United Healthcare®

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Medical Policy Update Bulletin: September 2025

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Take Note

Annual ICD-10 and Quarterly CPT/HCPCS Code Updates

Beginning **Oct. 1, 2025**, all applicable Medical Policies and Medical Benefit Drug Policies will be updated to reflect the annual ICD-10 and quarterly CPT/HCPCS code additions, revisions, and deletions. Refer to the following sources for information on the code updates:

- American Medical Association: Current Procedural Terminology: CPT®
- Centers for Medicare & Medicaid Services: Healthcare Common Procedure Coding System (HCPCS) Quarterly Update
- Centers for Medicare & Medicaid Services: International Classification of Diseases, Tenth Revision (ICD-10) Codes

Complete details on impacted policies and corresponding code edits will be provided in the October 2025 edition of the Medical Policy Update Bulletin.

Medical Policy Updates

Updated

Policy Title	Effective Date	Summary of Changes
Autologous Cellular Therapy	Oct. 1, 2025	**Applicable Codes** • Removed CPT code 27599 **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information
Sympathetic Blockade	Sep. 1, 2025	**Medical Records Documentation Used for Review** • Updated list of Medical Records Documentation Used for Reviews; replaced "treatments tried, failed, or contraindicated; include the dates and reason for discontinuation" with "treatments tried, failed, or contraindicated; include the dates, *duration*, and reason for discontinuation" **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Cognitive Rehabilitation and Coma Stimulation	Oct. 1, 2025	**Title Change** • Previously titled *Cognitive Rehabilitation* **Coverage Rationale** • Replaced language indicating "Coma Stimulation (also known as coma arousal, coma responsiveness, multisensory stimulation, and coma care therapy/programs) is unproven and not medically necessary for any *indication, including individuals who are comatose, in a vegetative or minimally conscious state*" with "Coma Stimulation (also known as coma arousal, coma responsiveness, multisensory stimulation, and coma care therapy/programs) is unproven and not medically necessary for any *Disorder of Consciousness (DOC)*"	**Note**: This policy applies to outpatient Cognitive Rehabilitation services only. Refer to the member specific benefit document for inpatient services. **Cognitive Rehabilitation (CR) is proven and medically necessary under certain circumstances.** For medical necessity clinical coverage criteria, refer to the InterQual® LOC: Outpatient Rehabilitation & Chiropractic. Click here to view the InterQual® criteria. **Coma Stimulation (also known as Coma arousal, Coma responsiveness, multisensory stimulation, and Coma care therapy/programs) is unproven and not medically necessary due to insufficient evidence of efficacy for any Disorder of Consciousness (DOC).**

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

Cognitive Rehabilitation and Coma Stimulation (continued)	Oct. 1, 2025	**Definitions**
		• Added definition of "Disorder of Consciousness (DOC)"
		• Removed definition of:
		  ○ Coma/Persistent Vegetative State
		  ○ Minimally Conscious State
		Supporting Information
		• Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information	

Electric Tumor Treatment Field Therapy	Oct. 1, 2025	**Coverage Rationale**
		• Removed language indicating computer software used for therapeutic radiology clinical treatment planning in conjunction with electric tumor treatment fields (TTF) therapy is unproven and not medically necessary due to insufficient evidence of efficacy
		Medical Records Documentation Used for Review
		• Updated list of Medical Records Documentation Used for Reviews; added:
		  ○ For treatment of newly diagnosis glioblastoma: Physician notes to include history of all relevant surgeries
		  ○ For treatment of a recurrence of glioblastoma: Physician notes to include current treatments
			The following is proven and medically necessary for treating newly diagnosed histologically confirmed Supratentorial glioblastoma (GBM):
			• The use of U.S. Food and Drug Administration (FDA) approved devices to generate electric tumor treatment fields (TTF) when used according to FDA labeled indications, contraindications, warnings, and precautions and when all of the following criteria are met:
			  ○ Debulking surgery has been completed; and
			  ○ Treatment with radiation therapy has been completed; and
			  ○ Individual is receiving Temozolomide (TMZ) as the only cancer drug; and
			  ○ Individual has a Karnofsky Performance Status (KPS) score of ≥ 60 or Eastern Cooperative Oncology Group (ECOG) Performance Status ≤ 2; and
			  ○ Individual has been counselled that the electric TTF device must be worn at least 18 hours daily
			
			When all of the above criteria are met for newly diagnosed GBM (ndGBM), an initial 3 months of electric TTF therapy will be approved.
			
			The following is proven and medically necessary for treating radiologically confirmed recurrence of GBM (rGBM) in the Supratentorial region of the brain:
			• The use of FDA approved devices to generate electric TTF after initial chemotherapy when used according to FDA labeled indications,

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Electric Tumor Treatment Field Therapy (continued)	Oct. 1, 2025	**Applicable Codes** • Removed CPT code 77299 **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	contraindications, warnings, and precautions and when all of the following criteria are met: ○ The device is used as the only treatment; and ○ Individual has a KPS score of ≥ 60 or ECOG Performance Status ≤ 2; and ○ Individual has been counselled that the electric TTF device must be worn at least 18 hours daily When all of the above criteria are met for rGBM, an initial 3 months of electric TTF therapy will be approved. **Subsequent approval(s) for continuation beyond the initial 3 months of electric TTF for treatment of histologically confirmed Supratentorial GBM is based on:** • Magnetic resonance imaging (MRI) scan has been performed ≤ 2 months prior to request and documents no evidence of disease progression; and • Individual with ndGBM continues to receive TMZ as the only cancer drug or the device is used as the only treatment for an individual with rGBM; and • KPS score of ≥ 60 or ECOG Performance Status ≤ 2; and • Documentation that the individual has been using the electric TTF device at least 18 hours daily **Due to insufficient evidence of efficacy, the use of devices to generate electric TTF is unproven and not medically necessary when the criteria above are not met and for all other indications including but not limited to the following:** • Treatment of tumors other than GBM • Use of electric TTF therapy with concurrent medical therapy [e.g., bevacizumab (BEV) or chemotherapy] for treatment of rGBM
Genetic Testing for Cardiac Disease	Oct. 1, 2025	**Related Policies** • Added referenced link to the Medical Policy *Chromosome Microarray Testing (Non-Oncology Conditions)*	Pre-test genetic counseling is strongly recommended in order to inform persons being tested about the advantages and limitations of the test as applied to a unique person.

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Genetic Testing for Cardiac Disease (continued)	Oct. 1, 2025	**Coverage Rationale** ***Testing Based Only on Family History*** • Replaced language indicating "genetic testing for cardiomyopathies, arrhythmias, or aortic vascular disease is unproven and not medically necessary *for all other indications [not listed in the policy as medically necessary]* due to insufficient evidence of efficacy" with "*all other* genetic testing for cardiomyopathies, arrhythmias, or aortic vascular disease [not listed in the policy as medically necessary] is unproven and not medically necessary due to insufficient evidence of efficacy; *this does not apply to chromosome microarray analysis for isolated severe congenital heart disease*" **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	**Inherited Arrythmias** **Multi-Gene Panel testing for the diagnosis of a hereditary arrhythmia syndrome is proven and medically necessary in individuals with a confirmed or suspected diagnosis of any of the following conditions:** • Brugada syndrome (BrS); or • Catecholaminergic polymorphic ventricular tachycardia (CPVT); or • Familial long QT syndrome (LQTS) when acquired causes have been ruled out and one of the following criteria are met: ○ Prolonged QTc (> 460ms) on exercise or ambulatory electrocardiogram (ECG), Holter monitoring, or during pharmacologic provocation testing; or ○ T wave abnormalities on ECG suggestive of LQTS (i.e., Torsade de pointes, T wave alternans, or notched T wave in 3 leads); or ○ Profound congenital bilateral sensorineural hearing loss and prolonged QTc; or ○ Schwartz Score ≥ 1.5 points or • Short QT syndrome (SQTS) **Inherited Cardiomyopathies** **Multi-Gene Panel testing for the diagnosis of a hereditary cardiomyopathy is proven and medically necessary in individuals with a confirmed or suspected diagnosis of any of the following conditions:** • Arrhythmogenic right ventricular dysplasia/cardiomyopathy (ARVD/C); or • Dilated cardiomyopathy (DCM), without an identifiable cause, when one of the following criteria are met: ○ Individual has cardiac conduction disease (first-, second-, or third-degree block); or ○ Sudden cardiac death in a First- or Second-Degree Relative at age 45 or younger or • Hypertrophic cardiomyopathy (HCM) without an identifiable cause (e.g., valvular disease, hypertension, infiltrative or neuromuscular disorder); or • Left ventricular noncompaction cardiomyopathy (LVNC)

