

UnitedHealthcare Community Plan of New Jersey Medical Policy Update Bulletin: October 2026

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Take Note

Quarterly HCPCS Code Updates

Effective **Oct. 1, 2026**, the following Medical Benefit Drug Policies have been updated to reflect the quarterly HCPCS code additions and deletions. Refer to the [Centers for Medicare & Medicaid Services: Healthcare Common Procedure Coding System \(HCPCS\) Quarterly Update](#) for information on the code updates.

Policy Title	Summary of Changes
Medical Therapies for Enzyme Deficiencies	Added HCPCS codes J1757 and J1818
Oncology Medication Clinical Coverage	- Added HCPCS codes J0643 and J0644 - Removed HCPCS code J0640

Medical Policy Updates

Updated			
Policy Title	Effective Date	Summary of Changes	
Injectable Dermal Fillers and Bulking Agents (for New Jersey Only)	Nov. 1, 2026	Applicable Codes - Removed CPT codes 31570, 31571, and 31574 Supporting Information - Updated <i>Description of Services</i>, <i>Clinical Evidence</i>, <i>FDA</i>, and <i>References</i> sections to reflect the most current information	
Pharmacogenetic Panel Testing (for New Jersey Only)	Oct. 1, 2026	Applicable Codes - Updated list of applicable CPT codes to reflect quarterly edits; added 0697U - Added notation to indicate CPT codes 0650U and 0652U are not on the State of New Jersey Medicaid Fee Schedule and therefore may not be covered by the State of New Jersey Medicaid Program Supporting Information - Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information	
Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Breast Imaging for Screening and Diagnosing Cancer (for New Jersey Only)	Dec. 1, 2026	Coverage Rationale - Revised list of unproven and not medically necessary indications; replaced: “Magnetic Resonance Elastography” with “Magnetic Resonance Elastography of the Breast” “Molecular Breast Imaging (e.g., breast specific gamma imaging, scintimammography, Positron Emission Mammography)” with “Molecular Breast Imaging (e.g., breast specific gamma imaging, scintimammography) for routine screening in normal or high-risk individuals or Positron Emission Mammography”	Note: This policy does not address routine preventive breast cancer screening using conventional mammography. The following are proven and medically necessary: - Magnetic resonance imaging (MRI) of the breast for individuals who are at high risk for breast cancer, as defined as having any of the following: - Heterogeneously dense breasts (category C) or extremely dense breasts (category D) (screening beginning at age 40 years) - Prior thoracic radiation therapy between the ages of 10 and 30 years (screening starting at age 25 years or 8 years after treatment, whichever is later) - Lifetime risk estimated at greater than or equal to 20%, as defined by models that are largely dependent on family history (e.g., Gail, Claus, Tyrer-Cuzick, or BRCAPRO) (screening beginning at age 40 years*) - Personal history of breast cancer (not treated with bilateral mastectomy) - Personal history with any of the following: - ATM (screening beginning at age 30 years*) - BARD1 (screening beginning at age 40 years*) - BRCA1 or BRCA2 (screening beginning at age 25 years) - CDH1 (screening beginning at age 30 years*)

