○ Replaced "macular edema *secondary to branch retinal vein occlusion (BRVO) or central* retinal vein occlusion (*CRVO*)" with "macular edema *following* retinal vein occlusion (*RVO*)" ***Additional Information*** • Revised language to indicate: ○ Avastin (bevacizumab) is supplied in sterile vials containing a solution of 25 mg/mL and doses utilized in ophthalmic conditions generally range from 6.2 mcg to 2.5 mg; therefore, bevacizumab vials are often divided into single-dose, prefilled syringes for intravitreal use by compounding pharmacies ○ Compounding pharmacies must comply with the United States Pharmacopeia (USP) General Chapter 797: *Pharmaceutical Compounding – Sterile*	• History of intolerance, contraindication, or adverse event(s) to re-packaged Avastin (bevacizumab) **Treatment with Beovu, Byooviz, Cimerli, Lucentis, Susvimo, or Vabysmo is medically necessary for the treatment of neovascular (wet) age-related macular degeneration (AMD) when one of the following are met:** • **Both** of the following: ○ Trial of at least 3 doses, resulting in minimal clinical response to re-packaged Avastin (bevacizumab); **and** ○ History of use of Eylea, Eylea HD, or Pavblu, resulting in minimal clinical response to therapy **or** • History of contraindication, intolerance, or adverse event(s) to re-packaged Avastin (bevacizumab) **and** Eylea, Eylea HD, or Pavblu **Treatment with Beovu, Byooviz, Cimerli, Lucentis, Susvimo, and Vabysmo is medically necessary for all retinal conditions other than neovascular (wet) age-related macular degeneration when one of the following are met:** • History of use of Eylea, Eylea HD, or Pavblu, resulting in minimal clinical response to therapy; **or** • History of contraindication, intolerance, or adverse event(s) to Eylea, Eylea HD, or Pavblu **Diagnosis-Specific Requirements** The information below indicates the list of proven and medically necessary indications. In absence of a product listed, and in addition to applicable criteria outlined within the drug policy, prescribing and dosing information from the package insert is the clinical information used to determine benefit coverage. **Avastin (bevacizumab) is proven and medically necessary for the treatment of:** • Diabetic macular edema (DME) • Diabetic retinopathy (DR) • Macular edema following retinal vein occlusion (RVO)

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Ophthalmologic Vascular Endothelial Growth Factor (VEGF) Inhibitors (continued)	Apr. 1, 2026	*Preparations*, which sets standards for the compounding, transportation, and storage of compounded sterile products (CSP) ○ The American Academy of Ophthalmology recommends sourcing bevacizumab for intravitreal injections from a compounding pharmacy accredited by the Pharmacy Compounding Accreditation Board (PCAB), which adheres to these standards **Definitions** • Removed definition of "Type I Retinopathy of Prematurity (ROP)" **Applicable Codes** • Added HCPCS code C9257 • Removed HCPCS code J9035 • Updated list of applicable ICD-10 diagnosis codes for HCPCS code J0177; added H34.8110, H34.8111, H34.8112, H34.8120, H34.8121, H34.8122, H34.8130, H34.8131, H34.8132, H34.8190, H34.8191, H34.8192, H34.821, H34.822, H34.823, H34.829, H34.8310, H34.8311, H34.8312, H34.8320, H34.8321, H34.8322, H34.8330, H34.8331, H34.8332, H34.8390, H34.8391, and H34.8392	• Myopic choroidal neovascularization (mCNV) • Neovascular age-related macular degeneration (nAMD) • Neovascular glaucoma (NVG) • Neovascularization of the iris (NVI) • Type I retinopathy of prematurity (ROP) **Beovu (brolucizumab) is proven and medically necessary for the treatment of:** • Diabetic macular edema (DME) • Neovascular age-related macular degeneration (nAMD) **Byooviz (ranibizumab-nuna) is proven and medically necessary for the treatment of:** • Macular edema following retinal vein occlusion (RVO) • Myopic choroidal neovascularization (mCNV) • Neovascular age-related macular degeneration (nAMD) **Cimerli (ranibizumab-eqrn) is proven and medically necessary for the treatment of:** • Diabetic macular edema (DME) • Diabetic retinopathy (DR) • Macular edema following retinal vein occlusion (RVO) • Myopic choroidal neovascularization (mCNV) • Neovascular age-related macular degeneration (nAMD) **Eylea (aflibercept) is proven and medically necessary for the treatment of:** • Diabetic macular edema (DME) • Diabetic retinopathy (DR) • Macular edema following retinal vein occlusion (RVO) • Neovascular age-related macular degeneration (nAMD) • Retinopathy of prematurity (ROP)