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Genetic Testing for Cardiac Disease (continued)	Oct. 1, 2025		**Inherited Thoracic Aortic Disease** **Multi-Gene Panel testing is proven and medically necessary for either of the following:** • Individual has confirmed thoracic aortic disease; or • Thoracic aortic disease is suspected based on family history of thoracic aortic disease in a First- or Second-Degree Relative **Testing Based Only On Family History** **Multi-Gene Panel testing for the diagnosis of inherited arrhythmic disorders or cardiomyopathy is proven and medically necessary in asymptomatic individuals who have a First-Degree or Second-Degree Relative with one of the following conditions:** • Arrhythmogenic right ventricular dysplasia/cardiomyopathy (ARVD/C); or • Brugada syndrome (BrS); or • Catecholaminergic polymorphic ventricular tachycardia (CPVT); or • Congenital long QT syndrome (LQTS); or • Familial dilated cardiomyopathy (DCM); or • Hypertrophic cardiomyopathy (HCM); or • Left ventricular noncompaction cardiomyopathy (LVNC); or • Short QT syndrome (SQTS); or • A First-Degree Relative experienced sudden cardiac death or near sudden death at age 45 or younger **All other genetic testing for cardiomyopathies, arrhythmias, or aortic vascular disease is unproven and not medically necessary due to insufficient evidence of efficacy. (This does not apply to chromosome microarray analysis for isolated severe congenital heart disease.)** **Genetic testing for coronary artery disease (CAD) is unproven and not medically necessary due to insufficient evidence of efficacy.** This includes but is not limited to the following tests: • Gene expression tests • Microarray or other genetic profiles for cardiac disease risk (e.g., Cardiac DNA Insight®, Cardiac Healthy Weight DNA Insight®, Cardio IQ® gene tests and panels)

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Glaucoma Surgical Treatments	Oct. 1, 2025	**Coverage Rationale**
		• Revised list of proven and medically necessary indications:
		  ○ Added:
		  ▪ Goniotomy, trabeculotomy, canaloplasty (ab interno), or combined canaloplasty (ab interno) and trabeculotomy (e.g., OMNI® Surgical System, Streamline Surgical System) for adults (age 19 years or more) when used in combination with cataract surgery for treating mild to moderate open-angle glaucoma (OAG) and cataract in adults currently being treated with ocular hypotensive medication
		  ▪ Laser trabeculoplasty (e.g., Argon, Selective)
		  ▪ Laser iridotomy/ iridectomy (e.g., Nd: YAG)
		  ▪ Laser iridoplasty
		  ▪ Laser ciliary body destruction
		  ○ Replaced "*some* glaucoma drainage devices (*specifically* XEN System, Ex-PRESS™, Molteno implant, Baerveldt tube shunt, Ahmed glaucoma valve implant, and Krupin-Denver valve implant) for treating refractory glaucoma
			The following are proven and medically necessary:
			• Goniotomy or trabeculotomy for pediatric glaucoma (age 18 years or less)
			• Goniotomy, trabeculotomy, canaloplasty (ab interno), or combined canaloplasty (ab interno) and trabeculotomy (e.g., OMNI® Surgical System, Streamline Surgical System) for adults (age 19 years or more) when used in combination with cataract surgery for treating mild to moderate open-angle glaucoma (OAG) and cataract in adults currently being treated with ocular hypotensive medication
			• iStent®, iStent *inject*®, or Hydrus® Microstent when used in combination with cataract surgery for treating mild to moderate open-angle glaucoma (OAG) and cataract in adults currently being treated with ocular hypotensive medication
			• Glaucoma drainage devices (e.g., XEN System, Ex-PRESS™, Molteno implant, Baerveldt tube shunt, Ahmed glaucoma valve implant, and Krupin-Denver valve implant) for treating refractory glaucoma when medical or surgical treatments have failed or are inappropriate
			• Laser trabeculoplasty (e.g., Argon, Selective)
			• Laser iridotomy/iridectomy (e.g., Nd: YAG)
			• Laser iridoplasty
			• Laser ciliary body destruction
			
			All other FDA approved types of laser procedures are unproven and not medically necessary for treating any type of glaucoma due to insufficient evidence of efficacy and/or safety.

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Glaucoma Surgical Treatments (continued)	Oct. 1, 2025	when medical or surgical treatments have failed or are inappropriate" with "glaucoma drainage devices (*e.g.,* XEN System, Ex-PRESS™, Molteno implant, Baerveldt tube shunt, Ahmed glaucoma valve implant, and Krupin-Denver valve implant) for treating refractory glaucoma when medical or surgical treatments have failed or are inappropriate" • Added language to indicate all other U.S. Food and Drug Administration (FDA) approved laser procedures [not listed in the policy as proven and medically necessary] are unproven and not medically necessary for treating any type of glaucoma due to insufficient evidence of efficacy • Removed language indicating the following are unproven and not medically necessary for treating any type of glaucoma due to insufficient evidence of efficacy and/or safety: ○ Canaloplasty (ab interno) ○ Combined; canaloplasty (ab interno) and trabeculotomy (e.g., OMNI® Surgical System, Streamline Surgical System) ○ Glaucoma drainage devices that are not U.S. FDA approved	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Glaucoma Surgical Treatments (continued)	Oct. 1, 2025	○ Goniotomy or trabeculotomy (for indications not listed as proven and medically necessary) **Applicable Codes** ● Added CPT codes 0621T, 0622T, 0730T, 65855, 66710, 66711, 66761, and 66762 **Supporting Information** ● Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	
Hospital Services: Observation and Inpatient	Oct. 1, 2025	**Coverage Rationale** ● Removed language indicating observation services are considered medically necessary for a member who requires the following care in any location within a hospital: ○ Short-term monitoring for a condition that is expected to require at least 6 hours of assessment or treatment and improve significantly within 24-48 hours; and ○ At least one of the following: ▪ Acute treatment and reassessment ▪ Event monitoring (e.g., cardiac dysrhythmia) or response to therapy (e.g., from drug ingestion) that may require immediate intervention ▪ Diagnostic evaluation to establish a treatment plan	UnitedHealthcare uses InterQual® as a source of medical evidence to support medical necessity and level of care decisions, when applicable. InterQual® criteria are intended to be used in connection with the independent professional medical judgment of a qualified health care provider and do not constitute the practice of medicine or medical advice. Click here to view the InterQual® criteria. **An observation level of care is often used to manage the following clinical conditions and symptoms (list is not all-inclusive):** ● Abdominal pain ● Allergic reaction (generalized) ● Altered mental status (confusion) ● Anemia ● Asthma ● Atrial fibrillation ● Back pain ● Bronchiolitis ● Bronchitis ● Cellulitis ● Chest pain ● Chronic obstructive pulmonary disease ● Epistaxis ● Febrile illness ● Gastroenteritis ● Heart failure ● Hemoptysis ● Migraine ● Pneumonia ● Poisoning/toxic ingestions ● Renal colic, kidney stone ● Seizures ● Syncope and collapse ● Transient ischemic attack (TIA)

