UMR
Medical Policy Update Bulletin: January 2026

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Implementation Delay: Remote Physiologic Monitoring (RPM)

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

Annual CDT/CPT/HCPCS Code Updates

Effective **Jan. 1, 2026**, all applicable Medical Policies and Medical Benefit Drug Policies will be updated to reflect the 2026 Current Dental Terminology (CDT®), Current Procedural Terminology (CPT®), and Healthcare Common Procedure Coding System (HCPCS) code additions, revisions, and deletions. Refer to the following sources for information on the code updates:

- American Dental Association®. Current Dental Terminology: CDT®
- American Medical Association: Current Procedural Terminology: CPT®
- Centers for Medicare & Medicaid Services: Healthcare Common Procedure Coding System (HCPCS) Quarterly Update

Policy Title	Policy Type	Summary of Changes
Autologous Cellular Therapy	Medical Policy	• Added CPT codes 0999T, 1000T, and 1001T
Bariatric Surgery	Medical Policy	• Added CPT code 43889
Category III Codes	Medical Policy	• Added CPT codes 0990T, 0991T, 0992T, 0993T, 0994T, 0995T, 0996T, 0997T, 0998T, 1002T, 1003T, 1004T, 1005T, 1006T, 1007T, 1008T, 1009T, 1010T, 1013T, 1014T, 1015T, 1016T, 1017T, 1018T, and 1025T • Removed CPT codes 0623T, 0624T, 0625T, and 0626T
Discogenic Pain Treatment	Medical Policy	• Added CPT code 63032
Electrical Stimulation for the Treatment of Pain and Muscle Rehabilitation	Medical Policy	• Added CPT code 64567 • Removed CPT code0720T
FcRn Blockers (Rystiggo®, Vyvgart®, & Vyvgart Hytrulo®)	Medical Benefit Drug Policy	• Added HCPCS code J9256 • Removed HCPCS code C9305
Genetic Testing for Hereditary Cancer	Medical Policy	• Removed CPT codes 0131U, 0132U, and 0135U
Glaucoma Surgical Treatments	Medical Policy	• Added CPT code 1012T
Hearing Aids and Devices Including Wearable, Bone-Anchored, and Semi-Implantable	Medical Policy	• Removed CPT codes 92590, 92591, 92592, 92593, 92594, and 92595
Intensity-Modulated Radiation Therapy	Medical Policy	• Replaced CPT codes: ○ 77385 with 77407 ○ 77386 with 77412 • Removed HCPCS codes G6015, G6016, and G6017
Ketalar® (Ketamine) and Spravato® (Esketamine)	Medical Benefit Drug Policy	• Added HCPCS code J0013 • Removed HCPCS code S0013

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Policy Title	Policy Type	Summary of Changes
Lower Extremity Endovascular Procedures	Medical Policy	• Added CPT codes 37254, 37255, 37256, 37257, 37258, 37259, 37260, 37261, 37263, 37264, 37265, 37266, 37267, 37268, 37269, 37270, 37271, 37272, 37273, 37274, 37275, 37276, 37277, 37278, 37280, 37281, 37282, 37283, 37284, 37285, 37286, 37287, 37288, 37289, 37290, 37291, 37292, 37293, 37294, 37295, 37296, 37297, 37298, and 37299 • Removed CPT codes 37220, 37221, 37222, 37223, 37224, 37225, 37226, 37227, 37228, 37229, 37230, 37231, 37232, 37233, 37234, and 37235
Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) Scan – Site of Service	Medical Policy	• Removed CPT code 0042T
Maximum Dosage and Frequency	Medical Benefit Drug Policy	• Added HCPCS code J1073 • Removed HCPCS code S0189
Minimally Invasive Spine Surgery Procedures	Medical Policy	• Added CPT codes 62330 and 62331 • Removed CPT code 0275T • Revised description for CPT code 62287
Molecular Oncology Testing for Solid Tumor Cancer Diagnosis, Prognosis, and Treatment Decisions	Medical Policy	• Added CPT codes 0611U, 0612U, 0613U, and 81524
Noncontact Warming Therapy, Ultrasound Therapy, and Fluorescence Imaging for Wounds	Medical Policy	• Revised description for CPT codes 0598T and 0599T
Omnibus Codes	Medical Policy	**Ablation, Irreversible Electroporation (IRE) (CPT codes 0600T, 0601T, and 47384)** • Added CPT code 47384 • Revised description for CPT code 0600T **Chronic Baroreceptor Stimulation of the Carotid Sinus (CPT codes 64654, 64655, 64656, 64657, 64658, 64659, 93145, and 93146)** • Added CPT codes 64654, 64655, 64656, 64657, 64658, 64659, 93145, and 93146 • Removed CPT codes 0266T, 0267T, 0268T, 0269T, 0270T, 0271T, 0272T, and 0273T **High Dose Rate Electronic Brachytherapy (CPT code 0395T)** • Removed CPT code 0394T **Hyperspectral Imaging (CPT code 93998)** • Replaced CPT code 0631T with 93998
Oncology Medication Clinical Coverage	Medical Benefit Drug Policy	• Added HCPCS codes J9184 and Q5160
Orthognathic (Jaw) Surgery	Medical Policy	• Revised description for CDT codes D5934 and D5935

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Policy Title	Policy Type	Summary of Changes
Outpatient Surgical Procedures – Site of Service	Medical Policy	• Removed CPT code 55700
Preventive Care Services	Medical Policy	**Preventive Care Services** ***Chlamydia Infection Screening*** *and* ***Gonorrhea Screening*** • Added CPT code 87494 ***Wellness Examinations*** • Added CPT codes 90482, 90483, and 90484 **Expanded Women's Preventive Health** ***Contraceptive Methods (Including Sterilizations): Code Group 1*** • Added HCPCS code J7299
Prostate Surgeries and Interventions	Medical Policy	• Added CPT codes 52443 and 52597 • Removed CPT codes 0421T and 0619T
Proton Beam Radiation Therapy	Medical Policy	• Removed CPT/HCPCS codes 77385, 77386, G6015, G6016, and G6017
Radiation Therapy: Fractionation, Image-Guidance, and Special Services	Medical Policy	• Replaced CPT code 77401 with 77436, 77437, 77438, and 77439 • Removed CPT codes 77014, 77835, 77836, G6001, G6002, G6003, G6004, G6005, G6006, G6007, G6008, G6009, G6010, G6011, G6012, G6013, G6014, G6015, G6016, and G6017 • Replaced description for CPT codes 77402, 77407, and 77412
Sacroiliac Joint Interventions	Medical Policy	• Revised description for CPT codes 27278 and 27279
Skin and Soft Tissue Substitutes	Medical Policy	• Deleted HCPCS code Q4100 • Revised description for HCPCS codes A2001, A2002, A2005, A2006, A2007, A2008, A2009, A2010, A2011, A2012, A2013, A2015, A2016, A2018, A2019, A2021, A2022, A2027, A2029, A2031, A2032, A2034, A4100, Q4110, Q4111, Q4115, Q4117, Q4121, Q4122, Q4123, Q4125, Q4126, Q4127, Q4130, Q4132, Q4133, Q4134, Q4135, Q4136, Q4137, Q4138, Q4140, Q4141, Q4142, Q4143, Q4146, Q4147, Q4148, Q4150, Q4151, Q4152, Q4153, Q4154, Q4156, Q4157, Q4158, Q4159, Q4160, Q4161, Q4163, Q4164, Q4165, Q4166, Q4167, Q4169, Q4170, Q4173, Q4175, Q4176, Q4178, Q4179, Q4180, Q4181, Q4182, Q4183, Q4184, Q4186, Q4187, Q4188, Q4190, Q4191, Q4193, Q4194, Q4195, Q4196, Q4197, Q4198, Q4199, Q4200, Q4201, Q4203, Q4204, Q4205, Q4208, Q4209, Q4211, Q4214, Q4216, Q4217, Q4218, Q4219, Q4220, Q4221, Q4222, Q4224, Q4225, Q4227, Q4229, Q4232, Q4234, Q4235, Q4236, Q4237, Q4238, Q4239, Q4247, Q4248, Q4249, Q4250, Q4251, Q4252, Q4253, Q4254, Q4255, Q4256, Q4257, Q4258, Q4259, Q4260, Q4261, Q4262, Q4263, Q4264, Q4265, Q4266, Q4267, Q4268, Q4269, Q4270, Q4271, Q4272, Q4273, Q4274, Q4275, Q4276, Q4278, Q4279, Q4280, Q4281, Q4282, Q4283, Q4284, Q4287, Q4288, Q4289, Q4290, Q4291, Q4292, Q4293, Q4294, Q4295, Q4296, Q4297, Q4298, Q4299, Q4300, Q4301, Q4302, Q4303, Q4304, Q4305,

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Policy Title	Policy Type	Summary of Changes
Skin and Soft Tissue Substitutes (continued)	Medical Policy	Q4306, Q4307, Q4308, Q4309, Q4311, Q4312, Q4313, Q4314, Q4315, Q4316, Q4317, Q4318, Q4319, Q4320, Q4321, Q4322, Q4323, Q4324, Q4325, Q4326, Q4327, Q4328, Q4329, Q4330, Q4331, Q4332, Q4333, Q4334, Q4335, Q4336, Q4337, Q4338, Q4339, Q4340, Q4341, Q4342, Q4343, Q4344, Q4345, Q4346, Q4347, Q4348, Q4349, Q4350, Q4351, Q4352, Q4353, Q4354, Q4355, Q4356, Q4357, Q4358, Q4359, Q4360, Q4361, Q4362, Q4363, Q4364, Q4365, Q4366, Q4367, Q4368, Q4369, Q4370, Q4371, Q4372, Q4373, Q4375, Q4376, Q4377, Q4378, Q4379, Q4380, and Q4382
Sodium Hyaluronate	Medical Benefit Drug Policy	• Revised description for HCPCS code J7322
Surgery for the Prevention and Treatment of Lymphedema	Medical Policy	• Added CPT code 1019T
Surgery of the Knee	Medical Policy	• Removed CPT code 27445
Testosterone Replacement or Supplementation Therapy	Medical Benefit Drug Policy	• Added HCPCS code J1073 • Removed HCPCS code S0189
Whole Exome and Whole Genome Sequencing (Non-Oncology Conditions)	Medical Policy	• Added CPT code 81354