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Breast Imaging for Screening and Diagnosing Cancer (for New Jersey Only) (continued)	Dec. 1, 2026	Definitions - Removed definition of “Breast Specific Gamma Imaging (BSGI)” - Updated definition of “Molecular Breast Imaging” Supporting Information - Updated <i>Clinical Evidence</i>, <i>FDA</i>, and <i>References</i> sections to reflect the most current information	<i>CHEK2</i> (screening beginning at age 30 years*) <i>NF1</i> (screening beginning at age 30 years*) <i>PALB2</i> (screening beginning at age 30 years*) <i>PTEN</i> gene mutation (Cowden syndrome) (screening beginning at age 30 years*) <i>RAD51C</i> (screening beginning at age 40 years*) <i>RAD51D</i> (screening beginning at age 40 years*) <i>STK11</i> gene mutation (Peutz-Jehgers syndrome) (screening beginning at age 30 years*) <i>TP53</i> gene mutation (Li-Fraumeni syndrome) (screening beginning at age 20 years) - Family history with any of the following: - At least one first-degree relative who has a <i>BRCA1</i> or <i>BRCA2</i> mutation (screening beginning at age 40 years*) - First-degree relative who carries a genetic mutation in the <i>TP53</i> or <i>PTEN</i> genes (Li-Fraumeni syndrome, Cowden syndrome, Bannayan-Riley-Ruvalcaba syndrome, or Peutz-Jehgers syndrome) - At least two first-degree relatives with breast or ovarian cancer (screening beginning at age 40 years*) - One first-degree relative with bilateral breast cancer or both breast and ovarian cancer (screening beginning at age 40 years*) - First- or second-degree male relative (father, brother/half-brother, uncle, or grandfather) diagnosed with breast cancer (screening beginning at age 40 years*) *Screening can begin at the listed age or starting 10 years prior to the age at diagnosis of the youngest relative who has been diagnosed with breast cancer (up to third-degree relatives), whichever comes first, but not before age 25 years. The following are unproven and not medically necessary due to insufficient evidence of efficacy: - Computer-Aided Tactile Breast Imaging - Computed tomography of the breast - Magnetic Resonance Elastography of the Breast - MRI of the breast for individuals who do not meet the criteria above

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Breast Imaging for Screening and Diagnosing Cancer (for New Jersey Only) (continued)	Dec. 1, 2026		- Molecular Breast Imaging (e.g., breast-specific gamma imaging, scintimammography) for routine screening in normal or high-risk individuals - Positron Emission Mammography Note: For three-dimensional rendering of breast ultrasound, three-dimensional rendering of breast MRI, computed tomography of the breast, or additional indications for MRI of the breast, refer to the Breast Imaging Guidelines section of the <i>Cardiovascular and Radiology Imaging Guidelines</i>.
Cardiovascular Disease Risk Tests (for New Jersey Only)	Dec. 1, 2026	Coverage Rationale - Revised list of unproven and not medically necessary indications: - Replaced “advanced lipoprotein analysis [e.g., lipoprotein(a), subfractions, or particle size] as a method to determine risk for cardiovascular disease” with “subfractions or particle size advanced lipoprotein analysis as a method to determine risk for cardiovascular disease” - Added “noninvasive point-of-care cardiac diagnostic platforms (e.g., CorVista® System, CorVista System with CAD and PH add-ons) that are intended to synchronously collect and apply machine learning to predict the likelihood of cardiovascular diseases, including but not limited to coronary artery disease, pulmonary hypertension, or pulmonary capillary wedge pressure”	The following are unproven and not medically necessary due to insufficient evidence of efficacy: - Arterial compliance testing, using waveform analysis as a method to determine risk for cardiovascular disease - Carotid intima-media thickness measurement as an effective screening tool for the management of cardiovascular disease - Subfractions or particle size advanced lipoprotein analysis as a method to determine risk for cardiovascular disease - Lipoprotein-associated phospholipase A2 (Lp-PLA2) enzyme as a method to determine risk for cardiovascular disease or ischemic stroke - Endothelial function assessment using tools such as peripheral arterial tonometry (PAT) or brachial artery pressure ultrasound as a prognostic indicator to determine risk of cardiovascular disease - Multiprotein diagnostic biomarker: - Analysis of protein biomarkers by aptamer-based microarray and algorithm - Cardiovascular disease [high-density lipoprotein (HDL) reverse cholesterol transport], cholesterol efflux capacity, liquid chromatography–tandem mass spectrometry, and quantitative measurement of five distinct HDL-bound apolipoproteins (apolipoproteins A1, C1, C2, C3, and C4), with algorithm and reported as a risk score - Three proteins [high-sensitivity troponin, adiponectin, and kidney injury molecule-1 (KIM-1)], with algorithm and reported as a risk score - Four proteins [NT-proBNP, osteopontin, tissue inhibitor of metalloproteinase-1 (TIMP-1), and KIM-1], with algorithm and reported as a risk score