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Hospital Services: Observation and Inpatient (continued)	Oct. 1, 2025		• Croup • Dehydration • Diabetes mellitus • Epistaxis • Urinary tract infection • Vaginal bleeding (non-obstetrical) • Weakness If the individual's condition does not improve within 48 hours, additional clinical information should be submitted to support an inpatient level of care. **Observation services are not medically necessary for the convenience of the hospital, physicians, individuals, or individuals' families, or while awaiting placement to another health care facility.** **Note**: The observation services portion of this policy does not apply to an obstetric member during pregnancy, childbirth, or the post-partum period.
Skin and Soft Tissue Substitutes	Oct. 1, 2025	**Coverage Rationale** • Revised list of skin and soft tissue substitutes that are unproven and not medically necessary for any indication; added: ○ AdvoGraft Dual and AdvoGraft One ○ AeroGuard and NeoGuard ○ AmchoPlast EXCEL ○ AmchoThick ○ AmnioDefend FT Matrix ○ AmnioPlast 3 ○ Duograft AA, duoGRAFT AC, and triGRAFT FT ○ Membrane Wrap-Lite ○ Renew FT Matrix **Applicable Codes** • Added HCPCS codes Q4368, Q4369, Q4370, Q4371, Q4372, Q4373, Q4375, Q4376, Q4377, Q4378, Q4379, Q4380, and Q4382	**EpiFix or Grafix® (GrafixPL, GrafixPRIME, and GrafixPL PRIME) (Non-Injectable)** **EpiFix or Grafix is proven and medically necessary for treating a diabetic foot ulcer when all of the following criteria are met:** • Adequate circulation to the affected extremity as indicated by one or more of the following: ○ Pedal pulses palpable or pulses confirmed with doppler examination ○ Ankle-brachial index (ABI) between 0.7 and 1.2 • Glycated hemoglobin test (HgA1c) < 12% (within the last 90 days) • Ulcer has failed to demonstrate adequate healing with at least 4 weeks of standard wound care which includes **all** of the following: ○ Application of dressings to maintain a moist wound environment ○ Debridement of necrotic tissue if present ○ Offloading • No known contraindications which may include but are not limited to the following: ○ Active Charcot deformity or major structural abnormalities of the affected foot ○ Chronic infection to the ulcer site ○ Known or suspected malignancy of the current ulcer being treated ○ Ulcer being treated does not extend to tendon, muscle, capsule, or bone

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Skin and Soft Tissue Substitutes (continued)	Oct. 1, 2025	**Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	***EpiFix and Grafix Application Limitations*** • EpiFix is limited to one application per week for up to 12 weeks. • Grafix is limited to one application per week for up to 12 weeks. **Due to insufficient evidence of efficacy, EpiFix and/or Grafix are unproven and not medically necessary for all other indications including but not limited to:** • EpiFix application more frequently than once a week or beyond 12 weeks • Grafix application more frequently than once a week or beyond 12 weeks **TransCyte™** **TransCyte is proven and medically necessary for treating surgically excised Full-Thickness Thermal Burn wounds and deep Partial-Thickness Thermal Burn wounds before autograft placement.** **TransCyte is unproven and not medically necessary for all other indications due to insufficient evidence of efficacy.** **Other Skin and Soft Tissue Substitutes** **Other skin and soft tissue substitutes listed in the policy are unproven and not medically necessary for any indication due to insufficient evidence of efficacy.** Refer to the Medical Policy titled Breast Reconstruction for information about coverage for skin and soft tissue substitutes used during post mastectomy breast reconstruction procedures. **Note**: Refer to the *Clinical Evidence* section of the policy for specific product information.

Surgery of the Ankle	Oct. 1, 2025	**Coverage Rationale**
		• Revised medical necessity clinical coverage criteria; removed reference to the InterQual® Client Defined, CP: Procedures:
			Surgery of the ankle is proven and medically necessary in certain circumstances. For medical necessity clinical coverage criteria, refer to the:
			• InterQual® CP: Procedures:
			  ○ Arthrodesis, Ankle (Talotibial Joint)
			  ○ Arthroscopy, Surgical, Ankle
			  ○ Arthrotomy, Ankle

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Surgery of the Ankle (continued)	Oct. 1, 2025	○ Arthroplasty, Ankle (Without Implant) (Custom) - UHG ○ Arthroplasty, Removal or Revision, Ankle (Custom) - UHG **Applicable Codes** • Removed CPT codes 27700, 27703, 27704, and 28899 **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	○ Total Joint Replacement (TJR), Ankle Click here to view the InterQual® criteria. **Osteochondral allograft or autograft transplantation is unproven and not medically necessary for treating cartilage defects of the ankle due to insufficient evidence of efficacy.**
Transarterial Radioembolization (TARE)/Selective Internal Radiation Therapy (SIRT) for the Treatment of Malignant Cancers of the Liver	Oct. 1, 2025	**Coverage Rationale** • Added language to indicate this policy applies to individuals 19 years of age and older; Transarterial Radioembolization/ selective internal radiation therapy is covered without further review for individuals younger than 19 years of age • Revised list of proven and medically necessary indications for Transarterial Radioembolization (TARE)/selective internal radiation therapy (SIRT) using yttrium-90 microspheres: ○ Added “metastasis from uveal/ocular melanoma when confined to the liver” ○ Replaced: ▪ “Primary hepatocellular carcinoma (HCC) *that is unresectable and limited to the* liver” with “liver *dominant* primary	**Note**: This policy applies to individuals 19 years of age and older. Transarterial Radioembolization/selective internal radiation therapy 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 (HCC) in individuals who are not surgical candidates • Primary hepatocellular carcinoma as a bridge to liver transplantation • 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/ocular 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.**

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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 (continued)	Oct. 1, 2025	hepatocellular carcinoma (HCC) *in individuals who are not surgical candidates*" ▪ "*Unresectable* liver metastases from neuroendocrine tumors when systemic therapy has failed to control symptoms" with "liver metastases from neuroendocrine tumors *in individuals who are not surgical candidates* when systemic therapy has failed to control symptoms" ▪ "*Unresectable* liver metastases from colorectal carcinoma in individuals with *Limited Extra-Hepatic Disease who are* Refractory *to or relapsed following systemic chemotherapy*" with "liver metastases from colorectal carcinoma in individuals with *chemotherapy-resistant or* Refractory *disease and with predominant hepatic metastases*" ▪ "*Unresectable* intrahepatic cholangiocarcinoma" with "*liver metastases from* intrahepatic cholangiocarcinoma in	

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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 (continued)	Oct. 1, 2025	individuals *who are not surgical candidates*" **Medical Records Documentation Used for Review** • Updated list of Medical Records Documentation Used for Reviews: ○ Added "candidacy for surgery" ○ Removed "feasibility of resection" ○ Replaced "*location* of malignancy" with "*site and type of primary* malignancy *and metastatic lesion(s)*" **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	
Transcatheter Procedures for Heart Valve Conditions	Oct. 1, 2025	**Coverage Rationale** ***Tricuspid*** • Added language to indicate transcatheter edge-to-edge repair of the tricuspid heart valve is proven and medically necessary when used according to U.S. Food and Drug Administration (FDA) labeled indications, contraindications, warnings, and precautions and the individual meets all of the following criteria: ○ Symptomatic Severe Tricuspid Regurgitation (TR) ○ Receiving stable (≥ 30 days) guideline-directed medical therapy (GDMT) for heart failure	**Aortic** **Transcatheter aortic heart valve replacement is proven and medically necessary when performed according to U.S. Food and Drug Administration (FDA) labeled indications, contraindications, warnings, and precautions and all of the following criteria are met:** • Diagnosis of severe calcific native aortic valve stenosis as indicated by **one** of the following: ○ Mean aortic valve gradient ≥ 40 mmHg; or ○ Peak aortic jet velocity ≥ 4.0 m/s; or ○ Aortic valve area of ≤ 1.0 cm^2 • Individual is symptomatic [New York Heart Association (NYHA) class II or greater] and symptoms are due to aortic valve stenosis • An interventional cardiologist and an experienced cardiothoracic surgeon have determined that the procedure is appropriate • Individual has engaged in a Shared Decision Making conversation with an interventional cardiologist and an experienced cardiothoracic surgeon • Procedure is performed in a center that meets **all** of the following criteria:

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Transcatheter Procedures for Heart Valve Conditions (continued)	Oct. 1, 2025	○ Symptomatic NYHA class II or greater ○ Pulmonary artery systolic pressure of < 70 mmHg ○ Intermediate or greater risk for surgery as determined by the local heart team which includes board-certified specialists in cardiac surgery, interventional cardiology, echocardiology, and heart failure • Replaced language indicating "transcatheter tricuspid heart valve *repair*, reconstruction, or replacement is unproven and not medically necessary" with "transcatheter tricuspid heart valve reconstruction or replacement is unproven and not medically necessary" **Medical Records Documentation Used for Review** • Updated list of Medical Records Documentation Used for Reviews: ○ Added: ▪ For mitral valve repair, also include: – Mitral regurgitation (MR) grade – NYHA Classification – Surgical risk using PROM score – Physician composition of the care team	○ On-site heart valve surgery and interventional cardiology programs; and ○ Post-procedure intensive care unit with personnel experienced in managing individuals who have undergone open-heart valve procedures; and ○ Volume Requirements consistent with the Centers for Medicare and Medicaid Services (CMS); for additional information, refer to the corresponding CMS National Coverage Determination and the Society of Thoracic Surgeons/American College of Cardiology (STS/ACC) Transcatheter Valve Therapy (TVT) Registry **Transcatheter valve-in-valve (ViV) replacement within a failed bioprosthetic aortic valve is proven and medically necessary for individuals at high or prohibitive surgical risk (Predicted Risk of Mortality (PROM) score of ≥ 8%) when performed according to FDA labeled indications, contraindications, warnings, and precautions.** **Note**: Requests for transcatheter aortic heart valve replacement for low-flow/low-gradient aortic stenosis in individuals who do not meet the peak velocity, mean gradient, and valve area criteria listed above will be considered on a case-by-case basis. These requests will be evaluated using recommendations from the American College of Cardiology/American Heart Association Guideline for the Management of Patients With Valvular Heart Disease (Otto et al., 2021) when all the clinical evaluation has been facilitated by a transcatheter aortic heart valve replacement expert and after appropriate additional testing has been conducted. **Mitral** **Transcatheter edge-to-edge repair of the mitral heart valve is proven and medically necessary when used according to FDA labeled indications, contraindications, warnings, and precautions in individuals with one of the following clinical indications for intervention:** • Primary (degenerative) mitral regurgitation (MR) when **all** of the following criteria are met: ○ Moderate-to-severe or severe MR (grade ≥ 3); and ○ Symptomatic NYHA class III or IV; and ○ Prohibitive surgical risk as defined by **one** of the following:

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Transcatheter Procedures for Heart Valve Conditions (continued)	Oct. 1, 2025	▪ For tricuspid heart valve repair, also include: – Tricuspid regurgitation (TR) stage – NYHA Classification – Pulmonary artery systolic pressure – Surgical risk – Physician composition of the care team ○ Replaced: ▪ "Treatments tried, failed, or contraindicated" with "treatments tried, failed, or contraindicated; *include the dates, duration, and reason for discontinuation*" ○ Replaced reference to: ▪ "Aortic heart valve [procedures]" with "aortic heart valve *replacement* [procedures]" ▪ "Pulmonary heart valve [procedures]" with "pulmonary heart valve *replacement* [procedures]" **Definitions** • Added definition of "Symptomatic Severe Tricuspid Regurgitation" **Supporting Information** • Updated *Description of Services*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	▪ PROM score of ≥ 8% for individuals deemed likely to undergo mitral valve replacement; or ▪ PROM score of ≥ 6% for individuals deemed likely to undergo mitral valve repair; or ▪ Predicted risk of death or major morbidity at 1 year of over 50%; and ○ Care directed by a multidisciplinary heart team which includes a heart failure specialist, interventional cardiologist and cardiothoracic surgeon experienced in the evaluation and treatment of heart failure and mitral valve disease • Secondary (functional) MR when **all** of the following criteria are met: ○ Moderate-to-severe or severe MR (grade ≥ 3) with left ventricular ejection fraction (LVEF) ≥ 20 and ≤ 50; and ○ Symptomatic NYHA class II –IV (ambulatory); and ○ Optimal evidence-based management which includes pharmacologic therapy plus cardiac resynchronization therapy as indicated; and ○ High surgical risk (PROM score of ≥ 8%); and ○ Care directed by a multidisciplinary heart team which includes a heart failure specialist, interventional cardiologist and cardiothoracic surgeon experienced in the evaluation and treatment of heart failure and mitral valve disease **Transcatheter mitral heart valve repair (e.g., annuloplasty), except where noted above, is unproven and not medically necessary due to insufficient evidence of efficacy.** **Transcatheter mitral heart valve reconstruction or replacement is unproven and not medically necessary due to insufficient evidence of efficacy.** **Pulmonary** **Transcatheter pulmonary heart valve replacement and related devices (e.g., Alterra) are proven and medically necessary when used according to FDA labeled indications, contraindications, warnings, and precautions in individuals with right ventricular outflow tract (RVOT) dysfunction with one of the following clinical indications for intervention:**

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Transcatheter Procedures for Heart Valve Conditions (continued)	Oct. 1, 2025		• Moderate or greater pulmonary regurgitation; and/or • Pulmonary stenosis with a mean RVOT gradient ≥ 35 mmHg **Tricuspid** **Transcatheter edge-to-edge repair of the tricuspid heart valve is proven and medically necessary when used according to FDA labeled indications, contraindications, warnings, and precautions and the individual meets all of the following criteria:** • Symptomatic Severe Tricuspid Regurgitation (TR) • Receiving stable (≥ 30 days) guideline-directed medical therapy (GDMT) for heart failure • Symptomatic NYHA class II or greater • Pulmonary artery systolic pressure of < 70 mmHg • Intermediate or greater risk for surgery as determined by the local heart team which includes board-certified specialists in cardiac surgery, interventional cardiology, echocardiology, and heart failure **Transcatheter tricuspid heart valve reconstruction or replacement is unproven and not medically necessary due to insufficient evidence of efficacy.** **Other Devices and Procedures** **The following transcatheter heart valve devices and/or procedures are unproven and not medically necessary due to insufficient evidence of efficacy:** • Cerebral protection devices (e.g., Sentinel™) • Valve-in-valve (ViV) replacement within a failed bioprosthesis for mitral, pulmonary, or tricuspid valves; for coverage of experimental/investigational/unproven treatments for life-threatening illnesses or the treatment of serious rare diseases, refer to *Benefit Considerations* • Transcatheter superior and inferior vena cava prosthetic valve implantation (CAVI)

Medical Policy Updates

Retired		
Policy Title	**Effective Date**	**Summary of Changes**
Diagnostic Spinal Ultrasonography	Sep. 1, 2025	• Retired policy; diagnostic spinal ultrasonography no longer requires clinical review
Neuropsychological Testing Under the Medical Benefit	Sep. 1, 2025	• Retired policy; neuropsychological testing under the medical benefit no longer requires clinical review

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

Clotting Factors, Coagulant Blood Products, & Other Hemostatics	Oct. 1, 2025	**Coverage Rationale**
		• Removed reference link to the Medical Benefit Drug Policy titled *Review at Launch for New to Market Medications* for Qfitlia (fitusiran)
		• Removed medical necessity criteria for:
		  ○ Adynovate
		  ○ Afstyla
		  ○ Altuviiio
		  ○ Eloctate
		  ○ Jivi
		• Replaced language indicating:
		  ○ "[The listed drug products] are proven *and medically necessary* when the criteria [in the policy] are met" with "[the listed drug products] are proven when the criteria [in the policy] are met"
		  ○ "Concizumab-mtci (Alhemo) is proven for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in patients with hemophilia A/B *with factor VIII/factor IX inhibitors*" with "Concizumab-mtci (Alhemo) is proven for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in patients with hemophilia A/B"
		  ○ "Concizumab-mtci (Alhemo) is medically necessary for routine prophylaxis to prevent
			Refer to the policy for complete details.