Medical Policy Updates

Updated		
Policy Title	**Effective Date**	**Summary of Changes**
Elective Inpatient Services	Jan. 1, 2026	**Definitions** • Updated definition of "American Society of Anesthesiologists Physical Status Classification System Risk Scoring Tool" **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information
Hysterectomy	Jan. 1, 2026	**Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews: o Added: ▪ Relevant physical exam ▪ Physician treatment plan o Removed list of examples of reports of relevant diagnostic evaluations o Replaced: ▪ "*Complete* history *and physical exam including OB/GYN, surgical*, and comorbid medical condition(s), including thyroid disease" with "*relevant personal and family* history *of the medical condition(s) requiring treatment* and comorbid medical condition(s), including thyroid disease" ▪ "Reports of relevant diagnostic *evaluations, including: laboratory (including genetic testing results), pathology (including biopsy results), imaging includes ultrasound, MRI, CT, etc., and prior procedure/operative reports*" with "*all recent* reports of relevant *imaging studies and* diagnostic *tests*" ▪ "Diagnostic procedures history (e.g., endometrial sampling, PAP, laboratory studies, hysteroscopy, or D&C)" with "*all recent relevant surgical and* diagnostic procedures history (e.g. endometrial sampling, PAP, laboratory studies, hysteroscopy, or D&C)" ▪ "*Reports of all* treatments *attempted*, *declined*, contraindicated, or failed, including dates and *clinical response*" 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
Percutaneous Patent Foramen Ovale (PFO) Closure	Jan. 1, 2026	**Medical Records Documentation Used for Reviews** • Updated list of Medical Records Documentation Used for Reviews: o Added "condition requiring procedure" o Replaced: ▪ "History and comorbid medical condition(s)" with "history of the medical condition(s) *requiring treatment* and comorbidities" ▪ "*Member's* symptoms" with "*signs and* symptoms *including onset, duration, and frequency*" ▪ "*Complete* report(s) of diagnostic imaging *(MRI, CT scan, X-rays)*" with "*relevant recent* diagnostic imaging report(s)"

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Policy Title	Effective Date	Summary of Changes
Percutaneous Patent Foramen Ovale (PFO) Closure (continued)	Jan. 1, 2026	▪ "Results of diagnostic testing performed to rule out other causes including, but not limited to, carotid disease, hypercoagulable states, or atrial fibrillation" with "results of *recent* diagnostic testing performed to rule out other causes including, but not limited to, carotid disease, hypercoagulable states, or atrial fibrillation" **Supporting Information** • Updated *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Breast Imaging for Screening and Diagnosing Cancer	Feb. 1, 2026	**Coverage Rationale** • Revised coverage criteria for magnetic resonance imaging of the breast for individuals who are high risk for breast cancer: ○ Added criterion requiring "heterogeneously dense breasts (Category C) or extremely dense breasts (Category D) (screening beginning at age 40)" ○ Added language to the following criterion to indicate "screening begins at age 40": ▪ Lifetime risk estimated at greater than or equal to 20% as defined by models that are largely dependent on family history (e.g., Gail, Claus, Tyrer-Cuzick, or BRCAPRO) ▪ Family history with at least one first-degree relative who has a *BRCA1* or *BRCA2* mutation	**The following are proven and medically necessary:** • Magnetic resonance imaging (MRI) of the breast for individuals who are high risk for breast cancer as defined as having any of the following: ○ Heterogeneously dense breasts (Category C) or extremely dense breasts (Category D) (screening beginning at age 40) ○ Prior thoracic radiation therapy between the ages 10 and 30 (screening starting at age 25 or 8 years after treatment, whichever is later) ○ Lifetime risk estimated at greater than or equal to 20% as defined by models that are largely dependent on family history (e.g., Gail, Claus, Tyrer-Cuzick, or BRCAPRO) (screening beginning at age 40*) ○ Personal history of breast cancer (not treated with bilateral mastectomy) ○ Personal history with any of the following: ▪ *ATM* (screening beginning at age 30*) ▪ *BARD1* (screening beginning at age 40*) ▪ *BRCA1* or *BRCA2* (screening beginning at age 25) ▪ *CDH1* (screening beginning at age 30*) ▪ *CHEK2* (screening beginning at age 30*) ▪ *NF1* (screening beginning at age 30*) ▪ *PALB2* (screening beginning at age 30*) ▪ *PTEN* gene mutation (Cowden syndrome) (screening beginning at age 30*) ▪ *RAD51C* (screening beginning at age 40*) ▪ *RAD51D* (screening beginning at age 40*) ▪ *STK11* gene mutation (Peutz-Jehgers syndrome) (screening beginning at age 30*)

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Breast Imaging for Screening and Diagnosing Cancer (continued)	Feb. 1, 2026	▪ Family history with at least two first-degree relatives with breast or ovarian cancer ▪ Family history with one first-degree relative with bilateral breast cancer, or both breast and ovarian cancer ▪ Family history with first- or second-degree male relative (father, brother/ half-brother, uncle, grandfather) diagnosed with breast cancer • Updated language pertaining to the notated criteria to indicate screening can begin at the listed age or starting 10 years prior to the age of diagnosis of the earliest relative who has been diagnosed with breast cancer (up to third-degree relatives) whichever comes first, but not before age 25 • Revised list of unproven and not medically necessary services; replaced "MRI of the breast for individuals *with dense breast tissue not accompanied by defined risk factors as described [in the policy]*" with "MRI of the breast for individuals *who do not meet the criteria [listed in the policy]*"	▪ *TP53* gene mutation (Li-Fraumeni syndrome) (screening beginning at age 20) ○ Family history with any of the following: ▪ At least one first-degree relative who has a *BRCA1* or *BRCA2* mutation (screening beginning at age 40*) ▪ First-degree relative who carries a genetic mutation in the *TP53* or *PTEN* genes (Li-Fraumeni syndrome, Cowden syndrome, Bannayan-Riley-Ruvalcaba syndrome, or Peutz-Jehgers syndrome) ▪ At least two first-degree relatives with breast or ovarian cancer (screening beginning at age 40*) ▪ One first-degree relative with bilateral breast cancer, or both breast and ovarian cancer (screening beginning at age 40*) ▪ First- or second-degree male relative (father, brother/half-brother, uncle, grandfather) diagnosed with breast cancer (screening beginning at age 40*) *Screening can begin at the listed age or starting 10 years prior to the age of diagnosis of the youngest relative who has been diagnosed with breast cancer (up to third-degree relatives) whichever comes first, but not before age 25. **The following are unproven and not medically necessary due to insufficient evidence of efficacy:** • Computer-Aided Tactile Breast Imaging • Computed tomography (CT) of the breast • Magnetic Resonance Elastography (MRE) • MRI of the breast for individuals who do not meet the criteria above • Molecular Breast Imaging (e.g., Breast Specific Gamma Imaging, scintimammography, Positron Emission Mammography) **Note**: For 3D rendering of breast ultrasound, 3D rendering of breast MRI, CT of the breast, or additional indications for MRI of the breast, refer to the Breast Imaging Guidelines section of the *Cardiovascular and Radiology Imaging Guidelines*.

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Breast Imaging for Screening and Diagnosing Cancer (continued)	Feb. 1, 2026	**Definitions** • Added definition of "Breast Composition Categories" • Updated definition of "Positron Emission Mammography (PEM)" **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	
Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/ Replacements	Feb. 1, 2026	**Coverage Rationale** • Added language to indicate this policy does not apply to Durable Medical Equipment or supplies used in an outpatient or inpatient facility ***Home Mechanical Ventilators and Respiratory Assist Devices (Applies for 2 Years of Age or Older)*** • Added language to indicate home mechanical ventilators are not medically necessary for individuals with stable COPD with an arterial $PaCO_2$ of less than 52 mm Hg while awake on room air • Replaced language indicating: ○ "*For members 2 years of age and older,* ventilators are not medically necessary when *used only to deliver continuous or intermittent positive airway pressure for adults and children; any type of ventilator would not be medically necessary when* [the listed criteria are met]" with "*home*	This Medical Policy does not apply to Durable Medical Equipment or supplies used in an outpatient or inpatient facility. **Durable Medical Equipment (DME)**: Medical equipment that is all of the following: • Ordered or provided by a physician for outpatient use, primarily in a home setting • Used for medical purposes • Not consumable or disposable except as needed for the effective use of covered DME • Not of use to a person in the absences of a disease or disability • Serves a medical purpose for the treatment of a sickness or injury • Primarily used within the home **Home Mechanical Ventilators and Respiratory Assist Devices (Applies for 2 Years of Age or Older)** **Home mechanical ventilators are not medically necessary when:** • Used only in a bilevel positive airway pressure (PAP) mode (HCPCS codes E0470 and E0471); or • Used for conditions that qualify for use of a respiratory assistance device that are not life-threatening conditions for which interruption of respiratory support would quickly lead to serious harm or death; or • Used only to deliver continuous or intermittent PAP (HCPCS codes E0465 and E0466) **Home mechanical ventilators (HCPCS codes E0465 and E0466) are considered medically necessary to treat neuromuscular diseases,**

