United Healthcare Community Plan

UnitedHealthcare Community Plan of Pennsylvania
Medical Policy Update Bulletin: May 2026

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Medical Policy Updates

Updated

Policy Title	Effective Date	Summary of Changes
Plagiocephaly and Craniosynostosis Treatment (for Pennsylvania Only)	May 1, 2026	**Medical Records Documentation Used for Reviews** • Added language to indicate: ○ 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 ○ The patient's medical record must contain documentation that fully supports the medical necessity for the requested services ○ This documentation includes but is not limited to relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures ○ Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request
Whole Exome and Whole Genome Sequencing (Non-Oncology Conditions) (for Pennsylvania Only)	May 1, 2026	**Applicable Codes** • Updated list of applicable CPT codes to reflect annual edits; added 81354

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Catheter Ablation for Atrial Fibrillation (for Pennsylvania Only)	Jul. 1, 2026	**Coverage Rationale** • Added language to indicate catheter ablation for treating asymptomatic atrial fibrillation in individuals with a left ventricular ejection fraction greater than 40% is unproven and not medically necessary due to insufficient evidence of efficacy **Definitions** • Added definition of "Heart Failure With Reduced Ejection Fraction" **Supporting Information** • Added *Description of Services* and *Clinical Evidence* sections	**Note**: This policy does not apply to members aged < 18 years or those with arrhythmias other than atrial fibrillation. **Catheter ablation for atrial fibrillation is proven and medically necessary in certain circumstances.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Electrophysiology (EP) Testing +/- Catheter Ablation, Cardiac. Click here to view the InterQual® criteria. **Catheter ablation for treating asymptomatic atrial fibrillation in individuals with a left ventricular ejection fraction greater than 40% is unproven and not medically necessary due to insufficient evidence of efficacy.**

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Catheter Ablation for Atrial Fibrillation (for Pennsylvania Only) (continued)	Jul. 1, 2026	• Updated *References* section to reflect the most current information	
Chemotherapy Observation or Inpatient Hospitalization (for Pennsylvania Only)	Jun. 1, 2026	**Related Policies** • Added reference link to the Medical Policy titled *Hospital Services: Observation and Inpatient (for Pennsylvania Only)* **Coverage Rationale** • Revised drug regimen requirements for an inpatient stay; removed list of applicable cancer type(s) for the listed regimens **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	**Note**: This policy does not apply to individuals under 18 years of age. Most cancer chemotherapies can be administered safely and effectively in a physician's office or through home health care services. However, because of the risk of certain toxicities or individual comorbidities, some cancer chemotherapy may be administered either in a facility observation or inpatient unit. **An inpatient stay is medically necessary for drug regimens that require inpatient monitoring or complex administration over multiple days.** Refer to the policy for a list of applicable regimens/drugs. **The following are clinical conditions or complications of cancer chemotherapy that may require an observation stay:** • Congestive heart failure or chronic renal failure requiring high volume fluid infusions • Known hypersensitivity reactions from previous infusion • TACE (Transcatheter Arterial Chemoembolization) or intra-arterial chemotherapy infusion **The following are clinical conditions that require an inpatient hospital stay:** • Acute leukemia • Intra-arterial infusion of chemotherapy • Prophylaxis of tumor lysis syndrome in cases of high-grade lymphoma with large masses Conditions requiring observation or inpatient hospital treatment other than those noted above will be reviewed on a case-by-case basis. For medical necessity clinical coverage criteria in these instances, refer to the InterQual® LOC: Acute Adult, Hematology/Oncology: Complications or Disease Progression and/or InterQual® LOC: Acute Adult Hematology/Oncology: Treatments.

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Chemotherapy Observation or Inpatient Hospitalization (for Pennsylvania Only) (continued)	Jun. 1, 2026		Click here to view the InterQual® criteria. **Notes**: • A written protocol will be expected to be followed by the provider administering the chemotherapy drug. • Any requests for an extension of the inpatient stay beyond the recommended day(s) must be clinically reviewed.
Implantable Loop Recorders and Wearable Heart Rhythm Monitors (for Pennsylvania Only)	Jul. 1, 2026	**Coverage Rationale** • Added language to indicate this policy does not apply to individuals < 18 years of age • Revised circumstances for which Implantable Loop Recorders are proven and medically necessary for evaluating suspected cardiac arrhythmias when noninvasive cardiac event recording is contraindicated or has yielded nondiagnostic results after at least 2 weeks of monitoring; added: ○ Post-cavotricuspid isthmus ablation for typical atrial flutter if the individual is not on long-term anticoagulation and is at high thromboembolic risk (e.g., CHA_2DS_2-VASc ≥ 2 or HATCH score of at least 2) ○ Atrial fibrillation detected during an acute medical illness or following surgery, particularly after noncardiac procedures and in individuals with stroke risk factors (e.g., CHA_2DS_2-VASc ≥ 2) **Medical Records Documentation Used for Reviews** • Added language to indicate:	**Note**: This policy does not apply to individuals < 18 years of age. **Implantable Loop Recorders are proven and medically necessary for evaluating suspected cardiac arrhythmias when noninvasive cardiac event recording is contraindicated or has yielded nondiagnostic results after at least 2 weeks of monitoring in one or more of the following circumstances:** • Suspected paroxysmal atrial fibrillation in the setting of a cryptogenic stroke or another documented systemic thromboembolic event • Suspected or known ventricular arrhythmia • High risk for arrhythmia secondary to structural or infiltrative heart disease such as aortic stenosis, hypertrophic cardiomyopathy, cardiac sarcoidosis, congenital heart disease, family history, dilated ischemic or nonischemic cardiomyopathy, or use of medications known to cause malignant arrhythmias such as those prolonging the QT interval • Recurrent or unexplained infrequent syncope after modification of potentially syncope-causing medications or associated with autonomic dysfunction • Post-cavotricuspid isthmus ablation for typical atrial flutter if the individual is not on long-term anticoagulation and is at high thromboembolic risk (e.g., CHA_2DS_2-VASc ≥ 2 or HATCH score of at least 2) • Atrial fibrillation detected during an acute medical illness or following surgery, particularly after noncardiac procedures and in individuals with stroke risk factors (e.g., CHA_2DS_2-VASc ≥ 2) • Abnormal tests such as electrophysiology study or tilt table testing **Replacement of Implantable Loop Recorders is considered medically necessary for an individual who continues to meet all initial criteria for insertion described above and the existing device is beyond its useful lifespan, irreparable, or no longer operating.**