Medical Benefit Drug Policy Updates

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Ophthalmologic Vascular Endothelial Growth Factor (VEGF) Inhibitors (continued)	Apr. 1, 2026	**Supporting Information** • Updated *Background*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	**Eylea HD (aflibercept) is proven and medically necessary for the treatment of:** • Diabetic macular edema (DME) • Diabetic retinopathy (DR) • Macular edema following retinal vein occlusion (RVO) • Neovascular age-related macular degeneration (nAMD) **Lucentis (ranibizumab) is proven and medically necessary for the treatment of:** • Diabetic macular edema (DME) • Diabetic retinopathy (DR) • Macular edema following retinal vein occlusion (RVO) • Myopic choroidal neovascularization (mCNV) • Neovascular age-related macular degeneration (nAMD) **Pavblu (aflibercept-ayyh) is proven and medically necessary for the treatment of:** • Diabetic macular edema (DME) • Diabetic retinopathy (DR) • Macular edema following retinal vein occlusion (RVO) • Neovascular age-related macular degeneration (nAMD) **Susvimo (ranibizumab) is proven and medically necessary for the treatment of:** • Diabetic macular edema (DME) that has previously responded to ≥ 2 intravitreal injections of a VEGF inhibitor • Diabetic retinopathy (DR) that has previously responded to ≥ 2 intravitreal injections of a VEGF inhibitor medication • Neovascular age-related macular degeneration (nAMD) that has previously responded to ≥ 2 intravitreal injections of a VEGF inhibitor **Vabysmo (faricimab-svoa) is proven and medically necessary for the treatment of:** • Diabetic macular edema (DME) • Macular edema following retinal vein occlusion (RVO) • Neovascular age-related macular degeneration (nAMD)

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Ophthalmologic Vascular Endothelial Growth Factor (VEGF) Inhibitors (continued)	Apr. 1, 2026		**Additional Information** Avastin (bevacizumab) is supplied in sterile vials containing a solution of 25 mg/mL. Doses utilized in ophthalmic conditions generally range from 6.2 mcg to 2.5 mg. Therefore, bevacizumab vials are often divided into single-dose, prefilled syringes for intravitreal use by compounding pharmacies. Compounding pharmacies must comply with the United States Pharmacopeia (USP) General Chapter 797: Pharmaceutical Compounding – Sterile Preparations, which sets standards for the compounding, transportation, and storage of compounded sterile products (CSP). The American Academy of Ophthalmology recommends sourcing bevacizumab for intravitreal injections from a compounding pharmacy accredited by the Pharmacy Compounding Accreditation Board (PCAB), which adheres to these standards.
Sodium Hyaluronate	Apr. 1, 2026	**Application** ***Louisiana*** • Removed content/language pertaining to the state of **Louisiana** **Coverage Rationale** • Removed language indicating the preferred product criteria for sodium hyaluronate in this section applies to the states of **Minnesota** (MN) and **Mississippi** (MS) • Added language to indicate Hymovis One is contingent on the *Preferred Product Criteria* and *Diagnosis-Specific Criteria* [sections of the policy] • Revised list of FDA approved sodium hyaluronate products and their respective FDA labeled dosage per treatment course per joint; added Hymovis One for 1 injection per joint	The sodium hyaluronate preferred product criteria in this section applies to the following states: AZ, FL, HI, KY, MD, MI, NJ, NM, NY, RI, TN, TX, VA, WA, and WI. For all other states, coverage will be provided contingent on the coverage criteria in the *Diagnosis-Specific Criteria* section. Coverage for Durolane, Euflexxa, and Gelsyn-3 is contingent on criteria in the *Diagnosis-Specific Criteria* section. Coverage for GenVisc 850, Hyalgan, Supartz, Visco-3, Hymovis, Hymovis One, Orthovisc, Synvisc or Synvisc-One, Gel-One, Monovisc, Triluron, TriVisc, or Synojoynt is contingent on *Preferred Product Criteria* and *Diagnosis-Specific Criteria*. In order to continue coverage, members already on these products will be required to change therapy to Durolane, Euflexxa, or Gelsyn-3 unless they meet the criteria below **Preferred Product Criteria** **Treatment with GenVisc 850, Hyalgan, Supartz, Visco-3, Hymovis, Hymovis One, Orthovisc, Synvisc or Synvisc-One, Gel-One, Monovisc, Triluron, TriVisc, or Synojoynt is medically necessary for the indications specified in this policy when one of the criteria below are met:** • **Both** of the following: ○ History of a trial of adequate dose and duration of Durolane, Euflexxa, and Gelsyn-3, resulting in minimal clinical response; **and**