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/ Replacements (continued)	Feb. 1, 2026	*mechanical* ventilators are not medically necessary when [the listed criteria are met]" ○ "A bilevel PAP *device*, with or without backup rate, is considered unproven and not medically necessary due to insufficient *high-quality* evidence of safety and efficacy for individuals with central sleep apnea (CSA) and obstructive sleep apnea (OSA) when adherent use of BiPAP is for less than 4 hours during sleep time on at least 21 to 30 consecutive 24-hour periods" with "BiPAP, with or without backup rate, is considered unproven and not medically necessary due to insufficient evidence of safety and efficacy for individuals with central sleep apnea and obstructive sleep apnea when adherent use of bilevel PAP is for less than 4 hours during sleep time on at least 21 to 30 consecutive 24-hour periods" ○ "Bilevel PAP is *considered* unproven and not medically necessary due to insufficient *high-quality* evidence of safety and efficacy for *patients* with chronic obstructive pulmonary disease (COPD) *when an* arterial $PaCO_2$ *is* less than 52	**thoracic restrictive diseases, and chronic respiratory failure consequent to chronic obstructive pulmonary disease (COPD) in certain clinical scenarios.** For medical necessity clinical coverage criteria, refer to the InterQual® Client Defined, CP: Durable Medical Equipment Home Mechanical Ventilation Devices: Invasive, Noninvasive, and Multifunction (Custom) – UHG. Click here to view the InterQual® criteria. **Home mechanical ventilators are not medically necessary for individuals with stable COPD, with an arterial $PaCO_2$ of less than 52 mm Hg while awake on room air.** **Bilevel PAP devices (HCPCS codes E0470 and E0471) are considered medically necessary in certain clinical scenarios.** For medical necessity clinical coverage criteria, refer to the InterQual® CP: Durable Medical Equipment, Noninvasive Airway Assistive Devices. Click here to view the InterQual® criteria. **Due to insufficient evidence of safety and efficacy, bilevel PAP, with or without backup rate, is considered unproven and not medically necessary for individuals with central sleep apnea and obstructive sleep apnea when adherent use of bilevel PAP is for less than 4 hours during sleep time on at least 21 to 30 consecutive 24-hour periods.** **Due to insufficient evidence of safety and efficacy, bilevel PAP is unproven and not medically necessary for individuals with COPD, with an arterial $PaCO_2$ of less than 52 mm Hg while awake on room air (even when the asleep $PaCO_2$ is at 55 mm Hg or more for at least 10 minutes or asleep $PaCO_2$ increase of > 10 mm Hg from baseline awake and > 50 mm Hg for at least 10 minutes during sleep time).** **Medical Necessity Plans** In the absence of a related policy or coverage indication, UnitedHealthcare uses the following guidelines for medical necessity, applied in the following order:

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Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/ Replacements (continued)	Feb. 1, 2026	mm Hg while awake, even when the asleep $PaCO_2$ is at 55 mmHg or more for at least 10 minutes, or asleep $PaCO_2$ increase of > 10 mmHg from baseline awake and > 50 mmHg for at least 10 minutes during sleep time" with "bilevel PAP is unproven and not medically necessary due to insufficient evidence of safety and efficacy for *individuals* with chronic obstructive pulmonary disease (COPD), *with an* arterial $PaCO_2$ *of* less than 52 mm Hg while awake *on room air* (even when the asleep $PaCO_2$ is at 55 mm Hg or more for at least 10 minutes or asleep $PaCO_2$ increase of > 10 mm Hg from baseline awake and > 50 mm Hg for at least 10 minutes during sleep time)" • Revised list of uses for home mechanical ventilators that are not medically necessary; replaced "ventilators, *such as Trilogy mechanical ventilators* (HCPCS codes E0465 and E0466), used *for the treatment of conditions that* deliver continuous or intermittent positive airway pressure" with "[ventilators] used *only* to deliver continuous or intermittent positive airway pressure (HCPCS codes E0465 and E0466)"	• InterQual® CP: Durable Medical Equipment • InterQual® Medicare: Post Acute & Durable Medical Equipment • Centers for Medicare & Medicaid Services (CMS) DME Medicare Administrative Contractor (MAC) **DME, related supplies, and orthotics are medically necessary when:** • Ordered by a physician; and • The item(s) meets the plan's medically necessary definition (refer to the member specific benefit plan document); and • Criteria are met (see above); and The item is not otherwise excluded from coverage

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/ Replacements (continued)	Feb. 1, 2026	• Revised language pertaining to medical necessity clinical coverage criteria for home mechanical ventilators (HCPCS codes E0465 and E0466): ○ Added reference to the InterQual® Client Defined, CP: Durable Medical Equipment Home Mechanical Ventilation Devices: Invasive, Noninvasive, and Multifunction (Custom) - UHG ○ Removed reference to the InterQual® Medicare: Post Acute & Durable Medical Equipment, Ventilators NCD ***Medical Necessity Plans*** • Revised list of guidelines UnitedHealthcare uses to determine medical necessity in the absence of a related policy or coverage indication [listed in the policy]: ○ Added InterQual® Medicare: Post Acute & Durable Medical Equipment ○ Removed InterQual® Medicare: Post Acute & Durable Medical Equipment, Ventilators NCD **Medical Records Documentation Used for Reviews** • Added language to indicate: ○ Benefit coverage for health services is determined by the member specific benefit plan document and applicable	

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Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/ Replacements (continued)	Feb. 1, 2026	laws that may require coverage for a specific service ○ Medical records documentation may be required to assess whether the member meets the clinical criteria for coverage but does not guarantee coverage of the service requested; refer to the guidelines titled Medical Records Documentation Used for Reviews **Definitions** • Updated definition of "Women's Health and Cancer Rights Act (WHCRA) of 1998, § 713 (a)" **Benefit Considerations** ***Dedicated Speech Generating Devices and Tracheo-Esophageal Voice Devices*** • Replaced language indicating "tracheo-esophageal *prosthetics and* voice aid *prosthetics are* covered as Durable Medical Equipment (DME)" with "*dedicated speech generating devices and* tracheo-esophageal voice *devices required for treatment of severe speech impairment or lack of speech directly due to sickness or injury may be* covered as DME" ***Walkers*** • Added language to indicate walkers are proven and medically	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Durable Medical Equipment, Orthotics, Medical Supplies, and Repairs/ Replacements (continued)	Feb. 1, 2026	necessary in certain circumstances ***Coverage Limitations and Exclusions*** • Updated list of coverage exclusions; added instruction to refer to the *Dedicated Speech Generating Devices and Tracheo-Esophageal Voice Devices* section of the policy for information on devices and computers to assist in communication and speech **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	
Preventive Care Services	Jan. 1, 2026	**Notice of Revision**: The following summary of changes has been modified. Revisions to the previous policy update announcement are outlined in red below. Please take note of the additional updates to be applied on **Jan. 1, 2026**. **Template Update** • Created shared policy version to support application to Oxford plan membership **Frequently Asked Questions (FAQ)** • Added Q&A #6 pertaining to listing required diagnosis codes on claims **Applicable Codes** ***Preventive Care Services*** Chlamydia Infection Screening ***and*** Gonorrhea Screening • Updated list of applicable CPT codes to reflect annual edits; added 87494 Syphilis Screening: Asymptomatic Pregnant Women • Revised service description: ○ Removed Sep. 2018 USPSTF “A” rating ○ Added May 2025 USPSTF “A” rating to indicate the USPSTF recommends early, universal screening for syphilis infection during pregnancy; if an individual is not screened early in pregnancy, the USPSTF recommends screening at the first available opportunity Wellness Examinations • Revised list of services with HRSA requirements for wellness examinations:	

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Policy Title	Effective Date	Summary of Changes / Coverage Rationale
Preventive Care Services (continued)	Jan. 1, 2026	○ Added "patient navigation services for breast and cervical cancer screening" ○ Replaced "screening and counseling for *interpersonal* domestic violence" with "screening and counseling for *intimate partner and* domestic violence" • Updated list of applicable CPT codes to reflect annual edits; added 90482, 90483, and 90484 Breastfeeding: Primary Care Behavioral Counseling Interventions • Revised service description: ○ Removed Oct. 2016 USPSTF "B" rating ○ Added Apr. 2025 USPSTF "B" rating to indicate the USPSTF recommends providing interventions or referrals during pregnancy and after birth to support breastfeeding Screening for Intimate Partner Violence • Revised service description: ○ Removed Oct. 2018 USPSTF "B" rating ○ Added Jun. 2025 USPSTF "B" rating to indicate the USPSTF recommends that clinicians screen for intimate partner violence (IPV) in women of reproductive age, including those who are pregnant and postpartum ***Expanded Women's Preventive Health*** Contraceptive Methods (Including Sterilizations): Code Group 1 • Updated list of applicable HCPCS codes to reflect annual edits; added J7299 Contraceptive Methods (Including Sterilizations): Code Group 6 • Updated list of applicable CPT codes; revised description for 58562 • Removed list of applicable ICD-10 diagnosis codes: Z30.432 and Z30.433 • Revised preventive benefit instructions to indicate the listed CPT code does not have diagnosis code requirements for preventive benefits to apply Screening and Counseling for Intimate Partner and Domestic Violence • Revised service description: ○ Removed Dec. 2016 HRSA requirement ○ Added Dec. 2024 HRSA requirement to indicate: ▪ The Women's Preventive Services Initiative recommends screening adolescent and adult women for intimate partner and domestic violence, at least annually, and, when needed, providing or referring to intervention services ▪ Intimate partner and domestic violence includes physical violence, sexual violence, stalking and psychological aggression (including coercion), reproductive coercion, neglect, and the threat of violence, abuse, or both ▪ Intervention services include, but are not limited to, counseling, education, harm reduction strategies, and appropriate supportive services