Medical Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Implantable Loop Recorders and Wearable Heart Rhythm Monitors (for Pennsylvania Only) (continued)	Jul. 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 ○ The patient's medical record must contain documentation that fully supports the medical necessity for the requested services ○ This documentation includes but is not limited to relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures ○ Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	**Wearable heart rhythm monitors or (Cardiac Self-Monitoring Devices) commercially available to the general public and purchased for home use are not medically necessary due to insufficient evidence of efficacy and are considered a convenience item. Such items include (but are not limited to):** • A self-monitoring device that includes an electrocardiographic monitor combined with a personal electronic device such as a cellular telephone or watch • Hardware or software required for downloading electrocardiographic data to a device such as personal computer, tablet, or smartphone

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Obstructive and Central Sleep Apnea Treatment (for Pennsylvania Only)	Jul. 1, 2026	**Coverage Rationale** ***Obstructive Sleep Apnea*** Diagnosis of Obstructive Sleep Apnea for Nonsurgical or Surgical Treatment • Added language to indicate the diagnosis of Obstructive Sleep Apnea (OSA) for nonsurgical and surgical treatment requires: ○ An individual presenting with symptoms of OSA has been seen for an evaluation (in person or via telemedicine) with a qualified physician or with an Advanced Practice Provider working under the direct supervision of a physician prior to beginning treatment ○ A qualified physician or an Advanced Practice Provider working under the direct supervision of a physician will diagnose OSA and recommend the course of treatment ***Nonsurgical Treatment*** • Replaced language indicating: ○ "Removable Oral Appliances are proven and medically necessary for treating OSA as documented by a steep study *(e.g., Polysomnography* or Home Sleep Apnea Testing)" with "Removable Oral Appliances are proven and medically necessary for	**Obstructive Sleep Apnea** ***Diagnosis of Obstructive Sleep Apnea for Non-Surgical or Surgical Treatment*** • An individual presenting with symptoms of Obstructive Sleep Apnea (OSA) has been seen for an evaluation (in person or via telemedicine) with a qualified physician or with an Advanced Practice Provider working under the direct supervision of a physician prior to beginning treatment • A qualified physician or an Advanced Practice Provider working under the direct supervision of a physician will diagnose OSA and recommend the course of treatment **Non-Surgical Treatment** **Removable Oral Appliances are proven and medically necessary for treating OSA meeting the diagnosis requirements above and which has been documented by a sleep study (e.g., Polysomnography (Attended), Home Sleep Apnea Testing).** Refer to the Medical Policy titled Sleep Studies for further information. Oral Appliance therapy may be an effective alternative to failed Positive Airway Pressure (PAP) therapy. Documentation from the individual's treating physician or Advanced Practice Provider that PAP therapy resulted in no therapeutic efficacy, or an individual is intolerant or has refused is required. For medical necessity clinical coverage criteria for removable Oral Appliances, refer to the InterQual® CP: Durable Medical Equipment, Noninvasive Airway Assistive Devices. Click here to view the InterQual® criteria. **Other Nonsurgical Procedures** **The following are unproven and not medically necessary due to insufficient evidence of efficacy:** • Devices for treating Positional OSA • Nasal dilator devices for treating OSA • Intranasal expiratory resistance valve (e.g., Bongo Rx) • Prefabricated Oral Appliance/device

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Obstructive and Central Sleep Apnea Treatment (for Pennsylvania Only) (continued)	Jul. 1, 2026	treating OSA *meeting the diagnosis requirements [listed in the policy] and which has been* documented by a sleep study [e.g., *Polysomnography (Attended)* or Home Sleep Apnea Testing]" ○ "Oral Appliance therapy (OAT) may be an effective alternative to failed Positive Airway Pressure (PAP) therapy *for many individuals*" with "Oral Appliance Therapy (OAT) may be an effective alternative to failed Positive Airway Pressure (PAP) therapy" • Revised language pertaining to documentation requirements to indicate documentation that PAP therapy resulted in no therapeutic efficacy or an individual is intolerant or has refused is required • Removed reference link to the Medical Policy titled *Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/Replacements (for Pennsylvania Only)* for information on snoring and Oral Appliances ***Surgical Treatment*** • Revised coverage criteria for: ***Uvulopalatopharyngoplasty (UPPP), Mandibular Osteotomy (MO), and***	• Nonsurgical electrical muscular training • Mandibular vertical repositioning devices (e.g., Slow Wave) • Morning repositioning devices • Epigenetic appliances [e.g., Homeoblock™, DNA® (Daytime/Nighttime appliance)] • Advanced Lightwire Functional (ALF) appliances **Surgical Treatment** **Uvulopalatopharyngoplasty, mandibular osteotomy, and maxillomandibular osteotomy and advancement (MMA) are proven and medically necessary in an adult individual when all the following criteria are met:** • Moderate to severe OSA meeting the diagnosis requirements above [Apnea-Hypopnea Index (AHI) ≥ 15 or Respiratory Disturbance Index ≥ 15], as determined by Polysomnography (Attended)* • Excessive daytime sleepiness documented with an Epworth Sleepiness Scale of > 10 or with another validated too • PAP therapy resulted in no therapeutic efficacy or individual's refusal or intolerance In addition, the following criteria need to be met: • For MMA, craniofacial disproportion or deformities with evidence of maxillomandibular deficiency • For mandibular osteotomy, retrolingual or lower pharyngeal function obstruction **Implantable hypoglossal nerve stimulation with a US Food and Drug Administration (FDA)–approved device is proven and medically necessary in an adult individual with moderate to severe OSA meeting the diagnosis requirements above when all the following criteria are met:** • Body Mass Index of ≤ 40 kg/m^2; and • AHI of ≥ 15 and ≤ 100, as determined by Polysomnography (Attended)*; and • Total AHI of < 25% for central and mixed Apneas, as evaluated by attended polysomnography; and