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Clotting Factors, Coagulant Blood Products, & Other Hemostatics (continued)	Oct. 1, 2025	or reduce the frequency of bleeding episodes in patients with hemophilia A/B *with factor VIII/factor IX inhibitors*" with "Concizumab-mtci (Alhemo) is medically necessary for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in patients with hemophilia A/B" • Added language to indicate: ○ Marstacimab-hncq (Hympavzi) is proven for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in patients with **hemophilia A** without factor VIII inhibitors when all of the following criteria are met [**Note**: marstacimab-hncq (Hympavzi) is a self-injectable medication that should be obtained under the member's pharmacy benefit unless the following criteria are met]: ***Initial Therapy*** ▪ Diagnosis of hemophilia A ▪ Patient is 12 years of age or older ▪ Prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis) ▪ Patient does not have a history of inhibitors to factor VIII	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Clotting Factors, Coagulant Blood Products, & Other Hemostatics (continued)	Oct. 1, 2025	▪ One of the following: – Patient cannot self-inject and does not have a caretaker who can be trained to administer Hympavzi – Patient is receiving Hympavzi from a contracted hemophilia treatment center ***Continuation of Therapy*** ▪ Patient has previously been treated with Hympavzi ▪ Prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis) ▪ Documentation of positive clinical response to Hympavzi therapy ▪ One of the following: – Patient cannot self-inject and does not have a caretaker who can be trained to administer Hympavzi – Patient is receiving Hympavzi from a contracted hemophilia treatment center ○ Marstacimab-hncq (Hympavzi) is medically necessary for routine prophylaxis to prevent or	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Clotting Factors, Coagulant Blood Products, & Other Hemostatics (continued)	Oct. 1, 2025	reduce the frequency of bleeding episodes in patients with **hemophilia A** without factor VIII inhibitors when all of the following criteria are met [**Note**: marstacimab-hncq (Hympavzi) is a self-injectable medication that should be obtained under the member's pharmacy benefit unless the following criteria are met]: ***Initial Therapy*** ▪ Both of the following: – Diagnosis of hemophilia A – Patient has not developed high-titer factor VIII inhibitors [i.e., patient has **not** developed factor VIII inhibitors greater than or equal to 5 Bethesda units (BU)] ▪ Patient is 12 years of age or older ▪ Prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis) ▪ One of the following: – Patient cannot self-inject and does not have a caretaker who can be trained to administer Hympavzi – Patient is receiving Hympavzi from a	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Clotting Factors, Coagulant Blood Products, & Other Hemostatics (continued)	Oct. 1, 2025	contracted hemophilia treatment center ***Continuation of Therapy*** ▪ Patient has previously been treated with Hympavzi ▪ Prescribed for the prevention of bleeding episodes (i.e., routine prophylaxis) ▪ Documentation of positive clinical response ▪ One of the following: – Patient cannot self-inject and does not have a caretaker who can be trained to administer Hympavzi – Patient is receiving Hympavzi from a contracted hemophilia treatment center • Removed language indicating Marstacimab-hncq [Hympavzi] is not medically necessary for routine prophylaxis to prevent or reduce the frequency of bleeding episodes in patients with **hemophilia A** without factor VIII inhibitors • Revised coverage criteria for initial therapy for: Antihemophilic Factor (recombinant), Pegylated-aucl (Jivi) ○ Replaced criterion requiring "the patient is ***12*** years of age	

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Clotting Factors, Coagulant Blood Products, & Other Hemostatics (continued)	Oct. 1, 2025	or older" with "the patient is **7** years of age or older" Concizumab-mtci (Alhemo) *Proven* ○ Removed criterion requiring the patient has developed high-titer factor VIII/factor IX inhibitors [≥ 5 Bethesda units (BU)] *Medical Necessity* ○ Added criterion to allow coverage when the patient has not developed high-titer factor VIII/factor IX inhibitors [i.e., patient has **not** developed factor VIII/factor IX inhibitors greater than or equal to 5 Bethesda units (BU)] Emicizumab-kxwh (Hemlibra) ○ Added criterion to allow coverage when the patient has not developed high-titer factor VIII inhibitors [i.e., patient has **not** developed factor VIII inhibitors greater than or equal to 5 Bethesda units (BU)] ○ Removed criterion requiring: ▪ Documentation of endogenous factor VIII level less than 1% of normal factor VIII (< 0.01 i.u./mL) ▪ Both of the following: – Diagnosis of moderate hemophilia A	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Clotting Factors, Coagulant Blood Products, & Other Hemostatics (continued)	Oct. 1, 2025	– Documentation of endogenous factor VIII level ≥ 1% < 5% (greater than or equal to 0.01 i.u./mL to less than 0.05 i.u./mL) ▪ Both of the following: – Diagnosis of mild hemophilia A – Documentation of endogenous factor VIII level ≥ 5% (greater than or equal to 0.05 i.u./mL) ▪ Submission of medical records (e.g., chart notes, laboratory values) documenting a failure to meet clinical goals (e.g., continuation of spontaneous bleeds, inability to achieve appropriate trough level, previous history of inhibitors) after a trial of prophylactic factor VIII replacement products ○ Replaced criterion requiring: ▪ "Diagnosis of *severe* hemophilia A" with "diagnosis of hemophilia A" ▪ "The patient has developed high-titer factor VIII inhibitors [≥ 5 Bethesda units (BU)]" with "the patient has	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Clotting Factors, Coagulant Blood Products, & Other Hemostatics (continued)	Oct. 1, 2025	developed high-titer factor VIII inhibitors [*i.e., patient has developed factor VIII inhibitors* greater than or equal to 5 Bethesda units (BU)]" Marstacimab-hncq (Hympavzi): Hemophilia B ○ Added criterion to allow coverage when the patient has not developed high-titer factor IX inhibitors [i.e., patient has **not** developed factor IX inhibitors greater than or equal to 5 Bethesda units (BU)] ○ Removed criterion requiring: ▪ Documentation of endogenous factor IX level less than 1% of normal factor IX (< 0.01 i.u./mL) ▪ Both of the following: – Diagnosis of moderate hemophilia B – Documentation of endogenous factor IX level ≥ 1% < 5% (greater than or equal to 0.01 i.u./mL to less than 0.05 i.u./mL) ▪ Both of the following: – Diagnosis of mild hemophilia B – Documentation of endogenous factor IX level ≥ 5% (greater	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Clotting Factors, Coagulant Blood Products, & Other Hemostatics (continued)	Oct. 1, 2025	than or equal to 0.05 i.u./mL) ▪ Submission of medical records (e.g., chart notes, laboratory values) documenting a failure to meet clinical goals (e.g., continuation of spontaneous bleeds, inability to achieve appropriate trough level, previous history of inhibitors) after a trial of prophylactic factor IX replacement products ▪ The patient does not have a history of inhibitors to factor IX ○ Replaced criterion requiring "diagnosis of *severe* hemophilia B" with "diagnosis of hemophilia B" Fitusiran (Qfitlia) ○ Added criterion to allow coverage when: ▪ The patient has not developed high-titer factor VIII/factor IX inhibitors [i.e., patient has **not** developed factor VIII/factor IX inhibitors greater than or equal to 5 Bethesda units (BU)] ▪ One of the following: – Based on clinical patient assessment, the provider has	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Clotting Factors, Coagulant Blood Products, & Other Hemostatics (continued)	Oct. 1, 2025	determined that the patient is not an appropriate candidate for Hympavzi (document reason) – Patient is currently on Qfitlia therapy ○ Removed criterion requiring: ▪ Documentation of endogenous factor VIII/factor IX level less than 1% of normal factor VIII/factor IX (< 0.01 i.u./mL) ▪ Both of the following: – Diagnosis of moderate hemophilia A/B – Documentation of endogenous factor VIII/factor IX level ≥ 1% < 5% (greater than or equal to 0.01 i.u./mL to less than 0.05 i.u./mL) ▪ Both of the following: – Diagnosis of mild hemophilia A/B – Documentation of endogenous factor VIII/factor IX level ≥ 5% (greater than or equal to 0.05 i.u./mL) ▪ Submission of medical records (e.g., chart notes, laboratory values) documenting a failure to meet clinical goals (e.g.,	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Clotting Factors, Coagulant Blood Products, & Other Hemostatics (continued)	Oct. 1, 2025	continuation of spontaneous bleeds, inability to achieve appropriate trough level, previous history of inhibitors) after a trial of prophylactic factor VIII/factor IX replacement products ○ Replaced criterion requiring: ▪ "Diagnosis of *severe* hemophilia A/B" with "diagnosis of hemophilia A/B" ▪ "The patient has developed high-titer factor VIII/factor IX inhibitors [≥ 5 Bethesda units (BU)]" with "the patient has developed high-titer factor VIII/factor IX inhibitors [*i.e., patient has developed factor VIII/factor IX inhibitors* greater than or equal to 5 Bethesda units (BU)]" **Supporting Information** • Updated *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	
Gamifant® (Emapalumab-Lzsg)	Oct. 1, 2025	**Coverage Rationale** ***Hemophagocytic Lymphohistiocytosis (HLH)*** • Added coverage criteria for proven indications requiring:	**Gamifant is proven for the treatment of primary hemophagocytic lymphohistiocytosis (HLH) in patients who meet all of the following criteria:** • Diagnosis of primary hemophagocytic lymphohistocytosis; **and** • Patient has refractory, recurrent or progressive disease, or intolerance with conventional HLH therapy (e.g., etoposide, corticosteroids,