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Cardiovascular Disease Risk Tests (for New Jersey Only) (continued)	Dec. 1, 2026	Applicable Codes - Updated list of applicable CPT codes: - Added 1104T*(*quarterly edit) - Removed 83695 Supporting Information - Updated <i>Description of Services</i>, <i>Clinical Evidence</i>, <i>FDA</i>, and <i>References</i> sections to reflect the most current information	- Seven proteins (IL-16, FAS, FASLigand, HGF, CTACK, EOTAXIN, and MCP-3), with algorithm and reported as a risk score - Noninvasive point-of-care cardiac diagnostic platforms (e.g., CorVista® System, CorVista System with CAD and PH add-ons) that are intended to synchronously collect and apply machine learning to predict the likelihood of cardiovascular diseases, including but not limited to: - Coronary artery disease - Pulmonary hypertension - Pulmonary capillary wedge pressure
Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) (for New Jersey Only)	Nov. 1, 2026	Coverage Rationale Re-Evaluations Replaced language indicating “re-evaluations must be completed at least once every 12 months or more frequently, based on state regulatory requirements, to support the need for on-going services” with “re-evaluations must be completed at least once every 6 months or more frequently, based on state regulatory requirements, to support the need for on-going services”	Note: This Medical Policy does not apply to cognitive therapy. For outpatient cognitive therapy, refer to the Medical Policy titled Cognitive Rehabilitation and Coma Stimulation (for New Jersey Only). Habilitation, rehabilitation, and maintenance are proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® LOC: Outpatient Rehabilitation & Chiropractic. Click here to view the InterQual® criteria. Note: For rehabilitative physical and speech-language therapy performed in a physician’s office, treatment shall be individual and shall consist of a minimum of 30 minutes. (N.J.A.C § 10:54-5.35) Upon clinical review and when appropriate, UnitedHealthcare may authorize therapies based on the medical necessity criteria above for up to six months in accordance with generally accepted standards of practice. The services must not be duplicate services of another service provided concurrently by any other type of therapy (such as speech, physical, and occupational therapy), and must provide different treatment goals, plans, and therapeutic modalities. The documentation requirements outlined below are used in addition to InterQual® to assess whether the individual meets the clinical criteria for coverage, but does not guarantee coverage of the service requested.

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) (for New Jersey Only) (continued)	Nov. 1, 2026		Initial Therapy Evaluation/Initial Therapy Visit Requests A provider (PCP) (MD, DO, PA, or NP) or appropriate specialist referral for the speech, physical, and occupational therapy evaluation must be on file prior to the completion of the evaluation, unless this requirement is exempted by the state. The therapy evaluation report must include all the following: • A statement of the individual's medical history; and • A comparison of prior level of function to current level of function, as applicable; and • A description of the individual's functional impairment, including its impact on their health, safety, and/or independence; and • A clear diagnosis, including the appropriate <i>International Statistical Classification of Diseases, Tenth Revision</i> (ICD-10) code; and • Reasonable prognosis, including the individual's potential for meaningful and noteworthy progress; and • Baseline objective measurements (current versions of standardized assessments), including a description of the individual's current deficits and their severity level, which include: ○ Current standardized assessment scores, age equivalents, percentage of functional delay, criterion-referenced scores, and/or other objective information as appropriate for the individual's condition or impairment ○ Standardized assessments administered must correspond to the delays identified and relate to the long- and short-term goals ○ Standardized assessment results will not be used as the sole determinant as to the medical necessity of the requested initial therapy visit ○ If the individual has a medical condition that prevents them from completing standardized assessment(s), alternatives could include: ▪ The therapist provides in-depth, objective clinical information, using task analysis to describe the individual's deficit area(s) in lieu of standardized assessments ▪ The therapist should include checklists, caregiver reports or interviews, and clinical observation