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Obstructive and Central Sleep Apnea Treatment (for Pennsylvania Only) (continued)	Jul. 1, 2026	***Maxillomandibular Osteotomy and Advancement (MMA) in an Adult Individual*** ○ Replaced criterion requiring "individual has moderate to severe OSA Apnea Hypopnea Index (AHI) ≥ 15 or Respiratory Disturbance Index (RDI) ≥ 15 as determined by Polysomnography (Attended)" with "individual has moderate to severe OSA *meeting the diagnosis requirements [listed in the policy]* [Apnea Hypopnea Index (AHI) ≥ 15 or Respiratory Disturbance Index ≥ 15] as determined by Polysomnography (Attended)" ***Implantable Hypoglossal Nerve Stimulation With an FDA-Approved Device in Adolescents Aged 10 to 18 Years With Down Syndrome*** ○ Replaced criterion requiring: ▪ "Diagnosis of severe OSA [as determined by *Polysomnography* (Attended) and an AHI ≥ 10 and Respiratory Disturbance Index ≤ 50 events per hour]" with "diagnosis of severe OSA *meeting the diagnosis requirements [listed in the*	• Absence of a complete blockage or complete concentric collapse of the soft palate, confirmed by drug-induced sleep endoscopy; and • PAP therapy resulted in no therapeutic efficacy or individual's refusal or intolerance; and • Used in accordance with FDA guidelines **Implantable hypoglossal nerve stimulation with an FDA-approved device is proven and medically necessary in adolescents aged 10 to 18 years with Down syndrome when all the following criteria are met:** • Diagnosis of severe OSA meeting the diagnosis requirements above and [as determined by a Polysomnogram (Attended)* and an AHI ≥ 10 and Respiratory Disturbance Index ≤ 50 events per hour]; and • Body Mass Index of < 95th percentile for age; and • Total AHI of < 25% for central and mixed Apneas; and • Contraindication for or not effectively treated with a prior adenotonsillectomy; and • Confirmed failure or intolerance of PAP therapy, despite attempts to improve adherence; and • Absence of tracheostomy use during sleep; and • Absence of a complete blockage or concentric collapse of the soft palate level, confirmed by drug-induced sleep endoscopy; and • Individual and caregiver refusal of an MMA procedure for nonconcentric palatal collapse; and • Used in accordance with FDA guidelines *Polysomnography should be repeated if there has been clinically significant weight loss or gain, changes in cardiovascular disease, or persistent or recurrent symptoms since the last study (Caples et al., 2021). **Other Surgical Procedures** **The following surgical procedures are unproven and not medically necessary for treating OSA due to insufficient evidence of efficacy (not an all-inclusive list):** • Lingual suspension – also referred to as tongue stabilization, tongue stitch, and tongue fixation • Isolated hyoid myotomy

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Obstructive and Central Sleep Apnea Treatment (for Pennsylvania Only) (continued)	Jul. 1, 2026	*policy]* [as determined by *Polysomnogram* (Attended) and an AHI ≥ 10 and Respiratory Disturbance Index ≤ 50 events per hour]" ▪ "Confirmed failure or intolerance of PAP therapy, despite attempts to improve *compliance*" with "confirmed failure or intolerance of PAP therapy, despite attempts to improve *adherence*" • Replaced language indicating "implantable hypoglossal nerve stimulation with a U.S. Food and Drug Administration (FDA) approved device is proven and medically necessary in an adult *patient* with moderate to severe OSA when all the [listed] criteria are met" with "implantable hypoglossal nerve stimulation with a U.S. Food and Drug Administration (FDA) approved device is proven and medically necessary in an adult *individual* with moderate to severe OSA *meeting the diagnosis requirements [listed in the policy]* when all the [listed] criteria are met" ***Other Surgical Procedures*** • Revised list of unproven and not medically necessary procedures; removed:	• Stand-alone uvulectomy • Transoral robotic surgery • Distraction osteogenesis for maxillary expansion **Central Sleep Apnea** **Implantable phrenic nerve stimulation devices (e.g., the remedē® System) for the treatment of Central Sleep Apnea are unproven and not medically necessary due to insufficient evidence of safety and/or efficacy.** **Removable Oral Appliances for treating Central Sleep Apnea are unproven and not medically necessary due to insufficient evidence of efficacy.**

Medical Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Obstructive and Central Sleep Apnea Treatment (for Pennsylvania Only) (continued)	Jul. 1, 2026	○ Laser-assisted uvulopalatoplasty (LAUP) ○ Palatal implants ○ Radiofrequency ablation of the soft palate and/or tongue base ***Central Sleep Apnea*** • Replaced language indicating "implantable *neurostimulation* devices for the treatment of Central Sleep Apnea (CSA) are unproven and not medically necessary due to insufficient evidence of safety and/or efficacy" with "implantable *phrenic nerve* stimulation devices *(e.g., the remedē® System)* for the treatment of Central Sleep Apnea are unproven and not medically necessary due to insufficient evidence of safety and/or efficacy" **Medical Records Documentation Used for Reviews** • Added language to indicate: ○ 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	