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Sodium Hyaluronate (continued)	Apr. 1, 2026	**Applicable Codes** • Revised description for HCPCS code J7322 **Supporting Information** • Updated *FDA* and *References* sections to reflect the most current information	○ Physician attests that, in their clinical opinion, the clinical response would be expected to be superior than experienced with Durolane, Euflexxa, and Gelsyn-3 **or** • **Both** of the following: ○ History of failure, contraindication, or intolerance to Durolane, Euflexxa, and Gelsyn-3; **and** ○ Physician attests that, in their clinical opinion, the same failure, contraindication, or intolerance would not be expected to occur with GenVisc 850, Hyalgan, Supartz, Visco-3, Hymovis, Hymovis One, Orthovisc, Synvisc or Synvisc-One, Gel-One, Monovisc, Triluron, TriVisc, or Synojoynt **Diagnosis-Specific Criteria** ***Initial Authorization (Sodium Hyaluronate-Naïve Patients)*** **Intra-articular injections of sodium hyaluronate are proven and medically necessary when all of the following are met:** • Diagnosis of knee osteoarthritis; **and** • The member has not responded adequately to conservative therapy which may include physical therapy or pharmacotherapy [e.g., non-steroidal anti-inflammatory drugs (NSAIDs), acetaminophen, and/or topical capsaicin cream] or injection of intra-articular steroids and such therapy has not resulted in functional improvement after at least 3 months, or the member is unable to tolerate conservative therapy because of adverse side effects; **and** • The member reports pain which interferes with functional activities (e.g., ambulation, prolonged standing); **and** • The pain is attributed to degenerative joint disease/primary osteoarthritis of the knee; **and** • There are no contraindications to the injections (e.g., active joint infection, bleeding disorder); **and** Dosing is in accordance with the U.S. Food and Drug Administration (FDA) approved labeling as shown in the table in the policy; **and** • Initial authorization is for a single injection course once per joint for 6 months