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Preventive Care Services (continued)	Jan. 1, 2026	Breast Cancer Screening for Women at Average Risk • Revised service description: ○ Removed Dec. 2016 HRSA requirement ○ Added Dec. 2024 HRSA requirement to indicate: ▪ The Women's Preventive Services Initiative recommends that women at average risk of breast cancer initiate mammography screening no earlier than age 40 years and no later than age 50 years; screening mammography should occur at least biennially and as frequently as annually ▪ Women may require additional imaging to complete the screening process or to address findings on the initial screening mammography; if additional imaging [e.g., magnetic resonance imaging (MRI), ultrasound, mammography] and pathology evaluation are indicated, these services also are recommended to complete the screening process for malignancies ▪ Screening should continue through at least age 74 years, and age alone should not be the basis for discontinuing screening ▪ Women at increased risk also should undergo periodic mammography screening; however, recommendations for additional services are beyond the scope of this recommendation • Added lists of applicable codes and preventive benefit instructions for: *Mammography Screening* ○ Added CPT codes 77063 and 77067 ○ Added revenue code 0403 ○ Added language to indicate: ▪ The listed CPT codes do not have diagnosis code requirements for the preventive benefit to apply ▪ There is no age limit for mammography screening *Mammography Diagnostic – To Complete the Screening Process* ○ Added CPT/HCPCS codes 77061, 77062, 77065, 77066, and G0279 ○ Added revenue code 0401 ○ Added language to indicate: ▪ The listed CPT/HCPCS codes require one of the listed *Average Risk Diagnosis Codes* ▪ There is no age limit for mammography diagnostics to complete the screening process *Breast Ultrasound – To Complete the Screening Process* ○ Added CPT codes 0857T, 76641, and 76642 ○ Added language to indicate: ▪ The listed CPT codes require one of the listed *Average Risk Diagnosis Codes* ▪ There is no age limit for breast ultrasound to complete the screening process *Breast MPI – To Complete the Screening Process* ○ Added CPT/HCPCS codes 77046, 77047, 77048, 77049, A9575, A9576, A9577, A9578, A9579, A9581, and A9585	

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Policy Title	Effective Date	Summary of Changes / Coverage Rationale
Preventive Care Services (continued)	Jan. 1, 2026	○ Added language to indicate: ▪ The listed CPT/HCPCS codes require one of the listed *Average Risk Diagnosis Codes* ▪ There is no age limit for breast MRI to complete the screening process *Pathology Evaluation – To Complete the Screening Process* ○ Added CPT/HCPCS codes 19081, 19082, 19083, 19084, 19085, 19086, 19100, 19101, 19281, 19282, 19283, 19284, 19285, 19286, 19287, 19288, 76942, 77002, 88172, 88173, 88177, 88305, 96374, 99152, 99153, 99156, 99157, and Q9967 ○ Added language to indicate: ▪ The listed CPT/HCPCS codes require one of the listed *Average Risk Diagnosis Codes* ▪ There is no age limit for breast pathology evaluation to complete the screening process *Average Risk Diagnosis Codes* ○ Added ICD-10 diagnosis codes for: ▪ **Cysts**: N60.01, N60.02, N60.09, N60.11, N60.12, N60.19, N60.41, N60.42, and N60.49 ▪ **Hypertrophy**: N62 ▪ **Mammographic calcification or inconclusive findings**: R92.0, R92.1, R92.2, and R92.8 ▪ **Dense breast(s)**: R92.30, R92.311, R92.312, R92.313, R92.321, R92.322, R92.323, R92.331, R92.332, R92.333, R92.341, R92.342, and R92.343 ▪ **Screening**: Z12.31, Z12.39, Z13.71, and Z13.79 ▪ **Personal history, genetic susceptibility, or family history**: Z14.8, Z15.01, Z15.02, Z15.09, Z15.89, Z71.83, Z80.3, Z85.3, and Z86.000 ▪ **Prophylactic or acquired absence of breast/nipple**: Z40.01, Z90.10, Z90.11, Z90.12, and Z90.13 ○ Added language to indicate one of these average risk diagnosis codes are required for: ▪ Mammography diagnostic to complete the screening process ▪ Breast ultrasound to complete the screening process ▪ Breast MRI to complete the screening process ▪ Pathology evaluation to complete the screening process Patient Navigation Services for Breast and Cervical Cancer Screening ● Added Dec. 2024 HRSA requirement to indicate: ○ The Women's Preventive Services Initiative recommends patient navigation services for breast and cervical cancer screening and follow-up, as relevant, to increase utilization of screening recommendations based on an assessment of the patient's needs for navigation services ○ Patient navigation services involve person-to-person (e.g., in-person, virtual, hybrid models) contact with the patient; components of patient navigation services should be individualized ○ Services include, but are not limited to, person-centered assessment and planning, health care access and health system navigation, referrals to appropriate support services (e.g., language translation, transportation, and social services), and patient education

Medical Policy Updates

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Preventive Care Services (continued)	Jan. 1, 2026	• Added instruction to refer to the *Wellness Examinations* section of the policy for applicable codes and preventive benefit instructions	
Skin and Soft Tissue Substitutes	Feb. 1, 2026	**Coverage Rationale** ***EPIFIX and GRAFIX Application Limitations*** • Removed language indicating EPIFIX and GRAFIX are limited to one application per week for up to 12 weeks • Removed list of examples of unproven and not medically necessary indications for EPIFIX and GRAFIX ***Other Skin and Soft Tissue Substitutes*** • Revised list of skin and soft tissue substitutes that are unproven and not medically necessary for any indication: ○ Added: ▪ Acelgraft ▪ Acesso TrifACA ▪ AmnioPlast Double ▪ Apollo FT ▪ Ascendion™ ▪ Axolotl DualGraft Ultra™ or Axolotl Graft Ultra™ ▪ Cohealyx Collagen Dermal Matrix ▪ G4Derm™ Plus ▪ GRAFIX® Duo ▪ InnovaMatrix® FD ▪ MariGen® Pacto ▪ Natalin ▪ NeoThelium FT,	**EPIFIX® or GRAFIX® (GRAFIX PL, GRAFIX PRIME, and GRAFIX PL PRIME) (Noninjectable)** **EPIFIX or GRAFIX is proven and medically necessary for treating a diabetic foot ulcer when all 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 between 0.7 and 1.2 • Glycated hemoglobin test < 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** 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 **Due to insufficient evidence of efficacy, EPIFIX and/or GRAFIX are unproven and not medically necessary for all other indications.** **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.**

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Skin and Soft Tissue Substitutes (continued)	Feb. 1, 2026	NeoThelium 4L, and NeoThelium 4L Plus ▪ Summit AAA ▪ SurGraft AC or SurGraft ACA ○ Replaced: ▪ "Dual Layer Impax" with "Dual Layer Impax *Membrane*™" ▪ "Vendaje *A*" with "Vendaje *AC*®" **Applicable Codes** • Added HCPCS codes A2036, A2037, A2038, A2039, Q4383, Q4384, Q4385, Q4386, Q4387, Q4388, Q4389, Q4390, Q4391, Q4392, Q4393, Q4394, Q4395, Q4396, and Q4397 **Supporting Information** ○ Updated *Description of Services*, *Clinical Evidence*, and *References* sections to reflect the most current information	**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 policy for complete details.

Replaced

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

New

Policy Title	Effective Date	Coverage Rationale
Gazyva® (Obinutuzumab)	Jan. 1, 2026	This policy refers to Gazyva (obinutuzumab) for intravenous infusion for non-oncology indications. Refer to the Medical Benefit Drug Policy titled Oncology Medication Clinical Coverage for updated information based upon the National Comprehensive Cancer Network (NCCN) Drugs & Biologics Compendium® (NCCN Compendium®) for oncology indications. **Active Lupus Nephritis** **Gazyva (obinutuzumab) is proven for the treatment of active lupus nephritis when all of the following criteria are met:** • For **initial therapy**, **all** of the following: ○ Diagnosis of active lupus nephritis; **and** ○ Currently receiving at least **one** standard of care treatment for active systemic lupus erythematosus (e.g., antimalarials, corticosteroids, or immunosuppressants) that is not a biologic; **and** ○ Patient is not receiving Gazyva in combination with Benlysta (belimumab) or Lupkynis (voclosporin); **and** ○ Gazyva is dosed according to US Food and Drug Administration labeled dosing; **and** ○ Initial authorization is for no more than 12 months • For **continuation of therapy**, **all** of the following: ○ Patient has previously received Gazyva injection for intravenous infusion; **and** ○ Documentation of positive clinical response; **and** ○ Currently receiving at least **one** standard of care treatment for active systemic lupus erythematosus (e.g., antimalarials, corticosteroids, or immunosuppressants) that is not a biologic; **and** ○ Patient is not receiving Gazyva in combination with Benlysta (belimumab) or Lupkynis (voclosporin); **and** ○ Gazyva is dosed according to US Food and Drug Administration labeled dosing; **and** ○ Authorization is for no more than 12 months **Gazyva (obinutuzumab) is medically necessary for the treatment of active lupus nephritis when all of the following criteria are met:** • For **initial therapy**, **all** of the following: ○ Diagnosis of active lupus nephritis; **and** ○ Provider attestation that diagnosis is biopsy proven or biopsy is contraindicated in the patient; **and** ○ Currently receiving at least **one** standard of care treatment for active systemic lupus erythematosus (e.g., antimalarials, corticosteroids, or immunosuppressants) that is not a biologic; **and** ○ Patient is not receiving Gazyva in combination with Benlysta (belimumab) or Lupkynis (voclosporin); **and** ○ Gazyva is dosed according to US Food and Drug Administration labeled dosing; **and** ○ Prescribed by or in consultation with a rheumatologist or nephrologist; **and** ○ Initial authorization is for no more than 12 months • For **continuation of therapy**, **all** of the following: ○ Patient has previously received Gazyva injection for intravenous infusion; **and**

Medical Benefit Drug Policy Updates

New

Policy Title	Effective Date	Coverage Rationale
Gazyva® (Obinutuzumab) (continued)	Jan. 1, 2026	○ Documentation of positive clinical response; **and** ○ Currently receiving at least **one** standard of care treatment for active systemic lupus erythematosus (e.g., antimalarials, corticosteroids, or immunosuppressants) that is not a biologic; **and** ○ Patient is not receiving Gazyva in combination with Benlysta (belimumab) or Lupkynis (voclosporin); **and** ○ Gazyva is dosed according to US Food and Drug Administration labeled dosing; **and** ○ Prescribed by or in consultation with a rheumatologist or nephrologist; **and** ○ Authorization is for no more than 12 months

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Cimzia® (Certolizumab Pegol)	Feb. 1, 2026	**Coverage Rationale** • Replaced references to "targeted immunomodulator" with "*systemic* targeted immunomodulator" • Revised coverage criteria: ○ Added medical necessity criterion requiring prescriber attestation that the patient or caregiver is not able to be trained or are physically unable to administer Cimzia U.S. FDA labeled for self-administration (the prescriber must submit the explanation) ***Crohn's Disease (CD)*** ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with Cimzia for treatment of the same indication: ▪ Added: – Entyvio (vedolizumab) – Omvoh (mirikizumab-mrkz)	This policy refers to Cimzia (certolizumab pegol) injection. Cimzia (certolizumab pegol) for self-administered subcutaneous injection is obtained under the pharmacy benefit, unless otherwise specified in the member's benefit plan documents. Exception: For members enrolled in UnitedHealthcare of California plans with a delegated provider group conducting the prior authorization review, the self-administered Cimzia may be obtained under the medical benefit. Refer to the policy for complete details.