Medical Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Obstructive and Central Sleep Apnea Treatment (for Pennsylvania Only) (continued)	Jul. 1, 2026	○ The patient's medical record must contain documentation that fully supports the medical necessity for the requested services ○ This documentation includes but is not limited to relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures ○ Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request **Definitions** • Added definition of "Positive Airway Pressure" • Removed definition of "Sleep Medicine Training" • Updated definition of: ○ Body Mass Index ○ Central Sleep Apnea ○ Home Sleep Apnea Testing ○ Oral Appliance **Applicable Codes** • Added CPT codes 64568 and 64569 • Removed CPT code 42299 **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Prostate Surgeries and Interventions (for Pennsylvania Only)	Jul. 1, 2026	**Coverage Rationale** ***Prostatic Urethral Lift*** • Replaced language indicating "prostatic urethral lift (PUL) is proven and medically necessary when performed according to the [listed] U.S. Food and Drug Administration labeled indications, contraindications, warnings, and precautions" with "prostatic urethral lift (PUL) is proven and medically necessary *for treating urinary symptoms caused by benign prostatic hyperplasia (BPH)* when performed according to the [listed] U.S. Food and Drug Administration labeled indications, contraindications, warnings, and precautions" • Revised list of U.S. Food and Drug Administration labeled indications for prostatic urethral lift: ○ Replaced "treating symptoms due to urinary outflow obstruction secondary to BPH, including lateral, *with or without* median lobe hyperplasia, in men 45 years of age or older" with "treating symptoms due to urinary outflow obstruction secondary to BPH, including lateral *and* median lobe hyperplasia, in men 45 years of age or older"	**Transurethral Ablation** **Transurethral ablation of the prostate is proven and medically necessary in certain circumstances.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Prostatectomy, Transurethral Ablation. Click here to view the InterQual® criteria. **Transurethral ablation of the prostate is unproven and not medically necessary for all other indications due to insufficient evidence of safety and/or efficacy.** **Cryoablation** **Cryoablation of the prostate is proven and medically necessary for recurrent prostate cancer diagnosed by biopsy.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Cryoablation, Prostate. Click here to view the InterQual® criteria. **Cryoablation of the prostate is unproven and not medically necessary for initial treatment of prostate cancer and for all other indications due to insufficient evidence of safety and/or efficacy.** **Prostatic Urethral Lift** **Prostatic urethral lift is proven and medically necessary for treating urinary symptoms caused by benign prostatic hyperplasia (BPH) when performed according to the following U.S. Food and Drug Administration–labeled indications, contraindications, warnings, and precautions:** • Treating symptoms due to urinary outflow obstruction secondary to BPH, including lateral and median lobe hyperplasia,* in men 45 years of age or older; and • The following are not present: ○ Prostate volume of > 100 cc ○ A urinary tract infection

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Prostate Surgeries and Interventions (for Pennsylvania Only) (continued)	Jul. 1, 2026	○ Added notation to indicate lobe hyperplasia can be either lateral or median ***Transurethral Water Jet Ablation*** ● Replaced language indicating "transurethral water jet ablation for the treatment of *malignant* prostate *tissue* and all other indications [not listed in the policy as proven and medically necessary] is unproven and not medically necessary" with "transurethral water jet ablation for the treatment of prostate *cancer (in individuals who do not meet the [listed] criteria)* and all other indications [not listed in the policy as proven and medically necessary] is unproven and not medically necessary" ***Prostate Artery Embolization*** ● Revised list of proven and medically necessary indications for prostate artery embolization: ○ Added: ▪ Individual has lower urinary tract symptoms attributable to BPH, as confirmed by a board-certified urologist, with failure of conservative therapy (α-blockers and/or 5-α reductase inhibitors) and any of the following: ○ Urethra conditions that may prevent insertion of delivery system into the bladder ○ Urinary incontinence due to an incompetent sphincter ○ Current gross hematuria *__Note__: Can be either lateral or median lobe hyperplasia **Prostatic urethral lift is unproven and not medically necessary for all other indications due to insufficient evidence of safety and/or efficacy.** **High-Energy Water Vapor Thermotherapy** **High-energy water vapor thermotherapy for the treatment of BPH is proven and medically necessary in certain circumstances.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Procedures, Prostatectomy, Transurethral Ablation. Click here to view the InterQual® criteria. **High-energy water vapor thermotherapy for the treatment of malignant prostate tissue and all other indications is unproven and not medically necessary due to insufficient evidence of safety and/or efficacy.** **Transurethral Water Jet Ablation** **Transurethral water jet ablation of the prostate is proven and medically necessary for the resection and removal of prostate tissue for the treatment of lower urinary tract symptoms due to BPH.** **Transurethral water jet ablation for the treatment of prostate cancer (in individuals who do not meet the criteria above), and all other indications is unproven and not medically necessary due to insufficient evidence of safety and/or efficacy.** **Prostate Artery Embolization** **Prostate artery embolization is proven and medically necessary for individuals with any of the following:** ● Persistent gross hematuria originating from the prostate

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Prostate Surgeries and Interventions (for Pennsylvania Only) (continued)	Jul. 1, 2026	– Significant comorbidities (e.g., American Society of Anesthesiologists Physical Status Classification of class III or higher) – Presence of coagulopathy – Inability to stop anticoagulation or platelet therapy – A prostate volume of > 80 g confirmed by imaging (transrectal ultrasound, magnetic resonance imaging, or computed tomography) ○ Removed "individuals with BPH who are ineligible for other procedures due to surgical constraints (i.e., prostate size) or anesthesia risk (i.e., comorbidities)" ***Other Procedures*** • Revised list of unproven and not medically necessary indications; added: ○ Irreversible electroporation ablation ○ Autologous (e.g., sural) or allogeneic nerve grafts to restore erectile function during or after radical prostatectomy	• Lower urinary tract symptoms attributable to BPH, as confirmed by a board-certified urologist, with failure of conservative therapy (α-blockers and/or 5-α reductase inhibitors) and any of the following: ○ Significant comorbidities (e.g., American Society of Anesthesiologists Physical Status Classification of class III or higher) ○ Presence of coagulopathy ○ Inability to stop anticoagulation or platelet therapy ○ A prostate volume of > 80 g confirmed by imaging (transrectal ultrasound, magnetic resonance imaging, or computed tomography) **Prostate artery embolization is unproven and not medically necessary for all other indications due to insufficient evidence of safety and/or efficacy.** **Other Procedures** **The following procedures are unproven and not medically necessary due to insufficient evidence of safety and/or efficacy:** • Transperineal focal laser ablation • Insertion of a temporary prostatic urethral stent • Transperineal laser ablation (TPLA) • Ablation of malignant prostate tissue by magnetic field induction • Transurethral drug coated balloon dilation • Transurethral thermal ultrasound ablation (TULSA) • Irreversible electroporation ablation • Autologous (e.g., sural) or allogeneic nerve grafts to restore erectile function during or after radical prostatectomy