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) (for New Jersey Only) (continued)	Nov. 1, 2026		Plan of Care The initial authorization for therapy must also include a plan of care (POC). Providers must develop an individual's POC based on the results of the evaluation. The POC must include all the following: • Functional or physical impairment; and • Short- and long-term therapeutic goals and objectives: ○ Treatment goals should be specific to the individual's diagnosed condition or functional or physical impairment ○ Treatment goals must be functional, measurable, attainable, and time based ○ Treatment goals must relate to individual-specific functional skills and • Treatment frequency and duration and anticipated length of treatment session(s) Requests for Continuation of Therapy Visits For continuation of therapy visits, in addition to the above, also include, when applicable: • Weeks of therapy previously authorized or treatment visits attended • Additional therapy(ies) being requested, including frequency, duration, and anticipated length of treatment session(s) • Individual's current status as compared to evaluation baseline data and the prior progress reports, including objective measures of individual performance in functional terms • Physical and functional status compared to prior treatment measurements or assessments (using the same assessments or measures) • Objective measurements demonstrate continued physical and functional impairment compared to normal values or premorbid level of function • Provision of and need for continued skilled services Re-Evaluations Re-evaluations must be completed at least once every 6 months or more frequently, based on state regulatory requirements, to support the need for ongoing services. Re-evaluations performed more often than once should only be completed when the individual experiences a significant change in

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) (for New Jersey Only) (continued)	Nov. 1, 2026		functional level in their condition or functional status. The documentation must be reflective of this change. Re-evaluations must include current standardized assessment scores, percentage of functional delay, criterion-referenced scores, or other objective information as appropriate for the individual's condition or impairment. The therapy re-evaluation report must include all the following: • Date of last therapy evaluation; and • Number of therapy visits authorized and number of therapy visits attended; and • Adherence to home program; and • Description of the individual's current deficits and their severity level, documented using objective data; and • Objective demonstration of the individual's progress toward each treatment goal: ○ Using consistent and comparable methods to report progress on short-term and long-term treatment goals established ○ For all unmet goals, baseline, and current function so that the individual's progress toward goals can be measured - and • An updated statement of the prescribed treatment modalities and their recommended frequency/duration; and • A brief prognosis, with clearly established discharge criteria; and • An updated individualized POC must include updated measurable, functional, and time-based goals: ○ The updated POC/progress summary must not be older than 90 days; and ○ If the majority of the long- and short-term goals were not achieved, the POC must include a description of the barriers or an explanation of why the goal(s) needed to be modified or discontinued - and • A revised POC stating that the treating therapist has not made a meaningful update to support the need for continued services will not be accepted, in addition, the notation of the percentage accuracy toward the individual's goals alone is not sufficient to establish a need for continued medically necessary therapy

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) (for New Jersey Only) (continued)	Nov. 1, 2026		Treatment Session Notes All treatment session notes must include: • Date of treatment • Specific treatment(s) provided that match the CPT code(s) billed • Accurate documentation of the length of treatment session • The individual's response to treatment • Skilled ongoing reassessment of the individual's progress toward the goals • All progress toward the goals in objective, measurable terms, using consistent and comparable methods • Any problems with or changes to the POC • Individual or caregiver involvement in and feedback about home program activities • Signature and date from the treating provider Group Therapy The documentation must include all the following: • Prescribing provider's order for group therapy; and • Individualized treatment plan that includes frequency and duration of the prescribed group therapy and individualized treatment goals; and • Name and signature of licensed therapist providing supervision over the group therapy session; and • Specific treatment techniques used during the group therapy session and how the techniques will restore function; and • Accurate documentation of the length of treatment session; and • Group therapy setting or location; and • Number of clients in the group Feeding and Swallowing Disorders For feeding and swallowing evaluations, all the following must be submitted: • Interview/case history; and • Medical/clinical records, including the potential impact of medications, if any; and • Physical examination; and • Previous screening and assessments; and

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) (for New Jersey Only) (continued)	Nov. 1, 2026		• Collaboration with providers and other caregivers ○ During assessment, therapists determine whether the individual is an appropriate candidate for treatment and/or management; this determination is based on findings that include medical stability, cognitive status, nutritional status, and psychosocial, environmental, and behavioral factors • Assessment must result in one or more of the following outcomes: ○ Description of the characteristics of swallowing function, including any breakdowns in swallow physiology ○ Diagnosis of a swallowing disorder ○ Determination of the safest and most efficient route (oral vs nonoral) of nutrition and hydration intake ○ Identification of the effectiveness of intervention and support ○ Recommendations for intervention and support for oral, pharyngeal, and/or laryngeal disorders ○ Prognosis for improvement and identification of other relevant factors, if appropriate Discharge Criteria Discharge criteria include but are not limited to all the following (as applicable): • Treatment goals and objectives have been met • Functional abilities have become comparable to those of individuals of the same chronological age • The desired level of function that has been agreed to by the individual and provider has been achieved • The skill of a therapist or other licensed health care professional (within the scope of their licensure) is not required • The individual exhibits behavior that interferes with improvement or participation in treatment, and efforts to address these factors have not been successful • In some situations, the individual, family, or designated guardian may choose not to participate in treatment, may relocate, or may seek another provider if the therapeutic relationship is not satisfactory; therefore, discharge is also appropriate in the following situations, provided that the individual, family, and/or guardian have been advised of the likely outcomes of discontinuation:

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Habilitation and Rehabilitation Therapy (Occupational, Physical, and Speech) (for New Jersey Only) (continued)	Nov. 1, 2026		- There is a request to be discharged or request for continuation of services with another provider - The individual is transferred or discharged to another location at which ongoing service from the current provider is not reasonably available; efforts should be made to ensure continuation of services in the new locale - The individual is unable to tolerate treatment because of a serious medical, psychological, or other condition Speech and Language Considerations - Bilingual and multilingual speakers are frequently misclassified as developmentally delayed. Equivalent proficiency in both languages should not be expected. Individuals with limited English proficiency must receive culturally and linguistically adapted norm-referenced standardized testing in all languages that the child is exposed to in order to compare potential deficits. For speech and language therapy services for an individual with limited English proficiency, all the following criteria must be met: - All speech deficits must be present in the language in which the individual has the highest proficiency; and - Language deficits must be present in the language in which the individual has the highest proficiency; and - Delivery of services must be in the language in which the individual has the highest receptive language proficiency - For individuals with dyslexia, test results substantiating a diagnosis of receptive or expressive language delay must be included, with goals addressing the corresponding language deficits
Transarterial Radioembolization (TARE)/Selective Internal Radiation Therapy (SIRT) for the Treatment of Malignant Cancers of the Liver (for New Jersey Only)	Dec. 1, 2026	Coverage Rationale Revised list of proven and medically necessary indications for Transarterial Radioembolization (TARE)/selective internal radiation therapy (SIRT) using yttrium-90 microspheres; replaced “metastasis from uveal/ocular melanoma when	Note: This policy applies to individuals 19 years of age or older. Transarterial Radioembolization (TARE)/selective internal radiation therapy (SIRT) is covered without further review for individuals younger than 19 years of age. Transarterial Radioembolization (TARE)/selective internal radiation therapy (SIRT) using yttrium-90 microspheres is proven and medically necessary for the following indications in individuals with an Eastern Cooperative Oncology Group (ECOG) Performance Status of 0, 1, or 2: Liver-dominant primary hepatocellular carcinoma in individuals who are not surgical candidates

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Transarterial Radioembolization (TARE)/Selective Internal Radiation Therapy (SIRT) for the Treatment of Malignant Cancers of the Liver (for New Jersey Only) (continued)	Dec. 1, 2026	confined to the liver” with “metastasis from uveal melanoma when confined to the liver” Definitions - Updated definition of “Transarterial Radioembolization (TARE)” Supporting Information - Updated <i>Description of Services</i>, <i>Clinical Evidence</i>, and <i>References</i> sections to reflect the most current information	- Primary hepatocellular carcinoma as a bridge to liver transplant - Liver metastases from neuroendocrine tumors in individuals who are not surgical candidates when systemic therapy has failed to control symptoms - Liver metastases from colorectal carcinoma in individuals with chemotherapy-resistant or Refractory disease and with predominant hepatic metastases - Liver metastases from intrahepatic cholangiocarcinoma in individuals who are not surgical candidates - Metastasis from uveal melanoma when confined to the liver Transarterial Radioembolization (TARE)/selective internal radiation therapy (SIRT) using yttrium-90 microspheres is unproven and not medically necessary for all other indications due to insufficient evidence of efficacy.
Treatment of Temporomandibular Joint Disorders (for New Jersey Only)	Dec. 1, 2026	Coverage Rationale - Replaced language indicating “the [listed] temporomandibular joint (TMJ) <i>surgical services</i> are proven and medically necessary in certain circumstances” with “temporomandibular joint (TMJ) <i>arthroplasty</i> is proven and medically necessary in certain circumstances” - Revised language pertaining to medical necessity clinical coverage criteria: - Added reference to the InterQual® CP: Procedures, Arthroplasty, Temporomandibular Joint (TMJ) - Removed reference to the: - InterQual® CP: Procedures:	The following nonsurgical services are proven and medically necessary for treating disorders of the temporomandibular joint (TMJ): - Arthrocentesis - Intra-articular injections of corticosteroids - Trigger point injections - Physical therapy - Occlusal splint (stabilization and repositioning splints) TMJ arthroplasty is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures: Arthroplasty, Temporomandibular Joint (TMJ). Click here to view the InterQual® criteria. The following services are unproven and not medically necessary for treating disorders of the TMJ due to insufficient evidence of efficacy (this list is not all inclusive): - Biofeedback - Jaw mobility mechanical stretching devices (e.g., TheraBite Jaw Motion Rehabilitation System®, Jaw Dynasplint® System)