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Gamifant® (Emapalumab-Lzsg) (continued)	Oct. 1, 2025	○ Diagnosis of primary hemophagocytic lymphohistiocytosis ○ Patient has refractory, recurrent or progressive disease, or intolerance with conventional hemophagocytic lymphohistiocytosis (HLH) therapy (e.g., etoposide, corticosteroids, cyclosporine, anti-thymocyte globulin, methotrexate) ○ Dosing is in accordance with the U.S. Food and Drug Administration (FDA) approved labeling ○ Authorization will be for no more than 6 months • Revised medical necessity criteria; replaced criterion requiring: ○ "Confirmation of a gene mutation known to cause primary HLH (e.g., PRF1, UNC13D)" with "confirmation of a gene mutation known to cause primary HLH (e.g., PRF1, UNC13D, *RAB27A, STX11, STXBP2*)" ○ "Confirmation of fever ≥ *101.3°F*" with "confirmation of fever" ○ "Confirmation of low or absent natural killer cell activity *(according to local laboratory reference)*" with "confirmation of low or absent	cyclosporine, anti-thymocyte globulin, methotrexate); **and** • Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** • Authorization will be for no more than 6 months **Gamifant is medically necessary for the treatment of primary hemophagocytic lymphohistiocytosis (HLH) in patients who meet all of the following criteria:** • Submission of medical records (e.g., chart notes, laboratory values) confirming **one** the following: ○ Confirmation of a gene mutation known to cause primary HLH (e.g., PRF1, UNC13D, RAB27A, STX11, STXBP2); **or** ○ Confirmation that **five** of the following clinical characteristics are present: ▪ Fever ▪ Splenomegaly ▪ **Two** of the following cytopenias in the peripheral blood: – Hemoglobin < 9 g/dL; **or** – Platelet count < 100 x 109/L; **or** – Neutrophils < 1 x 109/L ▪ **One** of the following: – Hypertriglyceridemia defined as fasting triglycerides ≥ 3 mmol/L or ≥ 265 mg/dL; **or** – Hypofibrinogenemia defined as fibrinogen ≤ 1.5 g/L ▪ Hemophagocytosis in bone marrow, spleen, or lymph nodes with no evidence of malignancy ▪ Low or absent natural killer cell activity ▪ Ferritin ≥ 500 mcg/L ▪ Soluble CD25 (i.e., soluble IL-2 receptor) ≥ 2,400 U/mL **and** • Patient has refractory, recurrent or progressive disease, or intolerance with conventional HLH therapy (e.g., etoposide, corticosteroids, cyclosporine, anti-thymocyte globulin, methotrexate); **and** • Gamifant will be administered with dexamethasone; **and** • Patient is a candidate for hematopoietic stem cell transplant; **and** • Gamifant is being used as part of the induction or maintenance phase of hematopoietic stem cell transplant, which is to be discontinued at the

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Gamifant® (Emapalumab-Lzsg) (continued)	Oct. 1, 2025	natural killer cell activity" ○ "The patient has refractory, recurrent, or progressive disease, or intolerance with conventional HLH therapy (*i.e., etoposide + dexamethasone*)" with "the patient has refractory, recurrent, or progressive disease, or intolerance with conventional HLH therapy (*e.g., etoposide, corticosteroids, cyclosporine, anti-thymocyte globulin, methotrexate*)" ○ "*Approval is* for no more than 6 months" with "*authorization will be* for no more than 6 months" ● Replaced references to "stem cell transplant" with "*hematopoietic* stem cell transplant" ***Hemophagocytic Lymphohistiocytosis (HLH)/Macrophage Activation Syndrome (MAS)*** ● Added language to indicate: ○ Gamifant is proven for the treatment of HLH MAS in patients who meet all of the following criteria: Initial Therapy ▪ Diagnosis of hemophagocytic lymphohistiocytosis (HLH)/ macrophage activation syndrome (MAS)	initiation of conditioning for stem cell transplant; **and** ● Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** ● Authorization will be for no more than 6 months **Gamifant is proven for the treatment of hemophagocytic lymphohistiocytosis (HLH)/macrophage activation syndrome (MAS) in patients who meet all of the following criteria:** ● **Initial Therapy** ○ Diagnosis of hemophagocytic lymphohistiocytosis (HLH)/macrophage activation syndrome (MAS); **and** ○ Known or suspected diagnosis of Still's disease, including systemic juvenile idiopathic arthritis (sJIA); **and** ○ Inadequate response or intolerance to glucocorticoids; **and** ○ Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** ○ Approval is for no more than 12 months ● **Continuation of Therapy** ○ Documentation of a positive clinical response to Gamifant; **and** ○ Dosing is in accordance with the FDA approved labeling; **and** ○ Reauthorization will be for no more than 12 months **Gamifant is medically necessary for the treatment of hemophagocytic lymphohistiocytosis (HLH)/macrophage activation syndrome (MAS) in patients who meet all of the following criteria:** ● **Initial Therapy** ○ Submission of medical records (e.g., chart notes, laboratory values) confirming the following: ▪ Confirmed or suspected diagnosis of systemic juvenile idiopathic arthritis (sJIA) or adult onset Still's disease (AOSD); **and** ▪ Diagnosis of active MAS with **both** of the following: – Ferritin > 684 ng/mL – **Two** of the following laboratory criteria: • Platelet count ≤ 181 x 10^9/L; **or** • AST > 48 U/L • Triglycerides > 156 mg/dL • Fibrinogen level ≤ 360 mg/dL

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Gamifant® (Emapalumab-Lzsg) (continued)	Oct. 1, 2025	▪ Known or suspected diagnosis of Still's disease, including systemic juvenile idiopathic arthritis (sJIA) ▪ Inadequate response or intolerance to glucocorticoids ▪ Dosing is in accordance with the U.S. FDA approved labeling ▪ Approval is for no more than 12 months Continuation of Therapy ▪ Documentation of a positive clinical response to Gamifant ▪ Dosing is in accordance with the U.S. FDA approved labeling ▪ Reauthorization will be for no more than 12 months ○ Gamifant is medically necessary for the treatment of HLH MAS in patients who meet all of the following criteria: Initial Therapy ▪ Submission of medical records (e.g., chart notes, laboratory values) confirming the following: – Confirmed or suspected diagnosis of systemic juvenile idiopathic arthritis	**and** ○ Patient has had an inadequate response to high-dose intravenous glucorticoids; **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 of Therapy** ○ Documentation of a positive clinical response to Gamifant; **and** ○ Dosing is in accordance with the FDA approved labeling; **and** ○ Reauthorization will be for no more than 12 months **Gamifant is not proven or medically necessary for the treatment of secondary HLH.**

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Gamifant® (Emapalumab-Lzsg) (continued)	Oct. 1, 2025	(sJIA) or adult onset Still's disease (AOSD) – Diagnosis of active MAS with both of the following: • Ferritin > 684 ng/mL • Two of the following laboratory criteria: platelet count ≤ 181 x 10^9/L, AST > 48 U/L, triglycerides > 156 mg/dL, fibrinogen level ≤ 360 mg/dL ▪ Patient has had an inadequate response to high-dose intravenous glucocorticoids ▪ Dosing is in accordance with the U.S. FDA approved labeling ▪ Initial authorization will be for no more than 12 months Continuation of Therapy ▪ Documentation of a positive clinical response to Gamifant ▪ Dosing is in accordance with the U.S. FDA approved labeling ▪ Reauthorization will be for no more than 12 months	