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Sodium Hyaluronate (continued)	Apr. 1, 2026		***Reauthorization/Continuation*** **Repeated courses of intra-articular hyaluronan injections may be considered when all of the following are met:** • Diagnosis of knee osteoarthritis; **and** • Documentation of positive clinical response to therapy (e.g., significant pain relief was achieved with the prior course of injections); **and** • Pain has recurred; **and** • At least 6 months have passed since the prior course of treatment for the respective joint; **and** • Dosing is in accordance with the U.S. FDA approved labeling as shown in the table in the policy; **and** • Continuing authorization is for a single injection course once per joint for 6 months Refer to the policy for a list of FDA approved sodium hyaluronate products and their respective FDA labeled dosage per treatment course per joint. **Intra-articular injections of sodium hyaluronate are unproven and not medically necessary for treating any other indication due to insufficient evidence of efficacy including but not limited to the following:** • Hip osteoarthritis • Temporomandibular joint osteoarthritis • Temporomandibular joint disc displacement **Hyaluronic acid gel preparations to improve the skin's appearance, contour, and/or reduce depressions due to acne, scars, injury, or wrinkles are considered cosmetic and are not covered.**
Somatostatin Analogs	Apr. 1, 2026	**Application** ***Louisiana*** • Removed content/language pertaining to the state of **Louisiana** **Coverage Rationale** • Added language to indicate:	This policy refers to the following somatostatin analogs for non-oncology indications: • Lanreotide® Injection • Sandostatin® (octreotide acetate) • Sandostatin LAR® (octreotide acetate) • Signifor LAR® (pasireotide) • Somatostatin Depot® (lanreotide)

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Somatostatin Analogs (continued)	Apr. 1, 2026	○ This policy refers to the following somatostatin analogs for non-oncology indications: ▪ Lanreotide® injection ▪ Sandostatin® (octreotide acetate) ▪ Sandostatin LAR® (octreotide acetate) ▪ Signifor LAR® (pasireotide) ▪ Somatostatin Depot® (lanreotide) ○ Sandostatin (octreotide acetate) and Sandostatin LAR (octreotide acetate LAR) are proven for the treatment of the following conditions: ▪ Severe diarrhea and flushing episodes associated with metastatic carcinoid tumors ▪ Profuse watery diarrhea associated with vasoactive intestinal peptide (VIP) secreting tumors ○ Somatuline Depot (lanreotide) is proven for the treatment of the following conditions: ▪ Unresectable, well- or moderately-differentiated, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NETs) in adults	For oncology indications, refer to the Medical Benefit Drug Policy titled Oncology Medication Clinical Coverage for updated information based on the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium® (NCCN Compendium®). **Sandostatin (octreotide acetate) and Sandostatin LAR (octreotide acetate LAR) are proven and medically necessary for the treatment of bleeding gastroesophageal varices when both of the following criteria are met:** • Diagnosis of bleeding esophageal varices associated with liver disease; **and** • Octreotide acetate will be used as an adjunct to endoscopic therapy **Sandostatin (octreotide acetate) and Sandostatin LAR (octreotide acetate LAR) are proven for the treatment of the following conditions:** • Chemotherapy- and/or radiation-induced diarrhea • Malignant bowel disease • Severe diarrhea and flushing episodes associated with metastatic carcinoid tumors • Profuse watery diarrhea associated with vasoactive intestinal peptide (VIP) secreting tumors **Sandostatin immediate release (IR) is proven and medically necessary for the treatment of acromegaly when all of the following criteria are met:** • Diagnosis of acromegaly; **and** • Diagnosis has been confirmed by **one** of the following: ○ Serum GH level > 1 ng/mL after a 2 hour oral glucose tolerance test (OGTT) at time of diagnosis; **or** ○ Elevated serum IGF-1 levels (above the age and gender adjusted normal range as provided by the physician's lab) at time of diagnosis **and** • **One** of the following: ○ Inadequate response to **one** of the following: ▪ Surgery; **or** ▪ Radiotherapy; **or** ▪ Dopamine agonist (e.g., bromocriptine, cabergoline) therapy