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Cimzia® (Certolizumab Pegol) (continued)	Feb. 1, 2026	– Tremfya (guselkumab) ▪ Removed: – Enbrel (etanercept) – Olumiant (baricitinib) – Orencia (abatacept) – Simponi (golimumab) – Xeljanz (tofacitinib) ▪ Replaced "*Stelara* (ustekinumab)" with "ustekinumab" ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of Crohn's disease with which the patient has been previously treated for initial therapy: ▪ Added: – Entyvio (vedolizumab) – Omvoh (mirikizumab-mrkz) – Tremfya (guselkumab) ▪ Replaced "*Stelara* (ustekinumab)" with "ustekinumab" ***Rheumatoid Arthritis (RA)*** ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with Cimzia for treatment of the same indication; replaced "Xeljanz	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Cimzia® (Certolizumab Pegol) (continued)	Feb. 1, 2026	(tofacitinib)" with "Xeljanz/ *Xeljanz XR* (tofacitinib)" ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of rheumatoid arthritis with which the patient has been previously treated for initial therapy; replaced "Xeljanz (tofacitinib)" with "Xeljanz/ *Xeljanz XR* (tofacitinib)" ***Psoriatic Arthritis (PsA)*** ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with Cimzia for treatment of the same indication: ▪ Added Bimzelx (bimekizumab-bkzx) ▪ Removed Olumiant (baricitinib) ▪ Replaced: – "*Stelara* (ustekinumab)" with "ustekinumab" – "Xeljanz (tofacitinib)" with "Xeljanz/*Xeljanz XR* (tofacitinib)" ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of psoriatic arthritis with which the patient has been	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Cimzia® (Certolizumab Pegol) (continued)	Feb. 1, 2026	previously treated for initial therapy: ▪ Added Bimzelx (bimekizumab-bkzx) ▪ Removed Olumiant (baricitinib) ▪ Replaced: – "*Stelara* (ustekinumab)" with "ustekinumab" – "Xeljanz (tofacitinib)" with "Xeljanz/*Xeljanz XR* (tofacitinib)" ***Ankylosing Spondylitis (AS) and Non-Radiographic Axial Spondyloarthritis (nr-axSpA)*** ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with Cimzia for treatment of the same indication; added: ▪ Bimzelx (bimekizumab-bkzx) ▪ Cosentyx (secukinumab) ▪ Taltz (ixekizumab) ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of ankylosing spondylitis or nr-axSpA with which the patient has been previously treated for initial therapy: ▪ Added:	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Cimzia® (Certolizumab Pegol) (continued)	Feb. 1, 2026	– Bimzelx (bimekizumab-bkzx) – Cosentyx (secukinumab) – Enbrel (etanercept) – Olumiant (baricitinib) – Orencia (abatacept) – Taltz (ixekizumab) ▪ Replaced "Xeljanz (tofacitinib)" with "Xeljanz/ *Xeljanz XR* (tofacitinib)" ***Plaque Psoriasis (PS)*** ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with Cimzia for treatment of the same indication: ▪ Added: – Bimzelx (bimekizumab-bkzx) – Sotyktu (deucravacitinib) ▪ Removed: – Olumiant (baricitinib) – Orencia (abatacept) – Rinvoq (upadacitinib) – Simponi (golimumab) – Xeljanz (tofacitinib) ▪ Replaced "*Stelara* (ustekinumab)" with "ustekinumab" ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Cimzia® (Certolizumab Pegol) (continued)	Feb. 1, 2026	plaque psoriasis with which the patient has been previously treated for initial therapy: ▪ Added: – Bimzelx (bimekizumab-bkzx) – Cosentyx (secukinumab) – Enbrel (etanercept) – Ilumya (tildrakizumab) – Siliq (brodalumab) – Sotyktu (deucravacitinib) – Taltz (ixekizumab) ▪ Replaced "*Stelara* (ustekinumab)" with "ustekinumab" ***Polyarticular Juvenile Idiopathic Arthritis*** ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with Cimzia for treatment of the same indication; replaced "Xeljanz (tofacitinib)" with "Xeljanz/ *Xeljanz XR* (tofacitinib)" **Applicable Codes** • Removed CPT codes 96372 and 96401 **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information	

Medical Benefit Drug Policy Updates

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale

Infliximab (Avsola®, Inflectra®, Remicade®, & Renflexis®)	Feb. 1, 2026	**Coverage Rationale**
		• Removed coverage criteria for proven treatment of the following conditions:
		  ○ Ankylosing spondylitis
		  ○ Crohn's disease
		  ○ Plaque psoriasis
		  ○ Psoriatic arthritis
		  ○ Rheumatoid arthritis
		  ○ Ulcerative colitis
		• Revised medical necessity criteria:
		  ○ Replaced references to "targeted immunomodulator" with "systemic targeted immunomodulator"
		Ankylosing Spondylitis
		  ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with infliximab for treatment of the same indication; added:
		  ▪ Bimzelx (bimekizumab-bkzx)
		  ▪ Cosentyx (secukinumab)
		  ▪ Taltz (ixekizumab)
		  ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of ankylosing spondylitis with which the patient has been previously treated for initial therapy; added:
			This policy refers to the following infliximab products for intravenous use:
			• Avsola® (infliximab-axxq)
			• Inflectra® (infliximab-dyyb)
			• Remicade® (infliximab)
			• Renflexis® (infliximab-abda)
			• Any FDA-approved infliximab biosimilar product not listed here
			
			Refer to the policy for complete details.

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Infliximab (Avsola®, Inflectra®, Remicade®, & Renflexis®) (continued)	Feb. 1, 2026	▪ Bimzelx (bimekizumab-bkzx) ▪ Cosentyx (secukinumab) ▪ Olumiant (baricitinib) ▪ Orencia (abatacept) ▪ Taltz (ixekizumab) ***Crohn's Disease*** ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with infliximab for treatment of the same indication: ▪ Added: – Entyvio (vedolizumab) – Omvoh (mirikizumab-mrkz) – Tremfya (guselkumab) ▪ Removed: – Enbrel (etanercept) – Olumiant (baricitinib) – Orencia (abatacept) – Simponi (golimumab) – Xeljanz (tofacitinib) ▪ Replaced "*Stelara* (ustekinumab)" with "ustekinumab" ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of Crohn's disease with which the patient has been	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Infliximab (Avsola®, Inflectra®, Remicade®, & Renflexis®) (continued)	Feb. 1, 2026	previously treated for initial therapy: ▪ Added: – Entyvio (vedolizumab) – Omvoh (mirikizumab-mrkz) – Tremfya (guselkumab) ▪ Replaced "*Stelara* (ustekinumab)" with "ustekinumab" ***Noninfectious Uveitis*** ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with infliximab for treatment of the same indication; removed: ▪ Enbrel (etanercept) ▪ Cimzia (certolizumab) ▪ Olumiant (baricitinib) ▪ Orencia (abatacept) ▪ Rinvoq (upadacitinib) ▪ Simponi (golimumab) ▪ Xeljanz (tofacitinib) ***Plaque Psoriasis*** ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with infliximab for treatment of the same indication: ▪ Added:	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Infliximab (Avsola®, Inflectra®, Remicade®, & Renflexis®) (continued)	Feb. 1, 2026	– Bimzelx (bimekizumab-bkzx) – Sotyktu (deucravacitinib) ▪ Removed: – Olumiant (baricitinib) – Orencia (abatacept) – Rinvoq (upadacitinib) – Simponi (golimumab) – Xeljanz (tofacitinib) ▪ Replaced "*Stelara* (ustekinumab)" with "ustekinumab" ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of plaque psoriasis with which the patient has been previously treated for initial therapy: ▪ Added: – Bimzelx (bimekizumab-bkzx) – Sotyktu (deucravacitinib) ▪ Removed Orencia (abatacept) ▪ Replaced "*Stelara* (ustekinumab)" with "ustekinumab" ***Psoriatic Arthritis*** ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with infliximab	

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Infliximab (Avsola®, Inflectra®, Remicade®, & Renflexis®) (continued)	Feb. 1, 2026	for treatment of the same indication: ▪ Added Bimzelx (bimekizumab-bkzx) ▪ Removed Olumiant (baricitinib) ▪ Replaced: – "*Stelara* (ustekinumab)" with "ustekinumab" – "Xeljanz (tofacitinib)" with "Xeljanz/*Xeljanz XR* (tofacitinib)" ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of psoriatic arthritis with which the patient has been previously treated for initial therapy: ▪ Added Bimzelx (bimekizumab-bkzx) ▪ Removed Olumiant (baricitinib) ▪ Replaced: – "*Stelara* (ustekinumab)" with "ustekinumab" – "Xeljanz (tofacitinib)" with "Xeljanz/*Xeljanz XR* (tofacitinib)" ***Rheumatoid Arthritis*** ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving	