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Gamifant® (Emapalumab-Lzsg) (continued)	Oct. 1, 2025	**Applicable Codes** • Added ICD-10 diagnosis codes D76.2 and D76.3 **Supporting Information** • Updated *Background*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	
Maximum Dosage and Frequency	Oct. 1, 2025	**Coverage Rationale** • Revised list of applicable drug products; added: ○ denosumab-bbdz (Jubbonti® & Wyost®) ○ ustekinumab-stba (Steqeyma®) ○ ustekinumab-kfce (Yesintek™) ***Maximum Allowed Quantities by HCPCS Units*** • Added maximum allowed quantities for: ○ Jubbonti (denosumab-bbdz) (HCPCS code Q5136) ○ Steqeyma (ustekinumab-stba) (HCPCS code Q5099) ○ Wyost (denosumab-bbdz) (HCPCS code Q5136) ○ Yesintek (ustekinumab-kfce) (HCPCS code Q5100) ***Maximum Allowed Quantities for National Drug Code (NDC) Billing*** • Added maximum allowed quantities for: ○ Jubbonti (denosumab-bbdz) (NDC 61314-0240-63)	This policy provides information about the maximum dosage per administration and dosing frequency for certain medications administered by a medical professional. Most medications have a maximum dosage and frequency based upon body surface area or patient weight or a set maximal dosage and frequency independent of patient body size. **Drug Products** • abatacept (Orencia®) • abobotulinumtoxinA (Dysport®) • aflibercept (Eylea®) • aflibercept (Eylea® HD) • aflibercept-ayyh (Pavblu™) • atezolizumab (Tecentriq®) • avelumab (Bavencio®) • axatilimab-csfr (Niktimvo™) • benralizumab (Fasenra®) • bevacizumab (Avastin®) • bevacizumab-adcd (Vegzelma®) • bevacizumab-awwb (Mvasi™) • bevacizumab-bvzr (Zirabev®) • bevacizumab-maly (Alymsys®) • brolucizumab-dbll (Beovu®) • canakinumab (Ilaris®) • cemiplimab-rwlc (Libtayo®) • certolizumab pegol (Cimzia®) • crovalimab-akkz (PiaSky™) • daxibotulinumtoxina-lanm (Daxxify®) • pembrolizumab (Keytruda®) • ranibizumab (Lucentis®) • ranibizumab-nuna (Byooviz™) • ranibizumab-eqrn (Cimerli™) • ravulizumab-cwvz (Ultomiris®) • reslizumab (Cinqair®) • rimabotulinumtoxinB (Myobloc®) • risankizumab-rzaa (Skyrizi®) • rituximab (Rituxan®) • rituximab-pvvr (Ruxience™) • rituximab-abbs (Truxima®) • rituximab-arrx (Riabni™) • rituximab and hyaluronidase (Rituxan Hycela®) • rozanolixizumab-noli (Rystiggo®) • spesolimab-sbzo (Spevigo®) • testosterone cypionate (Depo-Testosterone®)

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Maximum Dosage and Frequency (continued)	Oct. 1, 2025	○ Steqeyma (ustekinumab-stba) (NDCs 72606-0027-01, 72606-0028-01, and 72606-0029-01) ○ Wyost (denosumab-bbdz) (NDC 61314-0228-94) ○ Yesintek (ustekinumab-kfce) (NDCs 83257-0023-41, 83257-0024-11, 83257-0025-41, and 83257-0026-11) ***Maximum Allowed Frequencies*** • Added maximum allowed frequencies for: ○ Jubbonti (denosumab-bbdz) ○ Steqeyma (ustekinumab-stba) ○ Wyost (denosumab-bbdz) ○ Yesintek (ustekinumab-kfce) **Applicable Codes** • Added HCPCS codes Q5099, Q5100, and Q5136 **Supporting Information** • Updated *References* section to reflect the most current information	• denosumab (Prolia® & Xgeva®) • denosumab-bbdz (Jubbonti® & Wyost®) • durvalumab (Imfinzi®) • eculizumab (Soliris®) • edaravone (Radicava®) • efgartigimod alfa-fcab (Vyvgart®) • efgartigimod alfa and hyaluronidase-qvfc (Vyvgart® Hytrulo) • eflapegrastim-xnst (Rolvedon™) • emicizumab-kxwh (Hemlibra®) • eptinezumab-jjmr (Vyepti®) • faricimab-svoa (Vabysmo™) • golimumab (Simponi Aria®) • guselkumab (Tremfya®) • inclisiran (Leqvio®) • incobotulinumtoxinA (Xeomin®) • infliximab (Remicade®) • infliximab-axxq (Avsola™) • infliximab-dyyb (Inflectra®) • infliximab-abda (Renflexis®) • ipilimumab (Yervoy®) • mepolizumab (Nucala®) • mirikizumab-mrkz (Omvoh®) • nivolumab (Opdivo®) • ocrelizumab (Ocrevus®) • omalizumab (Xolair®) • onabotulinumtoxinA (Botox®) • patisiran (Onpattro®) • pegcetacoplan (Syfovre™) • pegfilgrastim (Neulasta®) • pegfilgrastim-apgf (Nyvepria™) • pegfilgrastim-cbqv (Udenyca®) • pegfilgrastim-fpgk (Stimufend®) • pegfilgrastim-jmdb (Fulphila™) • testosterone enanthate • testosterone pellets (Testopel®) • testosterone undecanoate (Aveed®) • tezepelumab-ekko (Tezspire®) • tildrakizumab-asmn (Ilumya™) • tocilizumab (Actemra®) • tocilizumab-aazg (Tyenne®) • tocilizumab-bavi (Tofidence™) • tofersen (Qalsody™) • trastuzumab (Herceptin®) • trastuzumab-anns (Kanjinti™) • trastuzumab-dkst (Ogivri™) • trastuzumab-dttb (Ontruzant®) • trastuzumab-pkrb (Herzuma®) • trastuzumab-qyyp (Trazimera™) • ustekinumab (Stelara®) • ustekinumab-aauz (Otulfi™) • ustekinumab-aekn (Selarsdi) • ustekinumab-stba (Steqeyma) • ustekinumab-auub (Wezlana™) • ustekinumab-kfce (Yesintek) • ustekinumab-ttwe (Pyzchiva®) • vedolizumab (Entyvio®) • vutrisiran (Amvuttra™) • zoledronic acid (zoledronic acid, Reclast®)

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Maximum Dosage and Frequency (continued)	Oct. 1, 2025		**The use of medications included in this policy when given within the maximum dosage and/or frequency based upon body surface area or patient weight or a set of maximal dosage and/or frequency independent of patient body size are proven when used according to labeled indications or when otherwise supported by published clinical evidence [e.g., well-designed systematic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials, the National Comprehensive Cancer Network (NCCN) guidelines].** **The use of medications included in this policy when given beyond maximum dosages and/or frequency based upon body surface area or patient weight or a set maximal dosage independent of patient body size are not supported by package labeling or published clinical evidence and are unproven.** **Continued use of a medication or dosages used beyond labeled indication or other published clinical evidence [e.g., well-designed systematic reviews (with or without meta-analyses) of multiple well-designed randomized controlled trials, NCCN guidelines] is considered not medically necessary.** This policy creates an upper dose limit based on the clinical evidence and the 95th percentile for adult body weight (140 kg) and body surface area (2.71 meters^2) in the U.S. (adult male, 30 to 39 years, Fryar, 2021). In some cases, the maximum allowed units and/or vials may exceed the upper level limit as defined within this policy due to an individual patient body weight > 140 kg or body surface area > 2.71 meters^2. Refer to the policy for complete details.
Oncology Medication Clinical Coverage	Oct. 1, 2025	**Coverage Rationale** • Revised list of UnitedHealthcare preferred and non-preferred oncology products: ○ Added: ▪ Hercessi (trastuzumab-strf) + Perjeta (pertuzumab) (non-preferred for all oncology	**Description** This policy provides parameters for coverage of injectable oncology medications (including, but not limited to octreotide acetate, leuprolide acetate, leucovorin, and levoleucovorin), including therapeutic radiopharmaceuticals, covered under the medical benefit based upon the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium® (NCCN Compendium®). The Compendium lists the appropriate drugs and biologics for specific cancers using US Food and Drug Administration (FDA)-approved disease indications and specific NCCN panel