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Prostate Surgeries and Interventions (for Pennsylvania Only) (continued)	Jul. 1, 2026	**Medical Records Documentation Used for Reviews** • Added language to indicate: ○ 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 ○ The patient's medical record must contain documentation that fully supports the medical necessity for the requested services ○ This documentation includes but is not limited to relevant medical history, physical examination, and results of pertinent diagnostic tests or procedures ○ Documentation supporting the medical necessity should be legible, maintained in the patient's medical record, and must be made available upon request **Definitions** • Added definition of “American Society of Anesthesiologists	

Medical Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Prostate Surgeries and Interventions (for Pennsylvania Only) (continued)	Jul. 1, 2026	(ASA) Physical Status Classification System" **Applicable Codes** • Added CPT codes 52443, 52597, 55877, 55899, and 64999 • Removed CPT codes 0421T and 0619T **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**
Nerve Graft to Restore Erectile Function During Radical Prostatectomy (for Pennsylvania Only)	Jul. 1, 2026	• Replaced policy; refer to the Medical Policy titled Prostate Surgeries and Interventions (for Pennsylvania Only)

Medical Benefit Drug Policy Updates

New

Policy Title	Effective Date	Coverage Rationale

Itvisma® (Onasemnogene Abeparvovec-Brve)	Jun. 1, 2026	**Itvisma is proven and medically necessary for one treatment per lifetime for the treatment of spinal muscular atrophy (SMA) in patients who meet all of the following criteria:**
		• Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation or deletion of genes in chromosome 5q resulting in one of the following:
		  ○ Homozygous gene deletion or mutation of survival motor neuron 1 (*SMN1*) gene (e.g., homozygous deletion of exon 7 at locus 5q13); **or**
		  ○ Compound heterozygous mutation of *SMN1* gene [e.g., deletion of *SMN1* exon 7 (allele 1) and mutation of *SMN1* (allele 2)]
		and
		• Submission of medical records (e.g., chart notes, laboratory values) confirming that patient has 2 or 3 *SMN2* gene copies; **and**
		• Patient is ≥ 2 years of age; **and**
		• Patient is not dependent on **either** of the following:
		  ○ Invasive ventilation or tracheostomy; **or**
		  ○ Use of non-invasive ventilation beyond use for naps and nighttime sleep
		and
		• Prescribed by a neurologist with expertise in the treatment of SMA; **and**
		• Patient is not to receive routine concomitant SMN modifying therapy [e.g., Evrysdi (risdiplam), Spinraza (nusinersen)] (patient's medical record will be reviewed and any current authorizations for SMN modifying therapy will be terminated upon Itvisma approval); **and**
		• Patient does not have an elevated anti-AAV9 antibody titer above 1:50; **and**
		• Patient will receive prophylactic prednisolone (or glucocorticoid equivalent) prior to and following receipt of Itvisma in accordance with the United States Food and Drug Administration (FDA) approved Itvisma labeling; **and**
		• Patient will receive Itvisma as a single-dose intrathecal injection in accordance with the FDA approved labeling; **and**
		• Patient has never received gene therapy treatment [i.e., Zolgensma (onasemnogene abeparvovec-xioi), Itvisma] for SMA in the patient's lifetime; **and**
		• Provider does not request a planned inpatient admission for the sole purpose of administering Itvisma; **and**
		• Authorization will be issued for no more than one treatment per lifetime and for no longer than 45 days from approval
		
		Additional Information Relevant to the Review Process but not Impacting the Determination of Medical Necessity
		• Provider attests that the patient will be assessed via the Hammersmith Functional Motor Scale Expanded (HFMSE) scale to establish a baseline functional assessment within the 2 weeks **prior** to Itvisma administration†; **and**

Medical Benefit Drug Policy Updates

New

Policy Title	Effective Date	Coverage Rationale
Itvisma® (Onasemnogene Abeparvovec-Brve) (continued)	Jun. 1, 2026	• Provider attests that the patient, while under the care of the provider, will be assessed by (HFMSE) during subsequent office visits† †For quality purposes only, this information will not be considered as part of the individual coverage decision. **Itvisma is not proven or medically necessary for:** • The treatment of SMA for patients younger than 2 years of age; **or** • SMA without chromosome 5q mutations or deletions; **or** • The routine combination treatment of SMA with concomitant SMN modifying therapy

Updated

Policy Title	Effective Date	Summary of Changes
Maximum Dosage and Frequency (for Pennsylvania Only)	May 1, 2026	**Coverage Rationale** ***Maximum Allowed Quantities by HCPCS Units*** • Updated list of applicable HCPCS codes to reflect quarterly edits: Bildyos ○ Replaced C9399, J3490, and J3590 with Q5162 Bilprevda ○ Replaced C9399 and J9999 with Q5162 **Applicable Codes** • Updated list of applicable HCPCS codes to reflect quarterly edits; added Q5162
Veopoz® (Pozelimab-Bbfg)	May 1, 2026	**Coverage Rationale** • Updated list of examples of complement protein C5 inhibitors the patient must not be receiving in combination with Veopoz; replaced "*Soliris* (eculizumab)" with "eculizumab"

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Amondys 45® (Casimersen) (for Pennsylvania Only)	Jun. 1, 2026	**Coverage Rationale** • Revised coverage criteria; added criterion requiring Amondys 45 will not be used concomitantly with Duvyzat (givinostat) **Supporting Information** • Updated *References* section to reflect the most current information	**Amondys 45 (casimersen) may be covered for the treatment of Duchenne muscular dystrophy (DMD) in patients who meet all of the following criteria:** **Initial Therapy** • Diagnosis of Duchenne muscular dystrophy by, or in consultation with, a neurologist with expertise in the diagnosis of DMD; **and** • Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation of the DMD gene is amenable to exon 45 skipping; **and**