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Treatment of Temporomandibular Joint Disorders (for New Jersey Only) (continued)	Dec. 1, 2026	– Arthroscopy, Temporomandibular Joint (TMJ) – Discectomy, Temporomandibular Joint (TMJ) – Reconstruction, Temporomandibular Joint (TMJ) ▪ InterQual® Client Defined, CP: Procedures, Arthroplasty, Temporomandibular Joint (TMJ) (Custom) - UHG Applicable Codes • Removed CPT codes 21060, 21247, 29800, and 29804 Supporting Information • Updated <i>Clinical Evidence</i> and <i>References</i> sections to reflect the most current information	• Multiple occlusal splints (e.g., daytime, and nighttime splints, maxillary and mandibular splints) • Epigenetic appliances [e.g., Homeoblock™, DNA® (Daytime/Nighttime appliance), Advanced Lightwire Functional appliance] For information regarding intra-articular injections of sodium hyaluronate for TMJ disorders, refer to the Medical Benefit Drug Policy titled Sodium Hyaluronate. For information regarding botulinum toxin injections for TMJ disorders, refer to the Medical Benefit Drug Policy titled Botulinum Toxins A and B.
Retired			
Policy Title	Effective Date	Summary of Changes	
Virtual Upper Gastrointestinal Endoscopy (for New Jersey Only)	Oct. 1, 2026	• Retired policy; virtual upper gastrointestinal endoscopy no longer requires clinical review	

Medical Benefit Drug Policy Updates

Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Antiemetics for Oncology	Nov. 1, 2026	Coverage Rationale - Revised coverage criteria; updated list of risk factors for anticancer agent-induced nausea/vomiting: - Added “less than 7 hours of sleep the night before chemotherapy” - Replaced “<i>high anxiety</i>” with “<i>anxiety/high pretreatment expectation of nausea</i>” Supporting Information - Updated <i>Clinical Evidence</i>, <i>FDA</i>, and <i>References</i> sections to reflect the most current information	This policy refers to the following products used as antiemetics for oncology use: - Akynzeo® (palonosetron/netupitant) capsule - Akynzeo® (palonosetron/fosnetupitant) injection - Aloxi® (palonosetron) injection - Cinvanti™ (aprepitant) injectable emulsion - Emend® (fosaprepitant) injection - Emend® (aprepitant) capsule - Focinvez™ (fosaprepitant) injection - Posfrea™ (palonosetron) injection - Sustol® (granisetron extended release) injection - Kytril® (granisetron) injection, tablets - Varubi® (rolapitant) tablet - Zofran® (ondansetron) injection, tablets Inclusion of oral antiemetics in this policy and application of the preferred product criteria to them is limited to when these are administered prior to the chemotherapy infusion and not when they are self-administered by the patient outside of the infusion. Refer to the policy for a list of preferred and non-preferred products. Coverage for antiemetics will be provided contingent on the coverage criteria in the <i>Diagnosis-Specific Criteria</i> section. Any U.S. Food and Drug Administration (FDA)–approved product that may belong to UnitedHealthcare <i>Preferred</i> or <i>Non-Preferred Product</i> categories but not listed by name in this policy will be considered non-preferred until reviewed by the UnitedHealthcare Pharmacy & Therapeutics (P&T) committee. Preferred Product Criteria Treatment with non-preferred NK1 RA, 5HT3 RA, or NK1 RA/5HT3 RA combination product is medically necessary for the indications specified in the policy when one of the following is met: Both of the following: - History of a trial of adequate dose and duration to one of the preferred NK1 RA or 5HT3 RA products, resulting in minimal clinical