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Oncology Medication Clinical Coverage (continued)	Oct. 1, 2025	indications) ▪ Tecentriq (atezolizumab) + Mvasi (bevacizumab-awwb) (preferred for hepatocellular carcinoma: combination systemic therapy) ▪ Tecentriq Hybreza (atezolizumab and hyaluronidase-tqjs) + Mvasi (bevacizumab-awwb) (preferred for hepatocellular carcinoma: combination systemic therapy) ▪ Imjudo (tremelimumab-actl) + Imfinzi (durvalumab) (preferred for hepatocellular carcinoma: combination systemic therapy) ▪ Tecentriq (atezolizumab) + any of the following: Avastin (bevacizumab), Zirabev (bevacizumab-bvzr), Alymsys (bevacizumab-maly), Vegzelma (bevacizumab-adcd) (non-preferred for hepatocellular carcinoma: combination systemic therapy) ▪ Tecentriq Hybreza (atezolizumab and hyaluronidase-tqjs) + any of the following: Avastin (bevacizumab), Zirabev	recommendations. Each recommendation is supported by a level of evidence category. Coverage of White Blood Cell Colony Stimulating Factors and Erythropoiesis-Stimulating Agents are addressed in separate policies. This policy does not provide coverage criteria for Chimeric Antigen Receptor (CAR)-T cell or Tumor-Infiltrating Lymphocyte (TIL) cell products. Coverage determinations are based on the member's benefits and the OptumHealth Transplant Solutions criteria for covered transplants; refer to the Clinical Guideline titled Chimeric Antigen Receptor T-cell (CAR T) Therapy, Tumor-Infiltrating Lymphocyte (TIL) Cell Therapy. **Coverage Rationale** ***Medical Necessity Plans*** The Oncology Products table [in the policy] lists the UnitedHealthcare preferred oncology products and respective non-preferred products. Coverage will be provided for the UnitedHealthcare preferred oncology product contingent on the coverage criteria in the *Diagnosis-Specific Criteria* section. Coverage for any respective non-preferred oncology product will be provided contingent on the criteria in the *Preferred Product Criteria* and the *Diagnosis-Specific Criteria* sections. Members new to therapy will be required to utilize the UnitedHealthcare preferred oncology product unless they meet the criteria in this section. ***Preferred Product Criteria*** ***(For Medicare reviews, refer to the CMS section of the policy.)*** **Treatment with the respective non-preferred product specified in the Oncology Products table [in the policy] is medically necessary for oncology indications when both of the following are met:** • History of intolerance or contraindication to one of the UnitedHealthcare's preferred oncology products; and • Physician attests that, in their clinical opinion, the same intolerance, contraindication, or adverse event would not be expected to occur with the respective non-preferred product

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Oncology Medication Clinical Coverage (continued)	Oct. 1, 2025	(bevacizumab-bvzr), Alymsys (bevacizumab-maly), Vegzelma (bevacizumab-adcd) (non-preferred for hepatocellular carcinoma: combination systemic therapy) ▪ Opdivo (nivolumab) + Yervoy (ipilimumab) (non-preferred for hepatocellular carcinoma: combination systemic therapy) ○ Replaced indication listed as "head and neck cancers: recurrent, unresectable, oligometastatic, or metastatic disease, nasopharyngeal" with "head and neck cancers: *cancer of the nasopharynx*, recurrent, unresectable, oligometastatic, or metastatic disease, nasopharyngeal" **Applicable Codes** • Added HCPCS codes J9289 and Q5146	**Oncology Products** Refer to the policy for a list of UnitedHealthcare preferred and non-preferred oncology products and corresponding indications. Any U.S. Food and Drug Administration approved product that may belong to UnitedHealthcare Preferred or Non-preferred Oncology Product categories but not listed by name in this policy will be considered non-preferred until reviewed by UnitedHealthcare P&T committee. **Diagnosis-Specific Criteria** ***Injectable Oncology Medications*** UnitedHealthcare recognizes indications and uses of injectable oncology medications, including therapeutic radiopharmaceuticals, listed in the NCCN Drugs and Biologics Compendium with Categories of Evidence and Consensus of 1, 2A, and 2B as proven and medically necessary, and Categories of Evidence and Consensus of 3 as unproven and not medically necessary. UnitedHealthcare will cover all chemotherapy agents for individuals under the age of 19 years for oncology indications. The majority of pediatric patients receive treatments on national pediatric protocols that are quite similar in concept to the NCCN patient care guidelines. Refer to *Preferred Product Criteria* for the UnitedHealthcare preferred oncology products and indications.
White Blood Cell Colony Stimulating Factors	Oct. 1, 2025	**Coverage Rationale** • Revised list of applicable white blood cell colony stimulating factors (CSFs); added Ryzneuta® (efbemalenograstim alfa-vuxw) • Added language to indicate: ○ Coverage for Ryzneuta will be provided contingent on the criteria in the *Preferred Product Criteria* section [of	This policy refers to the following white blood cell colony stimulating factors (CSFs): • Long-acting pegfilgrastim agents: ○ Fulphila® (pegfilgrastim-jmdb) ○ Fylnetra® (pegfilgrastim-pbbk) ○ Neulasta® (pegfilgrastim) ○ Nyvepria™ (pegfilgrastim-apgf) ○ Udenyca® (pegfilgrastim-cbqv) ○ Stimufend® (pegfilgrastim-fpgk) ○ Ziextenzo® (pegfilgrastim-bmez)

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White Blood Cell Colony Stimulating Factors (continued)	Oct. 1, 2025	the policy] and the coverage criteria in the *Diagnosis-Specific Criteria* section [of the policy]; in order to continue coverage, members already on Ryzneuta will be required to change therapy to Neulasta or Udenyca unless they meet the criteria in the *Preferred Product Criteria* section [of the policy] ○ Treatment with Ryzneuta 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 of Neulasta or Udenyca, resulting in minimal clinical response – Physician attests that, in their clinical opinion, the clinical response would be expected to be superior with Ryzneuta than experienced with Neulasta or Udenyca ▪ Both of the following: – History of intolerance, contraindication, or Adverse Event to Neulasta or Udenyca	• Short-acting filgrastim agents: ○ Granix® (tbo-filgrastim) ○ Neupogen® (filgrastim) ○ Nivestym® (filgrastim-aafi) ○ Nypozi™ (filgrastim-txid) ○ Releuko® (filgrastim-ayow) ○ Zarxio® (filgrastim-sndz) • Leukine® (sargramostim) • Rolvedon™ (eflapegrastim-xnst) • Ryzneuta® (efbemalenograstim alfa-vuxw) • Any FDA-approved white blood cell colony stimulating factor product not listed here Refer to the policy for complete details.

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White Blood Cell Colony Stimulating Factors (continued)	Oct. 1, 2025	– Physician attests that, in their clinical opinion, the same intolerance, contraindication, or Adverse Event would not be expected to occur with Ryzneuta ○ Ryzneuta is proven and medically necessary for the following indications when criteria in the policy are met: ▪ Hematopoietic syndrome of acute radiation syndrome ▪ Primary prophylaxis of chemotherapy-induced Febrile Neutropenia (FN) ▪ Secondary prophylaxis of Febrile Neutropenia (FN) ▪ Treatment of Febrile Neutropenia **Applicable Codes** ● Added HCPCS code J9361 **Supporting Information** ● Updated *Background*, *FDA*, and *References* sections to reflect the most current information	
Xolair® (Omalizumab)	Oct. 1, 2025	**Coverage Rationale** ● Revised coverage criteria; replaced criterion requiring "the patient is not receiving any of [the listed therapies] in combination with Xolair" with "the patient is not receiving any of [the listed therapies] in combination with	This policy refers to Xolair (omalizumab) subcutaneous injection for administration by a healthcare professional. Xolair (omalizumab) for self-administered subcutaneous injection is obtained under the pharmacy benefit. Refer to the policy for complete details.

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Xolair® (Omalizumab) (continued)	Oct. 1, 2025	Xolair *for treatment of the same indication*" **Supporting Information** • Updated *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	

General Information

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

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

UnitedHealthcare respects the expertise of the physicians, health care professionals, and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Medical Policy Update Bulletin was developed to share important information regarding changes to our 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 Medical Policies and Medical Benefit Drug Policies is available at **UHCprovider.com/policies** > For Commercial Plans > Medical & Drug Policies.