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Amondys 45® (Casimersen) (for Pennsylvania Only) (continued)	Jun. 1, 2026		• Submission of medical records documenting a baseline evaluation, including a standardized assessment of motor function by a neurologist with experience in treating Duchenne muscular dystrophy, prior to beginning Amondys 45 therapy; **and**
			• **One** of the following:
			  ○ Patient has not previously received gene therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)] for the treatment of DMD; **or**
			  ○ **Both** of the following:
			  ▪ Patient has previously received gene therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)] for the treatment of DMD; **and**
			  ▪ Submission of medical records (e.g., chart notes, laboratory values) documenting a clinically meaningful functional decline resulting from loss of muscle strength/motor ability (e.g., loss of a motor milestone) since receiving gene replacement therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)]
			and
			• Amondys 45 will not be used concomitantly with **any** of the following:
			  ○ Duvyzat (givinostat); **or**
			  ○ Other exon skipping therapies for DMD [e.g., Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]; **and**
			• Prescribed by, or in consultation with, a neurologist with expertise in the treatment of DMD; **and**
			• Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
			• Initial authorization will be for no more than 12 months
			
			Continuation Therapy
			• Documentation of continued clinical benefit based on prescriber's assessment, including an evaluation with a standardized assessment of motor function ability by a neurologist with experience in treating Duchenne muscular dystrophy; **and**
			• Amondys 45 will not be used concomitantly with **any** of the following:
			  ○ Duvyzat (givinostat); **or**
			  ○ Other exon skipping therapies for DMD [e.g., Exondys 51 (eteplirsen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]; **and**

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Amondys 45® (Casimersen) (for Pennsylvania Only) (continued)	Jun. 1, 2026		• Prescribed by, or in consultation with, a neurologist with expertise in the treatment of DMD; **and** • Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** • Reauthorization will be for no more than 12 months **Unproven** **Amondys 45 is unproven and not medically necessary for the treatment of other forms of muscular dystrophy (e.g., Becker muscular dystrophy).**

Exondys 51® (Eteplirsen) (for Pennsylvania Only)	Jun. 1, 2026	**Coverage Rationale**
		• Revised coverage criteria; added criterion requiring Exondys 51 will not be used concomitantly with Duvyzat (givinostat)
		Supporting Information
		• Updated *References* section to reflect the most current information
			Exondys 51® (eteplirsen) may be covered for the treatment of Duchenne muscular dystrophy (DMD) in patients who meet all of the following criteria:
			
			Initial Therapy
			• Diagnosis of Duchenne muscular dystrophy by, or in consultation with, a neurologist with expertise in the diagnosis of DMD; **and**
			• Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation of the DMD gene is amenable to exon 51 skipping; **and**
			• Submission of medical records documenting a baseline evaluation, including a standardized assessment of motor function by a neurologist with experience in treating Duchenne muscular dystrophy, prior to beginning Exondys 51 therapy; **and**
			• **One** of the following:
			  ○ Patient has not previously received gene therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)] for the treatment of DMD; **or**
			  ○ **Both** of the following:
			  ▪ Patient has previously received gene therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)] for the treatment of DMD; **and**
			  ▪ Submission of medical records (e.g., chart notes, laboratory values) documenting a clinically meaningful functional decline resulting from loss of muscle strength/motor ability (e.g., loss of a motor milestone) since receiving gene replacement therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)]
			
			and

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Exondys 51® (Eteplirsen) (for Pennsylvania Only) (continued)	Jun. 1, 2026		• Exondys 51 will not be used concomitantly with **any** of the following:
			  ○ Duvyzat (givinostat); **or**
			  ○ Other exon skipping therapies for DMD [e.g., Amondys (casimersen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]; **and**
			• Prescribed by, or in consultation with, a neurologist with expertise in the treatment of DMD; **and**
			• Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
			• Initial authorization will be for 12 months
			
			Continuation Therapy
			• Documentation of continued clinical benefit based on prescriber's assessment, including an evaluation with a standardized assessment of motor function ability by a neurologist with experience in treating Duchenne muscular dystrophy; **and**
			• Exondys 51 will not be used concomitantly with **any** of the following:
			  ○ Duvyzat (givinostat); **or**
			  ○ Other exon skipping therapies for DMD [e.g., Amondys (casimersen), Viltepso (viltolarsen), Vyondys 53 (golodirsen)]; **and**
			• Prescribed by, or in consultation with, a neurologist with expertise in the treatment of DMD; **and**
			• Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
			• Reauthorization will be for no more than 12 months
			
			Unproven
			Exondys 51 is unproven and not medically necessary for the treatment of other forms of muscular dystrophy (e.g., Becker muscular dystrophy).

Hemgenix® (Etranacogene Dezaparvovec-Drlb)	Jun. 1, 2026	**Title Change** • Previously titled *Gene Therapies for Hemophilia B* **Coverage Rationale** • Removed content/language pertaining to Beqvez (product discontinued)	**Hemophilia B (i.e., Congenital Factor IX Deficiency, Christmas Disease)** **Hemgenix is proven and medically necessary for the treatment of hemophilia B (congenital factor IX deficiency) when all of the following criteria are met:** • Patient is 18 years of age or older; **and** • **One** of the following: ○ **Both** of the following:

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Hemgenix® (Etranacogene Dezaparvovec-Drlb) (continued)	Jun. 1, 2026	**Applicable Codes** • Removed HCPCS code J1414 **Supporting Information** • Updated *Background*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	▪ Diagnosis of severe hemophilia B; **and** ▪ Documentation of endogenous factor IX levels less than 1% of normal factor IX (< 0.01 IU/mL) **or** ○ **All** of the following: ▪ Diagnosis of moderately severe hemophilia B; **and** ▪ Documentation of endogenous factor IX levels ≥ 1% ≤ 2% (greater than or equal to 0.01 IU/mL to less than or equal to 0.02 IU/mL); **and** ▪ **One** of the following: – Patient has current or historical life-threatening hemorrhage; **or** – Patient has repeated, serious spontaneous bleeding episodes **and** • **One** of the following: ○ Patient is currently receiving routine prophylaxis for hemophilia B with a non-factor replacement therapy [i.e., Alhemo (concizumab-mtci), Hympavzi (marstacimab-hncq), Qfitlia (fitusiran)]; **or** ○ **Both** of the following: ▪ Patient currently uses factor IX prophylaxis therapy; **and** ▪ Patient has had a minimum of 50 exposure days to a factor IX agent **or** ○ Patient has been determined to be an appropriate candidate for Hemgenix by the Hemophilia Treatment Center based on willingness to adhere to initial and long-term monitoring and management **and** • Patient does not have a history of inhibitors to factor IX greater than or equal to 0.6 Bethesda units (BU); **and** • Patient does not screen positive for active factor IX inhibitors as defined as greater than or equal to 0.6 Bethesda units (BU) prior to administration of Hemgenix; **and** • Patient has not gone through immune tolerance induction (ITI); **and** • Liver health assessments including enzyme testing [e.g., alanine aminotransferase (ALT), aspartate aminotransferase (AST), alkaline phosphatase (ALP), and total bilirubin], and hepatic ultrasound, and/or

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Hemgenix® (Etranacogene Dezaparvovec-Drlb) (continued)	Jun. 1, 2026		elastography are performed to rule out radiological liver abnormalities and/or sustained liver enzyme elevations; **and**
			• **All** of the following:
			  ○ Documentation that the patient has been evaluated for the presence of preexisting neutralizing antibodies to the adenovirus vector (e.g., AAV-5) used to deliver the therapy; **and**
			  ○ Patient has had pre-existing anti-AAV5 neutralizing antibodies measured through the laboratory developed, CLIA-validated AAV5 Neutralizing Antibody Test made available through CSL Behring; **and**
			  ○ The patient does not have high anti-AAV antibody (e.g., AAV-5) titers that may be associated with a lack of response to treatment based on published clinical evidence
			and
			• **One** of the following:
			  ○ Patient is not HIV positive; **or**
			  ○ Patient is HIV positive and is virally suppressed with anti-viral therapy (i.e., < 200 copies of HIV per mL)
			and
			• The patient's hepatitis B surface antigen is negative; **and**
			• **One** of the following:
			  ○ Patient's hepatitis C virus (HCV) antibody is negative; **or**
			  ○ Patient's HCV antibody is positive and the patient's HCV RNA is negative
			and
			• The patient is not currently using antiviral therapy for hepatitis B or C; **and**
			• Patient has not previously received treatment with Hemgenix (etranacogene dezaparvovec-drlb) or another gene therapy [e.g., Beqvez (fidanacogene elaparvovec-dzkt)] for the treatment of hemophilia B; **and**
			• Hemgenix is prescribed and managed by a bleeding disorder specialist on staff at a Hemophilia Treatment Center (HTC) that holds Federal designation as evidenced by being listed within the CDC's HTC directory; **and**
			• Prescriber attests that the patient's ALT and AST as well as factor IX activity will be monitored weekly for at least 3 months following administration of Hemgenix and regularly thereafter per the monitoring

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Hemgenix® (Etranacogene Dezaparvovec-Drlb) (continued)	Jun. 1, 2026		schedule recommended in the prescribing information; **and** • Prescriber attests that counseling has been provided to the patient around the risks of alcohol consumption following administration of Hemgenix; **and** • Hemgenix dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** • Provider does not request a planned inpatient admission for the sole purpose of administering Hemgenix; **and** • Authorization will be issued for no more than one treatment per lifetime and for no longer than 45 days from approval **Additional information relevant to the review process for Hemgenix but not impacting the determination of medical necessity:** • Prescriber attests that the patient, while under the care of the prescriber, will be assessed for treatment efficacy including, but not limited to, evaluation of factor IX expression, breakthrough bleeding episodes, factor IX product utilization, inhibitor development;* **and** • Prescriber acknowledges that UnitedHealthcare may request documentation, not more frequently than biannually, and not for a period to exceed 5 years of follow-up patient assessment(s) including, but not necessarily limited to, evaluation of factor IX expression, breakthrough bleeding episodes, factor IX product utilization, inhibitor development while the patient is under the care of the prescriber* *For quality purposes only, this information will not be considered as part of the individual coverage decision. **Hemgenix is unproven and not medically necessary in the following:** • The treatment of hemophilia A • The repeat administration of Hemgenix for the treatment of hemophilia B • The treatment of hemophilia B after previously receiving another factor IX gene therapy product • The routine combination treatment with chronically administered prophylactic therapy for hemophilia B • The treatment of hemophilia B in patients less than 18 years of age

Medical Benefit Drug Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Somatostatin Analogs (for Pennsylvania Only)	Jun. 1, 2026	**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)
		  ○ 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
			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)
			
			For oncology indications, refer to the Medical Benefit Drug Policy titled Oncology Medication Clinical Coverage (for Pennsylvania Only) 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

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Somatostatin Analogs (for Pennsylvania Only) (continued)	Jun. 1, 2026	gastroenteropancreatic neuroendocrine tumors (GEP-NETs) in adults ▪ Carcinoid syndrome in adults ○ Lanreotide Injection is proven for the treatment of unresectable, well- or moderately-differentiated, locally advanced, or metastatic gastroentero-pancreatic neuroendocrine tumors (GEP-NETs) in adults • Removed language indicating Signifor is proven and medically necessary for the treatment of 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	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 **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**

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**

Somatostatin Analogs (for Pennsylvania Only) (continued)	Jun. 1, 2026		**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
			
			Signifor LAR (pasireotide) is proven and medically necessary for the treatment of acromegaly when both 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 both 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

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Somatostatin Analogs (for Pennsylvania Only) (continued)	Jun. 1, 2026		• **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) 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
			• Carcinoid syndrome in adults
			
			Lanreotide Injection is proven for the treatment of the following condition:
			• Unresectable, well- or moderately-differentiated, 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
			• 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.
			Requests outside of this criteria will be reviewed for medical necessity on a case-by-case basis.