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Infliximab (Avsola®, Inflectra®, Remicade®, & Renflexis®) (continued)	Feb. 1, 2026	in combination with infliximab for treatment of the same indication; replaced "Xeljanz (tofacitinib)" with "Xeljanz/ *Xeljanz XR* (tofacitinib)" ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of rheumatoid arthritis with which the patient has been previously treated for initial therapy; replaced "Xeljanz (tofacitinib)" with "Xeljanz/ *Xeljanz XR* (tofacitinib)" ***Sarcoidosis*** ○ Removed list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with infliximab for treatment of the same indication ***Ulcerative Colitis*** ○ Updated list of examples of systemic targeted immunomodulators the patient must not be receiving in combination with infliximab for treatment of the same indication: ▪ Added: – Entyvio (vedolizumab) – Omvoh (mirikizumab-mrkz) – Tremfya (guselkumab) – Zeposia (ozanimod)	

Medical Benefit Drug Policy Updates

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Infliximab (Avsola®, Inflectra®, Remicade®, & Renflexis®) (continued)	Feb. 1, 2026	▪ Removed: – Enbrel (etanercept) – Cimzia (certolizumab) – Olumiant (baricitinib) – Orencia (abatacept) – Xeljanz (tofacitinib) ▪ Replaced: – "*Stelara* (ustekinumab)" with "ustekinumab" – "Xeljanz (tofacitinib)" with "Xeljanz/*Xeljanz XR* (tofacitinib)" ○ Updated list of examples of systemic targeted immunomodulators U.S. FDA approved for the treatment of ulcerative colitis with which the patient has been previously treated for initial therapy: ▪ Added: – Entyvio (vedolizumab) – Omvoh (mirikizumab-mrkz) – Skyrizi (risankizumab) – Tremfya (guselkumab) – Zeposia (ozanimod) ▪ Replaced: – "*Stelara* (ustekinumab)" with "ustekinumab" – "Xeljanz (tofacitinib)" with "Xeljanz/*Xeljanz XR* (tofacitinib)"	

Medical Benefit Drug Policy Updates

Revised			
Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Infliximab (Avsola®, Inflectra®, Remicade®, & Renflexis®) (continued)	Feb. 1, 2026	***Immune Checkpoint Inhibitor-Related Toxicities*** ○ Added criterion requiring diagnosis of an immune checkpoint inhibitor-related toxicity ○ Removed criterion for initial therapy requiring diagnosis of one of the following: ▪ Moderate (G2) or severe (G3-4) immunotherapy-related diarrhea or colitis ▪ Severe (G3-4) immunotherapy-related pneumonitis ▪ Severe (G3) or life-threatening (G4) immunotherapy-related acute renal failure/elevated serum creatinine; severe (G3-4) immunotherapy-related uveitis ▪ Life threatening (G4) immunotherapy-related myocarditis, pericarditis, arrhythmias, impaired ventricular function, or conduction abnormalities ▪ Severe immunotherapy-related inflammatory arthritis ▪ Moderate, severe, or life-threatening immunotherapy-related, steroid-refractory myalgias or myositis	

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Infliximab (Avsola®, Inflectra®, Remicade®, & Renflexis®) (continued)	Feb. 1, 2026	(muscle weakness) ○ Replaced criterion requiring "the patient has had inadequate improvement in toxicities or symptoms despite systemic corticosteroid therapy of adequate dose and duration for the diagnosis" with "the patient has had inadequate improvement in toxicities or symptoms despite systemic corticosteroid therapy of adequate dose and duration for the *specific severity and* diagnosis" **Applicable Codes** • Removed HCPCS code Q5109 **Supporting Information** • Updated *Clinical Evidence* and *References* sections to reflect the most current information • Removed *Documentation Requirements* section	
Kisunla™ (Donanemab-Azbt)	Feb. 1, 2026	**Coverage Rationale** • Changed initial authorization duration from "no more than ***6*** months" to "no more than ***12*** months" • Revised coverage criteria for **continuation of therapy**: ○ Removed criterion requiring one of the following: ▪ The patient has mild cognitive impairment (MCI) due to Alzheimer's disease	**Kisunla (donanemab-azbt) is proven for the treatment of Alzheimer's disease (AD) when all of the following criteria are met:** • For **initial therapy**, **all** of the following: ○ Diagnosis of **one** of the following based on National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria: ▪ Mild cognitive impairment (MCI) due to Alzheimer's disease; **or** ▪ Mild dementia due to Alzheimer's disease **and** ○ Presence of amyloid beta pathology has been confirmed; **and** ○ A baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment; **and** ○ Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Leqembi); **and**

Revised

Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Kisunla™ (Donanemab-Azbt) (continued)	Feb. 1, 2026	▪ The patient has mild dementia due to Alzheimer's disease ▪ The patient has progressed into moderate or severe stages of dementia due to Alzheimer's disease and the prescriber attests that the patient has shared in decision-making to continue Kisunla therapy ○ Replaced criterion requiring: ▪ "The patient has received Kisunla therapy for less than or equal to ***6*** months" with "the patient has received Kisunla therapy for less than or equal to ***18*** months" "The patient has received Kisunla therapy for greater than ***6*** months, *post-treatment amyloid PET brain imaging obtained between 12 and 18 months of total treatment is positive for amyloid based on visual read,* and *for treatment beyond 18 months of therapy,* post-treatment amyloid PET brain imaging is performed at least once per 12 months and is positive for amyloid based on visual read" with "the patient has received Kisunla therapy for greater than ***18*** months and post-treatment amyloid PET brain imaging is performed at least once per 12 months and is positive for amyloid based on visual read"	○ Kisunla dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** ○ Initial authorization will be for no more than 12 months • For **continuation of therapy**, **all** of the following: ○ Diagnosis of Alzheimer's disease; **and** ○ Follow-up brain MRI has been completed after the initiation of therapy; **and** ○ Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Leqembi); **and** ○ Kisunla dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** ○ Reauthorization is for no more than 12 months **Kisunla (donanemab-azbt) is medically necessary for the treatment of Alzheimer's disease (AD) when all of the following criteria are met:** • For **initial therapy**, **all** of the following: ○ Diagnosis of **one** of the following based on National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria: ▪ Mild cognitive impairment (MCI) due to Alzheimer's disease; **or** ▪ Mild dementia due to Alzheimer's disease **and** ○ Submission of medical records (e.g., chart notes, laboratory values) documenting **one** of the following: ▪ Mini-Mental State Examination (MMSE) score of 20 to 30 ▪ Montreal Cognitive Assessment (MoCA) score of 17 to 30 ▪ Saint Louis University Mental Status (SLUMS) score of 17 to 30 **and** ○ Submission of medical records (e.g., chart notes, laboratory values) documenting the presence of amyloid beta pathology, as evidenced by positive amyloid positron emission tomography (PET) brain imaging; **and** ○ Other differential diagnoses [e.g., dementia with Lewy bodies (DLB), frontotemporal dementia (FTD), vascular dementia, pseudodementia due to mood disorder, vitamin B12 deficiency, encephalopathy, etc.] have been ruled out; **and** ○ **One** of the following: ▪ Patient is not currently taking an anticoagulant (e.g., warfarin,

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Kisunla™ (Donanemab-Azbt) (continued)	Feb. 1, 2026		dabigatran); **or** ▪ **Both** of the following: – Patient is currently taking an anticoagulant (e.g., warfarin, dabigatran); **and** – Counseling has been provided that the combined use of Kisunla with anti-coagulant drugs may increase the risk of cerebral macrohemorrhage and prescriber attests that the patient has shared in decision-making to initiate Kisunla therapy **and** ○ Patient has no history of intracerebral hemorrhage within the previous year prior to initiating treatment; **and** ○ Counseling has been provided on the risk of amyloid-related imaging abnormalities [ARIA characterized as ARIA with edema (ARIA-E) and ARIA with hemosiderin (ARIA-H)] and patient is aware to monitor for headache, dizziness, visual disturbances, nausea, and vomiting; **and** ○ **All** of the following: ▪ Counseling has been provided on how testing for apolipoprotein E (ApoE) epsilon 4 (ε4) status informs the risk of developing ARIA when deciding to initiate treatment with Kisunla; **and** ▪ Testing for ApoE ε4 status has been offered to the patient and prescriber attests that the patient has shared in decision-making to initiate Kisunla therapy **and** ○ A baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment; **and** ○ Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Leqembi); **and** ○ Prescribed by a neurologist, geriatric psychiatrist, or geriatrician who specializes in treating dementia; **and** ○ Kisunla dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** ○ Initial authorization will be for no more than 12 months • For **continuation of therapy**, **all** of the following: ○ **One** of the following: ▪ **Both** of the following:

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Kisunla™ (Donanemab-Azbt) (continued)	Feb. 1, 2026		– Patient has received Kisunla therapy for less than or equal to 18 months; **and** – **One** of the following: • Post-treatment amyloid PET brain imaging is positive for amyloid based on visual read; **or** • Prescriber attests that amyloid PET imaging will be performed prior to 18 months of total treatment to assess for the effect of Kisunla treatment on amyloid plaque **or** ▪ **Both** of the following: – Patient has received Kisunla therapy for greater than 18 months; **and** – Post-treatment amyloid PET brain imaging is performed at least once per 12 months and is positive for amyloid based on visual read **and** ○ **Both** of the following: ▪ Submission of medical records (e.g., chart notes) confirming follow-up brain magnetic resonance imaging (MRI) has been completed after the initiation of therapy; **and** ▪ **One** of the following: – ARIA has not been observed on MRI; **or** – All of the following: • ARIA has been observed on MRI; **and** • Prescriber attests that continuation of therapy with Kisunla is appropriate based on the severity of the patient's clinical symptoms; **and** • **One** of the following: ○ Follow-up MRI demonstrates radiographic resolution and/or stabilization; **or** ○ Prescriber attests that continuation of therapy with Kisunla is appropriate based on the radiographic severity of ARIA **and** ○ Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Leqembi); **and**