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Somatostatin Analogs (continued)	Apr. 1, 2026	▪ Carcinoid syndrome in adults ○ Lanreotide Injection is proven for the treatment of unresectable, well- or moderately-differentiated, locally advanced, or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NETs) in adults • Removed language indicating Signifor is proven and medically necessary for the treatment of patients with Cushing's disease when the patient has an inadequate response to pituitary surgery or Is not a candidate for pituitary surgery **Applicable Codes** • Added ICD-10 diagnosis codes C7A.023, C25.3, E24.8, and E24.9 **Supporting Information** • Updated *Background*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	**or** ○ Not a candidate for **any** of the following: ▪ Surgery; **and** ▪ Radiotherapy; **and** ▪ Dopamine agonist (e.g., bromocriptine, cabergoline) therapy **Sandostatin LAR is proven and medically necessary for the treatment of acromegaly when all of the following criteria are met:** • Diagnosis of acromegaly; **and** • Diagnosis has been confirmed by **one** of the following: ○ Serum GH level > 1 ng/mL after a 2 hour oral glucose tolerance test (OGTT) at time of diagnosis; **or** ○ Elevated serum IGF-1 levels (above the age and gender adjusted normal range as provided by the physician's lab) at time of diagnosis **and** • **One** of the following: ○ Inadequate response to **one** of the following: ▪ Surgery; **or** ▪ Radiotherapy; **or** ▪ Dopamine agonist (e.g., bromocriptine, cabergoline) therapy **or** ○ Not a candidate for **any** of the following: ▪ Surgery; **and** ▪ Radiotherapy; **and** ▪ Dopamine agonist (e.g., bromocriptine, cabergoline) therapy **and** • Initial treatment with octreotide immediate release (IR) has been shown to be effective and tolerated **Signifor LAR (pasireotide diaspartate) is proven and medically necessary for the treatment of Cushing's disease when both of the following criteria are met:** • Diagnosis of Cushing's disease; **and** • **One** of the following: ○ Inadequate response to pituitary surgery; **or** ○ Not a candidate for pituitary surgery

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Somatostatin Analogs (continued)	Apr. 1, 2026		**Signifor LAR (pasireotide) is proven and medically necessary for the treatment of acromegaly when all of the following criteria are met:**
			• Diagnosis of acromegaly; **and**
			• Diagnosis has been confirmed by **one** of the following:
			  ○ Serum GH level > 1 ng/mL after a 2 hour oral glucose tolerance test (OGTT) at time of diagnosis; **or**
			  ○ Elevated serum IGF- 1 levels (above the age and gender adjusted normal range as provided by the physician's lab) at time of diagnosis **and**
			• **One** of the following:
			  ○ Inadequate response to **one** of the following:
			  ▪ Surgery; **or**
			  ▪ Radiotherapy; **or**
			  ▪ Dopamine agonist (e.g., bromocriptine, cabergoline) therapy **or**
			  ○ Not a candidate for **any** of the following:
			  ▪ Surgery; **and**
			  ▪ Radiotherapy; **and**
			  ▪ Dopamine agonist (e.g., bromocriptine, cabergoline) therapy
			
			Somatuline Depot (lanreotide) and Lanreotide Injection are proven and medically necessary for the treatment of acromegaly when all of the following criteria are met:
			• Diagnosis of acromegaly; **and**
			• Diagnosis has been confirmed by **one** of the following:
			  ○ Serum GH level > 1 ng/mL after a 2 hour oral glucose tolerance test (OGTT) at time of diagnosis; **or**
			  ○ Elevated serum IGF- 1 levels (above the age and gender adjusted normal range as provided by the physician's lab) at time of diagnosis **and**
			• **One** of the following:
			  ○ Inadequate response to **one** of the following:
			  ▪ Surgery; **or**
			  ▪ Radiotherapy; **or**
			  ▪ Dopamine agonist (e.g., bromocriptine, cabergoline) therapy **or**
			  ○ Not a candidate for **any** of the following:

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Somatostatin Analogs (continued)	Apr. 1, 2026		▪ Surgery; **and** ▪ Radiotherapy; **and** ▪ Dopamine agonist (e.g., bromocriptine, cabergoline) therapy **Somatuline Depot (lanreotide) is proven for the treatment of the following conditions:** • Unresectable, well- or moderatelydifferentiated, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NETs) in adults • Carcinoid syndrome in adults **Lanreotide Injection is proven for the treatment of the following condition:** • Unresectable, well- or moderatelydifferentiated, locally advanced or metastatic gastroenteropancreatic neuroendocrine tumors (GEP-NETs) in adults **Somatostatin analogs are unproven and not medically necessary for treating the following conditions:** • HIV-AIDS-related diarrhea • Chylothorax • Dumping syndrome • Pancreatitis • Persistent hyperinsulinemic hypoglycemia of infancy • Prevention of postoperative complications following pancreatic surgery • Short bowel syndrome **Somatostatin analogs are unproven for treating other conditions not listed above as proven, due to the lack of published clinical evidence of safety and/or efficacy in published peer-reviewed medical literature.**
Uplizna® (Inebilizumab-Cdon)	Apr. 1, 2026	**Application** ***Indiana*** • Removed language indicating this Medical Benefit Drug Policy does not apply to the state of **Indiana**	**Uplizna (inebilizumab-cdon) is proven and medically necessary for the treatment of neuromyelitis optica spectrum disorder (NMOSD) when all of the following criteria are met:** • For **initial therapy**, **all** of the following: ○ Diagnosis of neuromyelitis optica spectrum disorder (NMOSD) by a neurologist, confirming **all** of the following:

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Uplizna® (Inebilizumab-Cdon) (continued)	Apr. 1, 2026	***Louisiana*** • Removed content/language pertaining to the state of **Louisiana** **Coverage Rationale** ***Neuromyelitis Optica Spectrum Disorder (NMOSD)*** • Revised coverage criteria; removed criterion requiring one of the following: ○ History of one or more relapses that required rescue therapy during the previous 12 months prior to initiating Uplizna ○ History of two or more relapses that required rescue therapy during the previous 24 months prior to initiating Uplizna ***Generalized Myasthenia Gravis (gMG)*** • Added language to indicate Uplizna is proven and medically necessary for the treatment of gMG in patients who are anti-acetylcholine receptor (AChR) antibody positive or antimuscle-specific tyrosine kinase (MuSK) antibody positive when all of the following criteria are met: Initial Therapy ○ Submission of medical records (e.g., chart notes, laboratory values, etc.) confirming all of the following:	▪ Past medical history of **one** of the following: – Optic neuritis; **or** – Acute myelitis; **or** – Area postrema syndrome: episode of otherwise unexplained hiccups or nausea and vomiting; **or** – Acute brainstem syndrome; **or** – Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions; **or** – Symptomatic cerebral syndrome with NMOSD-typical brain lesions **and** ▪ Positive serologic test for anti-aquaporin-4 immunoglobulin G (AQP4-IgG)/NMO-IgG antibodies; **and** ▪ Diagnosis of multiple sclerosis or other diagnoses have been ruled out **and** ○ **One** of the following: ▪ History of failure of rituximab therapy; **or** ▪ **Both** of the following: – History of intolerance or contraindication to rituximab; **and** – Physician attests that, in their clinical opinion, the same intolerance or severe adverse event would not be expected to occur with Uplizna **and** ○ Uplizna is initiated according to the U.S. Food and Drug Administration (FDA) labeled dosing for NMOSD; **and** ○ Prescribed by, or in consultation with, a neurologist; **and** ○ Patient is **not** receiving Uplizna in combination with **any** of the following for treatment of the same indication: ▪ Multiple sclerosis disease modifying therapies [e.g., dimethyl fumarate, fingolimod, Ocrevus (ocrelizumab), etc.] ▪ Complement inhibitors [e.g., eculizumab, PiaSky (crovalimab), Ultomiris (ravulizumab)] ▪ Anti-IL6 therapy (e.g., tocilizumab) ▪ Anti-CD20 therapy (e.g., rituximab) **and** ○ Initial authorization will be for no more than 12 months