Medical Benefit Drug Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Viltepso® (Viltolarsen) (for Pennsylvania Only)	Jun. 1, 2026	**Coverage Rationale**
		• Revised coverage criteria; added criterion requiring Viltepso will not be used concomitantly with Duvyzat (givinostat)
			Viltepso® (viltolarsen) may be covered for the treatment of Duchenne muscular dystrophy (DMD) in patients who meet all of the following criteria:
			
			Initial Therapy
			• Diagnosis of Duchenne muscular dystrophy by, or in consultation with, a neurologist with expertise in the diagnosis of DMD; **and**
			• Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation of the DMD gene is amenable to exon 53 skipping; **and**
			• Submission of medical records documenting a baseline evaluation, including a standardized assessment of motor function by a neurologist with experience in treating Duchenne muscular dystrophy, prior to beginning Viltepso® therapy; **and**
			• **One** of the following:
			  ○ Patient has not previously received gene therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)] for the treatment of DMD; **or**
			  ○ **Both** of the following:
			  ▪ Patient has previously received gene therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)] for the treatment of DMD; **and**
			  ▪ Submission of medical records (e.g., chart notes, laboratory values) documenting a clinically meaningful functional decline resulting from loss of muscle strength/motor ability (e.g., loss of a motor milestone) since receiving gene replacement therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)]
			and
			• Viltepso will not be used concomitantly with **any** of the following:
			  ○ Duvyzat (givinostat); **or**
			  ○ Other exon skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Vyondys 53 (golodirsen)]
			and
			• Prescribed by, or in consultation with, a neurologist with expertise in the treatment of DMD; **and**
			• Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**
			• Initial authorization will be for no more than 12 months

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Viltepso® (Viltolarsen) (for Pennsylvania Only) (continued)	Jun. 1, 2026		**Continuation Therapy** • Documentation of continued clinical benefit based on prescriber's assessment, including an evaluation with a standardized assessment of motor function ability by a neurologist with experience in treating Duchenne muscular dystrophy; **and** • Viltepso will not be used concomitantly with **any** of the following: ○ Duvyzat (givinostat); **or** ○ Other exon skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Vyondys 53 (golodirsen)] **and** • Prescribed by, or in consultation with, a neurologist with expertise in the treatment of DMD; **and** • Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** • Reauthorization will be for no more than 12 months **Unproven** **Viltepso is unproven and not medically necessary for the treatment of other forms of muscular dystrophy (e.g., Becker muscular dystrophy).** Requests outside of this criteria will be reviewed for medical necessity on a case-by-case basis.
Vyondys 53® (Golodirsen) (for Pennsylvania Only)	Jun. 1, 2026	**Coverage Rationale** • Revised coverage criteria: ○ Added criterion requiring Vyondys 53 will not be used concomitantly with Duvyzat (givinostat) ○ Replaced criterion for continuation of therapy requiring "documentation of an evaluation with an assessment of motor function ability by a neurologist with experience in treating Duchenne muscular	**Vyondys 53 may be covered for the treatment of Duchenne muscular dystrophy (DMD) in patients who meet all of the following criteria:** **Initial Therapy** • Diagnosis of Duchenne muscular dystrophy by, or in consultation with, a neurologist with expertise in the diagnosis of DMD; **and** • Submission of medical records (e.g., chart notes, laboratory values) confirming the mutation of the DMD gene is amenable to exon 53 skipping; **and** • Submission of medical records documenting a baseline evaluation, including a standardized assessment of motor function by a neurologist with experience in treating Duchenne muscular dystrophy, prior to beginning Vyondys 53 therapy; **and** • **One** of the following:

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Vyondys 53® (Golodirsen) (for Pennsylvania Only) (continued)	Jun. 1, 2026	dystrophy" with "documentation *of continued clinical benefit based on prescriber's* assessment, *including* an evaluation with a *standardized* assessment of motor function ability by a neurologist with experience in treating Duchenne muscular dystrophy"	○ Patient has not previously received gene therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)] for the treatment of DMD; **or** ○ **Both** of the following: ▪ Patient has previously received gene therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)] for the treatment of DMD; **and** ▪ Submission of medical records (e.g., chart notes, laboratory values) documenting a clinically meaningful functional decline resulting from loss of muscle strength/motor ability (e.g., loss of a motor milestone) since receiving gene replacement therapy [e.g., Elevidys (delandistrogene moxparvovec-rokl)] **and** • Vyondys 53 will not be used concomitantly with **any** of the following: ○ Duvyzat (givinostat); **or** ○ Other exon skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen)] **and** • Prescribed by, or in consultation with, a neurologist with expertise in the treatment of DMD; **and** • Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** • Initial authorization will be for 12 months **Continuation Therapy** • Documentation of continued clinical benefit based on prescriber's assessment, including an evaluation with a standardized assessment of motor function ability by a neurologist with experience in treating Duchenne muscular dystrophy; **and** • Vyondys 53 will not be used concomitantly with **any** of the following: ○ Duvyzat (givinostat); **or** ○ Other exon skipping therapies for DMD [e.g., Amondys (casimersen), Exondys 51 (eteplirsen), Viltepso (viltolarsen)] **and** • Prescribed by, or in consultation with, a neurologist with expertise in the treatment of DMD; **and** • Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and**

Medical Benefit Drug Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Vyondys 53® (Golodirsen) (for Pennsylvania Only) (continued)	Jun. 1, 2026		• Reauthorization will be for no more than 12 months **Unproven** **Vyondys 53 is unproven and not medically necessary for the treatment of other forms of muscular dystrophy (e.g., Becker muscular dystrophy).**

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 Pennsylvania 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 Pennsylvania Medical Policies and Medical Benefit Drug Policies is available at **UHCprovider.com/PA** > Community Plan (Medicaid) > Current Policies and Clinical Guidelines > Medical & Drug Policies.