Medical Benefit Drug Policy Updates

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Kisunla™ (Donanemab-Azbt) (continued)	Feb. 1, 2026		○ Prescribed by a neurologist, geriatric psychiatrist, or geriatrician who specializes in treating dementia; **and** ○ Kisunla dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** ○ Reauthorization is for no more than 12 months **Kisunla (donanemab-azbt) is unproven and not medically necessary for any indication other than Alzheimer's disease.**
Leqembi® (Lecanemab-Irmb)	Feb. 1, 2026	**Coverage Rationale** • Changed initial authorization duration from "no more than ***6*** months" to "no more than ***12*** months" • Revised coverage criteria for **continuation of therapy**; removed criterion requiring one of the following: ○ The patient has mild cognitive impairment (MCI) due to Alzheimer's disease ○ The patient has mild dementia due to Alzheimer's disease ○ The patient has progressed into moderate or severe stages of dementia due to Alzheimer's disease and the prescriber attests that the patient has shared in decision-making to continue Leqembi therapy	This policy refers to Leqembi (lecanemab-irmb) for administration by intravenous infusion by a healthcare professional. Leqembi IQLIK for self-administered subcutaneous injection is obtained under the pharmacy benefit, unless otherwise specified in the member's benefit plan documents. Exception: For members enrolled in UnitedHealthcare of California plans with a delegated provider group conducting the prior authorization review, the self-administered Leqembi IQLIK may be obtained under the medical benefit. **Leqembi is proven for the treatment of Alzheimer's disease (AD) when all of the following criteria are met:** • For **initial therapy**, **all** of the following: ○ Diagnosis of **one** of the following based on National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria: ▪ Mild cognitive impairment (MCI) due to Alzheimer's disease; **or** ▪ Mild dementia due to Alzheimer's disease **and** ○ Presence of amyloid beta pathology has been confirmed; **and** ○ A baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment; **and** ○ Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Kisunla); **and** ○ Leqembi dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** ○ Initial authorization will be for no more than 12 months • For **continuation of therapy**, **all** of the following: ○ Diagnosis of Alzheimer's disease; **and** ○ Follow-up brain MRI has been completed after the initiation of therapy; **and**

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Leqembi® (Lecanemab-Irmb) (continued)	Feb. 1, 2026		○ Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Kisunla); **and** ○ Leqembi dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** ○ Reauthorization is for no more than 12 months **Leqembi (lecanemab-irmb) is medically necessary for the treatment of Alzheimer's disease (AD) when all of the following criteria are met:** • For **initial therapy**, **all** of the following: ○ Diagnosis of **one** of the following based on National Institute on Aging and the Alzheimer's Association (NIA-AA) criteria: ▪ Mild cognitive impairment (MCI) due to Alzheimer's disease; **or** ▪ Mild dementia due to Alzheimer's disease **and** ○ Submission of medical records (e.g., chart notes, laboratory values) documenting **one** of the following: ▪ Mini-Mental State Examination (MMSE) score of 20 to 30 ▪ Montreal Cognitive Assessment (MoCA) score of 17 to 30 ▪ Saint Louis University Mental Status (SLUMS) score of 17 to 30 **and** ○ Submission of medical records (e.g., chart notes, laboratory values) documenting the presence of amyloid beta pathology, as evidenced by **one** of the following: ▪ Positive amyloid positron emission tomography (PET) brain imaging; **or** ▪ Cerebrospinal fluid (CSF) biomarker testing documents abnormalities suggestive of beta-amyloid accumulation in the brain (e.g., Aβ42/40 ratio, p-tau 181/Aβ42 ratio, t-tau/Aβ42 ratio) **and** ○ Other differential diagnoses [e.g., dementia with Lewy bodies (DLB), frontotemporal dementia (FTD), vascular dementia, pseudodementia due to mood disorder, vitamin B12 deficiency, encephalopathy, etc.] have been ruled out; **and** ○ **One** of the following: ▪ Patient is not currently taking an anticoagulant (e.g., warfarin, dabigatran); **or** ▪ **Both** of the following:

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Leqembi® (Lecanemab-Irmb) (continued)	Feb. 1, 2026		– Patient is currently taking an anticoagulant (e.g., warfarin, dabigatran); **and** – Counseling has been provided that the combined use of Leqembi with anti-coagulant drugs may increase the risk of cerebral macrohemorrhage and prescriber attests that the patient has shared in decision-making to initiate Leqembi therapy **and** ○ Patient has no history of intracerebral hemorrhage within the previous year prior to initiating treatment; **and** ○ Counseling has been provided on the risk of amyloid-related imaging abnormalities [ARIA characterized as ARIA with edema (ARIA-E) and ARIA with hemosiderin (ARIA-H)] and patient is aware to monitor for headache, dizziness, visual disturbances, nausea, and vomiting; **and** ○ **All** of the following: ▪ Counseling has been provided on how testing for apolipoprotein E (ApoE) epsilon 4 (ε4) status informs the risk of developing ARIA when deciding to initiate treatment with Leqembi; **and** ▪ Testing for ApoE ε4 status has been offered to the patient and prescriber attests that the patient has shared in decision-making to initiate Leqembi therapy **and** ○ A baseline brain magnetic resonance imaging (MRI) has been completed within 12 months prior to initiating treatment; **and** ○ Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Kisunla); **and** ○ Prescribed by a neurologist, geriatric psychiatrist, or geriatrician who specializes in treating dementia; **and** ○ Leqembi dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** ○ Initial authorization will be for no more than 12 months • For **continuation of therapy**, **all** of the following: ○ **Both** of the following: ▪ Submission of medical records (e.g., chart notes) confirming follow-up brain magnetic resonance imaging (MRI) has been completed after the initiation of therapy; **and**

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Policy Title	**Effective Date**	**Summary of Changes**	**Coverage Rationale**
Leqembi® (Lecanemab-Irmb) (continued)	Feb. 1, 2026		▪ **One** of the following: – ARIA has not been observed on MRI; **or** – All of the following: • ARIA has been observed on MRI; **and** • Prescriber attests that continuation of therapy with Leqembi is appropriate based on the severity of the patient's clinical symptoms; **and** • **One** of the following: ○ Follow-up MRI demonstrates radiographic resolution and/or stabilization; **or** ○ Prescriber attests that continuation of therapy with Leqembi is appropriate based on the radiographic severity of ARIA **and** ○ Not used in combination with other Aβ monoclonal antibodies (mAbs) for Alzheimer's Disease (e.g., Kisunla); **and** ○ Prescribed by a neurologist, geriatric psychiatrist, or geriatrician who specializes in treating dementia; **and** ○ Leqembi dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** ○ Reauthorization is for no more than 12 months **Leqembi (lecanemab-irmb) is unproven and not medically necessary for any indication other than Alzheimer's disease.**
Respiratory Interleukins (Cinqair®, Fasenra®, & Nucala®)	Feb. 1, 2026	**Coverage Rationale** ***Chronic Obstructive Pulmonary Disorder (COPD)*** • Revised medical necessity criteria: ○ Replaced criterion requiring "diagnosis of chronic obstructive pulmonary disorder (COPD) defined by post-bronchodilator FEV1 % predicted greater than or equal to ***30%*** and less than or equal to ***70%***" with "diagnosis	This policy refers to the following drug products for administration by a healthcare professional: • Cinqair® (reslizumab) for intravenous (IV) route • Fasenra® (benralizumab) for subcutaneous (SC) route • Nucala® (mepolizumab) for subcutaneous (SC) route Refer to the policy for complete details.

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Respiratory Interleukins (Cinqair®, Fasenra®, & Nucala®) (continued)	Feb. 1, 2026	of chronic obstructive pulmonary disorder (COPD) defined by post-bronchodilator FEV1 % predicted greater than or equal to ***20%*** and less than or equal to ***80%***" ○ Removed criterion requiring symptoms of chronic productive cough for at least 3 months in the past year	
Tezspire® (Tezepelumab-Ekko)	Feb. 1, 2026	**Coverage Rationale** ***Severe Asthma*** • Replaced language indicating "the [listed] criteria *[must be met] for continuation of therapy*" with "*authorization for continued use will be approved for patients currently on Tezspire for the treatment of severe asthma based on* the [listed] criteria" ***Chronic Rhinosinusitis With Nasal Polyps (CRSwNP)*** • Added language to indicate: ○ Tezspire, for provider administration, is proven for patients who meet the following criteria for initial therapy: ▪ Diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) ▪ Will be used as add-on maintenance therapy ▪ Patient has had an inadequate response to	This policy refers to Tezspire (tezepelumab-ekko) vial and pre-filled syringe for administration by a healthcare professional. Tezspire (tezepelumab-ekko) prefilled pen for self-administration is obtained under the pharmacy benefit, unless otherwise specified in the member's benefit plan documents. Exception: For members enrolled in UnitedHealthcare of California plans with a delegated provider group conducting the prior authorization review, the self-administered Tezspire (tezepelumab-ekko) may be obtained under the medical benefit. **Severe Asthma** **Tezspire for provider administration is proven for add-on maintenance treatment for patients that meet the following criteria:** • For **initial therapy**, **all** of the following: ○ Diagnosis of severe asthma; **and** ○ Will be used as add-on maintenance therapy; **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 • For **continuation of therapy**, **all** of the following: ○ Documentation of positive clinical response; **and** ○ Used in combination with an inhaled corticosteroid (ICS)-containing maintenance medication; **and** ○ Patient is not receiving Tezspire in combination with any of the following for treatment of the same indication: ▪ Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)]