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Antiemetics for Oncology (continued)	Nov. 1, 2026		response; and - Physician attests that, in their clinical opinion, the clinical response would be expected to be superior with non-preferred NK1 RA, 5HT3 RA, or NK1 RA/5HT3 RA combination product than experienced with preferred NK1 RA or 5HT3 RA product or Both of the following: - History of intolerance, contraindication, or adverse event to one of the preferred NK1 RA or 5HT3 RA products; and - Physician attests that, in their clinical opinion, the same intolerance, contraindication, or adverse event would not be expected to occur with non-preferred NK1 RA, 5HT3 RA, or NK1 RA/5HT3 RA combination products Diagnosis-Specific Criteria For the coverage criteria below, in absence of specified drug products, the term “antiemetics” will be used in this policy where the coverage criteria apply to all products listed above. Antiemetics are proven and medically necessary for the following indications: NK1 RA (Cinvanti, Emend, Focinvez, Varubi) may be indicated when one of following are present: Both of the following: - Prevention of chemotherapy-induced nausea and vomiting due to High Emetic Risk parenteral anticancer agents; and - In combination with a 5HT3 RA or All of the following: - Prevention of chemotherapy-induced nausea and vomiting due to Moderate Emetic Risk parenteral anticancer agents; and - In combination with a 5HT3 RA; and One of the risk factors for anticancer agent-induced nausea/vomiting: - Younger age (< 55 years); or - Female sex; or

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Antiemetics for Oncology (continued)	Nov. 1, 2026		– Previous history of chemotherapy-induced nausea or vomiting; or – Little or no previous alcohol use; or – History of motion sickness or morning sickness during pregnancy; or – Anxiety/high pretreatment expectation of nausea – Less than 7 hours of sleep the night before chemotherapy • 5HT3 RA (Aloxi, Kytril, Posfrea, Sustol, Zofran) may be indicated when one of the following are present: ○ Both of the following: ▪ Prevention of chemotherapy-induced nausea and vomiting due to High Emetic Risk parenteral anticancer agents; and ▪ In combination with a NK1 RA or ○ Prevention of chemotherapy-induced nausea and vomiting due to Moderate Emetic Risk parenteral anticancer agents; or ○ All of the following: ▪ Prevention of chemotherapy-induced nausea and vomiting due to Moderate Emetic Risk parenteral anticancer agents; and ▪ In combination with a NK1 RA; and ▪ One of the risk factors for anticancer agent-induced nausea/vomiting: – Younger age (< 55 years); or – Female sex; or – Previous history of chemotherapy-induced nausea or vomiting; or – Little or no previous alcohol use; or – History of motion sickness or morning sickness during pregnancy; or – Anxiety/high pretreatment expectation of nausea; or – Less than 7 hours of sleep the night before chemotherapy or ○ Treatment of breakthrough nausea and/or vomiting due to anticancer agent(s) • NK1 RA/5HT3 RA combination product (Akynzeo) may be indicated when one of the following are present: ○ All of the following:

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Antiemetics for Oncology (continued)	Nov. 1, 2026		▪ Prevention of chemotherapy-induced nausea and vomiting due to Moderate Emetic Risk parenteral anticancer agents; and ▪ One of the risk factors for anticancer agent-induced nausea/vomiting: – Younger age (< 55 years); or – Female sex; or – Previous history of chemotherapy-induced nausea or vomiting; or – Little or no previous alcohol use; or – History of motion sickness or morning sickness during pregnancy; or – Anxiety/high pretreatment expectation of nausea; or – Less than 7 hours of sleep the night before chemotherapy or ○ Prevention of chemotherapy-induced nausea and vomiting due to High Emetic Risk parenteral anticancer agents
Evenity® (Romosozumab-Aqqg)	Nov. 1, 2026	Coverage Rationale • Revised coverage criteria; added criterion to allow coverage when the patient is considered to have very high fracture risk defined by the presence of at least one of the following: ○ Recent fracture in the past 12 months ○ Fracture while on approved osteoporosis therapy ○ Multiple fractures (occurrence of more than one broken bone, which can include fractures of different ages or types, such as bilateral fractures, epiphyseal separations, and complex skull fractures) ○ Fractures while on drugs causing skeletal harm (e.g.,	Evenity® is proven and medically necessary for the treatment of osteoporosis in postmenopausal patients at high risk for fracture when all of the following criteria are met: • Diagnosis of osteoporosis; and • One of the following: ○ BMD T-score ≤ -2.5 based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site); or ○ History of one of the following resulting from minimal trauma: ▪ Vertebral compression fracture; or ▪ Fracture of the hip; or ▪ Fracture of the distal radius; or ▪ Fracture of the pelvis; or ▪ Fracture of the proximal humerus or ○ Both of the following: ▪ BMD T-score between -1 and -2.5 (BMD T-score greater than -2.5 and less than or equal to -1) based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site); and ▪ One of the following:

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Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Evenity® (Romosozumab-Aqqg) (continued)	Nov. 1, 2026	- long-term glucocorticoids) ○ BMD T-score < -3.0 based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site) ○ High risk for falls or history of injurious falls ○ One of the following: ▪ FRAX 10-year fracture probabilities: major osteoporotic fracture at 30% or more ▪ FRAX 10-year fracture probabilities: hip fracture at 4.5% or more Supporting Information • Updated <i>Clinical Evidence</i> section to reflect the most current information	– FRAX 10-year fracture probabilities: major osteoporotic fracture at 20% or more; or – FRAX 10-year fracture probabilities: hip fracture at 3% or more and • One of the following: ○ Patient is considered to have very high fracture risk defined by the presence of at least one of the following: ▪ Recent fracture in the past 12 months; or ▪ Fracture while on approved osteoporosis therapy; or ▪ Multiple fractures (occurrence of more than one broken bone, which can include fractures of different ages or types, such as bilateral fractures, epiphyseal separations, and complex skull fractures); or ▪ Fractures while on drugs causing skeletal harm (e.g., long-term glucocorticoids); or ▪ BMD T-score < -3.0 based on BMD measurements from lumbar spine (at least two vertebral bodies), hip (femoral neck, total hip), or radius (one-third radius site); or ▪ High risk for falls or history of injurious falls; or ▪ One of the following: – FRAX 10-year fracture probabilities: major osteoporotic fracture at 30% or more; or – FRAX 10-year fracture probabilities: hip fracture at 4.5% or more or ○ Both of the following: ▪ History of intolerance to oral bisphosphonate therapy; and ▪ History of failure, contraindication, or intolerance to intravenous bisphosphonate therapy (e.g., pamidronate, zoledronic acid) or ○ History of failure or contraindication to oral bisphosphonate therapy; or ○ History of failure, contraindication, or intolerance to intravenous bisphosphonate therapy and • Patient is not receiving Evenity in combination with any of the following:

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Revised			
Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Evenity® (Romosozumab-Aqqg) (continued)	Nov. 1, 2026		○ Parathyroid hormone analogs (e.g., Forteo, Tymlos) ○ RANK ligand inhibitors (e.g., Prolia, Xgeva) and ● Evenity dosing is in accordance with the U.S. Food and Drug Administration (FDA)–approved labeling; and ● Authorization is for no more than 12 months Reauthorization/Continuation of Care Criteria The clinical benefit of Evenity® has not been demonstrated beyond 12 months in phase 3 clinical trials. The continued use of Evenity® beyond 12 months is unproven and not medically necessary.

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 of New Jersey 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 of New Jersey Medical Policies and Medical Benefit Drug Policies is available at UHCprovider.com/NJ > Community Plan (Medicaid) > Current Policies and Clinical Guidelines > [Medical & Drug Policies](#).