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Uplizna® (Inebilizumab-Cdon) (continued)	Apr. 1, 2026	▪ Patient has not failed a previous course of Uplizna therapy for the treatment of generalized myasthenia gravis ▪ Diagnosis of gMG ▪ One of the following: – Positive serologic test for anti-AChR antibodies – Positive serologic test for anti-MuSK antibodies ▪ Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy ▪ Patient has a Myasthenia Gravis Activities of Daily Living scale (MG-ADL) total score ≥ 5 at initiation of therapy ○ One of the following: ▪ If anti-acetylcholine receptor (AChR) antibody positive, one of the following: – History of failure of at least two immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, corticosteroids,	● For **continuation of therapy**, **all** of the following: ○ Documentation of positive clinical response; **and** ○ Uplizna is dosed according to the U.S. Food and Drug Administration (FDA) labeled dosing for NMOSD; **and** ○ Patient is **not** receiving Uplizna in combination with **any** of the following for treatment of the same indication: ▪ Multiple sclerosis disease modifying therapies [e.g., dimethyl fumarate, fingolimod, Ocrevus (ocrelizumab), etc.] ▪ Anti-IL6 therapy (e.g., tocilizumab) ▪ Complement inhibitors [e.g., eculizumab, PiaSky (crovalimab), Ultomiris (ravulizumab)] ▪ Anti-CD20 therapy (e.g., rituximab) **and** ○ Reauthorization will be for no more than 12 months **Uplizna (inebilizumab-cdon) is proven and medically necessary for the treatment of immunoglobulin G4-related disease (IgG4-RD) when all the following criteria are met:** ● For **initial therapy**, **all** of the following: ○ Diagnosis of immunoglobulin G4-related disease (IgG4-RD); **and** ○ Confirmation of IgG4-RD by a positive assessment using the ACR/EULAR classification criteria, demonstrated by **all** of the following: ▪ Involvement of at least 1 or more organ(s) in a manner consistent with IgG4-RD; **and** ▪ Exclusion criteria is negative and consistent with an IgG4-RD diagnosis (e.g., clinical findings, serologic results, radiology assessments, pathology interpretations); **and** ▪ Inclusion criteria is positive and signifies a diagnosis of IgG4-RD (e.g., clinical findings, serologic results, radiology assessments, pathology interpretations) **and** ○ **Both** of the following: ▪ History of failure, contraindication, or intolerance to glucocorticoids; **and** ▪ **One** of the following: – History of failure of rituximab therapy; **or**

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Uplizna® (Inebilizumab-Cdon) (continued)	Apr. 1, 2026	▪ An FcRn blocker [e.g., Imaavy (nipocalimab), Rystiggo (rozanolixizumab), Vyvgart (efgartigimod alfa), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase)] ▪ An immune globulin (e.g., Hizentra, Gammagard, Alyglo, etc.) ○ Patient will be given Uplizna no sooner than two weeks after the first initial dose and every 6 months thereafter for subsequent infusions ○ Uplizna is dosed according to the U.S. FDA labeled dosing for gMG ○ Prescribed by, or in consultation with, a neurologist ○ Initial authorization will be for no more than 12 months Continuation of Therapy ○ Patient has previously been treated with Uplizna ○ Submission of medical records (e.g., chart notes, laboratory tests) demonstrating all of the following: ▪ Improvement and/or maintenance of at least a 2 point improvement (reduction in score) in the MG-ADL score from pre-	– Positive serologic test for anti-AChR antibodies; **or** – Positive serologic test for anti-MuSK antibodies **and** ▪ Patient has a Myasthenia Gravis Foundation of America (MGFA) Clinical Classification of class II, III, or IV at initiation of therapy; **and** ▪ Patient has a Myasthenia Gravis Activities of Daily Living scale (MG-ADL) total score ≥ 5 at initiation of therapy **and** ○ **One** of the following: ▪ If anti-acetylcholine receptor (AChR) antibody positive, **one** of the following: – History of failure of at least **two** immunosuppressive agents over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.); **or** – Patient has a history of failure of at least one immunosuppressive therapy and has required four or more courses of plasmapheresis/plasma exchanges and/or immune globulin over the course of at least 12 months without symptom control **or** ▪ If anti-muscle-specific tyrosine kinase (MuSK) antibody positive: – History of failure of at least one immunosuppressive agent over the course of at least 12 months (e.g., azathioprine, corticosteroids, cyclosporine, methotrexate, mycophenolate, etc.) **and** ○ Patient is **not** receiving Uplizna in combination with any of the following for treatment of the same indication: ▪ A complement inhibitor [e.g., eculizumab, Ultomiris (ravulizumab), Zilbrysq (zilucoplan)]; **and** ▪ An FcRn blocker [e.g., Imaavy (nipocalimab), Rystiggo (rozanolixizumab), Vyvgart (efgartigimod alfa), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase)]; **and** ▪ An immune globulin (e.g., Hizentra, Gammagard, Alyglo, etc.) **and**