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Tezspire® (Tezepelumab-Ekko) (continued)	Feb. 1, 2026	previous therapies ▪ Patient is not receiving Tezspire in combination with any of the following for treatment of the same indication: – Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)] – Anti-IgE therapy [e.g., Xolair (omalizumab)] – Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] ▪ Initial authorization will be for no more than 12 months ○ Tezspire, for provider administration, is medically necessary when all of the following criteria are met for initial therapy: ▪ Diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) defined by all of the following: – Two or more of the following symptoms for longer than 12 weeks duration: nasal mucopurulent discharge, nasal obstruction/blockage/	▪ Anti-IgE therapy [e.g., Xolair (omalizumab)] ▪ Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] **and** ○ Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** ○ Reauthorization will be for no more than 12 months **Tezspire for provider administration is medically necessary when all of the following criteria is met:** • For **initial therapy**, **all** of the following: ○ Diagnosis of severe asthma; **and** ○ Classification of asthma as uncontrolled or inadequately controlled as defined by at least **one** of the following: ▪ Poor symptom control (e.g., ACQ score consistently greater than 1.5 or ACT score consistently less than 20); **or** ▪ Two or more bursts of systemic corticosteroids for at least 3 days each in the previous 12 months; **or** ▪ Asthma-related emergency treatment (e.g., emergency room visit, hospital admission, or unscheduled physician's office visit for nebulizer or other urgent treatment); **or** ▪ Airflow limitation (e.g., after appropriate bronchodilator withhold FEV1 less than 80% predicted (in the face of reduced FEV1/FVC defined as less than the lower limit of normal); **or** ▪ Patient is currently dependent on maintenance therapy with oral corticosteroids for the treatment of asthma **and** ○ Used in combination with **one** of the following: ▪ **One** maximally-dosed (appropriately adjusted for age) combination inhaled corticosteroid (ICS)/long-acting beta$_2$ agonist (LABA) product [e.g., Advair/AirDuo Respiclick (fluticasone propionate/salmeterol), Symbicort (budesonide/formoterol), Breo Ellipta (fluticasone furoate/vilanterol)]; **or** ▪ Combination therapy including **both** of the following: – One maximally-dosed (appropriately adjusted for age) ICS product [e.g., ciclesonide (Alvesco®), mometasone furoate (Asmanex®), beclomethasone dipropionate (QVAR®)]; **and**

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Tezspire® (Tezepelumab-Ekko) (continued)	Feb. 1, 2026	congestion, facial pain/pressure/ fullness, and/or reduction or loss of sense of smell – One of the following findings using nasal endoscopy and/or sinus computed tomography (CT): purulent mucus or edema in the middle meatus or ethmoid regions, polyps in the nasal cavity or the middle meatus, or radiographic imaging demonstrating mucosal thickening or partial or complete opacification of paranasal sinuses – Presence of bilateral nasal polyposis or the patient has previously required surgical removal of bilateral nasal polyps – Patient has required prior sinus surgery, has required systemic corticosteroids (e.g., prednisone, methylprednisolone) for CRSwNP in the previous 2 years, or	– One additional asthma controller medication [e.g., LABA - olodaterol (Striverdi®) or indacaterol (Arcapta®), leukotriene receptor antagonist – montelukast (Singulair®), theophylline] **and** ○ Patient is not receiving Tezspire in combination with **any** of the following for treatment of the same indication: ▪ Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)] ▪ Anti-IgE therapy [e.g., Xolair (omalizumab)] ▪ Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] **and** ○ Tezspire dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** ○ Tezspire is prescribed by a pulmonologist or allergist/immunologist; **and** ○ Initial authorization will be for no more than 12 months ***Reauthorization/Continuation of Care Criteria*** **For patients currently on Tezspire for the treatment of severe asthma, authorization for continued use will be approved based on all of the following criteria:** • Documentation of a positive clinical response as demonstrated by at least **one** of the following: ○ Reduction in the frequency of exacerbations ○ Decreased utilization of rescue medications ○ Increase in percent predicted FEV1 from pretreatment baseline ○ Reduction in severity or frequency of asthma-related symptoms (e.g., wheezing, shortness of breath, coughing, etc.) **and** • Used in combination with an ICS-containing maintenance medication; **and** • Patient is not receiving Tezspire in combination with **any** of the following for treatment of the same indication: ○ Anti-interleukin 5 therapy [e.g., Cinqair (reslizumab), Fasenra (benralizumab), Nucala (mepolizumab)] ○ Anti-IgE therapy [e.g., Xolair (omalizumab)] ○ Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)]

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Tezspire® (Tezepelumab-Ekko) (continued)	Feb. 1, 2026	has been unable to obtain symptom relief after trial of two of the following classes of agents: • Nasal saline irrigations • Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone) • Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton) ▪ Patient will receive Tezspire as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone) ▪ Patient is not receiving Tezspire in combination with any of the following for treatment of the same indication: – Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)]	**and** • Tezspire dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** • Reauthorization will be for no more than 12 months **Chronic Rhinosinusitis With Nasal Polyps (CRSwNP)** **Tezspire, for provider administration, is proven for patients who meet the following criteria:** • For initial therapy, all of the following: ○ Diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP); **and** ○ Will be used as add-on maintenance therapy; **and** ○ Patient has had an inadequate response to previous therapies; **and** ○ Patient is not receiving Tezspire in combination with **any** of the following for treatment of the same indication: – Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)] – Anti-IgE therapy [e.g., Xolair (omalizumab)] – Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] ○ Initial authorization will be for no more than 12 months **Tezspire, for provider administration, is medically necessary when all of the following criteria are met:** • For initial therapy, all of the following: ○ Diagnosis of chronic rhinosinusitis with nasal polyps (CRSwNP) defined by **all** of the following: ▪ **Two or more** of the following symptoms for longer than 12 weeks duration: – Nasal mucopurulent discharge – Nasal obstruction, blockage, or congestion – Facial pain, pressure, and/or fullness – Reduction or loss of sense of smell **and** ▪ **One** of the following findings using nasal endoscopy and/or sinus computed tomography (CT): – Purulent mucus or edema in the middle meatus or ethmoid regions; **or** – Polyps in the nasal cavity or the middle meatus; **or**

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Tezspire® (Tezepelumab-Ekko) (continued)	Feb. 1, 2026	– Anti-IgE therapy [e.g., Xolair (omalizumab)] – Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] ▪ Dosing is in accordance with the U.S. FDA approved labeling ▪ Prescribed by an allergist/immunologist/ otolaryngologist/ pulmonologist ▪ Initial authorization will be for no more than 12 months ○ For patients currently on Tezspire for the treatment of CRSwNP, authorization for continued use will be approved based on all of the following criteria: ▪ Documentation of positive clinical response to Tezspire therapy ▪ Patient will continue to receive Tezspire as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone) ▪ Patient is not receiving Tezspire in combination with any of the following for treatment of the same indication:	– Radiographic imaging demonstrating mucosal thickening or partial or complete opacification of paranasal sinuses **and** ▪ **One** of the following: – Presence of bilateral nasal polyposis; **or** – Patient has previously required surgical removal of bilateral nasal polyps **and** ▪ **One** of the following: – Patient has required prior sinus surgery; **or** – Patient has required systemic corticosteroids (e.g., prednisone, methylprednisolone) for CRSwNP in the previous 2 years; **or** – Patient has been unable to obtain symptom relief after trial of two of the following classes of agents: • Nasal saline irrigations • Intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone) • Antileukotriene agents (e.g., montelukast, zafirlukast, zileuton) **and** ○ Patient will receive Tezspire as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone); **and** ○ Patient is not receiving Tezspire in combination with **any** of the following for treatment of the same indication: ▪ Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)] ▪ Anti-IgE therapy [e.g., Xolair (omalizumab)] ▪ Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] **and** ○ Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** ○ Prescribed by an allergist/immunologist/otolaryngologist/ pulmonologist; **and** ○ Initial authorization will be for no more than 12 months

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Policy Title	Effective Date	Summary of Changes	Coverage Rationale
Tezspire® (Tezepelumab-Ekko) (continued)	Feb. 1, 2026	– Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)] – Anti-IgE therapy [e.g., Xolair (omalizumab)] – Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] ▪ Dosing is in accordance with the U.S. FDA approved labeling ▪ Reauthorization will be for no more than 12 months **Applicable Codes** • Added ICD-10 diagnosis codes J31.0, J32.0, J32.1, J32.2, J32.3, J32.4, J32.8, J32.9, J33.0, J33.1, J33.8, and J33.9 **Supporting Information** • Updated *Background*, *Clinical Evidence*, *FDA*, and *References* sections to reflect the most current information	***Reauthorization/Continuation of Care Criteria*** **For patients currently on Tezspire for the treatment of CRSwNP authorization for continued use will be approved based on all of the following criteria:** • Documentation of positive clinical response to Tezspire therapy; **and** • Patient will continue to receive Tezspire as add-on maintenance therapy in combination with intranasal corticosteroids (e.g., fluticasone, mometasone, triamcinolone); **and** • Patient is not receiving Tezspire in combination with **any** of the following for treatment of the same indication: ○ Anti-interleukin 5 therapy [e.g., Cinqair (resilizumab), Fasenra (benralizumab), Nucala (mepolizumab)] ○ Anti-IgE therapy [e.g., Xolair (omalizumab)] ○ Anti-interleukin 4 therapy [e.g., Dupixent (dupilumab)] **and** • Dosing is in accordance with the United States Food and Drug Administration approved labeling; **and** • Reauthorization will be for no more than 12 months

General Information

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

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

UnitedHealthcare respects the expertise of the physicians, health care professionals, and their staff who participate in our network. Our goal is to support you and your patients in making the most informed decisions regarding the choice of quality and cost-effective care, and to support practice staff with a simple and predictable administrative experience. The Medical Policy Update Bulletin was developed to share important information regarding changes to our 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.

UMR is a wholly owned subsidiary of UnitedHealthcare, a part of UnitedHealth Group. UMR is a third-party administrator (TPA) for self-funded plans.

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 UMR Medical Policies and Medical Benefit Drug Policies is available at **UHCprovider.com/policies** > For Commercial Plans > UnitedHealthcare | UMR Medical & Drug Policies.