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Uplizna® (Inebilizumab-Cdon) (continued)	Apr. 1, 2026	treatment baseline ▪ Reduction in signs and symptoms of myasthenia gravis ▪ Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting Uplizna (note: add on, dose escalation of IST, or additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on Uplizna therapy will be considered as treatment failure) ○ Patient is not receiving Uplizna in combination with any of the following for treatment of the same indication: ▪ A complement inhibitor [e.g., eculizumab, Ultomiris (ravulizumab), Zilbrysq (zilucoplan)] ▪ An FcRn blocker [e.g., Imaavy (nipocalimab), Rystiggo (rozanolixizumab), Vyvgart (efgartigimod alfa), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase)]	○ Patient will be given Uplizna no sooner than two weeks after the first initial dose and every 6 months thereafter for subsequent infusions; **and** ○ Uplizna is dosed according to the US FDA labeled dosing for gMG; **and** ○ Prescribed by, or in consultation with, a neurologist; **and** ○ Initial authorization will be for no more than 12 months • For continuation of therapy, **all** of the following: ○ Patient has previously been treated with Uplizna; **and** ○ Submission of medical records (e.g., chart notes, laboratory tests) demonstrating **all** of the following: ▪ Improvement and/or maintenance of at least a 2 point improvement (reduction in score) in the MG-ADL score from pre-treatment baseline; **and** ▪ Reduction in signs and symptoms of myasthenia gravis; **and** ▪ Maintenance, reduction, or discontinuation of dose(s) of baseline immunosuppressive therapy (IST) prior to starting Uplizna (**Note**: Add on, dose escalation of IST, or additional rescue therapy from baseline to treat myasthenia gravis or exacerbation of symptoms while on Uplizna therapy will be considered as treatment failure.) **and** ○ Patient is **not** receiving Uplizna in combination with any of the following for treatment of the same indication: ▪ A complement inhibitor [e.g., eculizumab, Ultomiris (ravulizumab), Zilbrysq (zilucoplan)]; **and** ▪ An FcRn blocker [e.g., Imaavy (nipocalimab), Rystiggo (rozanolixizumab), Vyvgart (efgartigimod alfa), Vyvgart Hytrulo (efgartigimod alfa and hyaluronidase)]; **and** ▪ An immune globulin (e.g., Hizentra, Gammagard, Alyglo, etc.) **and** ○ Patient is not being given Uplizna sooner than 6 months from the start of the previous treatment cycle; **and** ○ Uplizna is dosed according to the US FDA labeled dosing for gMG; **and** ○ Prescribed by, or in consultation with, a neurologist; **and** ○ Reauthorization will be for no more than 12 months

Medical Benefit Drug Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Uplizna® (Inebilizumab-Cdon) (continued)	Apr. 1, 2026	▪ An immune globulin (e.g., Hizentra, Gammagard, Alyglo, etc.) ○ Patient is not being given Uplizna sooner than 6 months from the start of the previous treatment cycle ○ Uplizna is dosed according to the U.S. FDA labeled dosing for gMG ○ Prescribed by, or in consultation with, a neurologist ○ Reauthorization will be for no more than 12 months **Applicable Codes** • Added ICD-10 diagnosis codes G70.00 and G70.01 **Supporting Information** • Updated *Background*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	

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.